# Appalachia

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# Appalachia

**A JOURNAL DEVOTED TO THE SPECIAL PROBLEMS OF REGIONAL DEVELOPMENT**

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**This Month's Cover**


President Carter greets ARC Federal Cochairman Robert W. Scott at the signing of the Rural Health Clinic Service bill (see story on page 19).

# State Lines, Great Minds and Vital Signs

**By Mercy Hardie Coogan**

Imagine a small farm near the Garrett County community of Friendsville in Appalachian Maryland. While playing on a fence, a nine-year-old girl falls, strikes her left temple on a sharp stone and is found unconscious several minutes later by her mother. The nearest hospital is in Oakland, about 20 miles away, but it is too small to have a staff neurosurgeon. So when the area's rescue squad arrives 15 minutes after the frantic mother's telephone call, emergency medical technicians place the injured child on a stretcher and, with lights swirling and sirens blaring, race, not to nearby Oakland, but 35 miles west into West Virginia, to that state's university hospital at Morgantown, where a neurosurgeon has been alerted to be ready to treat the child immediately upon her arrival.

Throughout the long journey (not all of the roads are four-lane highways) the ambulance driver and his co-worker keep in direct radio contact with the neurosurgeon, who is monitoring all changes in the patient's vital signs (blood pressure, pulse rate and temperature). When the ambulance arrives, the emergency room team goes into action. The child is rushed into surgery and operated upon; she lives.

Or imagine a small remote community hospital somewhere in Somerset County, Pennsylvania. A woman is in labor, about to give birth to what

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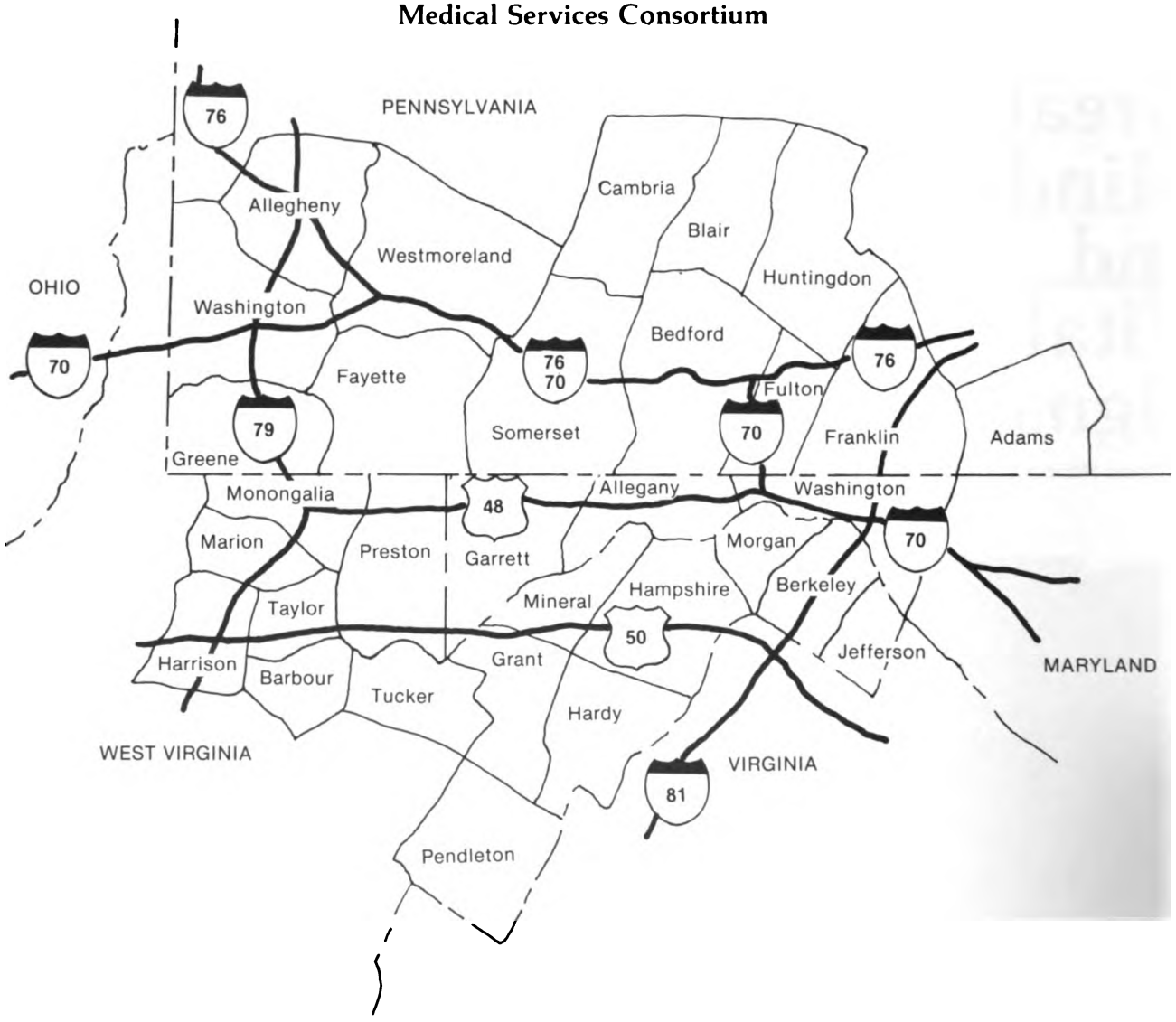
**Mercy Hardie Coogan is on the staff of *Appalachia*.**

Robert Rathe

## Area of the Interstate Emergency Medical Services Consortium




the local doctor had expected to be a healthy baby born in a normal delivery. But she has gone into labor three weeks too early, and the chances for the baby's survival after birth are very slim. The attending obstetrician quickly calls West Virginia University Hospital and requests that the regional neonatal mobile unit be dispatched to the small hospital immediately.

Pediatrician William Neal, a nurse and a medical technician ambulance driver rush to the waiting van, which is equipped with an incubator, oxygen and just about everything else the hospital has in its neonatal intensive care unit. The newborn, three-and-a-half pound infant is thus cared for by a specialist from the very moment Dr. Neal arrives at the rural hospital and throughout the return trip to Morgantown. The baby lives.

Two years ago, both of these instances might well have ended less happily. Back then, the rescue squad team would probably have taken the little girl with the head injury to the hospital in Oakland, where a physician would have examined her, realized that she required special treatment and sent her on to, perhaps, a hospital in Baltimore. The valuable

All photos in this story by Robert Rathe.

time lost under this arrangement might have meant death or permanent brain damage for the patient. Two years ago, the tiny premature infant might have died either in the underequipped community hospital or enroute to another treatment facility in an ordinary ambulance.

The difference lies in the establishment two years ago of the Interstate Emergency Medical Services Consortium, which has successfully eliminated many of the complications caused by poor coordination among existing emergency medical systems.

## Emergency Medical Services and the Consortium

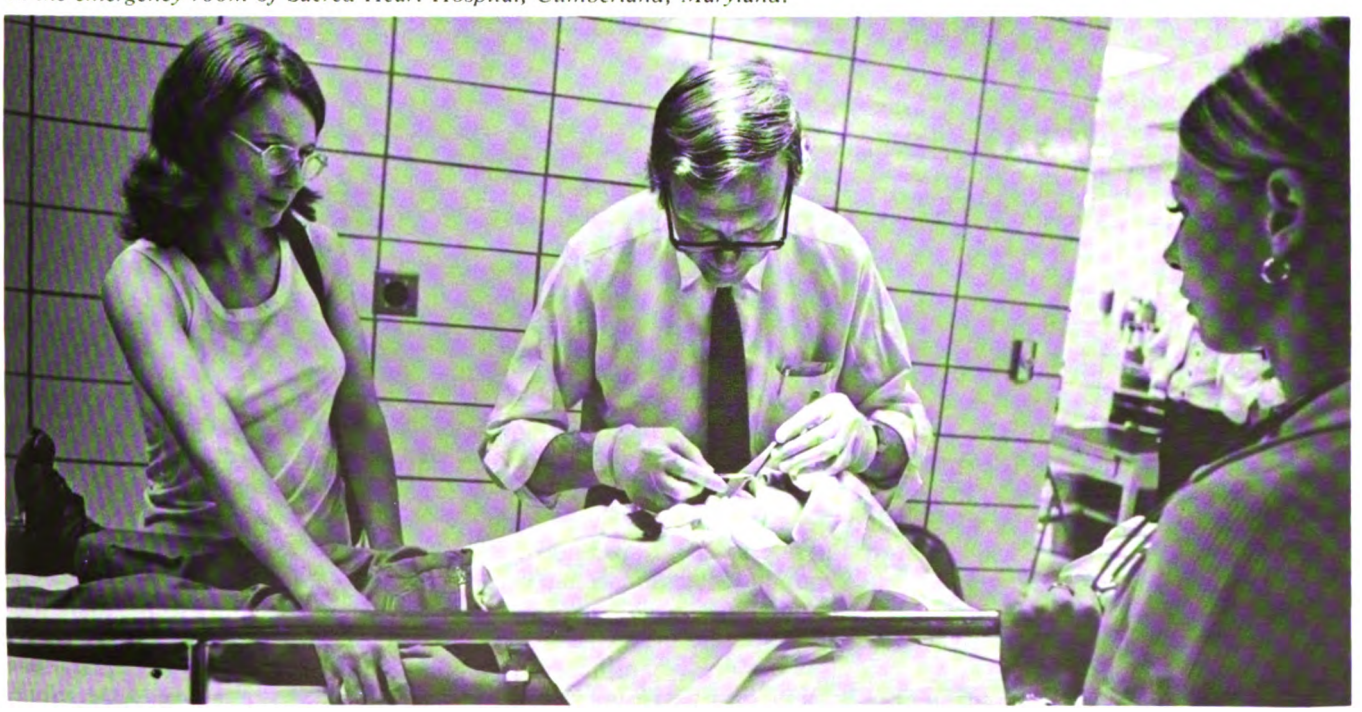
Emergency medical services (EMS) include those administered to a person outside a hospital in the case of accident or illness, as well as the services provided in emergencies in a hospital's emergency department. Firemen, ambulance drivers, rescue squad workers, emergency medicine physicians and nurses—all dispense various kinds of emergency care. Most such care falls within one of these six problem areas: burns, trauma, heart ailments, neonatal or newborn infant complications, alcoholism and drug addiction, and psychiatric problems.

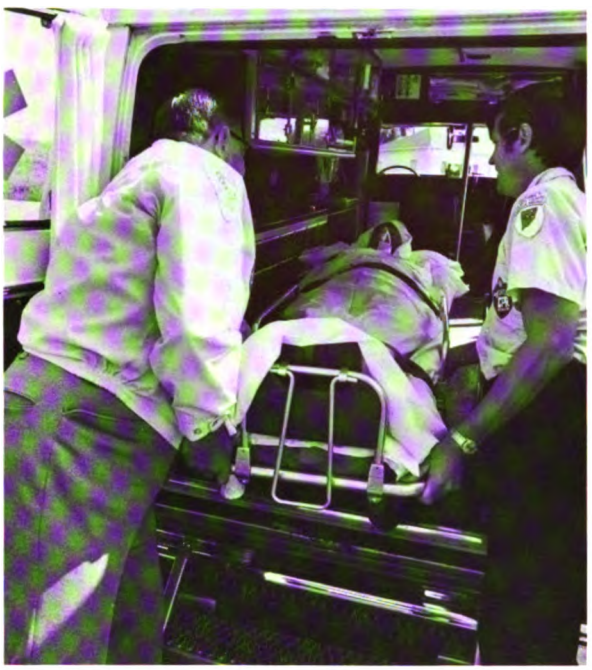
Statistics show that a high proportion of the people who die accidentally do so because of where they are rather than because of what happens to them. For example, the victim of a serious auto crash has a better chance for survival in Baltimore than in, say, rural Garrett County, Maryland, since in Baltimore he has ready access to the University of Maryland's shock-trauma center. The same relationship between quality of care and location holds true for burn cases, as well as for other serious emergency medical problems.

It was to put the rural areas of 31 counties in three states on more of a par with urban areas, as far as emergency care is concerned, that the Interstate Emergency Medical Services Consortium was established. Since it obtained funding from the Appalachian Regional Commission (ARC) in 1975, it has developed a network of programs to spread emergency personnel and equipment more evenly throughout the area.

The consortium is a "private, nonprofit corporation organized for the coordination and development of emergency medical services in the interstate market of Maryland, Pennsylvania and West Virginia." It grew out of the concern of some western Marylanders, who believed that the citizens in certain parts of southwestern Pennsylvania, western Maryland and north central West Virginia could improve the existing haphazard emergency medical care. One out of every ten emergency room patients in the 31-county area lives outside the state in which he or she receives medical treatment. This means transportation to a hospital across state lines, in an emergency vehicle that is registered in only one state and

*In the emergency room of Sacred Heart Hospital, Cumberland, Maryland.*





*(Above, left) Members of the Northern Garrett County Rescue Squad; (above, right) an ambulance arriving at Sacred Heart Hospital in Cumberland, Maryland; (right) inside the hospital.*

serviced by emergency medical technicians who are licensed in that state alone, and therefore not legally permitted to care for patients in other states. In addition, it is difficult for Medicare and Medicaid (and even private hospitalization) patients to get reimbursed for treatment received in another state.

Faced with these rather political hurdles and a variety of other complications, the consortium began by soliciting the assistance of local and state governments, of private hospitals and volunteer groups and of the whole gamut of individuals and organizations involved in EMS care within the three-state area. Many health care professionals are astonished that it has been able to develop a workable system for delivery of emergency health care services on an interstate basis.

## The Specialists

Two Peters, Crowell and Laqueur, essentially make up the interstate consortium. They operate out of a small office in Grantsville, Maryland, part of a complex, built with ARC funds,

*Peter Laqueur (left) and Pete Crowell.*

that houses a doctor's office (which is also a small public health clinic) and the local rescue squad. Pete Crowell serves as the project's director, Peter Laqueur as its coordinator. Both men worked in the EMS field prior to accepting their present positions two years ago, and both state that, as far as they know, the consortium has no duplicate in the entire country. The two men make it clear that they feel their mission, and that of the consortium, is mainly to *plan* how to deliver emergency care, rather than to be involved in actually providing the care.

"I'd say our most essential function," Pete Crowell explains, "is to provide people from the three states' different EMS groups with a chance to sit down together and solve some long-standing problems. We have made it easy for people to get together and develop an interstate EMS system. Our profile has purposely been kept very low, and we hope it stays that way."

Some may wonder why the three states involved could not simply get together of their own volition—why the consortium had to be created to act as intermediary. Peter Laqueur replies: "In many rural areas like ours, crossing county lines, not to mention state lines, can be a major production. Too often doctors and hospitals are so busy they don't know what exists outside their own fiefdoms—don't know and don't care. Then, too, it takes a third party, so to speak, to do all the behind-the-scenes work, to build a case, before the state governments will even consider such sticky problems as negotiating Medicaid/Medicare reimbursements across state lines or changing state certification requirements for emergency medical technicians or for paramedics."

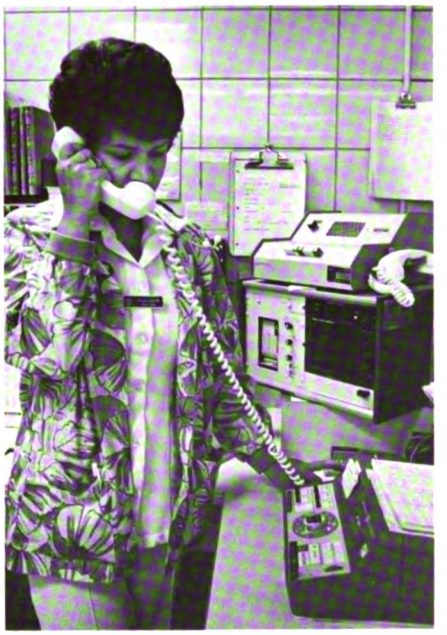
So Crowell and Laqueur find themselves engaging in a sort of shuttle diplomacy among the state governments. Separately and together they travel hundreds of miles each week meeting with rural hospital administrators, state EMS officials, civil defense personnel and all the other groups involved.

They also work closely with their board members, 24 men and women from the three participating states, all of whom are appointed by their respective Governors. Every board member is a director of some organization involved in EMS care. The group meets formally four times each year, but in their travels Crowell and Laqueur are always meeting informally with some of the members.

## The Consortium's Board

In Morgantown, Walter Moran, M.D., is a surgeon, a research specialist in endocrinology, the acting director of West Virginia University hospital's emergency room and a very active consortium board member.

"Emergency room care is called episodic medicine," Dr. Moran explains. "It's crisis care. In the last few



*Nurse Roxanne Laird at Sacred Heart Hospital in Cumberland.*

years people have come to recognize that it needs more attention. Now most hospitals are spending more money and more manpower in their emergency rooms."

Among Dr. Moran's pet projects ("My job here," he says, "is in the laboratory; the emergency room is more my hobby") has been the development of an elaborate communications system connecting the hospital's emergency room to ambulances and to all the other hospitals in the Morgantown area. A regionwide EMS communications system is currently being installed in Maryland and Pennsylvania, and, eventually, Dr. Moran's system will merge with first the West Virginia system and then the regionwide system. Such a communication linkage will establish at least one, and possibly several, clear channels for emergencies only and will allow a quick transfer of important information among hospitals, and between a hospital and an ambulance carrying a patient. If an ambulance is transporting a person stricken with a heart attack, for instance, the emergency medical techni-

cian can radio ahead to the [illegible] hospital with a cardiovascular specialist. If the specialist happens to be on vacation or away from the hospital, the central radio dispatcher will advise the driver to take the victim to the nearest facility where a cardiovascular specialist is available.

To take another example, in an accident involving many people, the regional communications system would locate hospitals with the necessary beds, equipment and personnel to treat the injured, thereby avoiding the loss of time and lives that often occurs when too many ambulances and their workers converge on one hospital.

[illegible] board member. As the project director of two federally funded EMS regions (the entire country was divided into regions by the Department of Health, Education and Welfare in 1973 when the EMS Act was passed), he has first-hand knowledge of a state EMS operation and recognizes the importance of an interstate program.

"Our group," LaFauci explains, "is in the business of providing such services as sponsoring training programs for emergency medical technicians, paramedics and nurses. We also purchase equipment, such as ambulances, for our regions' emergency organizations."

[illegible] LaFauci's regions that purchased the neonatal van mentioned earlier in the article. Working closely with pediatricians and custom van builders, LaFauci and his staff developed a van to suit the area's special needs. It cost $36,000 and is one of only two such vehicles in the state. "Our van is ideal for mountainous roads," he proudly asserts. "It's smaller and faster than most neonatal vehicles that I've ever seen."

And although the van was bought with funds from two West Virginia EMS regions, it is now a part of an interstate EMS network. Attesting to this fact, the van's first emergency patient was a baby picked up at a

hospital in Cumberland, Maryland, and brought back to West Virginia University's medical center—an interstate event that probably would not have occurred if the two hospitals had not been involved with the consortium.

The present chairman of the consortium board, Gerald Esposito, also directs an HEW-designated EMS region, one covering twelve counties in western Pennsylvania. Esposito says that when his region was asked to join the consortium, it did so eagerly because the organization is one of the "best examples going of interstate cooperation."

"The consortium has finally given us a way to get state governments involved in emergency matters that traverse state boundaries," he explains. "Before, EMS regions like ours, as well as other organizations responsible for EMS care, had neither the time nor the people to set up and carry out a plan that could cross state lines, even though we all recognized the great need."

Esposito has high praise for the two Peters, who, he says, are not only capable and willing, but also ingenious in devising methods to build bridges between the states.

"Young Crowell managed to obtain a reciprocity agreement among the three states in which each government recognizes the other's certified emergency medical technicians. If he did it with the technicians, I feel he can secure agreements in other areas as well."

An emergency medical technician (EMT) must have 81 hours of training, plus clinical experience, before he or she can be certified. Most ambulance workers in the interstate area are EMTs, which means that they know in general what not to do to accident victims (what might aggravate their injuries) as well as what to do (administer oxygen and apply bandages, for instance). They learn in which cases special care and immobilization of an injury should be completed before transporting the injured person to a hospital. Their training is geared toward stabilizing the patient's condition until more qualified care can be administered.

Until the consortium arranged the three-state agreement, EMTs were liable to lose their certification if they were caught tending to patients out-of-state. Although the ruling had not been invoked, its presence on the books threatened one day to cause major problems for one or more EMTs. "After all," says Peter Laqueur, half in jest and half in earnest, "an EMT could hardly say to a heart attack patient being rushed to a hospital: 'Sorry, I'll have to take you off oxygen since we just crossed into West Virginia, and I'm only certified in Maryland.' "

The next step, according to Pete Crowell, will be to obtain a similar reciprocal arrangement for ambulance paramedics—who are trained to administer more advanced medical aid than that offered by an EMT. (Paramedics can dispense drugs and give intravenous injections and other minor treatments prescribed by a physician.) Crowell is a paramedic, a member of the Northern Garrett County Rescue Squad, based in Grantsville. By participating actively in one of the many service organizations in the consortium area, the interstate project's director keeps close to the real world of emergency medical service.

"It's one thing to devise elaborate plans and to theorize on EMS effectiveness on a regional basis," he explains, "and quite another to work on a rescue vehicle and actually treat injured people. It's sobering, and it helps me keep things in their perspective, I think."

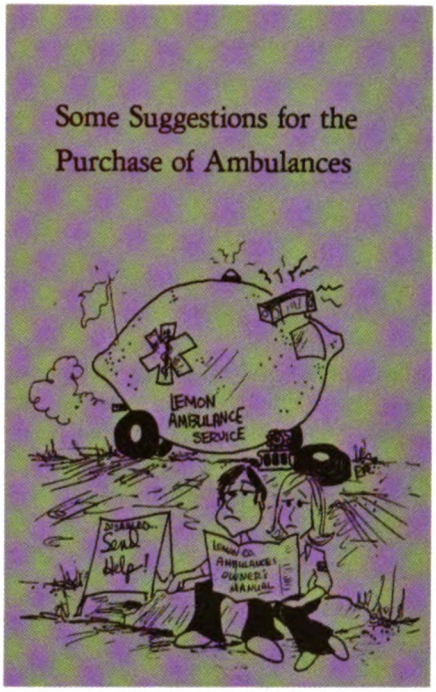
## The Forecast

Peter Laqueur and Pete Crowell have nearly achieved the close relationship among the region's many EMS groups that the consortium must have in order to thrive on a permanent basis. Crowell even goes so far as to suggest that, ideally, the two men will work themselves out of a job in the not-so-distant future—once all the parties have thoroughly committed themselves to the interstate concept and its implications, and the communications system, the various emergency personnel training pro-

*The Salisbury (Pennsylvania) Area Rescue Squad.*

grams and all the other phases have become fully operative.

Meanwhile, interstate and intercounty deliberations continue, and Peter Crowell and Peter Laqueur work to effect the remaining changes necessary to the consortium's final success. In addition, the men help evaluate individual EMS groups in and around the consortium's 31-county region. They act as consultants to other areas interested in an interstate plan. They collect ideas from various groups within their region and pass them along to others. They are also busily establishing a protocol manual aimed at educating area physicians to exactly what emergency services are available to them and their patients and how they may best utilize them. And just last year, Crowell and Laqueur put together a booklet for local EMS groups that gives pointers on purchasing new and/or used ambulances. The small booklet was the result of a common need the men saw among the various rescue squad organizations they visited; many were perplexed about the best way to select ambulances. The pamphlet advises on everything from vehicle specifications to the kind and quality of equipment and best way to bid on ambulances.




In current popular jargon, it can be said that all kinds of people and groups are into EMS—even television with its hit series, *Emergency*. Because popularity is fickle, however, the two Peters and the consortium members feel that they want to get the most out of today's pro-EMS sentiment before the spotlight shifts to some other branch of medical treatment. For they know that even when EMS is no longer Topic A, the demand for quality emergency health care will remain constant.

Emergencies are no respectors of political boundaries. In these 31 Appalachian counties there will be a constantly growing number of people who owe their very lives to the persistent and inventive founders of the Interstate Emergency Medical Services Consortium.