A TOTAL EMERGENCY MEDICAL SERVICE SYSTEM

FOR THE STATE OF ILLINOIS

by

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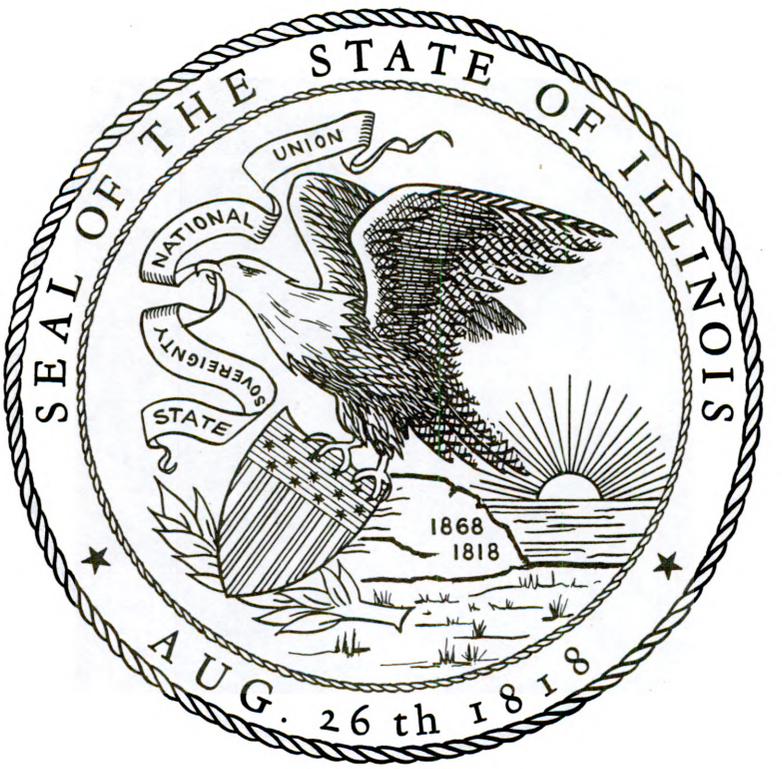


INTRODUCTION

It is now evident that an environment exists in the State of Illinois for the development of a total statewide emergency medical service delivery system. The lack of provision for emergency illnesses, accidental death and disability can no longer be justifiably classified as an insoluble health problem. Medical expertise and technology is now available in Illinois which can easily and efficiently be applied to this previously neglected health problem. In fact, it is only through the better utilization of presently available resources that an immediate beneficial effect will improve an existing but poorly organized program. In some areas only a total upgrading with development of an essentially nonexistent emergency medical care system will be necessary. Of all the problems in health today, a solution to the emergency medical service situation through establishment of a total systems approach to areas of medical and surgical life threatening emergencies is paramount.

Three years ago, President Nixon expressed concern about the impending "crisis in health care". This crisis is manifested by the lack of accessibility of available modern improvements in health to the consumer. This fact is becoming more and more evident in the area of emergency and critical care medicine. In Illinois, with the development of a Statewide Trauma Program, it has been shown that expert care which was previously available only in the University Centers can now be effectively and efficiently delivered throughout the State and especially in rural communities.

PROGRAM GOALS

The following is a list of program goals which will be implemented in the State of Illinois; Total Emergency Medical Service System (TEMS).

Goal I.

To provide accessibility and emergency medical service to every citizen of Illinois in order that they receive benefits of emergency and critical care medicine.

Goal II.

To develop a comprehensive emergency and critical care system which will fully utilize existing resources while stimulating the development of new care capabilities where these are insufficient or totally lacking.

Goal III.

To develop practical and workable solutions to the emergency medical service problem utilizing accepted forms of health care application.

Goal IV.

To plan and develop all phases of the program utilizing community and areawide planning.

Goal V.

To continuously evaluate and monitor programs in order to determine all critical factors to provide for ongoing modifications and analysis.

Goal VI.

To develop a total system that will be financially and administratively self-supporting without continued subsidization from external sources or reliance on a state bureaucracy.

Fortunately for the State of Illinois, a vast amount of experience in problem identification and systems modeling in the area of Emergency Medical Services has been gained. With the successful development of the Statewide Trauma Care Program, specific problems and their solutions have been identified and tested. By using the positive and negative feedback approach, the entire health community of the State has gained a considerable degree of sophistication in the area of emergency care systems development. Because of the statewide systems development of a Trauma Care Network there has been the emergence of a healthy and practical implementation environment where problems approached on an empirical basis have been studied as ongoing events by the entire health community. It is the effort over the past two years that is enabling Illinois to step forward to a total systems approach to emergency and critical care medicine on a statewide basis.

PROGRAM MODELING

A controlled systems approach to the problems of an emergency medical service is the most practical, sensible, and the one that will

yield the most return. This approach has already proven itself in the success of the Illinois Trauma Care Program. This innovative emergency delivery system has been developed in stages by defining a specific problem, "The critically injured patient; developing a plan based on established principles of management; implementing this plan in a systematic manner by utilizing and augmenting existing professional and technologic resources in a community".

The success of the Illinois Statewide Trauma Program for the Care of the Critically Injured is now an accepted fact. This program has not only established itself as a model that many other states are now following, but has also provided the necessary groundwork for the completion of a Total System of Emergency Medical Care for the entire State of Illinois. The closed loop feedback system has provided certain guideposts for evaluation of trauma and other community emergency health programs.

In this controlled implementation approach, the Division of Emergency Medical Services and Highway Safety has gained considerable experience in the problems of generating a major health care change on a statewide basis. In addition, the entire state health community has gained a great measure of sophistication in comprehensive areawide planning and implementation of emergency medical care systems. Illinois is now ready to expand its trauma care system to become a total emergency medical care system. Illinois can now effectively and efficiently utilize additional financial support to complement the present planning efforts. Without such a planned and controlled systems approach, additional support monies would only further disorganize a non-system of emergency health care.

COMMUNICATIONS

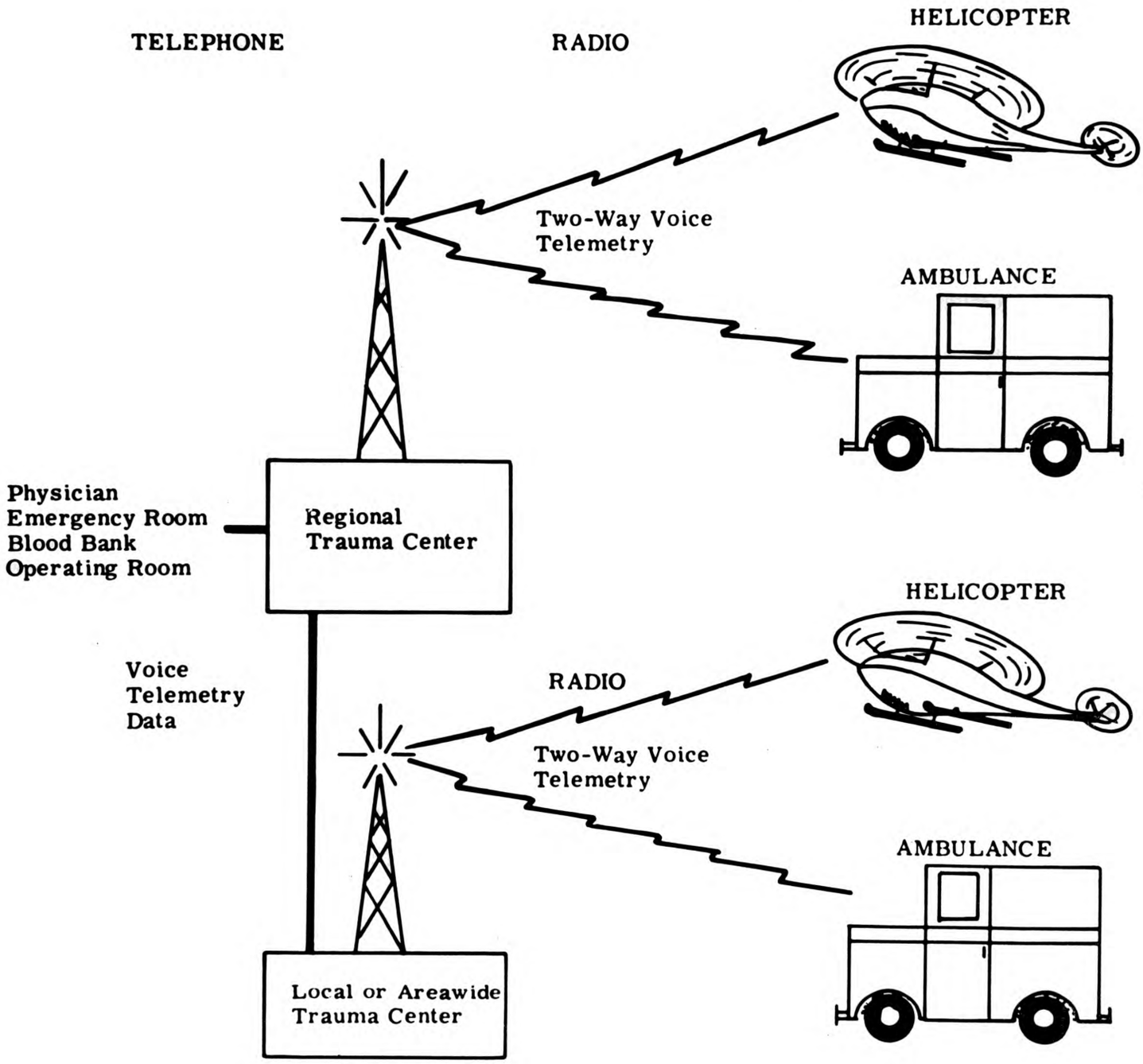
The second highest priority after the designation of the Trauma Centers of the Illinois Emergency Service Plan is the development of an organized comprehensive communication system. The Illinois Trauma Program has initiated this development. At the inception of this statewide program there were forty-six hospitals on the HEAR System and less than four per cent of ambulances could effectively communicate with any hospital even in the most rudimentary manner. The Illinois Emergency Medical Service Communication System is complementing the Illinois Hospital Association's program and utilizing the established Federal Communication Commission (F.C.C.) Medical Emergency Frequency 155.340 mH_Z. Hospital (base) and mobile ground and air vehicles will communicate on this band and within $\pm$ 0.7 per cent of 155.340 to include .160, .280, and .400. Multiple channels will be necessary in congested areas. Telemetry has been assigned a high band frequency (.460).

The partially implemented Illinois Hospital Association HEAR System is being redirected along the regional lines consistent within the Trauma Center concept. Multiple channel regional radio consoles are presently being installed. These radios have multiple channels (8 per console) and will be linked to satellite Local Trauma Centers and Outlying Critical Care Centers by lend-lease dedicated telephone lines. Two-way radio communications are now possible from Regional Centers to ambulances within their own vicinity (approximately a 25 mile radius). Also, a physician in a Regional Center can monitor an ambulance operating out of a satellite Hospital or Local Trauma Center via the regional console-lend-lease telephone line to the satellite base radio and on to the mobile unit out in that respective vicinity. The telephone-radio-patch capability enables this radio communications network to be linked together by standard conventional telephone.

One of the greatest problems in any communications system is the human link. The Division of Emergency Medical Services and Highway Safety's approach to this problem will involve a complete re-education and reorientation program. This proposed program will include the training for all existing communications personnel in the use of the regional radio-telephone system at each communication level. The next phase of the program will be to consolidate all emergency communications capability for controlled dispatching and better utilization of communications and medical personnel (*Trauma Newsletter* June, No. 8). In each regional and areawide community there is being established one emergency medical radiotelephone control center. Trained radio operators with previous military or similar training and background are being employed by the Division of Emergency Medical Services and Highway Safety to assist in the implementation of this program in each region of the State.

The Regional Radio Operations Coordi-

ILLINOIS EMERGENCY COMMUNICATIONS SYSTEM



nator will act as program catalyst and as a technical resource with which to put this comprehensive uniform system together. In the later phases and in the larger communities (90,000 to 250,000 population) there will be an effective centralized operation for fire, police and emergency medical operations. These operations will support outlying communities for similar needs. The established Trauma Communication System can be easily extended to include non-trauma center facilities by additional radios and dedicated telephone lend-lease lines.

AMBULANCE COMMUNICATIONS

The problems and deficiencies in ambulance-hospital communications capabilities are well known. Only four per cent of the ambulances in Illinois can talk effectively to hospitals during transport. In a recent survey it was established that there was a considerable amount of ignorance and confusion about the needs and potential of an ambulance-hospital radio system.

The contract has provided for the purchase of approximately 900 mobile ambulance radios. The Division of Telecommunications will purchase in large quantity, radios for the ILLINOIS MEDICAL COMMUNICATIONS NETWORK. The bulk purchase will result in a savings of up to thirty per cent. The title for this equipment is held by the State of Illinois and an overall service contract will be maintained for all participants by the State. The Regional Radio Operations Coordinator will assist local agencies in the installation and operation of this system.

OUTLYING CRITICAL CARE UNITS (O.C.C.U.)

The outlying critical care units will be an extension of coronary and other critical care capability of major hospitals to outlying rural community hospitals. This program of establishing O.C.C.U.'s is already underway in the Springfield Region (III-A) and has the support of the hospitals, medical staffs, and the Southern Illinois University Medical School. Satellite coronary and critical care units (O.C.C.U.), on-line to the advanced centers, will have up to three bed cardiac and intensive care monitoring and data-phone electrocardiographic (EKG) transmission.

The O.C.C.U. program monitoring will be accomplished by a coronary registry (modeled after the Trauma Registry, National Institutes of Health Grant, GM 18003-01). This will be in the form of easily filled in (mark-sense) data forms which will become part of the hospital record and can also be automatically data processed.

EMERGENCY MEDICAL TRANSPORTATION SYSTEM

In the development of the Illinois Statewide Trauma Program, many of the critical problems of patient transportation have been evaluated and with necessary experience gained. The Division of Emergency Medical Services and Highway Safety has a first hand knowledge of these problems and has begun to provide solutions utilizing innovative measures (*Trauma Center Newsletter,* No. 7). The problems of ambulance services vary and are dependent on many factors including population density, socio-economics, proprietary competition, municipal taxation structure and jurisdiction considerations. In one area, better coordination of existing services affords a partial solution. Other areas are totally devoid of transportation services. There are almost as many solutions as there are problems and while guidelines are helpful, these solutions must be stylized to meet the specific needs of each community. Trauma Coordinators have been very effective in assisting local governments (including Chicago) in finding workable solutions to their problems. By working with the Local Traffic Coordinator and the municipal leaders, the Division of Emergency Medical Services and Highway Safety has stimulated the purchase of some twenty emergency ambulances with National Highway Traffic Safety Act (402 NHTSA) matching funds in areas where no or substandard ambulance services were available.

1. THE PRIMARY RESPONSE SYSTEM, TRANSPORTATION

The Illinois Emergency Medical Service System plan will rely on ground ambulance transportation for the vast majority of emergency calls. Only on rare occasions in the foreseeable future will the helicopter be utilized for this purpose.

It is the goal of the Illinois Emergency Medical Services Plan to provide adequate safe and rapid transportation to all citizens in all areas of the State. At present, over 70 per cent of all rural ambulance services are provided by mortician-ambulance operators. There is a considerable anxiety in these communities to maintain some type of vehicular services. The pending ambulance legislation (H.B. 4335) when passed will provide authority to license ambulance services across the state. Basically the Bill identifies two types of vehicle: (1) the Emergency Ambulance, and (2) the Invalid Coach.

All Emergency Ambulances will comply with the specifications established by the National Highway Traffic Safety Administration Standard 11, Ambulance Equipment and Design. This includes basic life and limb support equipment, two-way radio voice communications, and EMT-A training (*Trauma Center Newsletter,* No. 3). A special training pack for Emergency Medical Technician-ambulance Training has been developed by the Division and is situated at the Trauma Centers. The Invalid Coach services will also be regulated by the Division. Services by the mortician-ambulance operators will be of continued necessity in Illinois for the present time until new systems of rural emergency transportation can be employed on a wide-scale basis.

At the Statewide Ambulance Seminar held in Peoria on April 7, 8, 1972, over 600 ambulance operators met to discuss their mutual problems. Topics discussed were the pending legislation, funding, equipment and design criteria, training programs, and other special problems. A great deal of uniformity of purpose by the ambulance industry in Illinois developed from this open forum.

The rural ambulance service problem will not be solved by traditional approaches. Even after the purchase of modern equipment the operation of these services will be unfeasible in many small communities. The Division of Emergency Medical Services and Highway Safety is setting out to develop new model systems of ambulance services. The details of which will be discussed in future *Trauma Center Newsletters.*

THE SECONDARY AMBULANCE RESPONSE SYSTEM

After a critically ill or injured patient is delivered to a small community hospital or Local Trauma Center and successfully resuscitated, a real dilemma sometimes develops. A life has now been saved but further support and definitive care are beyond the scope of this institution and a secondary transfer must be arranged. This secondary transfer is many times extremely difficult and its success is limited by the available transportation equipment and personnel. These transfers are further inhibited by local jurisdiction boundaries and weather conditions. Many times after a mode of transportation is arranged, the level of patient care provided during this movement is far below the referring hospital's supportive endeavors and the patient's condition worsens during the trip. It is for these reasons an independent regionally based secondary ground ambulance system is being developed.

OVERLAND CRITICAL CARE VANS (O.C.C.V.)

These Overland Critical Care Vans (O.C.C.V.) will be based at the Regional and Areawide Trauma Centers and provide the ultimate in specialized intensive (life support) care for patients while they are being transported to centers where specialized definitive care is available. There will be in no instance a duplication of effort, material, monies or manpower; but in fact this system will rely heavily on the existing Trauma Center Network for many of its operational components. This program will allow the extension of the Intensive Care Unit (I.C.U.) critical care capability of Regional and Areawide hospitals to less capable institutions. In the O.C.C.V., patients will receive continued and many times enhanced critical care during transfer. The threat of loss of continuity of patient care during these necessary transfers will not occur. The maximum distance of travel would be 50-75 miles (1 hour transport, 2 hours round trip) for most transfers and the patient would be safe with critical care being administered in route. While in the O.C.C.V. the return will be direct and leisurely because of the expert medical personnel, radio communications including telemetry, and treatment that will be available.

Uniform resuscitation equipment, fluids, drugs, ventilators, and critical laboratory aids will be installed in these vans.

O.C.C.V.'s will take the pressure off the local ambulance services' need for transportation beyond their jurisdictional areas and out of their respective regions. They could then maintain a better primary response capability in the respective areas of responsibilities. The O.C.C.V.'s will not be in competition with existing ambulance services and hospital centers might even subcontract with these services for drivers and other experienced emergency professional personnel.

The O.C.C.V.'s would be hospital based (Region and Areawide) for better (double) utilization of Emergency Medical Technicians (EMT's), nurses, and physicians. They will be so constructed with resuscitative equipment components as to be able to respond to any specific emergency event (e.g. coronary, or pediatric).

The O.C.C.V. will be staffed by a team to include: (1) driver, (2) nurse (trauma, coronary, pediatric), (3) EMT-A, and (4) appropriate house staff or physicians when necessary. The driver would be paid full salary by the hospital and probably be on their maintenance staff. The nurse would be part of the Emergency Room or ICU staff. The EMT-A could be a part or full time employee at the hospital. The operating costs will be absorbed by the hospital. The Division has already obtained approval and committments for participation by the Regional and Areawide Centers.

The Overland Critical Care Van (O.C.C.V.) will be multi-purpose and have the following equipment: Two-way radio, resuscitator, defibrillator, telemetry devices, laboratory aids (blood gas analyzer) and life saving medications. These will be stationed at Regional, Areawide and special treatment centers.

THE OUTREACH COMMUNITY CARE BUS (O.C.C.B.)

Many problems of emergency medical care continue to plague rural and inner-city communities. The goal of the Illinois Emergency Medical Services Program is to extend the care capability of the University and Urban centers to rural and deprived inner city communities across the State.

The development of a multipurpose mobile teaching and disaster control unit (O.C.C.B.) will be used to support emergent and non-emergency health and health education programs in special areas. The Outreach Community Care Bus will be used for presentation of the Emergency Medical Technician-Ambulance course in a large number of very small communities located in the remote areas of Illinois. These communities must be considered as a part of a total statewide emergency medical services system. Many of the citizens of these communities serve on voluntary rescue squads, ambulance and fire services. The Emergency Medical Technician-Ambulance (EMT-A), Medical Self-Help, and other non-emergency community health education programs will be taught from the O.C.C.B.'s. A Trauma (EMS) Coordinator will be assigned as driver/instructor and will establish and coordinate the training *cycle* for a given region of the State.

Some of the non-emergency health courses will be taught by Regional and State Public Health Nurses and assisted by local physicians and dentists, and will involve Community and Mental Health, Immunizations, Preventive Medicine and Dentistry instruction to name only a few. Also, active programs of immunization, health inventory, and mass screening programs (diabetes, myocardiac, and pulmonary detection). Subject matter considered beyond the training scope of the Trauma Coordinator will be presented by local physicians on a contractual basis. Subjects such as emergency births and child care will be presented by the Regional Health Nurse. Subjects dealing with automobile accident extrication and fire fighting procedures will be presented in coordination with qualified representatives from regional fire protection districts. These mobile training units will function on a continuing basis throughout the year.

DISASTER CONTROL CENTER

The Outreach Community Care Bus (O.C.C.B.) will be equipped to function as a mobile disaster control center. It will have a radio on the Emergency Medical Services and Highway Safety, fire, police and Civil Defense frequencies. The O.C.C.B. will have the capability to react to a disaster by rapidly moving into an area within its region and immediately becoming the Radio Command Post and Triage Center. One of the major deficiencies in almost all disaster programs is the failure to activate

and coordinate the emergency medical system early. Extensive and comprehensive disaster plans and manuals have been developed but rearely read or followed after a disaster occurs. In Illinois, we experienced at least one major tornado a month from March to September. Also, a major catastrophy such as a school bus and/or train wreck occurs almost monthly. These events occur suddenly and the medical supportive response is generally lacking or totally uncoordinated. Chaos usually results with the arrival of rescue squads, fire trucks, and police cars on the scene, but without any medical expertise and without any capability to seek medical help or alert the nearby hospitals regarding the status of the calamity. Usually at the disaster site there is no central communication capability, no triage or treatment center, and no readily available emergency medical supplies and equipment.

The Outreach Community Care Bus (O.C.C.B.) will be used for spontaneous natural disasters. Spontaneous disasters occur rapidly and the need for improved medical support is usually only a relatively short interval. In the past, this interval was prolonged especially when bodies were trapped in the wreckage and debris.

These unfortunate and unpredictable events are not served by presently available means including the Package Disaster Hospital (P.D.H.). The Package Disaster Hospitals In Illinois are the responsibility of the Division of Emergency Medical Services and Highway Safety. The Package Disaster Hospital Program is an excellent resource. It is best utilized in circumstances of floods and massive catastrophes with large numbers of casualties and dislocation of entire communities. The time and effort necessary to activate, transport, and set up a Package Disaster Hospital precludes it from use in most ordinary natural disasters that are commonly experienced in Illinois. The Outreach Community Care Bus would fill this emergency response capability very well and will contain some of the resources presently in the P.D.H.'s.

TRAINING AND EDUCATION

The continued quality of health care delivery in any system is dependent on the training and educational programs of the system. The lasting features of any such program is again dependent on the training at all levels including: allied health personnel, nurses, physicians and the public.

1. THE EMERGENCY MEDICAL TECHNICIAN-AMBULANCE (EMT-A)

At the present time, Emergency Medical Technicians-Ambulance (EMT-A) ambulance training is being conducted at the Trauma Centers. Current course content is based on the National Highway Safety Program Standard 11 – Emergency Medical Services. The training recommendations and guidelines were prepared by the Committee on Emergency Medical Services of the National Academy of Sciences, National Research Council, in conjunction with the American College of Surgeons (A.C.S.) and American Academy of Orthopedic Surgeons.

The EMT training program is now taking place at most Trauma Centers in conjunction with community colleges (*Trauma Center Newsletter,* No. 3). All of the teaching resources at the Trauma Centers, as well as the Illinois Trauma Core Library are available to the EMT-A trainees. In outlying areas this training will be conducted by using mobile training stations (Outreach Community Care Buses – O.C.C.B.).

Advanced EMT programs for ambulance emergency medical technicians, of approximately 400 hours duration, are now being developed to provide the next step in this health career ladder. This program will be expanded and become formalized with the objective of creating in each region and subregion of the State, academically oriented, graded curriculum at the community and senior college levels. The clinical experience will be provided in hospital emergency rooms, intensive care units, coronary and respiratory care units of associated and affiliated hospitals. The training program will become the responsibility of community health education programs as they develop. Equivalency examination procedures will be developed in order to serve as the basis for constructive credit for experience, such as military service.

2. THE CRITICAL CARE NURSE TRAINING PROGRAM

The Trauma Nurse Training Program is now being expanded to provide for critical care nursing. This nurse specialist is a graduate

trained to cope with the total needs of the critically injured patient and will be a multi-purpose, cross-trained, intensive care specialist who can handle well all types of emergency situations, from pediatric crises to drug intoxication, accident victims to cardiovascular attack victims. The critical care nurse will work closely with the attending physician. Intensified training programs beyond the established four weeks course will prepare the critical care nurse and will be conducted at the Regional Trauma Centers (*Trauma Center Newsletter,* No. 4).

EMERGENCY ROOM PHYSICIAN

The American College of Emergency Physicians (ACEP) is beginning to develop residency training programs for Emergency Room Physicians. Two proposed sites in Illinois for this program are the Evanston Hospital Regional Trauma Centers, Northwestern University Medical School, and at the St. Francis Hospital Regional Trauma Center, University of Illinois at Peoria.

A detailed curriculum for this residency is now being programmed and the general guidelines will be described in the *Trauma Center Newsletter.*

TRAUMA AND EMERGENCY MEDICAL SERVICES FELLOWS

Post-doctorial training in critical care medicine, trauma and emergency medicine is being sought by many highly qualified physicians and surgeons. Inability to sustain these trainees by those hospitals that are developing regional emergency medical service centers is apparent. These young and enthusiastic professionals should be an essential component to a growing and stable statewide program. Fellows will remain on their hospital staff and be a continued asset to the Emergency Medical Services program in that community by assisting in the patient care, and teaching aspects of the program. A one-half salary support plan will be available to the parent institution. Surgical and critical care Fellows will receive additional training in trauma, burn, intensive care management, as well as bio-instrumentation, systems development and program evaluation techniques. These Fellows will be the core of a sound continuing community service and academic program.

COORDINATION WITH AREA HEALTH EDUCATION CENTERS

All education programs at the Trauma (EMS) Centers are being implemented with the help of Trauma (EMS) Coordinators and taught by appropriate professionals. These programs are developing in close conjunction with selected Community Colleges and Universities with health education potential. This is anticipatory of the development of Area Health Education Centers (AHEC).

AMERICAN ACADEMY OF GENERAL PRACTICE

The American Academy of General Practice has again chosen the topic of trauma management for one of its continuing education courses for the Academic Year 72-73. This Program will be sponsored in part by the Division of Emergency Medical Services and Highway Safety and academically designed by the Department of Surgery, Abraham Lincoln School of Medicine and the Southern Illinois School of Medicine.

PROGRAM MONITORING – THE REGISTRY APPROACH

The success of the planning and implementation activities and the redistribution of emergency services must be documented to justify the necessary effort and cost. Integrated into the Trauma Care System is a Computerized Information System, The Trauma Registry, which has already proven to be an effective tool for epidemiologic and clinical investigations and is now and most importantly being used for project monitoring of the Trauma Program development. This registry will be necessarily expanded to include all aspects of emergency medical services.

This is a National Institutes of Heath Project (GM 18003-01) and is now being used throughout the Trauma Network in Illinois. There is also one unit reporting from Kansas City and several other Centers are evaluating this system for their own use.

The first addition to the Trauma Registry will be coronary care. The addition will be modular with the initial program to be developed in a subregion of the State. Following this, the other elements of emergency medical ser-

vices will be added, including poison control, acute psychiatric disorders, whole blood traffic, and organ procurement and transfer.

The remote data phone peripheral units are already operational in the Trauma Centers. At least another 25 remote terminals will be needed. Other emergency functions such as the statewide blood inventory and on-line tracking system, poison control and product related accident reporting, burn bed registry, and the renal transplant programs will utilize the same equipment as is now operational for the Statewide Trauma System.

In the Total Emergency Medical Services System, program monitoring will be facilitated by integrating critical care components into the registry and will be modeled after the original trauma component module.

PROGRAM IMPLEMENTATION AND APPROACH

The Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health is an operational agency with the proven expertise in the development of systems of emergency medical care.

The Division now has a staff of over fifty specialists and highly qualified personnel in the area of emergency medical services. These personnel include Trauma Coordinators, Trauma Nurse Coordinators, Field Blood Alcohol Technicians, Blood Bank Coordinators, and Communication Technicians as well as a large staff of full and part time professional consultants in all related fields.

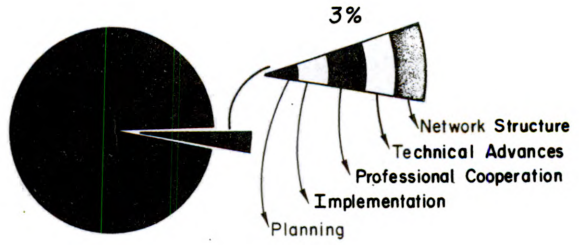
By July, 1972, over forty experienced ex-military medical corpsmen with a combined average experience of over fifteen years will be community based as Trauma (EMS) Coordinators. These coordinators will provide local expertise for emergency medical services.

Also, nine Trauma Nurse Coordinators will be established at the Regional Centers and will be developing trauma and emergency nurse training programs.

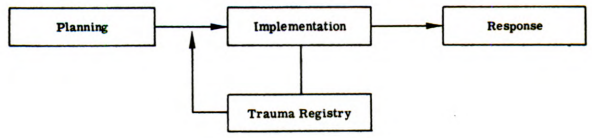
All persons in the State needing emergency medical care will be eligible for admission into the system from initial on-site medical care to acute definitive care to and through specialized definitive care if needed, without regard to any criterion other than need for the emergency service. All hospitals in the system will be obligated to "open referral" for emergency medical care patients. The regionalization and subregionalization of the trauma network has been developed by the joint action of the Subcommittee on Regionalization of the Governor's Committee for the Care of the Critically Injured Patient and local planning groups in cooperation with medical societies, public officials, professional health organizations and the various hospitals involved. In addition, local consumer groups have been involved to gain maximum community decision and support. At present, formalized Emergency Care Councils are in the process of development in accord with this regionalization. The development of the Total Emergency Medical Care System will follow this same basic approach.

The Emergency Care Councils have been formed by the CHP-B Agencies, where they exist in the state and have involved the total community in their formation, and will be developed in all other areas where such official planning agencies do not yet exist.

A SYSTEMS APPROACH TO EMERGENCY MEDICAL SERVICES



A CONTROLLED IMPLEMENTATION SYSTEM



THE SYSTEM PROPOSAL

The key items of concern in an Emergency Care System are quick response to the patient in getting to him as quickly as possible, ascertaining his need, providing immediate treatment where appropriate, and getting him to the appropriate facility that can best handle his need (alerting this designated facility so as to be prepared for the receipt of the patient and his subsequent treatment).

Although simply stated above, this is no mean undertaking, since it requires coordination and cooperation of many diverse resources. This is compounded by the fact that, in many areas of the state, these resources are either not readily available or inaccessible under the present system. For the most part, resources are present, but they have never been coordinated into a total system to pursue a specific mission (i.e., trauma, and critical care such as poisoning, drug intoxication, pediatric crisis, cardiovascular attacks, psychiatric emergencies, obstetrical emergencies, etc.). Also, accessibility is often a function of visibility, and this is a function of provider and public education. Both apsects will be stressed in this program, and this integrated system will make the resources both available and accessible. As a result of this process, there will be developed more substantial linkages between the users, providers, and resources that will be of an ongoing nature and not created per each emergency. The participants will recognize that they are working within a system of care and will benefit from this awareness.

The present trauma program has made many inroads to the solution of these problems by putting together many of these resources around the state and tying them together into a functional regional network. The goal of the Total Emergency Medical Program is to capitalize on this developing system in order to expand it into a full-blown system for total emergency care.

Basically these comprehensive packages will require:

1. Areawide community planning models for the provision of comprehensive emergency medical care.
2. Evidence of utilization of all available health resources with the area of service responsibility.
3. Show methods for providing comprehensive service care including the major categories of medicine (coronary), surgery (trauma), pediatric, drug and poisoning, psychiatric, etc.
4. Cooperation with and provision for an ongoing evaluation and data control during contract period.
5. Give evidence of self-sustaining potential of proposed project sub-contracts (obviously some one-purchase items will not require the same detail as other services delivery system components).
6. Submission of a written proposal to the Division of Emergency Medical Services and Highway Safety for approval and to develop the contract between with review and comment by existing comprehensive "B" Agencies when appropriate.

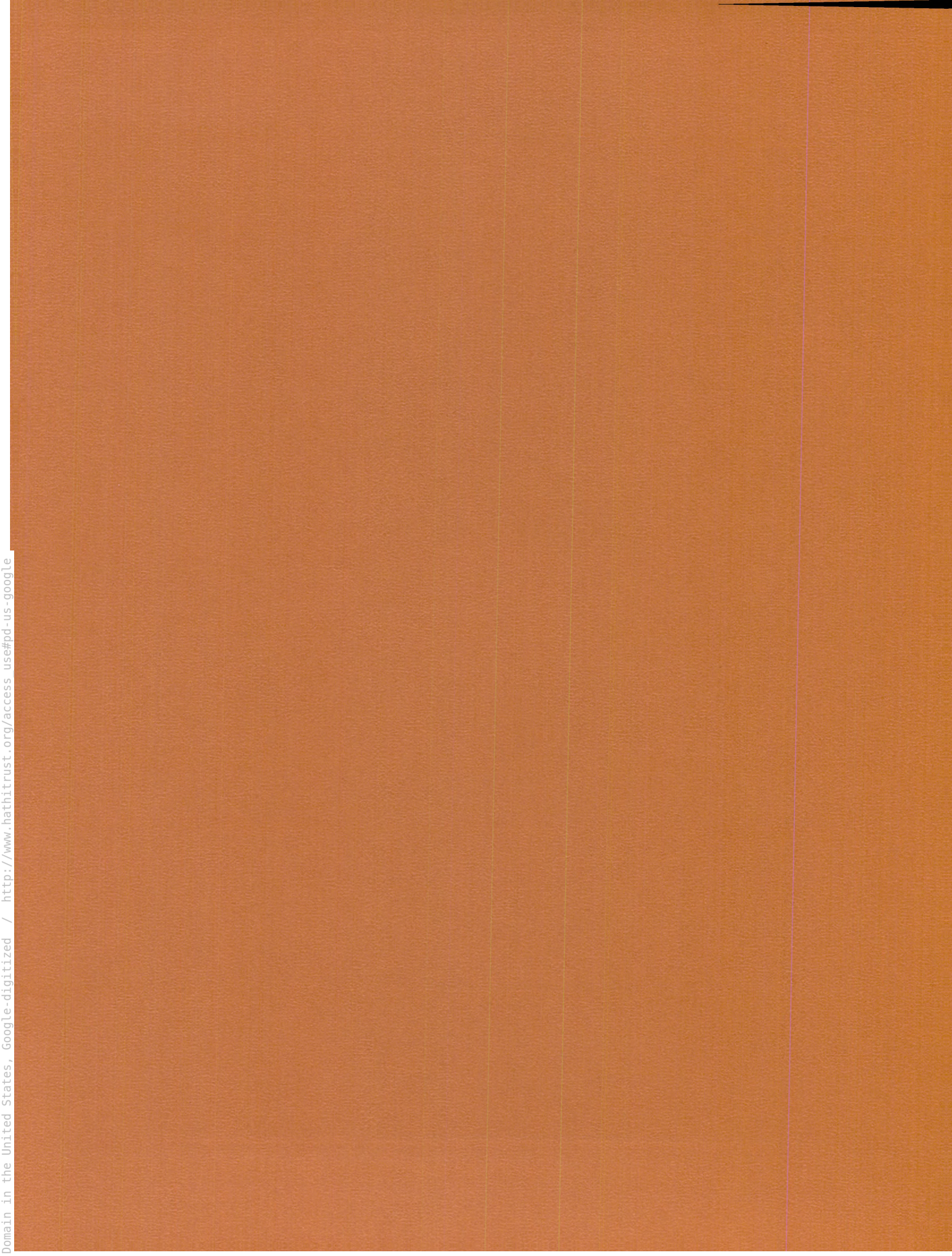
A Contract Grant is based on a different funding proposition – one of developing a successful system in the time allotted and to provide models that others can duplicate in representative communities across Illinois and the Nation. In distinction to the initial phases of the Trauma Program where a network system development was paramount, contractual monies must be spent to develop comprehensive packages of Emergency Medical Services which can be duplicated in Illinois over the next several years to complete a Total Emergency Medical Service System for the entire State.

The entire staff of the Division of Emergency Medical Services and Highway Safety, especially the Trauma (EMS) Coordinators across the State are available to assist you in developing a proposal. These Coordinators also act as advisors to the Emergency Medical Services Councils. More specific details of the various program activities will be available through various means, including the *Trauma Center Newsletter.*

Those proposals with the best probability of success will be reviewed most favorably for funding. As experience is gained with these initial proposals, other subcontracts will be supported in the very near future. Further expansion of the Statewide Trauma Program will continue and many of the working components of this system will be used to build on during the implementation of a Total Emergency Medical Services System for Illinois. Send proposals or inquiries to:

Division of Emergency Medical Services
and Highway Safety
Illinois Department of Public Health
1825 West Harrison Street
Chicago, Illinois 60612

Tel: 312/793-3880



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