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STATEMENT

NEW JERSEY EMERGENCY MEDICAL SERVICES

New Jersey State Department of Health
Office of Emergency Medical Services

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OVERVIEW

The New Jersey State EMS Project of the New Jersey State Health Department emphasizes the 15 components of emergency medical services as set forth and reiterated in the Federal EMS Amendments Act of 1976 (PL 94-573):

- | | |
|---------------------------|------------------------------------|
| 1. Manpower | 8. Access to Care |
| 2. Training | 9. Patient Transfer |
| 3. Communications | 10. Standardized Record-Keeping |
| 4. Transportation | 11. Public Information & Education |
| 5. Facilities | 12. Evaluation |
| 6. Critical Care | 13. Disaster Linkage |
| 7. Consumer Participation | 14. Mutual Aid Agreements |

The Project's current priorities focus on six areas of activity:

1. Medical Control

Basic EMS Critical Care Definitions

Hospital facilities rating

Designations of critical care units

Protocols & agreements for critical patient transfers

NJ Critical Care network (Definitive Care & Transport)

2. Communications

Development of a State EMS Radio Plan to include improvements in public access and EMS communications appropriate to basic and advanced clinical care.

3. Professional Education

Designing an EMS education strategy for ED physicians and nurses and supporting the EMS training priorities established by NJ Chapters of ACEP, EDNA, and the Committee on Trauma of the American College of Surgeons.

4. Allied Health Education

Continuance of the nationally standardized EMT training program by the NJSHD.

5. Basic Life Support Transport (BLS and ALS)

Adoption of official NJ ambulance equipment and training standards for the states ambulance personnel and vehicles currently providing basic and advanced life support services. These Standards will also be reviewed for compliance to Medicaid reimbursement norms.

6. Public Information and Education

The increase of public awareness and involvement in the State's EMS System. The Department's Cardiac Defender Program stresses basic CPR, and other EMS functions appropriate to the general public.

Special public hearings have been held on the particular EMS access needs of handicapped persons, i.e., hearing and visually impaired.

The NJ EMS Project continues to seek the active interest and endorsement of all County and Municipal governing bodies statewide. The New Jersey EMS Project is an official program of the State Department of Health, and functions under the advisory role of the NJ State EMS Council. The Council is comprised of 23 members representing the State Medical Society, the NJ Hospital Association and others including the HSA's of the State.

STATEMENT

I. GENERAL PERSPECTIVE

The near-equivalent of our entire U.S. population visit our nation's hospital Emergency Facilities each year according to data from the American Hospital Association. This is one indication of the growing significance of today's Emergency Medicine. However, various national estimates have characterized this high level emergency care utilization as 80% inappropriate, with emergent patient traffic at approximately 15%, and the truly critical patient arrivals at about 5% of the total ED and ambulance services census. There is reason to believe that specific NJ EMS utilization is significantly within this pattern. It is generally agreed that this situation poses some complex problems which must be addressed by EMS planning.

The apparent disproportionate allocation of emergency services and resources arises from dozens of contributing factors addressed in the following pages. However, several of these factors stand out as influencing all the others, and may be briefly stated:

1. a lack of information by many Physicians and hospital Administrators about the full extent of activities currently accompanying a medical emergency in a community before a patient's delivery to an ED.
2. the prevalence of misinformation and assumptions by the general public and EMS providers alike concerning present public accessibility to comprehensive and assured critical EMS care.
3. the frequent failure by Public Health specialists to attach functional or fiscal priority to accidental death and disability, which has been accurately described as the neglected disease of modern society.
4. the resulting fragmentation of EMS service components because of the lack of, or resistance to, adequate wide area planning.

Given the foregoing, an important early task of EMS Systems Design is to prioritize EMS Services and gradually to phase out its often stifling involvement with prehospital non-emergency care. Whether from an ambulance or ED viewpoint, the economic and critical care implications of such non-emergency services can no longer be overlooked. A true EMS Care System must fix primarily on emergent and critical care needs, and recast existing resources in ways that reflect a more economical and adequate EMS Critical Care strategy.

Once EMS is directed toward this primary objective, i.e., salvage of the seriously injured, problems in providing this care can be more carefully assessed. Services to less critical patients can then be placed in better perspective, and the many components making up an EMS System can be more effectively coordinated.

It is estimated, for example, that in New Jersey 75-80 persons die each day from coronary episodes alone, involving some three-quarters of a billion wasted dollars annually. (4) Between one-fourth and one-third of these fatalities are potentially salvageable at the scene or at the hospital with improved access to adequate care and current technology. Other accidental fatalities are similarly evaluated. Of the 1,434 neonatal death toll in 1975 in the State, one medical estimate suggests that a significant number might have been salvaged through a more adequate perinatal and neonatal EMS program.

Such knowledgeable observations by competent specialists greatly reinforce the characterization of accidental death and disability as the "neglected disease of modern society." (4,5,18) The socio-economic implications of this situation are both tragic and substantive.

EMS - a Service vs a System

EMS systemization today -- a federally endorsed national health priority -- became so in part because of concern for the burgeoning costs of non-systems, and the gaps existing today between EMS science and EMS service. Modern EMS systems, in the final analysis, attempt to redefine critical care within an expanded critical care technology. Today's Emergency Medical Technology was simply not available fifteen years ago during the days of the unstaffed "Accident Room" when ambulance function was frequently limited to rapid horizontal taxi service.

Among the problems encountered by today's EMS planners, general public apathy is often cited. However it sometimes appears that the more basic problem is that concerned individuals have had no place to go, no Agency or community leadership to invoke, to turn to. The disorganized EMS approach of former times continues to affect current EMS coordination efforts. Attempts to lead are often misunderstood and deemed threatening. What is required is described in the federal legislation as a "lead agency", i.e., a state or local governmental office with a statutory role in planning and providing health services. Without this lead agency, effective EMS system coordination is radically hampered.

With the intent of exercising this vital leadership, the New Jersey State Health Department requested and received federal grants under P.L. 93-154 and 94-573. Prior to this in 1969, the Office of Emergency Medical Services was established within the Division of Community Health Services and received other federal assistance. Today, the State Health Department is addressing the basic tasks of EMS systemization, (26) and has given highest priority to clinically defining EMS functions in ways that assure greater critical patient orientation, and a stronger base of medical control.

The State's perceptions of needs and programmatic objectives for EMS systemization are presented in the following statement. Recognition is given to the need to involve both professional and public sectors to develop and define higher standards of statewide emergency care. As an initial technical phase of this effort, the Department has convened Specialty Clinical Task Forces from Providers of emergency care whose personal and professional involvement in the struggle against accidental death and injury will lend both stability and credibility to what eventually evolves as the State's EMS System design draft.

As an integral part of its statutory public health role, the State Health Department invites serious comment and opinion from every citizen.

Watson E. Neiman, M.D.
Deputy Commissioner

II. Factors Influencing Current EMS Care

A number of constraints on today's EMS services which impede the development of a coordinated, responsive EMS System may be identified:

- ⊙ The ready assumptions, by physicians and laity alike, that accessibility, availability, and clinical caliber of emergency services are already very good to excellent.
- ⊙ The economics of supplying the required manpower and equipment to deliver emergency care in and out of the hospital (11, 12)
- ⊙ The parochial tendencies of those concerned with health care delivery, (hospitals, administrators, doctors, nurses, ambulance personnel and others) and their efforts to offer the broadest possible spectrum of services to their patients and communities. While this is a strong and positive force to build on, it is difficult to organize and manage in the interests of EMS of the general public and greater community.
- ⊙ The lack of serious area-wide EMS planning and clinical norms to provide EMS systems development with a unifying point of reference, objective assessment, and reduction or containment of current fragmentation.
- ⊙ The resistance to perceiving comprehensive EMS needs realistically in view of:
 - ⊙ present life-styles which increase risks of serious injury
 - ⊙ increased mobility
 - ⊙ increased dependency on hospital ED's
 - ⊙ rising senior citizen population
 - ⊙ changing demographics
 - ⊙ decreasing availability of physicians to their patients
 - ⊙ increased risks of liability in view of refinement of national EMS care standards

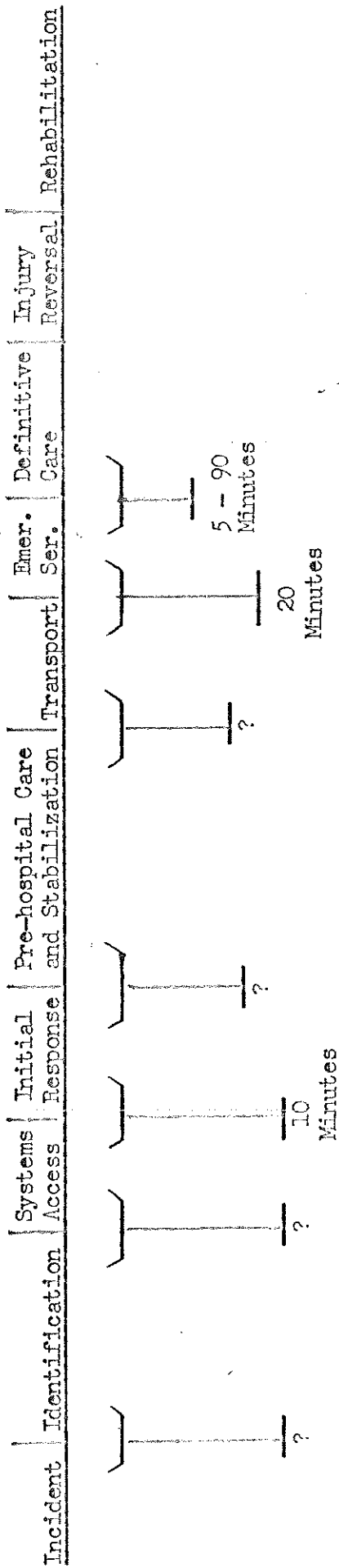
III. Consequences of Continuing Current Practices

Past experience has shown that an EMS non-system, left to itself, becomes increasingly inefficient. Uncoordinated EMS efforts, if continued, will produce a number of undesirable results. Among them:

- Hospitals will continue to staff and equip themselves with little or no reference to neighborhood or areawide needs or resources, with little benefit to the majority of patients and possible waste of scarce public or private health funds.
- Even where equipment costs can be met, scarcity of physicians, nurses, and ancillary staff members may leave the equipment partly or largely unused. It may not be possible for one facility to cover much more than immediate patient needs, and further specialized care will require patient transfers.
- Considerable time delays prior to the initiation of definitive treatment in a hospital ED will continue as a result of delays encountered in: 1) accessing the EMS system, 2) response lag time, particularly during the day when volunteer squads face critical manpower shortages, 3) transport time, and 4) ED mobilization to deal with the Emergent situation. Delays of up to 90 minutes are possible and the sequence of events may be depicted in a diagram. (See Figure 1)
- Thoracic, vascular, and neurosurgeons in private practice, and other medical specialists such as hematologists and neurologists spend considerable "circuit-riding" time between hospitals. A specialist occupied in or en route to one hospital and needed for an emergency in another is often cause for an additional delay in patient treatment in an ED. The commuting hours represent a serious erosion of medical resources without careful systems planning.
- With a significant number of hospital admissions now arriving through ED doors, and elective surgical/medical case loads decreasing because of medical advances, there is increasing pressure on hospitals to seek other means to maintain bed occupancy rates. In the absence of definitive state-wide EMS systems planning, it is not possible to stem or reverse the costly duplication or fragmentation which to a large extent continues to characterize Emergency Medical Services.
- The present EMS non-system does not fully address the medical needs of patients in advance of their admission to ED's, except as individual hospital policies, staffs, and emergency personnel perceive these needs. Such perceptions by service providers have tended to be less than EMS systems or patient oriented.

NEW JERSEY EMS SERVICES
 Estimated Average Times

HOSPITAL



(Figure 1)

- The application of field telemetric patient monitoring will continue to plague medical care traditionalists, legal experts, hospital staffs, and ambulance services until they and government can get together to assure proper testing of the advanced critical care, whether on-the-scene, or in transit.
- Economic arguments will continue to be used against EMS service improvements, while significant expenditures continue on behalf of the fragmented EMS "non-system." The subordination of local interests to broader area-wide or statewide EMS service needs will remain unachieved.

IV. The Need for Change in EMS

There are a number of interrelated variables which impact on the delivery of Emergency Medical Services in New Jersey. These factors tend to reinforce the current fragmentation of the EMS non-system and contributed to the less than ideal emergency care provided to the emergent or critically injured person.

If we are to achieve the desired objective of reduced death and disability via the provision of appropriate emergency medical care through the EMS System, the System must consider and respond to the following:

- recent developments in medical technology, such as telemetry, and the developing EMT and paramedic roles, which permit more appropriate on-the-scene treatment of the emergent and critically injured person.
- the critical illness time frame in cases of airway obstruction, cardiac arrest, etc., where patient survival is dependent on the initiation of treatment within a 3-4 minute response time.
- the problem of public access into the EMS System due to the lack of a single well advertised centralized phone number to call for emergency assistance, and the inability, - particularly of travelers and transients - to identify this number and clearly describe their geographic location.
- the expanded role of today's ambulance services from that of mere transport to on-the-scene injury assessment, initial patient stabilization and preparation for transport by trained and certified emergency personnel.
- the paramount need for closer medical involvement, supervision and control at each phase of the EMS system functions.
- the disparities which exist in the provision of emergency care by hospital Emergency Departments when evaluated in terms of staffing, equipment, and specific criteria for particular types of injury or illness (8).

V. The Need for Coordination

The time has come in the field of EMS for all the parties involved to get together to pursue the objective shared by all, i.e., critical and emergency care of patients. Physicians, administrators, nurses, and ambulance personnel must recognize the needs of the emergent or critically injured patient. A fully cooperative approach offers the best means to analyse and solve the myriad problems which must be faced. A cooperative approach also serves as more productive environment to address current EMS services not only from the view point of how many people are we saving, but also how many patients we might be losing.

In light of the foregoing, the NJ State Health Department has undertaken the "lead agency" role and responsibility. At this time the Department is pursuing a middle ground incremental approach to EMS care design. This has the advantage of generating a more congenial and positive environment, which assures not only a servicable EMS care design, but also one that will be more acceptable, effective, and stable in the longer view.

VI. Proposed Changes & Solutions

In view of these considerations, there are certain general goals that appear reasonable and significantly feasible:

- ① Upgrading Pre-hospital care proficiency levels to uniform standards.
- ① Creation of Central Dispatch Communications Centers to facilitate and improve patient access and movement through the EMS System.
- ① Rating of hospitals and Emergency facilities to determine life support capabilities.
- ① Development and testing advanced life support capability throughout the State.
- ① Designation of Specialty Critical Care Facilities according to patient care capabilities at various levels.
- ① Development of a Critical Care Facilities Network for New Jersey.
- ① Continuance of the Department's EMS Clinical Task Forces to serve as Technical Resources to EMS Systems implementation and expansion.

Upgrading Prehospital Care Proficiency and Assurance Levels

While ambulance squad accessibility and quality of prehospital emergency care were adequate in earlier years, in many instances today they are inadequate. A 1976 study (27) cited numerous deficiencies in equipment and training, among them: 40% of New Jersey ambulances failed to meet established national norms. At least 20% of active ambulance personnel were not certified or formally accredited under current national guidelines, even though certified training and refresher courses meeting National Standards have been in process since 1971 by the New Jersey State Health Department.

Efforts are now underway to redefine EMS ambulance functions within a tiered EMS Systems framework. The goal is to design, test and implement:

- more assured levels of ambulance response and function whether for basic or advanced life support for the prehospital phases of critical care at the accident scene, in transit, or during transfers.
- more assured trauma transport capability through voluntary designation of interested and eligible ambulance services, whether volunteer, commercial or municipal.
- closer coordination/cooperation with specialty care facilities.

EMS & Ambulances & Communications

Within the proposed idealized EMS tiered design, some ambulances will be designated on a voluntary and competitive basis for dispatch by EMS Communication Centers to the critical patient. These EMS Dispatch Centers will be appropriately distributed and linked across the State by a Public Communications network using a widely publicized toll free number, such as 911. Ideally the Centers will be interconnected with each other and with other public services such as fire, police, public works, and Emergency Facilities in the same areas. Centers will also monitor hospital availability for optimal ambulance routing. The eventual expansion of the State's current MICU demonstrations involving telemetric monitoring of the patient's vital signs will significantly extend medical control, and vastly improve or assure critical patient care.

Medical Control & Clinical EMS Planning

In order to achieve and maintain an EMS System consistent with today's EMS medical technology in both the prehospital and hospital phases, the New Jersey EMS System has given priority to the concept of Medical Control. In this regard, the work of the EMS Clinical Task Forces will establish definitive clinical requirements and norms related to prehospital phases of EMS, to include staffing and equipping of emergency vehicles, on-scene care protocols relative to patient needs in each of the Critical Care categories, patient transport, and the development of formal, written interfacility transfer agreements and protocols. The prehospital phase of emergency care will be coordinated by a trained medical dispatcher at a wide-area Communications Center who will initially screen emergency requests and direct emergency patient traffic. The dispatcher may simultaneously dispatch both a basic ambulance, and a Mobile Intensive Care Unit staffed by paramedics when direct Medical Control via telemetry appears appropriate within medical norms previously determined.

The Clinical Task Forces will also define the minimum criteria necessary for the treatment of the emergent or critically injured patient in terms of: staffing (physicians and nurses), equipment, and capability of performing specialized medical procedures. These criteria are to be used in the development of the Critical Care Network and the designation of certain hospitals as primary treatment sites for patients in one or more of the critical care categories. Utilizing these criteria, hospitals and ED's will be able to rate themselves or be rated, based on needs of the critical patient in each of the critical care categories of:

- o Burn Care
- o Cardiology
- o Poison
- o Neonatology
- o Neurosurgery
- o Psychiatry (Behavioral)
- o Surgical Care of the Severly Injured (Trauma)

Task Force discussions will focus on the scope and extent of the injury, specify what treatment modalities may be required, and suggest priorities for treatment sequence. The need for OR availability, specialized services and equipment, and the critical time frames of specific pathological states will also be addressed.

The Clinical Task Forces will make use of criteria for evaluating Emergency Care available through the NJ Committee on Trauma of the American College of Surgeons and other groups.

The commitment of the NJ State Health Dept. to develop an EMS System with a firm clinical base and medical involvement in both the prehospital and hospital phases is considered essential in terms of actual critical patient needs, and a more thorough and efficient treatment of the need throughout the State.

VII. Concept & Design of the EMS System

The Department through the Clinical Task Forces has studied EMS System models successfully implemented in Illinois, Maryland and other states, and will incorporate the desirable features of these models into the EMS System for New Jersey.

The New Jersey EMS System will provide a more assured level of emergency care to the critically injured or ill patient by encompassing the following elements:

- o Provision of rapid, identifiable patient access
- o Establishment of EMS Communication & Dispatch Centers
- o Clinically appropriate ambulance transport
- o Definition of hospital ED roles relative to immediate life-support, stabilization and critical care capabilities
- o A tiered Critical Care Facilities design to handle various levels of illness and injury for each of the Critical Care categories; Burns, Cardiac, Neonatal, Neurological, Psychiatric, Poison, and Trauma.

Patient Flow Through the EMS System

Prompt patient access to the EMS System must be facilitated by the utilization of uniform central access numbers, such as 9-1-1. The EMS Communications and Dispatch Centers will serve a number of functions, i.e., screening of requests to determine patient severity and needs, efficient patient transport by ground or air to the appropriate facility, provision of Medical Control to prehospital EMS personnel, coordination of EMS sectors with other public safety sectors, and control centers for disaster mobilization and response.

Dependent upon the severity of a patient's injury or illness as reported to a trained medical dispatcher at the communications center, an appropriately equipped and staffed ambulance will be dispatched to the scene. While some requests will require only transport, others will require the services of certified BLS personnel, such as an EMT, or a certified ALS paramedic within a Mobile-Intensive-Care Unit (MICU). Critical patient monitoring equipment will function under the direct Medical Control of a hospital based physician. The importance of fully coordinated radio communications in the prehospital phase of EMS is self-evident.

The critical patient will be transported to the hospital facility best qualified to meet the patient's immediate needs. A statewide Critical Care Network will be developed of appropriately staffed and equipped facilities. The Network design ideally will be tiered relative to the various levels of clinical need.

If it is not practical to transport the critical patient directly to the designated Critical Care facility, the patient will be transported to another hospital ED with capability to stabilize and initially treat a specific patient category. Hospital ED's will be evaluated on the basis of AMA and other clinical guidelines recommended by the Task Forces for each of the Critical Care categories. While certain ED's will be assigned special roles in the treatment of critical patients, all ED's must be capable of the basic medical procedures necessary for patient stabilization, prior to transfer to a tertiary care facility.

Since all critical patients may not initially be delivered to the most appropriate facility, and inter-facility transfers will need occur, an EMS Coordinator will be responsible for:

1. the development of written EMS critical patient transfer agreements
2. carrying out of transfers within previously established medical and administrative protocols.
3. facilitating communication between the referring and receiving physicians and administrations
4. Monitoring Critical Care traffic and bed availability
5. Apply medically established norms regarding method of transport.

Transfer Agreements and Protocols will be developed to facilitate transfers and assure that the needs of the critical patient re staffing, equipment, and medical control are provided for during transfer.

The EMS System design outlined here will provide the citizens of New Jersey with the highest quality Emergency Medical Care by effecting a more appropriate and efficient utilization of current resources.

VIII. Future Needs

The tasks of initial design and operation of a more adequate EMS system itself requires much expertise and resolute leadership, but no less so than the later task of maintaining the System once established. Among these latter concerns are:

- o A reliable EMS statistical data base
- o System growth through identification, testing and implementing new technologies
- o Increased public awareness and active participation
- o Professional Education
- o Effective management structures

The Department's EMS System design, now in process, will fully recognize the long-range needs of an effective, assured, and accountable strategy to deliver high quality emergency medical care. These needs demand the development of a reliable EMS statistical data base to evaluate progress and redirect project activities as necessary. There is also a need to test and integrate telemetric capabilities, train and certify prehospital personnel, and to promote a sense of professionalism and responsibility within each of the EMS System components.

The Public

There is an obvious need to address the general public's increasing awareness of EMS systemization, and to channel their interest through education to serve both their needs and EMS information objectives: System orientation, System utilization, System access, active citizen's participation as first responders, and System endorsement.

Under System participation it is urgent that basic CPR skills be widely promoted. To this end the Department's Cardiac Defender Program will be more fully tested and expanded. In today's EMS technology there is a unique and valuable role for the basically trained bystander or passerby, as well as for highly trained ambulance personnel assuredly trained as extenders of traditional ED professional staff. It is seldom that even the alert ambulance squad or prepared ED can reach the acute coronary emergency patient within the four minutes allowed by the unaided, arrested heart. The best hope is earlier intervention on the scene by the public at large.

EMS Education

Manpower needs for EMS systemization represent a formidable educational task. In New Jersey this is already being partially met by the EMS physician and nurse courses by CMDNJ in Newark and other limited efforts by ACEP, EDNA, and the Trauma Committee. Expansion of these and other educational programs is a continuing requirement. At present, hospital-based demonstrations of Mobile Intensive Care are being conducted, with paramedic training provided in a 500-hour program.

The American College of Emergency Physicians recognizes the need to develop well trained emergency physicians and is working at the national level to establish minimal training requirements (as expressed in a Specialty Board rating) for this group. While some controversy attends this, there is little disagreement concerning Emergency Medicine's growing importance within the spectrum of medical practice. Professional recognition and credentials for Emergency Physicians and Nurses is important to a stable EMS System.

Patient-oriented EMS

The need in New Jersey at this time is for design and functional implementation of an EMS System, i.e., a coordinated sequence of effective and prompt critical care whenever serious injury occurs. An EMS System must be seriously concerned that a suddenly ill or injured patient be assuredly identified, responded to, cared for appropriately at the scene, and transported safely to a point of definitive care, without adding to the physiological damage already incurred. This system must obviously be developed within today's general budget and resource constraints. The new system should stress more accountable allocation of existing available resources and need's assessment as a condition for increased resource expenditures.

The development of such a system is neither an easy task nor the responsibility of only a few. As in any cooperative effort, accommodations by some will be required for the sake of the larger community. The dominant concern of EMS systemization has to be the needs of the patient, as defined by those skilled in treating patients. With these definitions accomplished, other hospital and prehospital personnel will then be in a position to define their own roles vis-a-vis these patient needs. Unquestionably, physicians, nurses, administrators, ambulance technicians as well as planners should be involved. Each of these represent specific sections of current EMS concern. Through the participation of each, a Systems Plan will effectively be translated into assured, efficient, and effective emergency care for all citizens.

IX. Summary

The New Jersey State Health Department over the past few years has assumed a leadership role in designing a more coordinated system for the delivery of emergency care statewide. The need for such a system is in part based on the new EMS technology that is now available to critical care medicine, and the conviction that the continuing waste of human life and health through accidental death and injury can no longer be tolerated. EMS today views emergency care as appropriately beginning at the actual injury scene, and continuing at the hospital ED. This sharply differentiates EMS today from traditional emergency care.

The second part of the challenge is to achieve EMS adequacy within today's health care constraints, which include the increasing costs of staffing and equipping hospitals, defining and designating specialized critical care facilities, and the development of new professional and para-professional roles implicit to high quality and comprehensive EMS care. With the cost of medical technology demonstrably increasing, it becomes more and more urgent to develop greater EMS cost economies. Existing medical care resources must be better utilized through reasonable consolidation of critical care resources. EMS training and education must be more available and effective. These are positive goals which an EMS System will pursue.

Once the conceptualized "ideal" EMS System has been developed by the physician and the technical advisory groups, the administrative, nursing, ambulance, and official planning sectors will review and evolve their own requirements. Finally, the fully developed theoretical system will be submitted to official endorsement processes.

This incremental methodology and approach, with input from all concerned with emergency medical care, seems in the department's view a rational way of dealing with the task of providing all citizens of this State with optimal emergency care.

It also appears to provide the means of making the transition from the present non-system to a real system with minimal confusion, hurt feelings, and general upset. As citizens of this State, whether as providers and/or recipients of its medical care, it behooves us all to seek and work for the best emergency medical care attainable.

X. Medical Leadership

In a recent interview, David R. Boyd, M.D.C.M., National EMS Director, DHEW, stressed the critical importance of medical leadership for serious EMS systems development:

". . . Public Safety type leadership can only go so far. They can build ambulance services, but that's not the same as a good Emergency System. We must have local standup physicians who can fight for the system. . . .

". . . (The EMS System) . . . will be the first system in the country . . . that will take all comers at all hours. We have not had a system of care in this country. We have had a good medical practice, excellent resources, good institutions, well trained physicians and other personnel . . . We even do heart transplants, but the average person does not have (assured) access to services, especially in an emergency. EMS is the ground-floor of the health care system . . . " (28)

XI. Conclusion

The State of New Jersey is uniquely in possession of most of the ingredients of **an adequate** EMS System. What remains is for all the ingredients to be linked and coordinated into a holistic and comprehensive EMS care process, a process which can begin to provide quality prehospital and in-hospital EMS services whenever or wherever critical injury strikes.

The process of adequate care, which in a sense describes an EMS System, is itself dependent on successfully achieving a prior partnership of concern on the part of appropriate provider and consumer sectors.

The NJ State Health Department through its Office of EMS invites such a partnership.

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