REPORT TO THE GOVERNOR

Contents

EMS REPORT TO THE GOVERNOR

Summary

Most emergencies requiring medical assistance are responded to by community basic life support (BLS) providers. These include volunteer first aid squads, municipal and proprietary providers. Fifteen to twenty percent (15-20%) of all emergency calls, however, require advanced life support which is provided by trained and equipped Mobile Intensive Care Units (MICUs). MICU paramedics treat the patient needing advanced life support on the scene and accompany the patient, in the BLS ambulance, to a hospital.

Medicare rules for reimbursement require that ALS patients be transported in an advanced life support vehicle. The state was given a temporary waiver in 1983 which continued the more than $20 million annual Medicare payment for these services under New Jersey's unique system. The one year extension of this waiver recently granted Governor Kean expires October 31, 1987

This report recommends a systemic adjustment in the provision of advanced life support services which complies with Medicare criteria while retaining and continuing the critical transportation role of the BLS volunteer network. The report recommends that new quality assurance and response standards be developed to apply to all emergency medical services.

The Governor's charge to the Council

By Executive Order 146 on September 22, 1986, Governor Kean created the Governor's Council on Emergency Medical Services. The Council was given the following charge:

1. Recommend an overall policy direction for a comprehensive, coordinated, statewide emergency medical services system in New Jersey, including issues such as financing, training, communications, staffing and management, and administration;

2. Utilize consultants with national expertise to look for innovative and other efficient methods of providing emergency care;

3. Submit to the Governor a state plan on emergency medical services that will make maximum utilization of existing resources, and will ensure the coordination of the state volunteer/private sector efforts. This state plan shall be submitted to the Governor no later than November 30, 1988, and the Council shall terminate thirty (30) days thereafter.

Expert panel

The Governor's Emergency Medical Services Council convened in November, 1986. In order to assist in the deliberations of the Council, the Department of Health received a grant through The Robert Wood Johnson Foundation to retain a panel of experts in emergency medical services from outside New Jersey to assist in designing and describing the ideal Emergency Medical Services system. Their description is included in the Appendices of this report. The panel of experts is composed of the following persons:

Alasdair K. T. Conn, M.D. - Trauma Surgeon and Executive Medical Director, Boston Med-Flight Helicopter Consortium

Mary Elizabeth Michos, R.N. - Director, Emergency Medical Services, Montgomery County, Maryland; Captain, Montgomery County Fire Service; and training officer for the Fire Academy.

Ronald D. Stewart, M.D. - Director, Center for Emergency Medicine of Western Pennsylvania; and Chief, Division of Emergency Medicine, University of Pittsburgh

Emergency Medical Services 1973- present

Advanced life support (ALS) services are an extension of the hospital, bringing the capabilities of the hospital's emergency facilities to a patient in the field. Mobile Intensive Care Units (MICUs) are paramedic teams trained and equipped to bring ALS to the scene of an accident or medical emergency. Among those who benefit from these advanced life support services are persons suffering from heart attacks, cerebrovascular accidents, trauma, poisoning, near-drowning, allergic reactions, and diabetic emergencies.

In New Jersey, all MICU services are hospital-based and physician-directed. The paramedics and/or nurses who staff the MICU have been trained to deal with life threatening emergencies. New Jersey's paramedics meet United States Department of Transportation's criteria for full paramedic status. The paramedics operate under direct radio and telemetry supervision of a qualified physician or a mobile intensive care nurse who is under physician direction.

MICUs work side-by-side with basic life support (BLS) squads, which are about ninety percent (90%) volunteer. The volunteer BLS units respond to most of the emergency medical calls in New Jersey. The MICUs are called in those emergencies that require the more specialized level of care necessary to give a patient the best chance for survival. In most cases requiring advanced life support, the local volunteer BLS squads transport the patient to a hospital, accompanied by the MICU personnel providing continuing advanced life support care. It is a team effort which brings needed emergency health care to New Jersey's communities.

In most communities, the emergency call goes out to the local rescue squad or police dispatcher. Based on information gathered from the caller, the dispatcher may decide the situation warrants sending an MICU out on the case as well. Or a rescue squad may, upon arrival at the scene, determine the case needs advanced life support and summon the MICU.

This system came into being in 1973, with legislation which established Mobile Intensive Care pilot programs in New Jersey. These initial programs served approximately twenty-five percent (25%) of the state's residents and provided advanced life support services to over 8,000 patients during the pilot period. Because of the success of the pilot programs, legislation making the mobile intensive care concept permanent was passed in June, 1979. With the foundation provided by this legislation, hospitals working under the guidance of the State Department of Health were able to develop new programs increasing the area of emergency coverage. The Department of Health's Office of Emergency Medical Services established criteria for operation of these units which include organization, medical supervision, staffing, equipment, communications, service areas, and participation in areawide planning.

Each service area of the state is included under a Mobile Intensive Care consortium, headed by a regional coordinating center. The regional centers coordinate communications and advanced life support dispatch services for the hospitals in the consortium.

The regionalized system is developed to serve all hospitals and patients in a given area. A patient may request to be taken to the hospital of his/her choice, even when that choice is not the hospital in which the MICU is based. Regionalization reduces program costs, because each hospital does not have to separately purchase the equipment and staffing necessary to provide advanced life support services. The cooperative nature of regionalization means that non-MICU hospitals can be assured of being available and accessible. Regionalization also provides for mutual aid in the event a MICU needs additional help, or when a unit encounters difficulties in responding.

Generally only fifteen to twenty percent (15%-20%) of all emergency calls need the skills provided by MICUs. The screening of calls through regional dispatching centers and through BLS squads minimizes the number of MICU runs and false alarms, keeping the MICUs available for life threatening situations. On the average, seventy percent (70%) of MICU calls require hospital admission. Five to ten percent (5-10%) are dead on arrival. The balance are treated and released by the hospital's emergency department. In November 1985 legislation was enacted for implementation of Emergency Medical Technician-Intermediate (EMT-I) training and system development in the five rural counties (Warren, Sussex, Hunterdon, Cumberland and Salem) not covered by MICUs.

Reimbursement --- the Medicare MICU Waiver (Nov. 1983-present)

Prior to 1983, the cost of the Mobile Intensive Care Unit program was factored into the overall cost of hospital inpatient care. Medicare, Medicaid, and the other third party insurers shared the payment for MICU services, but the cost was never separately identified on the hospital billing. Individual patients served by the MICU received no separate billing for these services.

In late 1982, the Health Care Financing Administration ruled that the state's MICUs were not considered an inpatient service, and announced that reimbursement under Medicare's Part A, which covers inpatient care, would be terminated.

The reason for the change had to do with federal Medicare rules and the New Jersey hospital reimbursement system. The rules of the federal Medicare program for the elderly stipulate that an ambulance must have either a physician on board or must transport the patient to a hospital, as well as treat the person on the scene, in order to qualify for Medicare payment. Because New Jersey's MICUs are staffed by paramedics who stablize patients then use a volunteer ambulance for transport, the state's system did not meet the federal guidelines.

In addition, by New Jersey law, all hospital patients are supposed to be billed equally through the state's diagnosis related group all-payer reimbursement system. This means that if Medicare, as one of the payers, refuses to pay for any service, no patient or participating insurance program would be obligated to pay for the service.

Starting November 1983, therefore, Medicare, Medicaid, and other third party payers in New Jersey began covering MICU charges as an outpatient service. For Medicare, the charges were to be paid under Part B, unless the patient was admitted to a hospital. When an MICU patient was admitted, the MICU charge was to be included on the Part A inpatient bill.

The stated purpose of the waiver was to demonstrate the relative clinical validity and cost-effectiveness of the use of non-transport MICUs in conjunction with transport services provided by the BLS volunteer squads.

Under terms of the waiver agreement, the state is limited to sixty (60) reimbursable MICUs, approved through the Department of Health's Certificate of Need process. The waiver also limited the state to a total operating cost not to exceed twenty million dollars ($20,000,000) adjusted annually for cost of living. In addition, ambulance services are reimbursable under the Medicare Part B Program, when provided by an approved ambulance service to a local hospital or skilled nursing facility only when (1) the ambulance, its equipment and personnel meet Medicare requirements, and (2) transportation by other means could endanger the patient's health. The patient is responsible for a co-insurance payment of twenty percent (20%).

The 1983 MICU Medicare waiver was scheduled to expire October 31, 1986. In response to Governor Kean's request, the waiver was extended twelve (12) months, to October 31, 1987 provided that no additional extension would be required or requested.

Recognizing the importance of continued funding, Commissioner Coye has established formal contacts with the Health Care Financing Administration for resolution of the problem. Health Care Financing Administration reimbursement through Medicare and Medicaid patients represents approximately 50% of all revenues for advanced life support services.

AGREEMENTS IN PRINCIPLE

The Council investigated the issues surrounding reimbursement of MICU/ALS runs, as defined by the Health Care Financing Administration. One of the goals of the Governor's Emergency Medical Services Council is to establish a reimbursement mechanism that can be implemented with the least disruption of the current New Jersey Emergency Medical Services system.

The New Jersey State First Aid Council, the New Jersey Department of Health, and the Governor's Emergency Medical Services Council agree that New Jersey has a unique system in which prehospital care is delivered with the heavy participation of volunteers. Preservation of this basic volunteer system is in the best interest of the citizens of New Jersey.

The current mechanism of advanced life support service transport, either by MICU or BLS, will be acceptable if agreed upon response times can be met and quality assurance standards can be maintained.

It is agreed that MICUs will transport only if: (1) there is no mechanism for BLS transport within the community (not squad-by-squad),(2) response times and quality assurance standards cannot be met and maintained, or (3) the community requests it.

No system will be acceptable without a system of accountability which is universal, consistent, enforceable, well defined, agreed upon and implemented. Of primary importance, is the tracking and maintaining of quality care, not the mechanism of transport.

RECOMMENDATIONS

1. Comply with federal reimbursement criteria

Under terms of the current Medicare MICU waiver agreement, which terminates October 31, 1987, this state is limited to sixty (60) reimbursable Mobile Intensive Care Units and to a total operating cost of $20 million, adjusted to the cost of living, for advanced life support services.

The following recommendation meets federal criteria for continued funding under Medicare rules. The recommendation would result in MICU transportation arrangements in New Jersey, based on the needs of various local communities. In some communities MICU transportation would be accomplished by MICU vehicles, while other communities may elect to use their volunteer, municipal or proprietary squads to provide this transport after first ensuring that they achieve equipment and personnel certification for advanced life support.

RECOMMENDATION #1:

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 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 the patient who requires care which would qualify for advanced life support reimbursement under federal guidelines.**

(Note: It is recognized that the new reimbursement mechanism may result in a financial shortfall to the existing system and individual hospitals. The amount of this shortfall will be dependent upon the reimbursement rates to be determined by third party payers. The next phase of the Governor's Council activity will be concerned with financial implementation strategies. The objective is to have a well functioning reimbursement system in place prior to November 1, 1987.)

2. Response time

While all of New Jersey enjoys emergency medical service coverage, there are often lengthy delays between the time the citizen requests assistance and the time EMS crews are on the scene. Through agreements with other squads, arrangements are made for mutual aid coverage when the primary squad is either on another call or cannot get the required number of volunteer crew members to respond. However, the time required to engage each tier of this mutual aid system results in longer delays. Coverage in some areas of the state is especially sporadic during the day, when volunteer squad members are at their regular jobs.

Approximately ninety-five percent (95%) of New Jersey's population is covered by advanced life support units. However, in some areas response time can take as long as thirty (30) minutes.

RECOMMENDATION # 2:

Standard response times should be established for each of the following levels:

a. First responder/CPR trained citizen;
b. BLS squads;
c. MICU/ALS.

All citizens should have access to all aspects of emergency medical services within an acceptable time frame.

(Note: The problems of the delivery of advanced life support care in areas not currently serviced by MICUs will be addressed by the Governor's Council during the next phase.)

3. Training

Proprietary and municipal squads are required to have two (2) persons trained to the level of the federal Department of Transportation's 110 hour EMT-A Standard. The New Jersey First Aid Council requires that its members meet specific training standards. At present, volunteer squads not affiliated with the Council have a variety of training ranging from the Department of Transportation, Emergency Medical Technician-Ambulance. Some volunteers have had no specific training.

An MICU unit is staffed by two (2) qualified persons composed of two paramedics, two nurses, or one of each. Some units include a volunteer driver.

Citizen CPR training is available through the American Heart Association and the American Red Cross, but it is not a formal statewide training program. CPR training is mandatory in schools only when required by the local board of education.

Police and fire personnel are usually first responders on the scene of an emergency. First responder training provides basic first aid steps to be taken until those with more advanced training can take charge. Currently, the Department of Health's Office of Emergency Medical Services provides the federal Department of Transportation's First Responder Course in cooperation with police training personnel to all new police recruits at the state's approved police training academies. Some fire academies also participate. This program is not mandated to officers already on the force.

Of the range of training available, none is currently required by the state for volunteer units.

RECOMMENDATION #3:

A. Minimum training standards/certification should be established for the following categories of service: First responder, Basic Life Support, intermediate, Advanced Life Support, and dispatcher.

B. Dispatchers should have mandated uniform training in handling emergency medical service calls.

C. First responders must maintain current training certification.

D. Drivers of emergency medical service vehicles must have successfully completed vehicle driver training.

D. The minimum basic life support training will be the 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 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.)

F. A Statewide Training Advisory Council shall be established.

4. Vehicles and equipment

Proprietary and municipal vehicles are required to meet vehicle and equipment regulations and have periodic inspections. The Department of Health is working with the First Aid Council to have their volunteer squads meet the same regulated inspection requirements. Other non-affiliated squads have no requirements, although some meet regulations voluntarily.

Most of New Jersey's MICU vehicles are not capable of transport and, instead, are joined on their advanced life support calls by a basic life support unit, which transports patients to the hospital with the MICU paramedic on board.

RECOMMENDATION #4:

All ambulances should be required to meet appropriate uniform vehicle and equipment standards.

5. Medical Supervision

There are no requirements for medical direction or peer review of squad activities and review of the run reports of basic life support units. For advanced life support MICUs, New Jersey requires full medical control with telemetry capability, run review and quality assurance.

Recommendation # 5:

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, and Advanced Life Support.

All aspects of the N.J. emergency medical services system should be operated under appropriate medical control with a system of concurrent and retrospective quality assurance review.

6. Communications

The "911" telephone service is not available in most of the state. Where this service is provided the calls may be received by a community-based dispatch or a county centralized dispatch.

Basic life support communication is not consistently reliable. Some ambulances cannot communicate with the hospital at all. There is over-crowding of radio frequencies, often making coordination of communications difficult or impossible. The New Jersey Emergency Medical Services Communication Plan (JEMS) seeks to systematize frequency assignment. However, its use is not mandated and Emergency Medical Services must share frequencies with other service categories.

RECOMMENDATION #6:

Dispatch protocols should be established to include dispatch criteria and effective retrospective dispatch review.

All citizens should have equal access into the emergency medical services system. Emergency medical service communications resources should be coordinated on a regional basis. Appropriate dispatch criteria and protocols should be established.

7. Special treatment referrals

A victim of trauma is described as having a combination of medical problems requiring prompt triage and rapid evacuation to an appropriate medical facility. It has been found that trauma patients can be saved by early and sustained resuscitation and stabilization. Trauma patients are saved and morbidity is reduced by prompt placement in appropriate trauma care centers.

There are currently two (2) demonstration Level 1 trauma centers in New Jersey: Cooper Hospital and University Medical Center, Camden, and University of Medicine and Dentistry/University Hospital, Newark.

There is no formal protocol through existing hospital/physician referral patterns to determine when burn patients are to be transferred to special burn care centers, such as Saint Barnabas Medical Center, Livingston; Saint Agnes Burn Center, Philadelphia; and Chester-Crozier Medical Center, Chester Pennsylvania.

Acute care for spinal cord injury victims can be provided for at the state's Level 1 trauma centers, as well as at Morristown Memorial Hospital and at Thomas Jefferson University Hospital, Philadelphia. An informal spinal cord injury early notification system is a joint effort between Kessler Institute, the Department of Health's Emergency Medical Services, and the Division of Vocational Rehabilitation.

A statewide Poison Control Center is operated by Newark Beth Israel Medical Center. This service includes a twenty-four (24) hour telephone consultation availability at (1-800) 962-1253.

RECOMMENDATION # 7:

Appropriate advanced life support and basic life support treatment and triage protocols should be established for the following specialty classifications of patients: trauma, spinal cord injury, pediatric, and burns.

8. Emergency Medical Services Coordinating Areas (E.M.S.C.A.s)

The many resources of the emergency medical services system in New Jersey are unevenly distributed. These resources include personnel, facilities, equipment, training and communications which, with proper allocation would close many of the gaps that remain between current services and the ideal system.

RECOMMENDATION #8:

Local, multi-county and statewide emergency medical service coordinating areas should be established for all aspects of emergency medical care.

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APPENDICES

GOVERNOR'S COUNCIL ON EMERGENCY MEDICAL SERVICES

Molly Joel Coye, M.D., M.P.H.: Commissioner, New Jersey State Department of Health, Council co-chairman.

Col. Clinton Pagano: Superintendent, New Jersey State Police. Council co-chairman.

Drew Altman, Ph.D., Commissioner, New Jersey State Department of Human Services.
*Designee: Carl Skowronek, B.S., M.S., Medicaid, Supervisor, Hospital Reimbursement.

Joseph J. Czarnecki: HCFA, NJ Representative (onsite contractor/ specialist). Located at Prudential Insurance Company (Medicare intermediary) in Millville.

W. Cary Edwards: Attorney General State of New Jersey
*Designee: William C. Brown, Office of the Attorney General

Frederick W. Fuller, M.D.: Director, Burn Center, St. Barnabas Medical Center, Livingston, NJ. Member, OEmHS Burn Care Task Force in 1979.

Judson Fuller: NJ Area Coordinator, National Disaster Medical System, VA Medical Center, East Orange, NJ. National Planner for NDMS

James George, M.D., J.D: American College of Emergency Physicians. Works in Emergency Room at Underwood-Memorial Hospital, Woodbury, NJ Also practices law with George & Korin, Woodbury, NJ

John J. Gregory, M.D.: Representative from the American Heart Assoc., NJ Chapter. Cardiopulmonary Dept. Overlook Hospital. Consultant member, 1979 OEmHS Coronary Task Force.
*Designee: Jeanne Kerwin, M.I.C.P., MICU Project Director (Tri-County Mobile Intensive Care Network (Overlook Hospital)

C. Clayton Griffin, M.D.: Director NJ State Trauma Center, UMDNJ, Newark, NJ. Asst. Professor and Chief, Div. of Trauma Surgery at UMDNJ Med. School. Medical Director, University Hospital, EMS Division.

Winnie Hartvigsen: President, NJ First Aid Council. Dover-Brick Beach First Aid Squad (18 yrs.) Normandy Beach. Member 911 EMS Communication Commission - Highway Safety Advisory Council.
*Alternate: William Murray, Central Area Vice President, NJ State First Aid Council.

Joseph T. Imbesi, D.O., F.A.C.O.E.P.,: Dir. Emergency Dept. and MICU Director Union Hospital, Union, NJ. Chairman, MICU Advisory Council.

Lt. Joseph Imbriaco: Head of Aviation Bureau, NJ State Police.
*Alternate: SFC Salvatore A. Azzarello, Helicopter pilot for Governor.

Fred Kohler, Jr.: Senior Vice President-finance at Blue Cross/Blue Shield of NJ.
*Designee: Leonard Gorson, Jr., M.P.A., Blue Cross/Blue Shield of NJ.

George Leggett: Director of EMS - Robert Wood Johnson University Hospital.

Henry Liss, M.D.: Spinal Cord Center at Morristown Memorial Hospital. Neurosurgeon - member of 1979 OEmHS Task Force on Head and Spine Injury.

Steven Marcus, M.D.: Asst. Director, Dept. of Pediatrics, Newark Beth Israel Medical Center. Chairman, Accident Prevention & Child Safety Committee.

Mickey McCabe: President, Medical Transport. Assoc. of NJ. Director EMS - EMT since 1973. Graduate paramedic 1984.

Linda Mowad, R.N., M.A.: President, NJ Emergency Nurses Assoc. Clinical Dir. for Critical Care St. Mary's Hospital, Hoboken, NJ.

F. Carter Nance, M.D.: Chairman, Dept. of Surgery, St. Barnabas Medical Ctr. Clinical professor of surgery Univ. of Medicine & Dentistry/NJ College of Medicine, Newark.

Steven Ross, M.D.: Asst. Professor of Surgery UMDNJ/Robert Wood Johnson Medical School, Camden. Staff Traumatologist - SNJ Regional Trauma Center, Cooper Hospital/University/Med. Center.
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John H. Rutledge, M.D., J.D.: Deputy Commissioner, NJ State Dept. of Health.

Mark H. Schaeffer: EMT-A Program Coord. Passaic County College 1973 to present. Volunteer ambulance experience 20 years. Principal Training Technician, NJ State Dept. of Health 1972-73.

Rudolf Schwaeble, M.D.: Rep. from the EMS Committee, Medical Society of NJ Emergency room physician with long interest in state's EMS system.

Howard S. Schwartz, M.D., J.D.: Director of Emergency Medical Services, NJ State Dept. of Health. Spent 15 yrs. as an active emergency physician.

Louis P. Scibetta, F.A.C.H.A.: President, NJ Hospital Association.
*Alternate: Joseph Slavin, Vice President, Planning, NJ Hospital Assoc.

William Taylor: Manager, NJ Office of Highway Safety, Div. of Motor Vehicles.
*Alternate: William Hayes: Supervisor of Planning, Office of Highway Safety, Div. of Motor Vehicles.

L. Barry Ultan, M.D.: Represents physician specialties. Medical Dir. Mercer County Lifemobile (MICU) program. Cardiologist, practices at Helene Fuld Hospital. Member, 1979 OEmHS Coronary Task Force.

Richard O'Donnell: Consumer rep.- NJ Chapter American Assoc. of Retired Persons

Legislative Members

Honorable Frank D. Pallone, Jr. (D)
Senator, District #11

Honorable Richard A. Zimmer (R)
Senator, District #23

Honorable Gerard S. Naples (D)
Assemblyman, District #15

SUB-COMMITTEES

1. Finance

Co-Chairmen: Joseph Czarnecki and Joseph Slavin
Members: Mickey McCabe
Fred Koehler/Leonard Gorson
Carl Skowronek
George Leggett

2. Training

Chairman: Winnie Hartvigsen
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Howard Schwartz, M.D., J.D.
Jeanne Kerwin
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Center for Public Dispute Resolution

Thomas A. Fee, Esq.
Staff Attorney/Mediator

James E. McGuire
Director

This entire issue has many sub-issues and a variety of interested parties, each with concerns and interests specific to their organizations and constituencies. To help facilitate the Council's work and to encourage collaborative problem solving, the State Department of Health and the New Jersey State Police sought assistance from the Center for Public Dispute Resolution of the Public Advocate's Office. The Center's representatives have been involved as third-party neutrals who have guided the process of the Council since its inception. The Council's interim report to the Governor is a result of reasoned thought, a collaborative process and consensus.

The Governor's Council, Colonel Pagano, and Dr. Coye wish to express their sincere appreciation to Commissioner Alfred A. Slocum and Thomas Fee.

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"AGREEMENT IN PRINCIPLE"

The parties (N.J.D.O.H. & N.J.S.F.A.C.) agree that:

1. New Jersey is a unique environment in which pre-hospital care is delivered, given its heavy level of volunteer involvement.

2. Preservation of the volunteer system is in the best interest of the citizens of New Jersey.

3. The current mechanism of ALS transport (either MICU or BLS transport) is acceptable if:

   a. previously agreed upon response times can be met and maintained, and

   b. previously agreed upon quality assurance standards can be met and maintained,

4. MICU's will transport if:

   a. there is no mechanism for BLS transport within the community (not squad by squad), or

   b. agreed upon response times and quality assurance standards cannot be met and maintained, or

   c. the local community requests it.

5. No system will be acceptable without a system of accountability which is:

   a. universal

   b. consistent

   c. enforceable

   d. well-defined

   e. agreed upon

   f. implemented

6. Of primary importance is the tracking and maintaining of quality care, not the mechanism of transport.

[Unanimously agreed in principle by representatives from the N.J.D.O.H. & N.J.S.F.A.C. on March 18, 1987.]

[The Joint meeting of the SRO & Finance Subcommittees of the Governor's Council on EMS unanimously agreed to forward these

The Ideal EMS System*

This treatise is meant as a guide for structure, organization and management of an ideal EMS program. It is an attempt to delineate roles and responsibilities how the different components of the sytsem can work together to provide optimum patient care. It does not address the issue of reimbursement of ambulances or of an EMS system. Neither does it address legislation pertaining to the establishment and continuation of the system, rather that legislation needs to be in place in order for the system to function well.

No one state has an ideal EMS system, rather many different states have strengths and weaknesses; the strengths have been distilled into this document.

Responsibilities of the state EMS System. At the state level there should be a state office of Emergency Medical Services, preferably within the Department of Health. This office has enabling legislation establishing the authority and responsibility for the EMS system together with the necessary staff for development and enforcement of minimum regulations and standards. These regulations and standards should encompass minimal specifications for all levels of EMS personnel; for training; for EMS communications and for acute care designation. The state should also be responsible for the coordination and development of a statewide EMS plan which by necessity should coordinate with the State Health Plan. The state should also be in a position of being able to provide technical assistance for areas that wish to meet minimal qualifications or wish for example to upgrade from BLS to ALS. This technical assistance could be performed by grants, by funding special projects, by providing a clearing house capability and also for the dissemination of information for example, by a statewide EMS newsletter. The state should also have responsibility for funding the development, maintanence and enhancement of the statewide program, and also coordinating public education in the EMS arena.

Regional EMS System. In most states the EMS system is structured at a sub-state level into regions. These regions may be on a county level but are more commonly on a multi county level. This regional program is responsible for coordinating the arrangement of personnel, facilities, training, and equipment for an effective EMS response. Examples of such coordination occur under mutual aid agreements, disaster response or implementation of costly EMS programs such as a helicopter program.

The regional EMS orgainzation is the essential element at the regional level. This may be a private entity or a governmental entity staffed by a state position (Regional EMS Coordinator). This regional EMS organization should have a Medical Director and an Advisory Council; it should also be structured to have the authority to receive and disperse public and private funds for the purposes of the enhancement of the regional EMS system.

Local EMS System. At the local level there should be an EMS council to include all provider groups (both public and private) and including representatives from hospitals, medical societies, local boards of health, fire and police services, and also consumer representatives. This local EMS system should have representation on the regional EMS organization to ensure smooth coordination with neighboring communities.

Medical Direction. Emergency Medical Services should have a strong medical leadership. Within the ideal system there are medical advisory groups prepared to give the State Medical EMS Director technical assistance as to standing medical orders, medications to be carried on ALS vehicles, etc. to be in concordance with the changing pattern of health care.

STATE

STATE has following components:

* Statewide plan for E.M.S. (coordinates with health plan).
* Funds for development/maintenance for administration, for REMSO/grants
* Delineation of Responsibilities/Roles (legislation/regulations)
* Staff/expertise for enforcement of minimum regulations
* Support systems Technical assistance (guidelines, clearing house, newsletter, etc.)
  Training
  Communication planning, development, coordination
  Record keeping-standard data set
  Evaluation centralize data processing
  Public education
  Acute care designations
  Coordinate with other states; highway safety plan, etc.

STATE

ORGANIZATION:

* Shoud be in State Government to reflect health
* Should have advisory council advice to executive/legislative branches on policies/procedures program, funding, etc.
* Should have adequate managerial, technical and clerical staff
* Should have an M.D. (full or part time)

LEGISLATION:

* To authorize minimal standards (and enforcement)
* To provide funding

REGION

Should be private entity of government or a private entity. Should have capacity of receiving grants/disbursing funds.

* Regional System Planning
* Mutual Aid
* Multiple Casualty/Disaster response

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

EXECUTIVE ORDER NO. 146

WHEREAS, major initiatives relating to drunk driving, mandatory seat belt usage, improved highways, increased law enforcement, and a continual upgrading of the acute care network, have resulted in a reduction in fatal accidents in New Jersey; and

WHEREAS, the recent initiation of helicopter services to bring persons more quickly to life saving procedures is a significant addition to the State's emergency medical services programs; and

WHEREAS, it is our intention to use these beginnings and to build in New Jersey the most comprehensive network of emergency medical services for persons with emergency needs;

NOW, THEREFORE, I, THOMAS H. KEAN, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of the State, do hereby ORDER AND DIRECT:

A. There is hereby created a Governor's Council on Emergency Medical Services, hereafter referred to as the Council.

B. The Council shall consist of 33 members to be appointed by the Governor:

1. The Commissioner of Health, who shall also serve as Co-Chairperson of the Council;
2. The Superintendent of the State Police, Department of Law and Public Safety, who shall also serve as Co-Chairperson of the Council;
3. The Attorney General, or his designated representative;
4. The Commissioner of Human Services, or his designated representative from the Division of Medical Assistance;
5. The Deputy Commissioners of Health;
6. The Director of the Office of Emergency Health Services, Department of Health;
7. A representative from the New Jersey State Police, Aviation Bureau;
8. A representative from the Office of Highway Safety, Department of Law and Public Safety;

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D. The Council shall be charged with the following responsibilities:

1. Recommend an overall policy direction for a comprehensive, coordinated, statewide emergency medical services system in New Jersey, including issues such as financing, training, communications, staffing and management, and administration;

2. Utilize consultants with national expertise to look for innovative and other efficient methods of providing emergency care;

E. The Council shall convene as soon hereafter as is practicable. The Council shall submit to the Governor a State Plan on Emergency Medical Services that will make maximum utilization of existing resources and will ensure the coordination of the state volunteer/private sector efforts. This State Plan shall be submitted to the Governor no later than November 30, 1988 and the Council shall terminate 30 days thereafter.

F. Resources for the staffing of this Council shall be the responsibility of the Department of Health and the Department of Law and Public Safety, Division of State Police. The Department of Health shall provide the Executive Secretary for the Council.

G. This ORDER shall take effect immediately.

GIVEN, under my hand and seal
this 5th day of September
in the year of Our Lord

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 noninvasive (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 onsite, 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 noninvasive 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.

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.

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).

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.

Paramedic - See Mobile Intensive Care Paramedic.

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 - This 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.