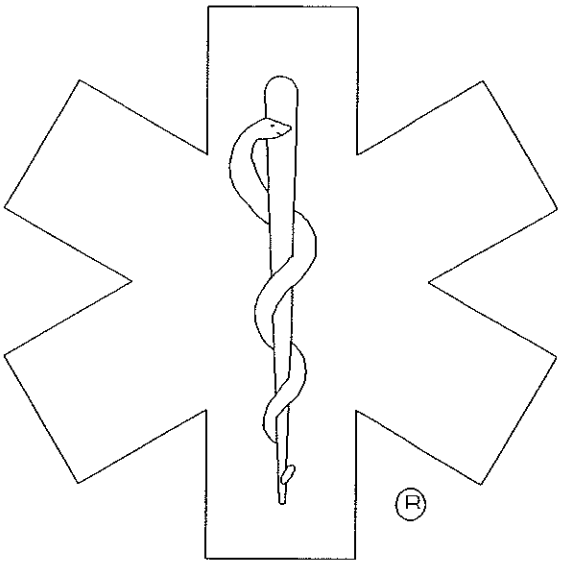
New Jersey

Emergency Medical Services Interim Committee



Final Report

to

Frances J. Dunston, MD, MPH
State Commissioner of Health

in reply to
Executive Order 150

July 1990

H. Mickey McCabe, Chairperson
Jeanne Kerwin, Vice Chairperson

EMERGENCY MEDICAL SERVICES INTERIM COMMITTEE

REPORT TO THE COMMISSIONER OF HEALTH

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H. MICKEY McCABE
PRESIDENT

201 858-1200

June 27, 1990

Frances J. Dunston, MD, MPH
State Commissioner of Health
New Jersey State Department of Health
CN 360
Trenton, NJ 08625

Dear Dr. Dunston,

It is with great pleasure that I present to you, on behalf of the Emergency Medical Services Interim Committee, the enclosed report. We respectfully submit this document pursuant to Executive Order No. 150, issued by your predecessor, Molly Joel Coye, MD, MPH.

Our Final Report, which deals with the future of EMS in New Jersey, is the culmination of many meetings held since January. It reflects the views of recognized experts in emergency medical services, as I am sure you can see by the attached list of committee members. In the space of six months, individuals with varied beliefs, concerns, and constituencies reached unanimous accord on a variety of issues. I believe this multi-disciplinary effort is indicative of the positive attitude that currently exists and which can make New Jersey's EMS system second to none.

The Committee used the Final Report (Emergency Medical Services Issues and Recommendations, Phase II, November 1988) of the Governor's Council on Emergency Medical Services as a major resource.

Inasmuch as many members of our Interim Committee also served on the Governor's Council, it was unnecessary to review the background of its recommendations in depth. We were, therefore, able to focus our efforts on preparing a document which we belive includes a highly workable formula for assuring that optimal emergency care is provided in our state.

We ask that you pay particular attention to the recommendation to establish a permanent New Jersey Emergency Medical Services Council to serve as a statewide advisory body. This Council is, without a doubt, the most vital component of our report.

Once the Council and its various elements have been established, we feel quite strongly that New Jersey will be recognized as a leader in the emrgency Medical Services field.

In closing, I want to say that it has been my pleasure to have served as chairman of such a distinguised and caring group of individuals who were working on such an important project. They each put aside many personal feelings and worked as a unit with only one concern in mind - the best possible system of emergency medical services patient care for the citizens of New Jersey.

Sincerely,

H. Mickey McCabe
Chairman
Emergency Medical Services
Interim Committee

Enc.

BACKGROUND AND SUMMARY

The Governor's Council on Emergency Medical Services was established by former Governor Thomas H. Kean, pursuant to Executive Order 146, on September 5, 1986. The Council was charged with recommending an overall policy direction that would enable New Jersey to provide a comprehensive network of emergency medical services. The Council's 33 members, representing a broad spectrum of viewpoints and expertise, presented its final (Phase II) report in November 1988. That report contained 35 recommendations which offered directions for developing and implementing an EMS system that would be among the best in the nation.

Another valuable contribution of the Governor's Council on Emergency Medical Services was bringing together, for the first time, representatives from all levels of EMS service to discuss EMS as a systems approach to care of the ill and injured. This created a network of people who were involved in EMS and who were knowledgable about its various aspects. These persons also served as a valuable resource.

In the year following publication of the EMS Council's recommendations, several positive steps were taken. However, with the expiration of the Council's charge at the end of 1988, there was no comprehensive focal point for addressing EMS issues in the state.

The Emergency Medical Services Interim Committee was formed by Executive Order No. 150, dated December 14, 1989, by former State Commissioner of Health Molly Joel Coye, MD, MPH. The Interim Committee was charged with the task of reporting to the incoming Commissioner the status of issues and recommendations regarding future development and implementation of New Jersey's emergency medical services system, utilizing the recommendations in the Phase II report ("Emergency Medical Services Issues and Recommendations") of the Governor's Council on Emergency Medical Services.

Specifically, the Committee was charged with the following responsibilities:

1. Assure that the recommendations in the report of the Governor's Council on Emergency Medical Services, released in 1988, form the basis of the Committee's actions.

2. Provide appropriate input on current EMS activities and issues to the incoming state administration.

3. Provide guidance to the Office of Emergency Medical Services on emerging issues related to EMS, including review of proposed guidelines and standards of practice.

4. Draft a proposal with recommendations and options for the establishment of a permanent Emergency Medical Services Advisory Group.

(See Appendix A for the full text of Executive Order No. 150.)

The full Committee met seven times during a six-month period to discuss various issues related to its official charges, including review of all 35 Governor's EMS Council recommendations. Additionally, some Committee work sessions were held and a Subcommittee on Pediatric EMS was formed (which held several meetings).

Emergency medical services is a dynamic field. Even while the Committee was deliberating, new issues arose which needed to be addressed. Therefore, the major recommendation of the Committee is endorsement of the Governor's EMS Council Recommendation #35, the establishment of a permanent Emergency Medical Services Council in New Jersey. The need for such an advisory body is borne out by the interest which the previous Governor's EMS Council's Phase I and Phase II reports generated. There is also a need for a continuing organization to follow EMS issues and to address the superstructure of EMS in New Jersey. The structure of such a Council was also identified, with a broad membership base to include all areas of expertise to better advise the Governor on EMS development in New Jersey (Figure 1).

The development of a permanent statewide EMS Council will facilitate local grassroots input into the state's EMS system through regional EMS councils, county EMS organizations, and local activities. This structure can include all components of the system and various aspects of other EMS-related services (Figure 2). The Council structure can also identify and deal with new EMS-related issues as they emerge.

To facilitate the operation of the proposed Council, this Committee also identified eight key interest areas. It recommends that these be developed into standing resource subcommittees to more specifically address issues. While realizing that many issues overlap, the Committee assigned primary responsibility for reviewing each recommendation of the Governor's EMS Council to one of the proposed subcommittees, with certain exceptions which are noted. This oversight responsibility is shown in Figure 3.

In addition to reviewing and categorizing the Governor's Emergency Medical Services Council Phase II recommendations, the Committee was also charged with recognizing additional EMS issues which may need discussion and direction through the structure of the new EMS Council. These issues -- stable funding for EMS, hospital diversion, and heavy rescue and extrication training -- are discussed at the end of the recommendations.

RECOMMENDATIONS

The major recommendation of the Emergency Medical Services Interim Committee is endorsement of the Governor's EMS Council's Recommendation #35.

RECOMMENDATION #35:

Establish a Statewide Advisory Council on EMS.

Such a Council is needed to provide continuity to the development of New Jersey's emergency medical services system, to follow emerging issues of concern, and to serve as a reservoir of knowledge and expertise in EMS. Surveys have shown that many states have EMS Councils. Most are mandated by state statute and most are advisory in nature.

The Committee agreed that the permanent New Jersey Emergency Medical Services Council should have the following mission:

- o Make recommendations to, and advise, the Office of the Governor and the Commissioner of Health regarding emergency medical services in New Jersey.
- o Monitor legislative developments (New Jersey, federal, and other states) and their impact on New Jersey EMS.
- o Review, update and recommend implementation of the Governor's Council on Emergency Medical Services 1988 Final Report.
- o Receive reports and recommendations of standing committees and ad hoc committees of the Council.
- o Support EMS educational activities in New Jersey.
- o Develop and support a statewide public information/education program for consumers regarding emergency medical services in New Jersey.

The proposed membership of the New Jersey Emergency Medical Services Council is shown in Figure 1. The proposal calls for 21 members with a broad range of interests and experience, reporting to the Governor.

To facilitate the operation of the proposed Council, the EMS Interim Committee has also identified eight key interest areas and recommends that these be developed into standing resource subcommittees to more specifically address issues. The subcommittees recommended for formation are: Operations, Professional Education and Certification, Legislative, System Finance, Public Education, Medical, Trauma, and Pediatric EMS. As needed, ad hoc groups could be formed to study short term issues, ideally reporting through one of the established subcommittees.

Further, it is recommended that the statewide EMS Council be supported at the grassroots level by three Regional EMS Councils (Northern, Central,

FIGURE 1

MEMBERSHIP: NEW JERSEY EMERGENCY MEDICAL SERVICES COUNCIL

Commissioner, New Jersey State Department of Health
Superintendent, New Jersey State Police
President, New Jersey State First Aid Council
Director, Division of Highway Traffic Safety, New Jersey Department of Law & Public Safety
President, New Jersey Hospital Association
Director, Office of Emergency Medical Services, New Jersey State Department of Health
President, Medical Transportation Association of New Jersey
Director, Division of Education in Trauma and Emergency Medical Services, University of Medicine and Dentistry of New Jersey,
President, MICU Program Administrators' Association
Chairperson, MICU Advisory Council
President, American College of Emergency Physicians, New Jersey Chapter
President, Emergency Nurses Association, New Jersey Chapter
Chairperson, Trauma Center Council *
Member of the Public (Consumer) #
Emergency Medical Technician (EMT) #
Mobile Intensive Care Paramedic (MICP) #
President, Senate - appointee
Speaker of the House - appointee
Northern Region Representative +
Central Region Representative +
Southern Region Representative +

Notes:

* The Committee agreed unanimously to support the proposal recommending the formation of a permanent state Trauma Center Council and to have the Chairperson of that Council be a member of the State EMS Council (see Appendix E).

To be appointed by the Governor

+ As regional councils develop, they will designate representatives to the State EMS Council.

The Office of the Attorney General will act as a resource to the State EMS Council.

The Office of Emergency Medical Services will act as a resource to the State EMS Council and will provide staff support.

Southern) and by EMS Councils in the individual counties (see Figure 2 for an organizational chart of the total proposal).

To follow the proposed system from the bottom up:

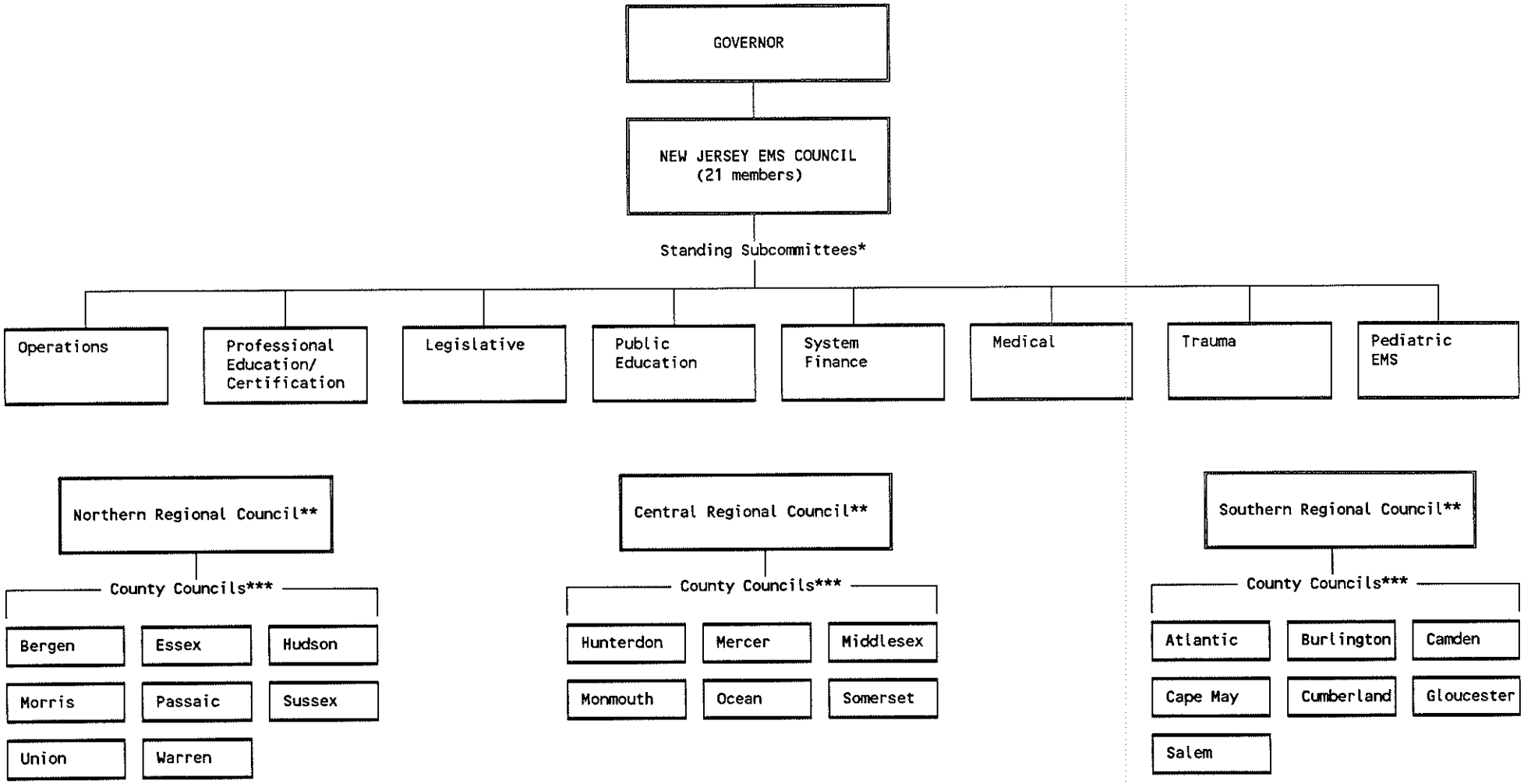
(1) A County EMS Council (21 County EMS Councils to be formed) will be composed of one representative from each EMS provider in the respective county.

(2) Each of the three Regional EMS Councils (Northern, Central, Southern) will be composed of one representative from each County EMS Council in its respective region, plus area EMS experts.

(3) The statewide New Jersey Emergency Medical Services Council's membership will include an elected representative from each Regional EMS Council, as well as specified ex officio and appointed positions (total of 21 members).

(4) Each of the New Jersey Emergency Medical Services Council's eight standing subcommittees will have two representatives from each Regional EMS Council and two members chosen from the membership of the statewide EMS Council.

Figure 2



* Standing Subcommittees: Two representatives from each Region and two members from State Council.
** Regional Councils: One representative from each county, plus area EMS experts.
*** County Councils: Representatives from all EMS providers in county. One representative to go to Regional Council.

Assignment of Remaining 34 Recommendations

Among its main responsibilities, the EMS Interim Committee was charged with assuring that the recommendations in the report of the Governor's Council on Emergency Medical Services, released in 1988, formed the basis of the Committee's actions. The Committee did review all 35 existing recommendations of the Governor's Council on Emergency Medical Services. It recommends that the 34 remaining recommendations be apportioned to the new EMS Council's subcommittees according to Figure 3. The recommendation numbers are given on the table. Exact wording of each recommendation is given below (in bold), along with the subcommittee it is being assigned to, and the current status of the issue.

RECOMMENDATION 1:

Establish response times for each of the following levels of EMS providers:

A. First Responder
B. BLS Squads
C. MICU/ALS Units

All citizens should have access to all aspects of emergency medical services within an acceptable time frame. Such time frames should be established and administered by the local governing body in accordance with nationally recognized standards for EMS.

Subcommittee Assignment: Operations

Status: ALS/MICU services must track response times and keep track of problem areas. Nothing being done at the BLS level. The only published recommendations are those from the American Heart Association promoting 4-6 minutes to start BLS and 8-12 minutes to provide ALS to the victim of cardiac arrest. Suggested response times in New Jersey may vary by setting (e.g., urban, suburban).

RECOMMENDATION #2:

Require all ambulances to meet appropriate uniform vehicle and equipment standards.

Subcommittee Assignment: Operations

Status: All paid, municipal, and hospital-based BLS ambulances and invalid coaches and all MICUs fall under state regulations and must presently meet standards. In the volunteer sector, the New Jersey State First Aid Council has a Standards Committee which sets similar standards for volunteer squads which are members of the Council. There is presently no mechanism to check on the standards of vehicles or crews for the non-affiliated volunteer basic life support squads.

RECOMMENDATION #3:

Establish appropriate dispatch criteria, protocols and quality assurance review.

FIGURE 3

DELEGATION OF RESPONSIBILITY FOR ADDRESSING ISSUES RAISED IN RECOMMENDATIONS OF GOVERNOR'S EMS COUNCIL

Responsible Subcommittee							
Operations	Professional Education/ Certification	Legislative	System Finance	Public Education	Medical	Trauma	Pediatric EMS
1	11	10	33	8	4/23*	4/23*	4/23*
2	12	13	34	20	18#	see	9
3/15	14	31		21	25	appendix,	16
4/23*	17			27		interface	
5	19			28		with	
6	22+			29		Trauma	
7				30		Council	
24/26				32			

Key

+ If this group is established, Recommendation 22 is accomplished.

* Work on Recommendations 4 and 23 should be a cooperative effort of the Operations, Medical, Trauma and Pediatric EMS Subcommittees.

Recommendation 18 should be led by the Medical Subcommittee with the cooperation of the Training Subcommittee.

Subcommittee Assignment: Operations (combine discussion with #15)

Status: The 911 Commission will be working on calltaker standards and APCO training will be used. The MICUs currently have dispatch criteria that is used by the area police departments (or other local dispatch centers) for MICU dispatch. Helicopter dispatch criteria are needed, as well as a quality assurance mechanism for all EMS dispatch (other than that existing for MICU).

RECOMMENDATION #4:

Establish appropriate basic life support, advanced life support and treatment and triage protocols for all patients, to include the following specialty classifications of patients: trauma, spinal cord injury, burns, neonatal and pediatrics.

Subcommittee Assignment: Cooperative Effort - Operations, Medical, Trauma, Pediatric EMS (combine discussion with #23)

Status: Treatment protocols are being used by the MICUs. BLS treatment protocols are in the final stages of development. Triage protocols need to be developed at all levels of care and for special areas (e.g., trauma, spinal cord injury, burns, pediatric EMS). Some local triage protocols may exist.

RECOMMENDATION #5:

Establish local, multi-county and statewide emergency medical service coordinating areas for all aspects of emergency medical care.

Subcommittee Assignment: Operations

Status: The Office of Emergency Medical Services has been working through three areas (North, Central, South) to provide staff to assist with EMS-related activities. No area offices exist. The EMT educational effort is also coordinated through these same three areas by the contract agent. There is presently no mechanism to receive broad input from the grassroots. The designation of the three areas is not structured.

RECOMMENDATION #6:

Develop and implement planning criteria for ALS, trauma services and all other critical care services.

Subcommittee Assignment: Operations

Status: The certificate-of-need mechanism for trauma services is in place (NJAC 8:33P). An additional Level I and 5 Level II trauma centers should be named by Fall 1990. ALS/MICU coverage is now designated statewide. The aeromedical program (NorthStar and SouthStar) has been implemented, but is not operational around-the-clock. Critical care planning is needed for pediatric EMS and for neonatal.

RECOMMENDATION #7:

Develop efficient critical care inter-hospital transfer services, including maternal and neonatal transport.

Subcommittee Assignment: Operations

Status: Changes to the certificate-of-need regulations for MICUs and critical care transport units put this activity on hold (CCTU was removed from the pending regulations). There is some interhospital transport being done, but the system is not cohesive and there are no standards.

RECOMMENDATION #8:

Promote the implementation of the enhanced 9-1-1 system.

Subcommittee Assignment: Public Education

Status: The 911 Commission is working on the implementation of the statewide 9-1-1 system. A statewide plan will be developed and regulations will be promulgated. Implementation targeted for the end of 1991; some counties may go on-line sooner. The task of the EMS system will be to continue to support this effort and to aid in implementation, when applicable.

RECOMMENDATION #9:

Develop a comprehensive pediatric emergency medical service system to include pediatric trauma centers, pediatric rehabilitative facilities, required pediatric equipment for ambulance and MICUs, and specialized pediatric emergency care training for all levels of EMS providers.

Subcommittee Assignment: Pediatric EMS

Status: This proposal contains a Pediatric EMS subcommittee to address issues of pediatric care, including the above. The Office of Emergency Medical Services has applied for a two-year Emergency Medical Services for Children grant from the federal Bureau of Maternal and Child Health. Pediatric ALS (PALS) is being taught at various centers around the state.

RECOMMENDATION #10:

Designate responsibility to local governments for assuring adequate EMS services in their communities.

Subcommittee Assignment: Legislative

Status: This recommendation requires legislation. Laws mandate that municipalities provide police and fire protection; there is no similar law mandating emergency medical services coverage be available.

RECOMMENDATION #11:

Establish minimum training standards/certification for the following categories of service: EMS Dispatcher, First Responder, Basic Life Support, EMT Defibrillation, Intermediate Life Support, Advanced Life Support and MICU Base Station Physician.

A. Require EMS dispatchers to have Uniform EMS dispatcher training.

B. Require First Responders to maintain current training certification.

C. Require all drivers of emergency medical service vehicles to successfully complete emergency vehicle driver training.

D. The minimum Basic Life Support training will be Emergency Medical Technician-A provided that:

i. New Jersey State First Aid Council continues to act as one of the providers of this training; and

ii. New Jersey State First Aid Council personnel will be certified as testers within this program by the Office of Emergency Medical Services; and

iii. There can be a variety of mechanisms for delivering this curriculum including modular training; and

iv. There will be a program of certifying current "five/eight pointers" as Emergency Medical Technician-As with appropriate and acceptable standards for recertification.

v. A single practical and written testing program is in place for new Emergency Medical Technician-As with testing by a neutral, third party (i.e., not the course instructor.)

E. When EMT-Defibrillation legislation is enacted in New Jersey the training requirements should follow nationally accepted training standards.

F. The EMT-Intermediate program currently exists as an approved demonstration project in five counties. The Council reserves its recommendations pending final evaluation of the project.

G. EMT-Paramedic training requirements should continue to meet Department of Transportation standards.

H. Require MICU Base Station Physicians to complete MICU Base Station training.

Subcommittee Assignment: Professional Education/Certification

Status: Emergency Medical Technician (EMT) is the basic level of care for regulated (paid, municipal, hospital-based) basic life support services and for member squads of the New Jersey State First Aid Council, but non-affiliated volunteer BLS services are not covered. ALS/MICU has standards

for training and certification. EMT-Defibrillator (EMT-D) is now authorized by law and a training program is being developed. The EMT-Intermediate (EMT-I) pilot program is being phased out (being covered by rural MICUs). Emergency Medical Dispatcher (EMD) training is not yet mandated (expect training standards to be set by the 911 Commission), although some training programs have been held. There are minimum training standards for Crash Injury Management/First Responder (CIM/FR), but there are no recertification standards (working with Police Training Commission). No standards for Emergency Vehicle Operators. There are standards for MICU base station physicians, but compliance is not mandatory.

RECOMMENDATION #12:

Implement the EMT-A standard, statewide as the minimum level of training for all providers of BLS on any ambulance by 1990.

Subcommittee Assignment: Professional Education/Certification

Status: Working to recertify the "grandfathered" EMT members of the New Jersey State First Aid Council from 1987 (by the end of 1990). No training requirements for members of non-affiliated volunteer first aid squads. At least two crew members on regulated basic life support services must be EMTs.

RECOMMENDATION #13:

Develop and implement an EMT certification for non-affiliated squad members.

Subcommittee Assignment: Legislative

Status: A companion process to "grandfathering" qualified, trained members of the New Jersey State First Aid Council as EMTs was offered to members of non-affiliated squads. Few persons participated in the testing process. Without enabling legislation, nothing can be done, since volunteer services are exempt by law (NJSA 27:5F-18 et seq.) from regulation.

RECOMMENDATION #14:

Support legislation to establish the EMT-D level of pre-hospital care and develop and implement a statewide EMT-D training program.

Subcommittee Assignment: Professional Education/Certification

Status: Enabling legislation has passed; implementation in process. There was no appropriation with the law and this is hampering speed of implementation.

RECOMMENDATION #15:

Uniform EMS dispatch criteria should be promulgated by Department of Health, Office of Emergency Medical Services to all agencies in New Jersey responsible for the dispatch of EMS units.

Subcommittee Assignment: Operations (combine discussion with #3)

Status: Dispatch criteria will come through the 911 Commission. OEMS will not be involved, except in its role on the Commission.

RECOMMENDATION #16:

Organized pediatric emergency care training curriculum should be incorporated into the ALS and BLS training programs.

Subcommittee Assignment: Pediatric EMS

Status: Training will be conducted by the Pediatric ALS Centers and by the paramedic training coordinators. Training opportunities have also been included in the pending Emergency Medical Services for Children grant.

RECOMMENDATION #17:

A. Develop a comprehensive MICU training program that consists of three concurrent, integrated components (i.e. didactic and clinical instruction and practical application).

B. Establish an EMS Management Training Program for EMS supervisors and administrators.

Subcommittee Assignment: Professional Education/Certification

Status: The four paramedic didactic training sites have developed integrated curricula for paramedic training. EMS management training programs have been incorporated into the annual EMS Symposium and the New Jersey State First Aid Council convention. The American Ambulance Association and several other groups have EMS management programs which can be taken at conventions.

RECOMMENDATION #18:

A. Develop MICU Base Station training for all physicians who operate a MICU console.

B. Establish that emergency room directors be held responsible for physicians receiving this training.

C. Require the Department of Health supply the mechanism by which that training is made available, working in cooperation with emergency rooms and MICU coordinators.

Subcommittee Assignment: Medical (with cooperation of Training)

Status: Training is currently available, but is not mandatory. The Committee recommends that Base Station Physician training be made mandatory for MICU base station physicians in New Jersey.

RECOMMENDATION #19:

All emergency department nurses should complete an orientation program which follows the Emergency Nurses Association's core curriculum (including practical application of MAST, KED, and other appropriate pre-hospital care equipment). In addition, all emergency department nurses should be

certified in Basic Life Support upon employment and certified in advanced Cardiac Life Support within one year. It is further recommended that trauma nurse training, following the TNCC program curriculum, be provided within one year for emergency nurses.

Subcommittee Assignment: Professional Education/Certification

Status: Training is addressed at the local level. No requirements presently.

RECOMMENDATION #20:

Require CPR as a necessary course for high school graduates.

Subcommittee Assignment: Public Education

Status: Applicable legislation has been submitted in every recent legislative session, but has not been passed. May be opposed by the Department of Education, because it would mandate another required course for high school graduation.

RECOMMENDATION #21:

Encourage statewide citizen participation in CPR and basic first aid courses.

Subcommittee Assignment: Public Education

Status: Cardiopulmonary resuscitation (CPR) training is offered locally by the American Heart Association and the American Red Cross.

RECOMMENDATION #22:

Establish a Statewide Training Advisory Council.

Subcommittee Assignment: Professional Education/Certification

Status: By virtue of the development of the statewide New Jersey Emergency Medical Services Council and its subcommittees (including Professional Education/Certification), the intent of this recommendation will be realized.

RECOMMENDATION #23:

Field Triage protocols should be established for all patients. There should be a uniform reporting system for emergency care, including: basic life support, intermediate care, advanced life support, emergency department care, and all aspects of the New Jersey Emergency Medical Services Systems should be operated under appropriate medical direction with a system of concurrent and retrospective quality assurance review.

A. All BLS providers should have a medical advisor. This medical advisor should be involved in all Quality Assurance. The advisor and the BLS providers should have a mutually agreeable relationship. When a BLS provider is unable to find an

appropriate medical advisor, the local medical society should implement a designation responsibility for a medical advisor. For example: as part of a hospital staff responsibility.

Under the guidance of this medical advisor each BLS provider will be responsible for developing its own Quality Assurance program. The results will be transmitted to the BLS provider's corresponding regional coordinating council.

B. Since it has been shown that the routine, appropriate and timely, recording information protects rather than exposes the BLS provider from litigation, all runs should be recorded in a complete and timely manner and documented on a uniform reporting system in a timely and complete manner.

These records will provide a vehicle for Quality Assurance, continuing education, and documentation of the needs of the BLS provider for example: personnel, equipment, etc.

C. All run sheets should be evaluated on a regular basis after implementation to assess usefulness, appropriateness and adequacy of charting.

Subcommittee Assignment: Cooperative Effort - Operations, Medical, Trauma, Pediatric EMS (combine discussion with #4)

Status: The MICU system has a standard reporting mechanism and each hospital has quality assurance for MICU. A uniform basic life support (BLS) run form is being developed, but its use will be voluntary for most providers. Run forms are required for the regulated BLS services (paid, municipal, hospital-based), but these are kept locally. Other data collection elements have not yet been developed. Presently no medical control or medical director required at the BLS level; this will be encouraged through the EMT-Defibrillator (EMT-D) program.

RECOMMENDATION #24:

Develop and implement standardized statewide ALS and BLS run reporting systems.

Subcommittee Assignment: Operations (combine discussion with #26)

Status: Run forms under development. ALS is closest to finalization; BLS should flow from that. The need for data to seek funding and the implementation of the trauma registry may encourage cooperation.

RECOMMENDATION #25:

Develop and implement a peer review and quality assurance system with appropriate medical direction for all levels of emergency medical service providers.

Subcommittee Assignment: Medical

Status: Does not exist.

RECOMMENDATION #26:

Utilize the data reporting system to develop and integrate an EMS registry.

Subcommittee Assignment: Operations (combine discussion with #24)

Status: Trauma registry starting to work on data collection.

RECOMMENDATION #27:

A. **Develop, publish and distribute a monthly EMS system newsletter - develop a statewide logo.**

B. **Develop and produce film/videotape materials on the EMS system.**

C. **Annually promote the sponsorship of a statewide EMS symposium and participation in the observation of national EMS week.**

Subcommittee Assignment: Public Education

Status: An outside grant or corporate support will probably be needed to adequately address this recommendation.

RECOMMENDATION #28:

Develop and implement a statewide public information and education program on accessing the local EMS system.

Subcommittee Assignment: Public Education

Status: This may be spearheaded by the 911 Commission and New Jersey Bell, once the 9-1-1 system is implemented.

RECOMMENDATION #29:

Develop and implement a statewide education program for citizens on what to do until the ambulance arrives.

Subcommittee Assignment: Public Education

Status: Currently being done only at the local level.

RECOMMENDATION #30:

Develop and distribute educational materials about the EMS system for medical professionals and government officials.

Subcommittee Assignment: Public Education

Status: Five maps have been developed to picture the State of the State in EMS (see Appendix C).

RECOMMENDATION #31:

Establish a mechanism to identify and clarify pending legislation and to communicate that information to the leadership in the EMS Community and other interested parties in an effort to provide expert testimony and support of EMS issues.

Subcommittee Assignment: Legislative

Status: The type of mechanism to be developed should be a joint decision between the New Jersey Emergency Medical Services Council and the Office of Emergency Medical Services.

RECOMMENDATION #32:

Initiate and implement recruitment campaigns for all levels of EMS providers through the statewide newsletter, the annual EMS symposium and through the EMS Coordinating areas. Encourage citizens to participate in local volunteer EMS services.

Subcommittee Assignment: Public Education

Status: Scattered efforts have been done locally. New Jersey State First Aid Council has a program for volunteer recruitment.

RECOMMENDATION #33:

Federal reimbursement criteria for advanced life support should be met in New Jersey by combining the use of both Mobile Intensive Care Units and the volunteer/proprietary Basic Life Services. Transportation of an advanced life support patient shall be provided by either of the following procedures:

A. Transportation in a Basic Life Support ambulance which has been specially equipped to accommodate Advanced Life Support medical and communications equipment, certified by the Department of Health as Advanced Life Support capable, with certified MICU paramedics on board, and a patient who requires care which would qualify for Advanced Life Support reimbursement under federal guidelines.

B. Transportation in a MICU ambulance which has been specially equipped with medical and communications equipment, certified by the Department of Health as an Advanced Life Support Ambulance, containing certified MICU paramedics and a patient who requires care which would qualify for advanced life support reimbursement under federal guidelines.

Subcommittee Assignment: System Finance

Status: Reimbursement for ALS has been addressed, but there continue to be issues revolving around the current reimbursement system, especially defaults on co-pay (which raises the "normal" billing amount to cover bad debt).

RECOMMENDATION #34:

A. Explore ongoing methods of EMS funding/support.

B. Explore reimbursement methods for BLS services.

C. Explore reimbursement methods for uncompensated care for MICU.

Subcommittee Assignment: System Finance

Status: No activities currently underway.

Pediatric EMS

At its first meeting, the Committee discussed the need to address the pediatric component of the state's EMS system. A standing subcommittee was appointed, chaired by Richard Flyer, MD. The subcommittee was asked to make its deliberations and to report back to the full Committee.

At the Committee's March 22 meeting, Dr. Flyer made a brief presentation on his subcommittee's direction in regard to emergency care for the pediatric patient. Fourteen pediatric intensivists were identified in New Jersey and were included on the subcommittee. The subcommittee used a white paper (Pediatric Critical Care Systems) from California as a model document. Also, Dr. Flyer noted that page 143 of the Report of the 97th Ross Conference on Pediatric Research succinctly summarized the needs for EMS for children. This chart shows how the EDAP (Emergency Departments Approved for Pediatrics) concept is integrated into the EMS system. EDAPs assure that every emergency department which sees children is prepared for pediatric care. These facilities should be coordinated with a hospital which can care for the more seriously ill or injured child, as well as with facilities with pediatric intensive care for trauma and non-trauma. The New Jersey State Department of Health has written regulations for licensure of facilities which offer pediatric care, including the transfer of children to a higher level facility.

The New Jersey State Department of Health, Office of Emergency Medical Services is preparing an application for a federal Emergency Medical Services for Children grant. Last year, a similar application was approved but not funded (enabling legislation limits funding to four applicants, New Jersey was ranked fifth).

The final report from the Pediatric EMS subcommittee was received and reviewed at the Committee's May 30 meeting. It was recommended that it be incorporated into the Committee's Final Report, together with the white paper and other supporting materials. These materials appear in Appendix D.

Trauma

Another area of special attention addressed by the Committee was trauma. A proposal was received (see Appendix E) to create a state trauma committee to serve in an advisory capacity and to coordinate the development of a "trauma system" in New Jersey. The Committee agreed to support the proposal, with the trauma committee to be represented on the

New Jersey Emergency Medical Services Council. The "New Jersey Trauma Center Council" will examine all trauma-related issues, including integration of the prehospital EMS services with the existing and soon-to-be-designated trauma centers, quality assurance, trauma center finance, and the statewide trauma registry.

Additional EMS Recommendations

The Emergency Medical Services Interim Committee was also charged with providing guidance on emerging issues in emergency medical services. The Committee has identified three key issues that need to be addressed by the permanent New Jersey Emergency Medical Services Council. These issues, among others, will gain increasing prominence as New Jersey's EMS system develops.

(1) Stable Funding for EMS: The state portion of the EMS system depends on legislative appropriations and various grants. Volunteer services depend on donations and local contributions. Hospitals, regulated BLS services, and MICU programs depend on patient revenues. The legislature has mandated that patients be charged for using the statewide aeromedical services. All of these income sources are variable. Several other states (e.g., Pennsylvania, Virginia) have added a set amount (earmarked for EMS use) to motor vehicle registrations or fines for moving violations. The funds are used to assist and enhance the state's EMS system. Consideration should be given to implementing a similar stable EMS funding mechanism in New Jersey.

(2) Hospital Diversion: When a hospital's supply of beds or manpower becomes low, a decision may be made to "divert" patients (all patients or certain critically ill patients arriving by ambulance) to another hospital. Diversions are a result of many problems in the health care system. Until these problems (including manpower shortages, critical care bed shortages, increasing admissions, and increasing severity of patient illness and injury) are solved, hospital diversions will continue to occur and quality of care may be jeopardized. Diversion has many negative impacts upon providers of emergency prehospital care. The Committee made a motion:

> We recommend to the Commissioner that regulations be promulgated regarding diversion status, based upon the recommendations of the Governor's Council on Emergency Medical Services Task Force on Diversion, in order to insure the public health.

The Committee also reviewed the document, A Full House: Hospital Diversion Guidelines, April 1990, of the New Jersey Hospital Association's Council on Planning and Committee on EMS. It recommends that the document be incorporated by reference into this Final Report (see Appendix F).

(3) Heavy Rescue and Extrication Training: Many emergency medical services calls, especially motor vehicle accidents, depend on the use of heavy rescue or extrication equipment. Except in the regulations for paid, municipal and hospital-based ambulances (NJAC 8:40), the minimal types of extrication and related equipment are not mandated. Even then, services can be provided under written agreement with another agency. Nowhere is training in operation of the equipment addressed, except at the local level. As heavy rescue equipment becomes more expensive and sophisticated to operate, it will be necessary to develop mechanisms to assure quality,

trained services are available in a timely manner to extricate accident victims. Training for appropriate operation would be far in advance of the "awareness" level training currently taught in EMT classes. Heavy wrecker operators and other professionals should be consulted when addressing this issue in the future.

Conclusion

The Emergency Medical Services Interim Committee recommends speedy implementation of the above recommendations, especially formation of the New Jersey Emergency Medical Services Council and its associated county and regional councils. Such a formal structure is important to maintaining and enhancing the high quality of emergency medical care which the citizens of New Jersey deserve.

State of New Jersey

DEPARTMENT OF HEALTH
CN 360, TRENTON, N.J. 08625-0360

MOLLY JOEL COYE, M.D., M.P.H.
COMMISSIONER

EXECUTIVE ORDER NO. 150 December 14, 1989

Whereas, the Governor's Council on Emergency Medical Services was created in 1986 to recommend steps toward building a comprehensive network of emergency medical services in New Jersey; and

Whereas, the recommendations of the Governor's Council on Emergency Medical Services included a recommendation that an ongoing EMS advisory group be formed to succeed the Council; and

Whereas, there is a need to ensure that there is continuity of the work of the Governor's Council on Emergency Medical Services in providing an understanding and analysis of the system in New Jersey; and

Whereas, there is a need for a source of ongoing expertise regarding the emergency medical services role in the state's health care system and for protocols regarding the handling of emergency medical services calls into the system; and

Whereas, there are major initiatives relating to a continual upgrading of the acute and critical care emergency medical services network and trauma systems and other vital issues affecting the need for and the delivery of emergency medical services;

Whereas, the citizens of New Jersey deserve the highest quality emergency medical care and;

Whereas, the Governor's Council on Emergency Medical Services has spent considerable time and effort on the identification and implementation of a statewide plan, and there needs to be a mechanism to continue these efforts;

NOW, THEREFORE, I, MOLLY JOEL COYE, Commissioner of Health of the State of New Jersey, by virtue of the authority vested in me do hereby ORDER AND DIRECT:

A. There is hereby created an Emergency Medical Services Interim Committee, hereafter referred to as the Committee.

B. The Committee shall consist of the following members:

H. Mickey McCabe
President, Medical Transport

Jeanne Kerwin
MICU Project Director, Tri-County Consortium

Mark Schaffer
Director, CENTEMS, UMDNJ

James Rapp
President, MICU Program Administrators

Winnie Hartvigsen
Emergency Medical Technician
Dover Brick First Aid Squad

William Hayes
Office of Highway Safety

Joseph Imbesi, D.O.
Chair, MICU Advisory Council

President, New Jersey State First Aid Council

Bartholomew Tortella, M.T.S., M.D.
Acting Director, New Jersey State Trauma Center
UMDNJ

Steven Ross, M.D.
Director, Southern New Jersey Regional Trauma Center

Colonel Clinton L. Pagano
Superintendent, New Jersey State Police

Leah Z. Ziskin, M.D.
Assistant Commissioner, Department of Health to serve ex-officio

Additionally, there may be 2 at large members to be appointed at the discretion of the Chair.

C. Members appointed shall hold office for a term not to exceed six months, beginning from the date of this order.

D. The Chair of this Committee shall be Mr. H. Mickey McCabe, President of the Medical Transportation Association.

E. The Committee shall be charged with the following responsibilities:

1. Assure that the recommendations in the report of the Governor's Council on Emergency Medical Services, released in 1988, form the basis of the Committee's actions.

2. Provide appropriate input on current EMS activities and issues to the incoming state administration.

3. Provide guidance to the Office of Emergency Medical Services on emerging issues related to EMS, including review of proposed guidelines and standards of practice.

4. Draft a proposal with recommendations and options for the establishment of a permanent Emergency Medical Services Advisory Group.

F. The Committee shall meet at the call of the Chair to organize itself and hold sufficient meetings to enable it to make recommendations set forth in Paragraph E of this order.

This body shall provide a status report of current issues and shall also make recommendations regarding next steps in the continuing development of the statewide Emergency Medical Services Systems in New Jersey to the Commissioner of Health.

G. The Committee may form any subcommittees necessary for it to perform its responsibilities. These subcommittees may meet as often as required by the nature of their assigned tasks.

H. All members shall serve without compensation.

I. The Committee shall submit a report to the Commissioner of Health no later than June 30, 1990.

J. This ORDER shall take effect immediately.

Molly Joel Coye, M.D., M.P.H.
State Commissioner of Health

Appendix B

Membership

Emergency Medical Services Interim Committee

H. Mickey McCabe, chairman: President, Medical Transportation Association of New Jersey; President, McCabe Ambulance Service

Jeanne Kerwin, MICP, vice chairman: Project Coordinator, Tri-County Mobile Intensive Care Network/Overlook Hospital

George D. Hansen, Sr.: President, New Jersey State First Aid Council

Robert Hansson: Principal Planner, Office of Emergency Management, New Jersey State Police

Winnie Hartvigsen: EMT, Dover-Brick Beach First Aid Squad; Past President, New Jersey State First Aid Council

William T. Hayes: Deputy Director, Division of Highway Traffic Safety, New Jersey Department of Law and Public Safety

Joseph T. Imbesi, DO, FACOEP: Chairperson, MICU Advisory Council; Director, Emergency Services, Union Hospital

George Leggett: Chief Administrator, Office of Emergency Medical Services, New Jersey State Department of Health

Clinton L. Pagano: Director, Division of Motor Vehicles, New Jersey Department of Law and Public Safety; Past Superintendent, New Jersey State Police

James Rapp, MICP: President, MICU Program Administrators; MICU Coordinator, Union Hospital

Steven Ross, MD: Director, Southern New Jersey Regional Trauma Center, Cooper Hospital/University Medical Center; Assistant Professor of Surgery, UMDNJ/Robert Wood Johnson Medical School, Camden

Mark H. Schaffer, Ed.M.: Director, Division of Education in Trauma & Emergency Medical Services, University of Medicine and Dentistry of New Jersey, Center for Continuing Education in the Health Professions

Diana F. Stager: Director, Hospital Management and Planning, New Jersey Hospital Association

Bartholomew J. Tortella, MTS, MD: Medical Director, NorthStar Aeromedical Program; Acting Medical Director, Emergency Medical Services, University Hospital

Leah Z. Ziskin, MD, MS: Acting Deputy Commissioner, New Jersey State Department of Health

****

Subcommittee Assistance: Richard H. Flyer, MD, FAAP, Chairman, Committee on Emergency Medical Services - Children, New Jersey Chapter/American Academy of Pediatrics, chaired the Committee's Subcomittee on Pediatric EMS

Editorial Assistance: Sarah M. Mathews, Coordinator, Special Projects, Office of Emergency Medical Services, compiled the Committee's deliberations and recommendations into this final report

NEW JERSEY
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
OPERATIONS

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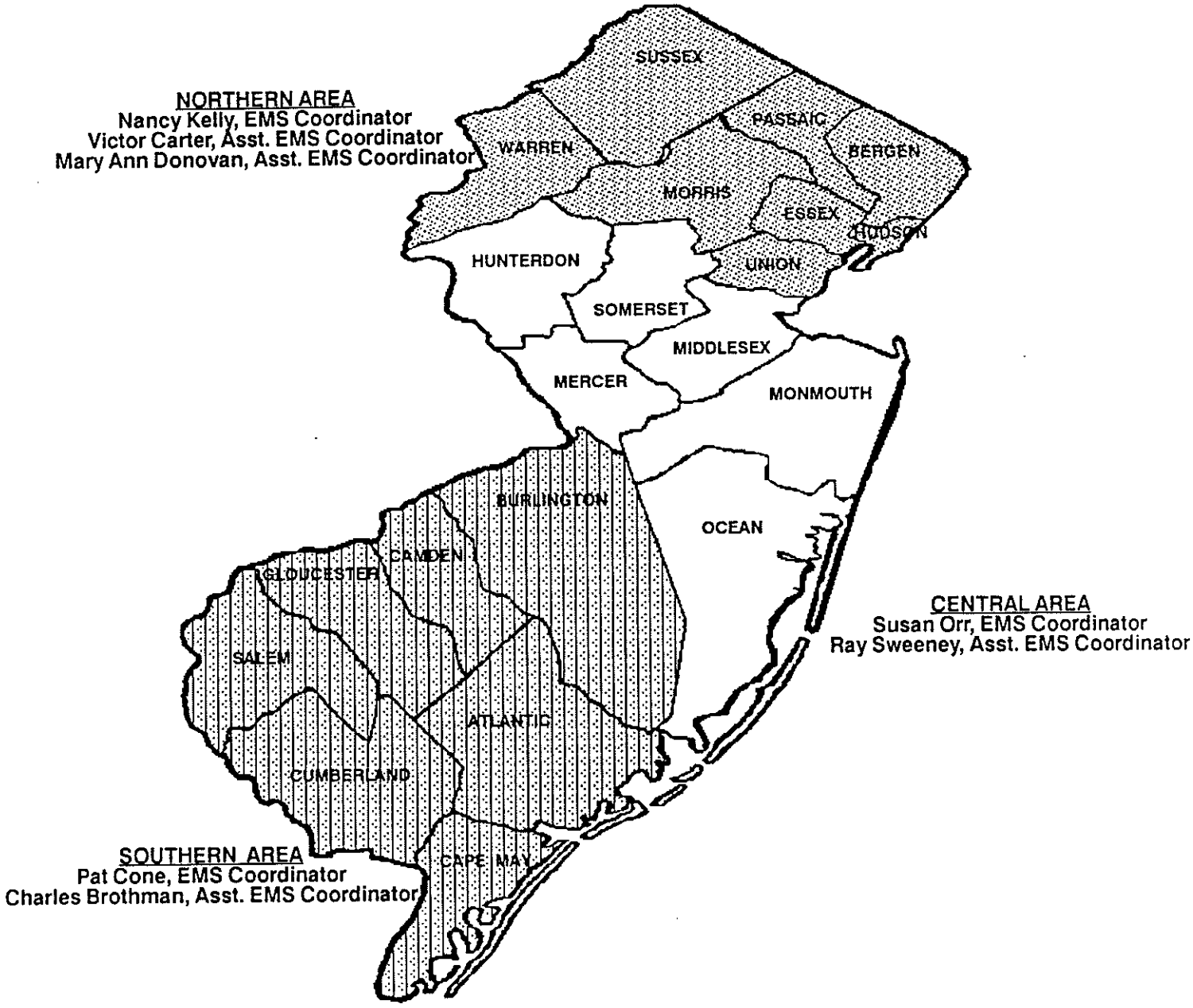
609-292-6789

George Leggett, Chief Administrator
James Murphy, Chief OEMS Operations
Karen Halupke, Coordinator OEMS Operations



G1504

NEW JERSEY
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
EMS TRAINING PROGRAMS

363 WEST STATE STREET
CN 364
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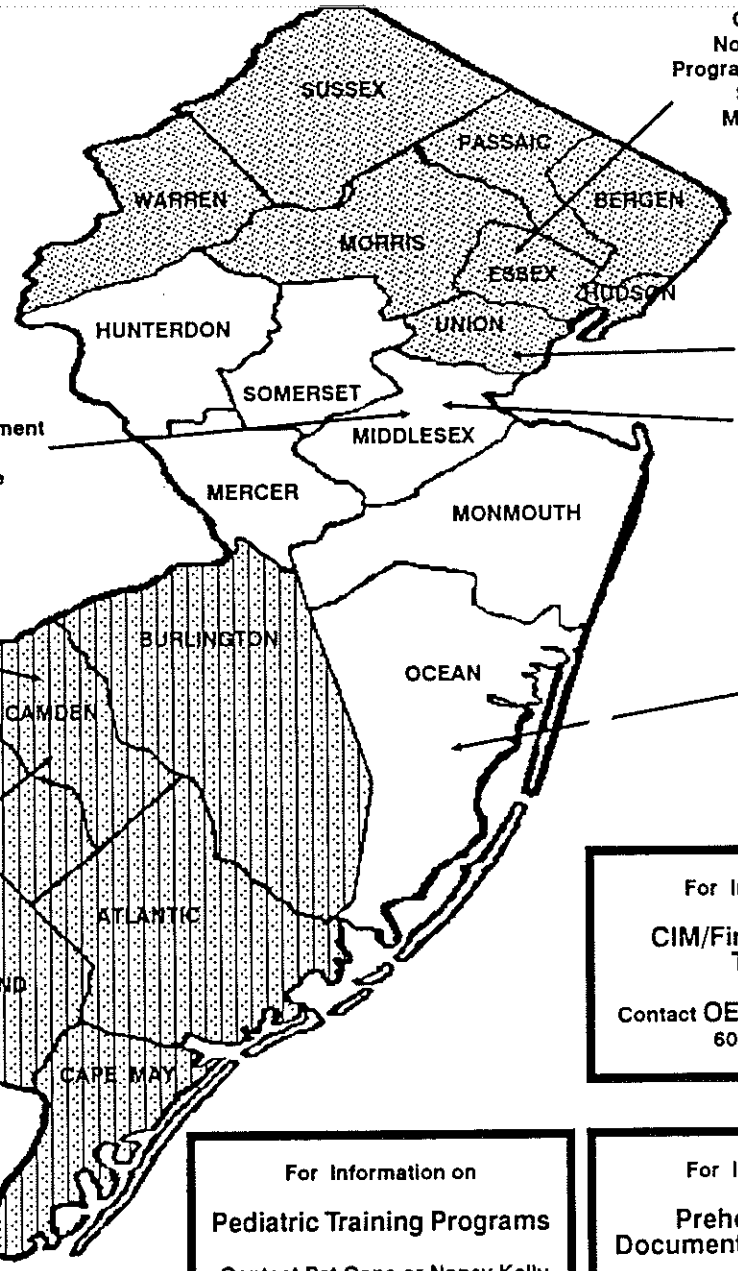
609-292-6789

George Leggett, Chief Administrator
Robert Dinetz, Training Coordinator
Peter Slaton, Assistant Training Coordinator

For Information on

EMT Training and Continuing Education Programs

Contact CENTEMS
201-456-3604



CENTEMS
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Program Development
Specialist
Mary Danish

Paramedic Didactic Program
Union County College
Tonnie Glick
201-709-7594

CENTEMS
Central Area
Program Development
Specialist
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Paramedic Didactic Program
UMDNJ SHRP
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Paramedic Didactic Program
WJersey Health System
Regina Twisdale
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Paramedic Didactic Program
Community Med Cent
Renee Keefe
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CENTEMS
Southern Area
Program Development
Specialist
Michele D'Andrea

For Information on

CIM/First Responder Training

Contact OEMS Training Section
609-292-6789

For Information on

EMS Curriculum and Training Policy

Contact OEMS Training Section
609-292-6789

For Information on

Pediatric Training Programs

Contact Pat Cone or Nancy Kelly
609-292-6789

For Information on

Prehospital Chart Documentation Workshops

Contact Susan Orr
609-292-6789

G1503

NEW JERSEY
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
MOBILE INTENSIVE CARE UNITS

363 WEST STATE STREET
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TRENTON, NEW JERSEY 08625
609-292-6789

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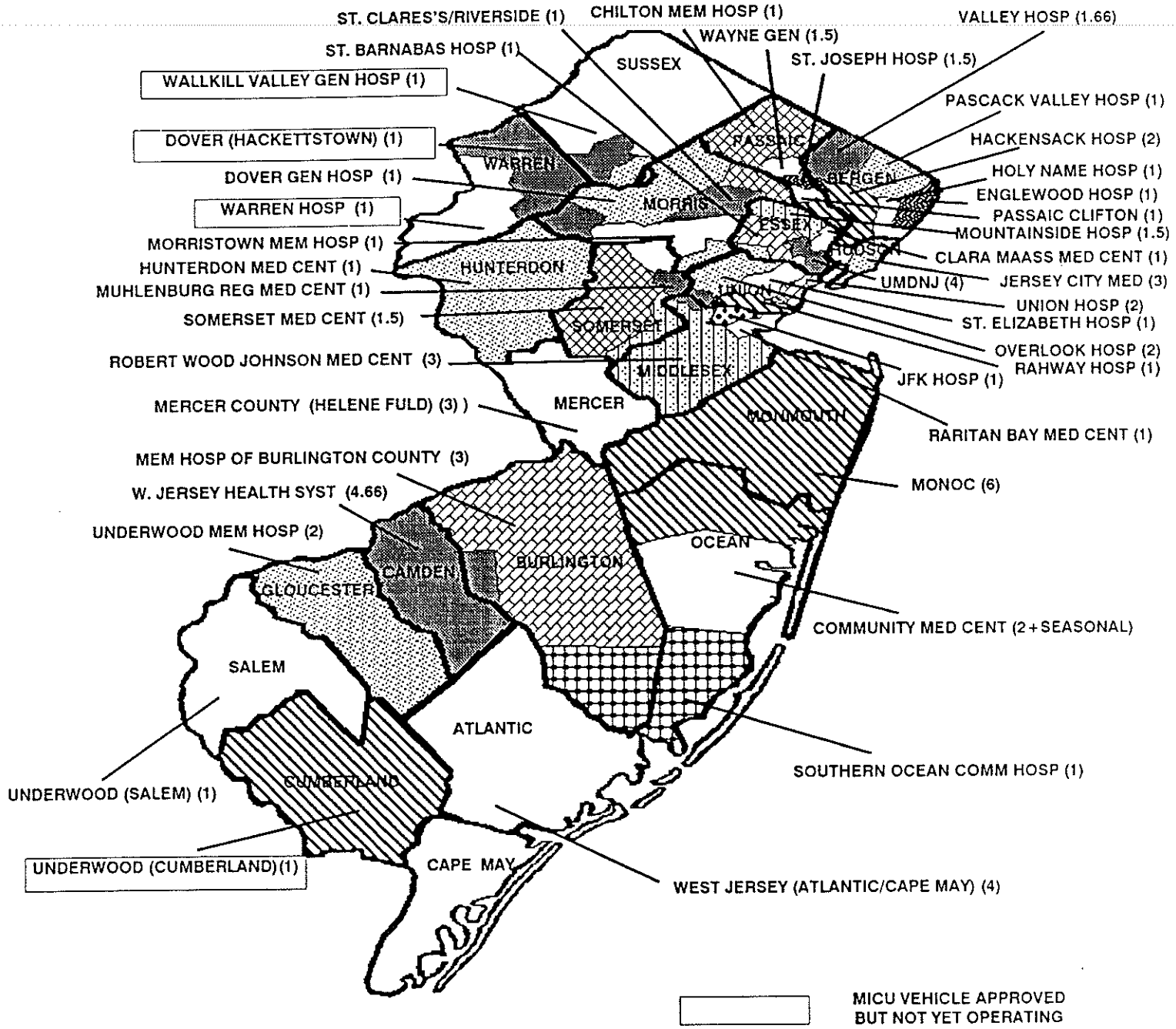
James Murphy, Chief OEMS Operations
Karen Halupke, Coordinator OEMS Operations



G1505

2/90

NEW JERSEY
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
AEROMEDICAL / TRAUMA CENTERS

363 WEST STATE STREET
CN 364
TRENTON, NEW JERSEY 08625
609-292-6789

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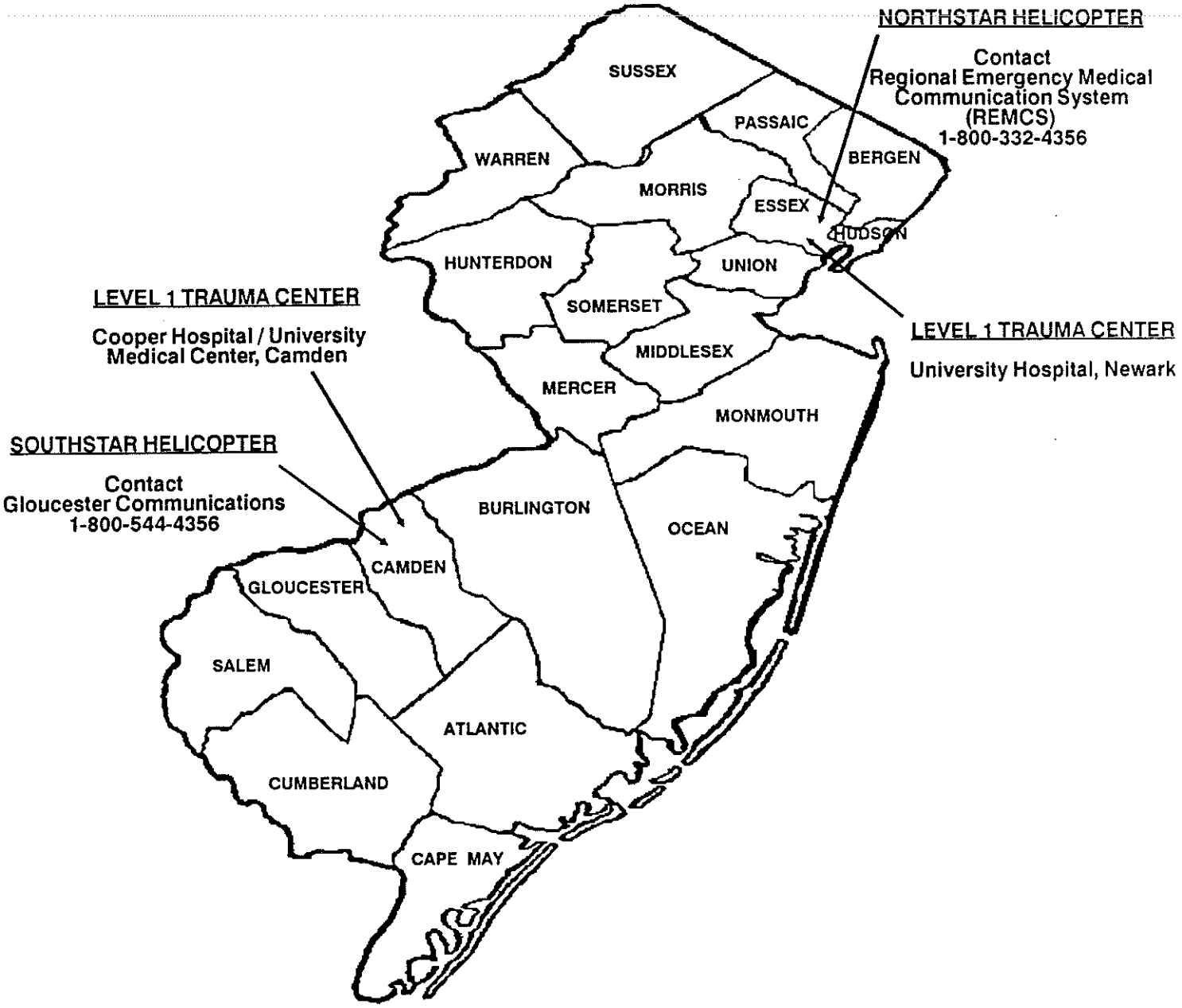
James Murphy, Chief OEMS Operations
Kevin Monaghan, Aeromedical Coordinator



WHAT INFORMATION IS NEEDED TO HAVE THE HELICOPTER DISPATCHED?

ONCE THE NEED FOR AN EMS HELICOPTER TO BE DISPATCHED IS DETERMINED, DIAL: **IN AREA CODE (609) 1-800-544-4356**
IN AREA CODE (201) 1-800-332-4356

PROVIDE THE COMMUNICATIONS CENTER WITH THE FOLLOWING INFORMATION:

* Communications Center's name
* Call back number
* County name
* Municipality name
* Nature of incident
* Location of incident with cross streets
* Local weather conditions
* Requesting unit number or name
* VHF communications frequency
* Operating number of the LANDING ZONE COORDINATOR
* Number of patients
* Approximate age and sex
* Number of patients who are entrapped
* Type and extent of injuries
* Vital signs if possible
* Nearest proposed landing site to the incident which is at least 110 feet in diameter and free of overhead obstructions.
* Any nearby landmarks such as radio or water towers

HOW DO WE COMMUNICATE WITH THE HELICOPTER?

Depending on the area of operations, **NORTHSTAR AND SOUTHSTAR** will usually communicate with ground units on New Jersey Fire Net (154.265 MHz.), JEMS 3 (155.280 MHz.), JEMS 2 (155.340 MHz.), or JEMS/SPEN 4 (153.785 MHz.). This will allow police, fire and/or EMS personnel to provide the pilot and medical crew with essential information.

In the event these frequencies are not available at the scene, other VHF frequencies will need to be designated by the calling party which can be tuned in by the helicopters on their multichannel VHF radios. All communications to the helicopter must be operated in the carrier squelch mode.

Whenever a request is made for the helicopter, the calling Party should be prepared to identify the VHF landing zone frequency and the radio call sign of the LANDING ZONE COORDINATOR. Communications from the helicopter to the ground will be established as soon as the aircraft is in range. Communications between the New Jersey State Police helicopters and the NORTHSTAR and SOUTHSTAR Communications Centers will be on the State Police 800 MHz. Trunked Communications System.

NEW JERSEY
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
EMS SPECIAL SERVICES

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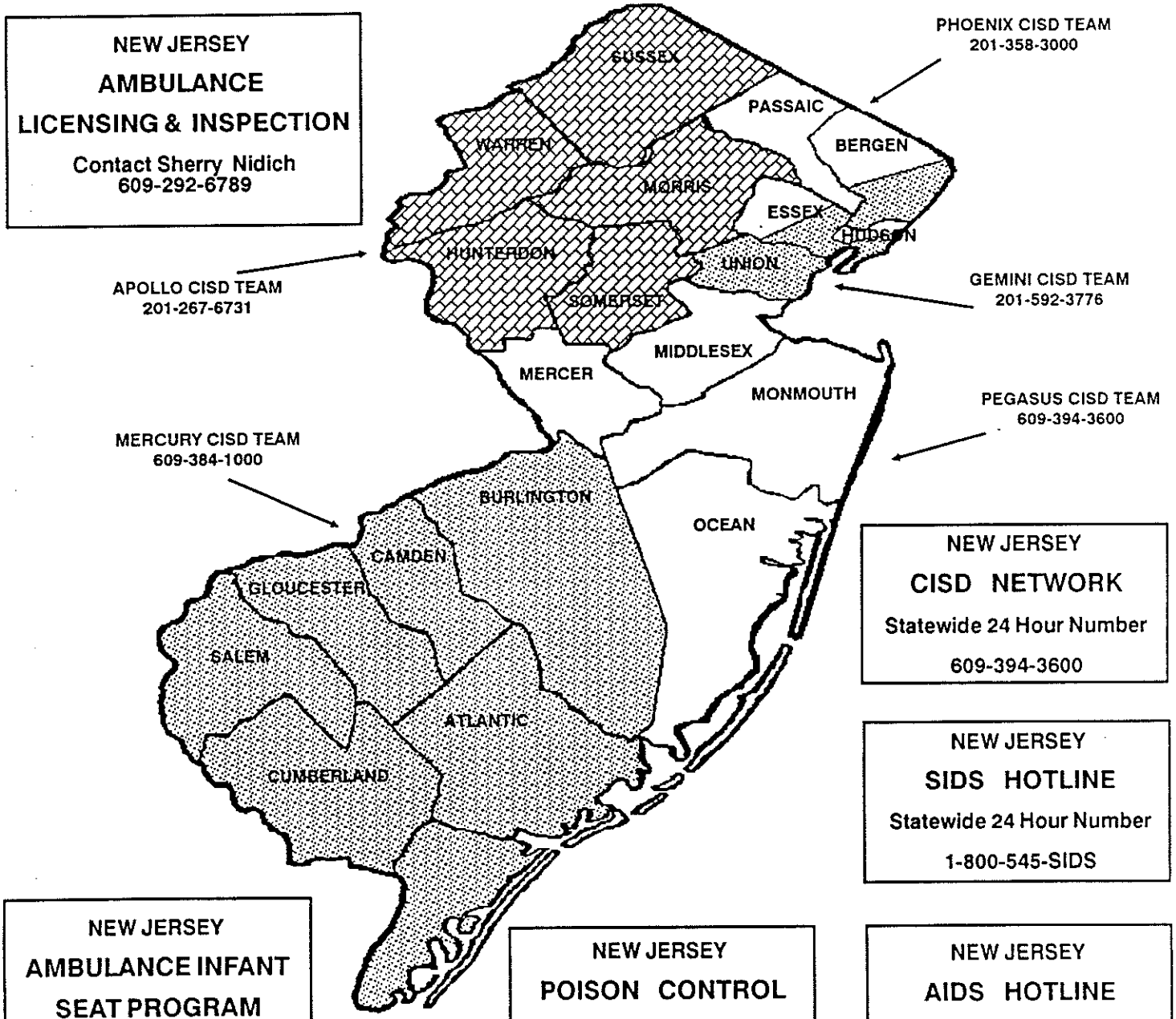
George Leggett, Chief Administrator
James Murphy, Chief OEMS Operations

NEW JERSEY
AMBULANCE
LICENSING & INSPECTION
Contact Sherry Nidich
609-292-6789



PHOENIX CISD TEAM
201-358-3000

APOLLO CISD TEAM
201-267-6731

GEMINI CISD TEAM
201-592-3776

MERCURY CISD TEAM
609-384-1000

PEGASUS CISD TEAM
609-394-3600

NEW JERSEY
CISD NETWORK
Statewide 24 Hour Number
609-394-3600

NEW JERSEY
SIDS HOTLINE
Statewide 24 Hour Number
1-800-545-SIDS

NEW JERSEY
AMBULANCE INFANT SEAT PROGRAM
Contact Pat Cone
609-292-6789

NEW JERSEY
POISON CONTROL
Statewide 24 Hour Number
1-800-962-1253

NEW JERSEY
AIDS HOTLINE
Statewide 24 Hour Number
1-800-624-2377

2/90

G1502

New Jersey Department of Health
Interim Committee on Emergency Medical Services
SUBCOMMITTEE ON EMERGENCY MEDICAL SERVICES-CHILDREN

The Governor's Council on Emergency Medical Services report clearly documented the absence of comprehensive, coordinated emergency medical services for children (EMSC) in New Jersey. Statewide emergency medical services (EMS) efforts in New Jersey have been, as it true nationally, designed to meet the needs of critically ill and injured adults. The special and distinct needs of critically ill and injured children, those New Jersey citizens aged birth through eighteen years, are not being optimally met.

Model systems for EMSC exist. Elements of EMSC (pre-hospital, hospital and rehabilitative) are functioning in New Jersey, but must be vastly improved and coordinated. The support for creation of EMSC is broad-based. As a state that treasures its children, New Jersey must assure optimal care for its critically ill and injured young by recognizing the need for EMSC and providing the resources to assure its creation, continuing function and ongoing improvement.

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Pediatric Intensivists

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UMDNJ/Robert Wood Johnson Medical School

Frank Briglia, M.D.
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Frank Castello, M.D.
Children's Hospital of New Jersey

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Toms River Community Medical Center

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Bartholomew Tortella, M.D.
University Hospital/Newark

Liaison with American College of Emergency Physicians:

Al Sacchetti, M.D.
Voorhees

May 25, 1990

APPENDICIES TO REPORT

1. White paper: Pediatric Critical Care Systems

2. Emergency Medical Services for Children
   Ross Conference Report

3. State Federal Grant Application
   Emergency Medical Services for Children 1989

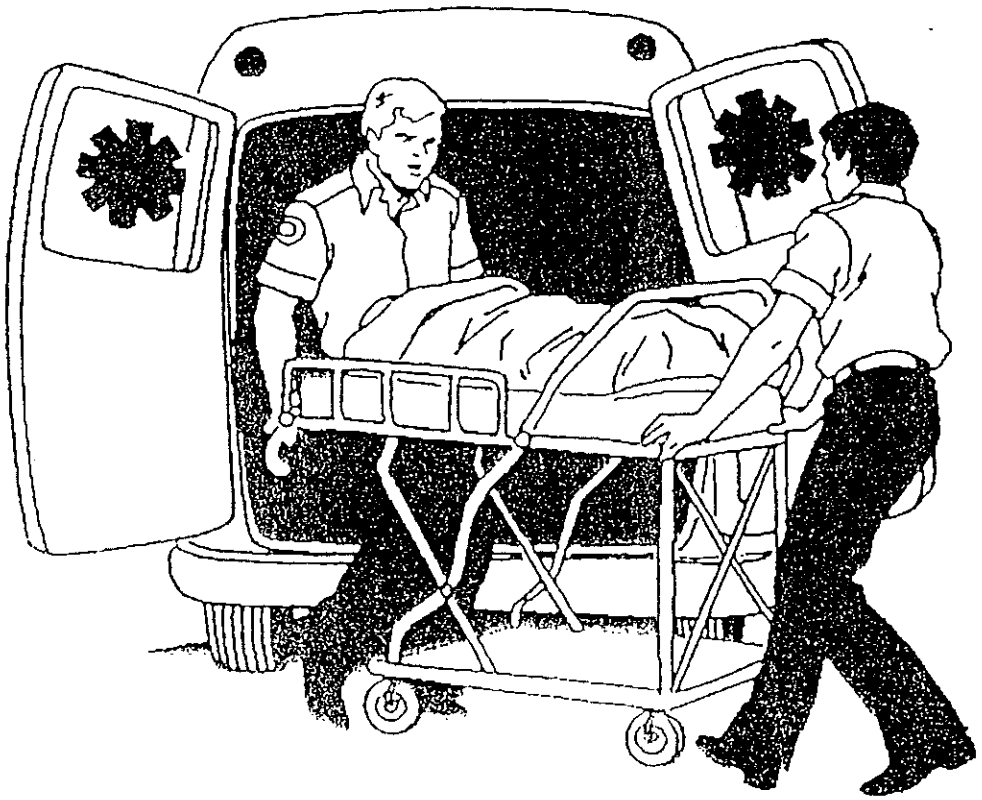
4. Report of Governor's Council on Emergency Medical Services

(incorporated by reference)

District IX, American Academy of Pediatrics

WHITE PAPER

Pediatric Critical Care Systems



(incorporated by reference)

Emergency Medical Services for Children

Report of the 97th Ross Conference on Pediatric Research

Published by Ross Laboratories
Columbus, Ohio 43216

PROPOSAL FOR TRAUMA CENTER COUNCIL FOR NEW JERSEY

MAY 28, 1990

Name: State of New Jersey Trauma Center Council

Philosophy:

This Council will serve to improve and strengthen the developing trauma system in New Jersey, and allow it to develop as a functional "system" rather than a loose collection of trauma centers. This is imperative to the development of excellence in trauma care in this State.

Purpose:

1. To advise and inform the Commissioner of health, and other appropriate governmental departments, regarding matters of trauma care, especially those impacting on trauma center function.

2. To develop medical protocols and quality assurance standards for designated Level I and II trauma centers in the State of New Jersey.

3. To develop and foster trauma educational programs to be sponsored by Level I and II trauma centers in the State (including, but not limited to, physician, nursing, prehospital care personnel, and lay public injury-prevention education programs).

4. To develop quality assurance standards for trauma care and to assist in the implementation of quality assurance program for trauma centers.

5. To provide guidance for the State-wide Trauma Registry.

6. To investigate financial and administrative issues impacting on trauma center care.

7. To provide a forum for coordinated efforts on behalf of the trauma system in the State of New Jersey.

8. As a subcommittee of the State EMS council, to assist in the coordination of trauma center and other emergency medical system functions in the State, including development

and implementation of field triage, and pre-hospital quality assurance standards for trauma care.

Membership:

The New Jersey State Trauma Center Council shall consist of:

New Jersey State Commissioner of Health (or designee)
Director of OEMS (or designee)

The following representatives of each designated trauma center in the State of New Jersey(both Level I and II):

Medical director (a physician)
Trauma nurse coordinator
Chief executive officer (or his designee)

In addition, a representative of the educational arm of each Level I trauma center shall sit with voice but without vote on the Council.

Officers:

The chairman of this Committee shall be the medical director of a Level I trauma center. This chairmanship shall rotate among the designated Level I trauma centers on a yearly basis. The vice-chairman shall be the chairman elect for the next year.

The Executive Committee shall consist of the medical directors, administrative representative, and nurse coordinator of the three Level I trauma centers and an administrator, a trauma nurse coordinator, and a medical director of Level II trauma centers elected by the members of the committee representing the Level II trauma centers. This Committee shall meet on a quarterly basis, or more frequently as needed. The main Committee shall meet on a quarterly basis.

Subcommittees:

There will be several standing subcommittees charged with specific areas of responsibility.

Education Subcommittee

This subcommittee shall be co-chaired by a clinical member of the Trauma Center Council (either a physician or nurse) at the appointment of the chairman of the main Committee. This shall be neither the chairman of the Council nor the nurse coordinator of his/her institution.

This subcommittee will be charged with developing and implementing educational programs as well as assuring that programs developed by a single institution will be shared with other institutions.

Quality Assurance

The chairman of this shall be the chairman of a Level I trauma center not currently serving as chairman or vice-chairman of the main Council. The co-chairman will be the nurse coordinator from that institution. The purpose of this subcommittee shall be to develop trauma quality assurance standards and programs for State-wide use amongst all trauma centers.

Trauma Nursing

This subcommittee with be chaired by the trauma nurse coordinator of the institution represented by the chairman of the overall Council. This subcommittee will deal primarily with trauma nursing issues, practices, and protocols and will interface with the Education Subcommittee in terms of trauma nursing education.

Trauma Center Finance

This will be chaired by a hospital administrator of a Level I trauma center other than that represented by the chairman of the overall Council and membership shall be open to all hospital administrative personnel serving on the council. A medical director of a Level I and of a Level II trauma center shall serve ex-officio as clinical advisors to this subcommittee. This subcommittee shall consider financial and administrative issues impacting on trauma centers and make recommendations to the Council regarding these issues.

Statewide Trauma Registry Advisory Committee

This committee is already consitituted, under the direction of Dr. Raymond Talucci, via a Federal Highway Traffic Safety grant. This committe would be best able to function as an integral subcommitte of this Trauma Center Committee.

All members of this Council will serve without special compensation. This Council with serve in an advisory capacity and will not make regulations.

(incorporated by reference)

A Full House

Hospital Diversion Guidelines

Recommendations of the
Council on Planning, Committee on EMS

April 1990

NEW JERSEY HOSPITAL ASSOCIATION
At the Center for Health Affairs
760 Alexander Road CN-1
Princeton, NJ 08543-0001 609-275-4000

EMERGENCY MEDICAL SERVICES (EMS) GLOSSARY

Advanced Life Support (ALS) Services - Implementation of the Fifteen Components (see below) of an EMS system to a level of capability which provides both non-invasive (basic life support) and invasive (intravenous lines, drug therapy, etc.) emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Vehicles are staffed by Mobile Intensive Care Paramedics (MICPs) and/or Mobile Intensive Care Nurses (MICNs), providing on-site, prehospital mobile intensive care under medical direction via two-way voice and/or telemetry. Examples of ALS care include care at the basic life support level plus administration of selected medications, drugs and solutions, intravenous therapy, cardiac defibrillation, and use of specialized techniques, procedures and equipment.

Basic Life Support (BLS) Services - Implementation of the 15 components of an EMS system to a level of capability which provides prehospital non-invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Examples of BLS care include identifying patients with possible illness or injury and assessing those problems, controlling bleeding, bandaging wounds, splinting fractures, administering oxygen, giving cardiopulmonary resuscitation (CPR), administering basic poisoning antidotes (e.g., Syrup of Ipecac), and maintaining an open airway.

Cardiopulmonary Resuscitation (CPR) - A combined, coordinated effort to artificially restore or maintain normal respiration and circulation functions (from "cardio" (heart) and "pulmonary" (lungs)).

Critical Care Units (Centers) - Sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill and injured patients. The units are available for the diagnosis and care of specific patient problems, including major trauma, critical burns, spinal cord injuries, poisoning, acute cardiac problems, high risk infant care, and behavioral emergencies.

Diversion - A decision made by a hospital, because of a low supply of beds or manpower, not to admit additional emergency patients arriving by ambulance (e.g., all patients or all critically ill patients). The hospital notifies area ambulance services, MICUs, and hospitals of the diversion and patients are "diverted" to another hospital until the shortages are alleviated. A hospital on "divert" must still treat and stabilize any patient brought to its door and then transfer the patient to another facility for admission, if appropriately staffed beds are still unavailable.

Emergency Medical Services (EMS) - Services utilized in responding to an individual's perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

EMS Personnel - Key individual EMS providers. This includes physicians, emergency and critical care nurses, Emergency Medical Technicians, Paramedics, EMT-Intermediates, other volunteer rescue squad personnel, central dispatchers, telephonic screeners, first responders (police, fire), project administrators, medical directors, medical consultants, and system coordinators.

EMS System - A system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or because of natural or manmade disasters).

EMS System Coordination - Ensuring the system's integration from the point of the first responder's identification of the emergency through communications coordination, transportation (primary and secondary), the hospital, and critical care facilities and/or links to rehabilitation centers (if needed).

Emergency Medical Technician-Ambulance (EMT-A or EMT) - A person trained in emergency medical care in accordance with national standards (i.e. basic 110-hour course). The EMT provides emergency medical services at the basic life support level.

Emergency Medical Technician-Defibrillator (EMT-D) - An emergency medical technician who has been certified to perform cardiac defibrillation, according to rules and regulations adopted by the Commissioner of Health. Legislation is pending to create this level of prehospital emergency medical care provider in New Jersey. (Note--A defibrillator is a device which counteracts uncoordinated contractions within the heart muscle by applying electrical impulses to the heart).

Emergency Medical Technician-Intermediate (EMT-I) - An EMT who has received additional training in specific advanced life support techniques in an approved training program accredited by the Commissioner of Health. Once certified by the Department of Health, the EMT-I is qualified to render limited services (e.g., cardiac defibrillation, administration of selected intravenous fluids for fluid replacement) which are generally considered to be advanced life support, in addition to providing care at the basic life support level.

Fifteen Components - Necessary elements to properly operate an EMS system. These include: adequate manpower, appropriate training, communications, transportation, facilities, critical care units, interfaces with public safety agencies (e.g., fire and police), consumer participation, access to care, patient transfer, coordinated patient recordkeeping, public information and education, review and evaluation, disaster planning and mutual aid.

Five Point Training Program - Training program for basic life support personnel provided by the New Jersey State First Aid Council consisting of modules relating to various skills. Additional modules were developed which, when added to the program, resulted in the program being named the Eight Point Training Program.

Health Care Financing Administration (HCFA) - The Health Care Financing Administration (HCFA) is the Federal agency which regulates Federal expenditures for Medicare and Medicaid. Located within the US Department of Health and Human Services, the agency has the authority to permit waiver of certain payment regulations for the purpose of demonstrating innovative approaches to the delivery of health services.

Health Care Administration Board (HCAB) - The body which has responsibility for approving final promulgation of all New Jersey State Department of health regulations in the areas encompassed by the New Jersey Health Care Facilities Planning Act of 1971. It is the appeals board for the certificate of need process.

Medical Control Center - The base station in the hospital where the physician receives radio and telemetry communications from the EMS personnel. The physician in turn provides medical direction.

Medical Direction - Directions and advice provided by physicians from a centrally designated medical facility which is staffed by appropriately trained EMS personnel who utilize regional treatment and triage protocols. Facility staff supply professional support through radio and/or telephone communication for onsite and intransit BLS and ALS services given by field personnel.

Medical Directors - Physicians employed at regional, area or local levels to direct and to administer the medical portion of EMS programs.

Mobile Intensive Care Paramedic (MICP) or Paramedic - Persons trained in advanced life support care in accordance with national standards and certified by the Commissioner of the New Jersey State Department of Health. The New Jersey paramedic training program requires 200 classroom hours and 400 clinical and field hours (combined) of training beyond the EMT level.

New Jersey State First Aid Council - An organization of volunteer ambulance first aid squads whose purpose is to enunciate policy directions and provide support for squads, such as training for personnel, dissemination of information, and advocacy.

Non-affiliated Provider - Any volunteer first aid or rescue squad which is not a member of the New Jersey State First Aid Council.

Paramedic - See Mobile Intensive Care Paramedic.

State of New Jersey Emergency Medical Communications Plan (JEMS Plan): - A coordinated communications plan, endorsed by major agencies and organizations within the state, to assure well-planned and integrated emergency medical services communications systems for access to all components in the most effective way possible.

Telemetry - Specialized electronic communication which transmits an electrocardiogram from the location of the patient to the medical control center in the hospital.

Transfer Agreements - Formal arrangements between hospitals and physicians concerning acceptance and procedures for interhospital transfer of critical patients. Included in these agreements are such things as prior physician consultation, treatment protocols, transportation arrangements and equipment, health professionals who will accompany the patient, and necessary records.

Transfer Protocols - Prearranged regionwide plans for transferring specific critical patients to appropriate, designated treatment facilities.

Trauma Center - Specialized critical care service with resources to treat victims of serious injury. These are categorized from Level I (highest) to Level III (lowest).

Treatment Protocols - Written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by appropriate physicians and/or medical groups.

Triage Protocols - Regionwide plans for identifying, selecting and transporting specific critical patients to appropriate, designated treatment facilities.