



## **Update from the Office of EMS Volume XVIII, Issue VIII**

### **Montgomery Fire/Rescue Department Leads the Way**

The Office of Emergency Medical Services would like to take this opportunity to recognize the Montgomery Fire/Rescue Department for its professional leadership and example setting performance.

At the time of this writing the Montgomery Fire/Rescue Department protects 162 square miles of territory for both fire suppression and provision of ALS Emergency Medical Services first response. It does so out of 15 fire stations located strategically throughout its response area, and with over 300 licensed EMS personnel. The Department maintains an ISO class rating of 1, granting Montgomery the privilege of fire protection quality only provided by 0.2% of the nation's fire departments. The Firefighter Combat Challenge team of the Department also has set two world records for Combat Challenge performance and competing against teams from fire departments around the country and around the world.

How does a fire department from Montgomery, Alabama achieve such impressive performance benchmarks and awards? Attention to detail - which did not go unnoticed in the Office of Emergency Medical Services' licensing section earlier this year.

Everyone in EMS is aware of the March 31<sup>st</sup> biennial deadline for licensure renewal, which mirrors that of certification renewal of the National Registry of Emergency Medical Technicians. During the first quarter of each year the workload in the OEMS licensure section increases exponentially. Alabama licenses over 12,000 EMS providers consistently. Paper applications often arrive late in the cycle, are sometimes only partially complete for attached documentation and signatures, and frequently must be returned to the applicant so that the problems can be corrected. Large departments and services regularly send the paperwork of their entire staff for renewal and it is not unprecedented for the entire bundle of applications to be returned for correction before they can be successfully processed.

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Enter this year the Montgomery Fire/Rescue Department, carrying a large container of hanging folders containing 318 license applications. As the staff began disassembling the package (which was delivered early enough in the process cycle that it could be quickly reviewed and data entered) each application was complete in its content, signatures, attached documentation (which included proof of citizenship) and was provided neatly in folders in the same orientation and in alphabetical order. What that accomplished was expedition of a large batch of files through an arduous review and entry process. The clerks performing the process were so impressed (as compared to the quality of the average license renewal application package) they reported the quality standard to their supervisors and to our staff in general.

The Office of Emergency Medical Services would like to thank the Montgomery Fire/Rescue Department for their extraordinary standards of quality, protecting our homes and offices, our lives; and making an otherwise tedious and time consuming task for our personnel much smoother than it could have otherwise been. Keep up the good work!





## **Birmingham Fire Rescue Department's Culture of Excellence**

Birmingham Fire Rescue Department has a great history and a very important job. The City of Birmingham consists of 146 square miles of the most densely packed streets in Alabama. It is composed of a variety of terrain, mostly hilly, with densely populated streets many of which are multistory buildings and houses. In addition, the conditions are often icy, many residents are factually homeless, and about 30% of registered citizens are living at or below the poverty level. The city is a matrix of major highways, interstates and heavily traveled streets and roads, through which some of the heaviest traffic in the southeast travels and rush hour is a thing of legend. Whereas Montgomery may hold the title of the legislative center of Alabama, Birmingham is both the economic and the education center of Alabama; hosting one of the premier medical and research based universities in the country and the world, the University of Alabama in Birmingham, among many other hallowed centers of learning. Because of the nature of its commerce and endeavors the population surges in the city to untold levels during every work day of every week and on weekends due to the many attractions found on the hilly landscape. Meeting these and other challenges every day is the Birmingham Fire Rescue Department.

Birmingham Fire Rescue provides its services out of 31 fire stations scattered deliberately throughout the rolling terrain of its response area. It is a massive organization with a brilliant history. The organization was one of the first in Alabama to initiate paramedic-level EMS service to its citizens, taking advantage of UAB's location within its territory. Dr. Alan Dimick, the BFRD's medical director is considered by most Alabama EMS historians to be one of the grandfathers of Alabama EMS. Dr. Dimick became the medical director of the federal grant that trained the first 33 paramedics in Alabama in 1972. A renowned surgeon and founder of the UAB Burn Center, he went on to be the medical director of the UAB Regional Technical Institute from 1973 to 1985 and oversaw the education of hundreds of EMS providers in the Birmingham area and the state of Alabama at large.

Birmingham Fire Rescue Department has always had a great deal to live up to. They are one of the premier EMS sites in the state and the southeast, their run volume is intense for both EMS and fire calls, and they are a transport EMS service with the Grandfather of Alabama EMS as their medical director. They demonstrated their ability to maintain their position on the forefront this month at the Office of Emergency Medical Services.

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Many of our readers are already aware of the issues our Office encounters during the EMS license renewal period every year. Individual license applications often arrive incomplete and without complete documentation and must be returned to the applicant. Alabama has over 12,000 licensed EMS providers at several levels and all must renew every two years. This process is all facilitated by the hands of our office staff and on paper applications. Birmingham Fire Rescue sent 379 applications to our office, all of which were complete in every aspect; signatures, documentation, copies of identification, etc. All were oriented, alphabetized, and contained in a manner that made the process of review and data entry as seamless as humanly possible and the completion of the process as quick as humanly possible. Our Office would like to commend the BFRD for their efforts and commitment to excellence in both their paperwork and their operations. Outstanding job.





## Compliance Issues

Name	Rule/Protocol	Complaint	Action Taken
Danny Cornelius Paramedic #9040949	420-2-1-.25	Scope of Practice	Remediation
David Hill Paramedic #0901140	420-2-1-.30	Guilty of Misconduct	Remediation
Christopher Kennard AEMT #0800689	420-2-1-.30	Guilty of Misconduct	Remediation
ALS Transport Service		Under Triaging Patients	No Violation Found
ALS Transport Service		Equipment Failures	No Violation Found
ALS Transport Service		Inappropriate Transport	No Violation Found
Coffee County EMS #892	420-2-1-.11	Utilizing Non-Licensed Personnel	Remediation
EMS Care #1112	420-2-1-.05	Not Providing 24hr Service	Probation
NorthStar #957	Protocol 1.12	Refusing to Transport	No Violation Found
EMT	420-2-1-.29	Impairment	Suspension
EMT	420-2-1-.29	Impairment	Suspension
EMT	420-2-1-.29	Impairment	Suspension
EMT	420-2-1-.29	Impairment	Suspension
Paramedic	420-2-1-.29	Impairment	Suspension
Paramedic	420-2-1-.29	Impairment	Suspension

## Provider Service Inspections

The inspection reports for the following services can be found on Compliance Issues page of the Office of EMS [webpage](#). These inspections were completed January-March, 2018.

Abbeville Fire Rescue	Care Ambulance-Montgomery County
AirEvac EMS-Colbert County	Care Ambulance-Russell County
AirEvac EMS-Jackson County	Cherokee Rescue Squad
Alabama Fire College	City of Lanett Fire and EMS
Albertville Fire and Rescue	Clanton Fire Department
AmServ EMS-Bibb County	Clay County Rescue Squad
A-Med Ambulance Service-Marshall County	Coffee County EMS
AmStar EMS-Sumter County	Collins Chapel Volunteer Fire Department
Anniston EMS	Columbia Fire Rescue
Ariton Rescue	Cottonwood Ambulance
Ashford Ambulance	Crawford Volunteer Fire Department
Bessemer Fire Department	Daleville Police Volunteer Rescue
Boaz Fire Rescue	Dekalb Ambulance Service
Brantley Rescue	Desoto Rescue Squad
Brookwood Volunteer Fire Department	East Alabama EMS
Cahaba Valley Fire	Echo EMS
Care Ambulance-Chilton County	





## **Provider Service Inspections continued**

Eclectic Fire Department

EMS Care-Russell County

Enterprise Fire

Enterprise Rescue

Excelsior Ambulance-  
Montgomery County

Fairview Fire Rescue

Green Pond Fire Rescue

Greene County EMS

Guntersville Fire Rescue

Haleburg Rescue

Haynes Ambulance-Autauga  
County

Haynes Ambulance-Elmore  
County

Haynes Ambulance-Montgomery  
County

Haynes LifeFlight

Headland Fire Resuce

Helena Fire Department

Highland Medical Center  
Ambulance Service

Indian Ford Fire District

Jacksonville Fire Department

Jefferson County Sherriff's Office  
Tactical Team

Jemison Fire Rescue

Keller EMS-Colbert County

Keller EMS-Franklin County

Lafayette Fire and EMS

Leeds Fire Rescue

Lifecare-Tuscaloosa County

Lifesaver 3-Chambers County

Littleville Fire Rescue

Livingston Fire Rescue

Locust Fork Fire Rescue

Luverne Rescue

Midland City Fire Rescue

Millbrook Fire Department

Montgomery Fire Department

Moody Fire Rescue

Nectar Fire Department

Nixon Chapel Volunteer Fire  
Department

## **Provider Service Inspections continued**

North Chilton Volunteer Fire  
Department

Northflight-Tuscaloosa County

Northport Fire Rescue

Northstar Paramedic Services-  
Tuscaloosa County

Odenville Fire Rescue

Oneonta Fire Rescue

Opelika Fire Rescue

Oxford EMS

Phil Campbell Rescue Squad

Pickens County Ambulance  
Service

Piedmont Rescue Squad

Pine Mountain Volunteer Fire  
and EMS District

Pintlala Volunteer Fire  
Department

Progressive Health

Rainsville Fire Rescue

Regional Air Medical Services-  
Walker County

Rosa Volunteer Fire Rescue

Scottsboro Fire Department

Shoals Ambulance-Colbert  
County

Shoals Ambulance-Jefferson  
County

Shoals Ambulance-Lauderdale  
County

Skipperville Volunteer Rescue

Smiths Station Fire Rescue

Steele Fire Rescue

Thorsby Fire Department

Tuscaloosa County Sheriff's  
Office

Tuscaloosa Fire Rescue

Valley EMS

Vines Ambulance Service

West Blount Fire District







## **Culture of Excellence**

Air Evac-Colbert County

Air Evac-Jackson County

Dekalb Ambulance Service

Eclectic Fire Department

Enterprise Rescue

Moody Fire and Rescue

Nectar Fire Department

Nixon Chapel Volunteer Fire Department

Pine Mountain Fire Department

Rainsville Fire and Rescue

Steele Fire and Rescue



## **Be the Star of Life**

"...so others may live..."

Your job in EMS isn't easy and only a few can do it. It can definitely be the most rewarding job of all for there is no greater feeling of accomplishment than that of saving a life. We know you don't do it for the money and you don't do it for the glory. You do it because it is what you were meant to do. You do what you have to and you do it every day, hoping and praying that you made a difference in someone's life.

You do all these things and definitely do not get the recognition you deserve. Always remember that you are more than "just an Ambulance Driver", or "just a Paramedic", or "just an "EMT", and you are even more than just an "everyday" worker. You are sent to help the wounded and to help the sick and you can be the difference between life and death. You are the reason that this woman is able to see her son graduate high school. You saved that man's life so that he can walk his daughter down the aisle at her wedding. You see the young man working at the store and know that you brought him back when he overdosed last year. You were there when he gave up on himself and now he is changing his life because of the second chance that you helped him achieve. You are the "Star of Life", and every day, you shine through in someone, brighter than ever.

Always remember that the care you provide to EVERY patient should be to the best of your ability. We, in EMS, tend to let the "non-sense" calls and frequent patients influence how we care for everyone we meet throughout the shift. We have all done it. Keep in mind that we come to them where they are, meet them as they are, and should always give them the best that we have to offer. You are the face of EMS in Alabama so be the "Star of Life" as well.

Thank you for what you do and for the service you provide. Thank you for being compassionate and being there for others in their worst moments and thank you for what you do for EMS in Alabama.

Jamie Gray  
Compliance Coordinator

## **The Alabama Opioid Assistance Project**

Drug overdose deaths are increasing at an alarming rate nationwide. According to the CDC, there was a 137% increase in the number of deaths due to drug overdoses between 2000 and 2014. Also, during this period, the rate of overdose deaths involving opioids increased by 200%. Drug overdose deaths now exceed deaths due to vehicle crashes.

The Alabama Department of Mental Health indicates that 4.71% of Alabama's population over the age of 17 (175,000+ individuals) are estimated to have used pain relievers for nonmedical purposes in the past year. In reviewing the statistics for nonmedical use of pain relievers between 2006-2012, the rate of nonmedical use in Alabama was higher than the rate of nonmedical use in the U.S. as a whole. Alabama has one of the highest opioid user rates in the world. With only 5% of the U.S. population, Alabama uses approximately 80% of all the opioid drugs in the nation. In addition, ADMH states that nearly 30,000 Alabamians over the age of 17 are estimated to be dependent upon heroin and/or prescription painkillers. Furthermore, in 2015, for the first time ever, admissions to substance abuse treatment for opioid use disorders exceeded those for alcohol use disorders in Alabama.

In 2013, ADMH indicates that students in 9th-12th grade in Alabama report more than a 200% higher rate of having used heroin in their lifetime, compared with their counterparts across the nation:

- 5.9% of male youth in Alabama used heroin compared to 2.8% in the nation
- 3.8% of female youth in Alabama used heroin compared to 1.6% in the nation
- 5.3% of both male and female youth in Alabama used heroin compared to 2.2% in the nation

The rates for Alabama's youth utilizing prescription drugs for nonmedical purposes is also higher than those of youth in the nation:

- 21.2% of male youth in Alabama used prescription drugs without a prescription compared to 18.3% in the nation
- 17.9% of male youth in Alabama used prescription drugs without a prescription compared to 17.2% in the nation
- 19.7% of both male and female youth in Alabama used prescription drugs without a prescription compared to 17.8% in the nation





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Prescription pain relievers and heroin are the primary drugs associated with overdose deaths in Alabama. The CDC reported that, in 2012, Alabama ranked first in the number of opioid pain reliever prescriptions written per 100 persons. Alabama also ranked fourth in the number of high dose opioid pain reliever prescriptions. The 2015 National Drug Control Strategy Data Supplement estimated that 218,000 Alabamians used a pain reliever for nonmedical use in 2013 and, according to the CDC, 598 Alabamians died in 2013 from a drug overdose which increased to 723 in 2014.

In efforts to combat this problem head on, the Alabama Office of EMS has been awarded a \$3.2M grant over the next 4 years to aid our efforts in the opioid crisis here in Alabama. This grant has many components and will be used to help supply naloxone to all licensed providers in the state. The grant will also be used to assist overdose victims in locating recovery information and support services including treatment facilities. The Office of EMS will be collaborating with the Alabama Council on Substance Abuse to better fill the needs of our patients and to supply real time support services to those in need. Prevention and education will be a component available to patients and well as our licensed personnel in the state. Continuing education classes will be offered for a number of topics to include subjects such as street drug recognition, stress management, dealing with trauma, and many others. The OEMS will also be utilizing this project to help educate the public on what constitutes a need for activating the 911 system so to better the efficiency of our EMS system and response capabilities.

As stated before, there are many components to this project so please be patient in the implementation process so that we may implement this process as seamlessly as possible.

## **Thrombolytic Checklist for Stroke**

Emergency medical services personnel (EMSP) are a critical component in stroke care. Early recognition and treatment of stroke offers more opportunity for treatment, which may save lives and reduce the long-term effects of stroke. Treatment for acute ischemic stroke, the most common type of stroke, may include tPA (tissue plasminogen activator) administration and/or mechanical thrombectomy, if certain criteria are met.

The Stroke Thrombolytic Checklist in the Emergency Medical Service (EMS) Protocols was revised in the recent protocol update. The changes were made based on suggestions from stroke care professionals and EMS Regional Directors. The checklist should be completed for any patient suspect of, or presenting with, acute stroke symptoms. A copy of the completed form should be left with the patient at the stroke center.

The Alabama Trauma Communications Center (ATCC) needs specific information to enter the patient into the Alabama Stroke System. As the EMSP completes the Thrombolytic Checklist for Stroke, the information for ATCC is documented which allows for a rapid report and Stroke System entry.

Stroke centers are trying to reduce door-to-needle times for tPA administration; therefore, time is critical and EMSP can help. A very important section of the thrombolytic checklist for hospital staff is the “Historian Cell Phone #.” If possible, the EMSP should collect the cell phone or historian contact information before leaving the scene. Current contact information provides a mechanism for stroke center staff to verify or collect additional information if needed.

For convenience, the Office of OEMS printed note pads of the revised Thrombolytic Checklist for Stroke and provided them to the EMS Regional Offices for further distribution. Providers may print their own copies from the [EMS Protocols Ninth Edition 2018](#) (Page 132) instead of using the pre-printed notepads.

Alice Floyd, BSN, RN  
Acute Health System Manager





## Update from the Education Coordinator

In the last several months, I have begun the process of reuniting with old friends in the world of Alabama EMS and making new ones. As you know, this is a small world in which we all operate, so the reunion has been nice. I have met many of you at conferences, meetings, or just as I travel throughout the state on business. For instance, I was in the northern portion of the state last month when I had the pleasure of dropping by Lawrence County EMS, Helen Keller EMS, Northwest-Shoals Community College, HEMSI, and Calhoun Community College. For the most part, this was merely to introduce myself as the new EMS Education Coordinator for the OEMS. We had a great time getting to know one another, and I hope to get around to many more of you soon.

I would like to introduce a new member of the OEMS staff, Mr. Kent Wilson. Kent was hired as an EMS Specialist and will be working with me on educational aspects of our office. Kent is also working with the Compliance division to help bring all ambulance inspections up to date.

As you know, we just released the new 9<sup>th</sup> Edition of the Alabama EMS Protocols. They will go into effect May 1, 2018 and can be found on our website under [Rules and Protocols](#). Please take a look at them and familiarize yourself with them. We would like to also emphasize that the protocols should be treated as a guideline rather than as a bible. You were trained to perform these duties and you passed the test. We want you to use those skills, but keep your scope of practice in mind as you practice your profession.

We are also updating the rules to include EMS education regulation. Many of you who have been around for a while probably remember that this was removed from the OEMS and given to the Alabama Community College System around 2006. Recently, we have been asked to take up this torch again. To assist us with ensuring we include all that is vital to teaching all EMS Personnel, we have created a committee of experts to write an updated version of these rules. The committee includes representatives from the OEMS, community colleges, the Alabama Fire College, the four year universities, the private universities, and the EMS regions. We are confident that a set of very good working rules can be drafted.

I am very pleased to be working in the OEMS again and with all of you as we continue to make EMS in Alabama stronger, safer, and unified.

Chris Hutto, MBA, NRP  
Education Coordinator



## **“To Transport... Or Not to Transport...THAT is the question...”**

By Gary L. Varner

### NATIONAL REGISTRY SCENARIO:

You are the lead paramedic on an Alabama licensed rural emergency response ambulance. Your partner is an Advanced EMT.

At 13:45 hours you are dispatched to a general illness call at a nearby familiar address. When you arrive on the scene you find a 65-year-old male sitting on the patio in an aluminum yard chair underneath a blooming crape myrtle tree. The temperature is neither hot nor cold, but just pleasant. The patient does not appear to be in a great deal of distress. His wife of 45 years is holding an ancient cordless telephone receiver and is seated in an identical chair and both are pushed up to a metal patio table. Both subjects have obviously been drinking from cold sweating glasses full of what appears to be iced tea. A small Chihuahua is bristled up under the table. As you approach the patient, the Chihuahua (who you recognize from your many interactions with this couple and know by the name “PePe”) begins his expected outburst of incessant, shrill barking. The couple (let’s call them “the McGillicuddys”) then begins their own outburst of bickering, which was also expected. Between the dog and the couple, you and your partner cannot understand the basis of the conversation between the two and the tirade between all three begins to resemble pandemonium. You and your partner approach the couple and when in hearing distance you both smile, you extend your hand to the man, and say “Mr. McGillicuddy...How can we help you today? What seems to be the problem?” Before Mr. McGillicuddy, yourself, your partner, or PePe can utter another sound, Mrs. McGillicuddy (a rather rotund woman of remarkable girth and shorter-than-average height, wearing a tie-died moo-moo, pink curlers and fuzzy bedroom slippers) states loudly in a shrill scratchy voice and thick Southern country accent; “Weeeeeelllll I’m gonna tell you smart-alecky boys this right NOW.... He’s A goin-to-go to the HOSPITAL NOOOO MATTER WHUT!!” To which a gruff and apparently exhausted Mr. McGillicuddy replies “I... ain’t-a... goin’.”

### REVIEW:

Could it be that you actually tried to analyze the scenario for the first 6-to-8 lines? Questions you formulated may include; Was it a rural type of medical complaint (toxicology, heat) and possibly farm related? Was the dispatch time being past lunch part of the mechanism of illness? If the address is known to you, what is the nature of chronic illness? Could the patient be allergic to the flowering of the tree, or to the bees that are drawn to them, or to the pollen? As the story unfolds from there, and you realize the situation (that you have probably personally encountered to a point) you may have become LESS clinically minded and MORE (what’s a nice term for it?) annoyed.

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The fact of the matter is - people make bad decisions when they are annoyed. We draw conclusions without reviewing all of the facts. We stick to our preferences rather than anticipating potential outcomes and analyzing the situation to avoid poor outcomes. Factors in this scenario that could possibly influence improper decisions include, but are not limited to:

1. The fact that historically the family calls 9-1-1 frequently.
2. Possible history of difficult interaction between EMS and one or both McGillicuddys (and maybe even Pepe).
3. Territoriality of Mrs. McGillicuddy's control over Mr. McGillicuddy's healthcare choices.
4. Territoriality of Mr. McGillicuddy's control over his own healthcare and destiny.
5. Disquieting stimulus of bickering couple amplified by loud incessant barking of the dog.
6. Ego-driven infuriation at the fact that two highly trained and educated (and perhaps experienced) registered and licensed EMS providers can be dressed down by a family member without similar sacrifice or attributes and whose mind cannot be changed by God or man; and were in fact challenged without the availability of reasonable response or recourse.
7. The professional duty and responsibility to protect Mr. McGillicuddy's civil rights while also protecting his health.

Now we all know that this scenario has a "textbook answer." If ten different EMTs read this article, then ten different (but perhaps similar) answers may brew on the other side of the digital screen. Because of rigorous training, we all know what to do:

1. Assure safety of the scene after donning BSI. Gain control of the conversation, calmly and reassuringly, and communicate with the parties involved. Note mechanism of illness and number of patients (which one or both) is ill.
2. Consider additional resources (animal control, police, other, none).
3. Form general impression of patient, and so on.

Now, put yourself realistically into the situation. If you read it carefully you should already feel a little bit of stress. Now instead of a daytime call (13:45 or 1:45 p.m.) let's make it 01:45 or 1:45 a.m. on a 24-hour shift where you finally went to bed at midnight after a long day of running. Can you feel an increase in stress? For me; I do. For me, throughout my field career, knowing my station pillow was getting cool on my bunk in the middle of the night for "a basic services call" (real or perceived) scaled my frustration levels up a bit.







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Florence ("Flo") and Leonard  
("Leo") McGillicuddy  
& PePe the Wonderdog.



#### TAKE HOME LESSONS SO FAR

Aside from the tongue-in-cheek familiarity that almost all of us have with this scenario. What else can we learn from it?

Here are a few ideas:

Your index of suspicion for a true medical emergency should elevate with the level of confusion in any given call. The weirder the call is – the harder you should look for a true emergency. Often calls can be like icebergs where most of the important factors may not be relatively obvious.

Even though untrained citizens often over-react, they also know and understand the physical and mental condition of their family members better than anyone and fearfully react to unexpected changes in them. The rescuer must remain calm and often the family member will likewise calm down, however, family members often exasperate rescuers when they refuse, or are unable, to calm down in a patient care situation. As the EMS professional we must remember that (a) fear multiplied by (b) a lack of understanding often results in anger, frustration and even violence.

ANY patient can refuse care if they have the "capacity" to refuse care. Determining capacity is sometimes not easy but is something we deal with on every call. If the patient is not cooperative (with EMS and/or family on scene) what are the possible causes? The laundry list of causation may include a closed head injury or other neurological process, such as stroke, etc. It may also include blood glucose variation (low or high), hypoxia, hypotension, severe pain, hormone imbalances, electrolyte imbalances, drugs, alcohol or other toxicology, acute mental health changes or even good old stubbornness.

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According to Dr. Christopher Colwell in his article “Know When Uncooperative Patients Can Refuse Care and Transport” in the August 1, 2016 issue of the Journal of Emergency Medical Services (JEMS) a patient must possess the following four abilities to have the capacity to make healthcare choices:

To communicate a choice;

To understand relevant information as it is communicated;

To appreciate the significance of the information to their own individual circumstances; and

To use reasoning to arrive at a specific choice.

Dr. Colwell offers the following five questions to ask patients in order to help determine their capacity:

Have you decided what you want to do?

What are the risks of the options we have discussed?

What could happen if you choose to do nothing at this time?

Why do you think this is the best option for you at this time?

Why have you chosen the option that you did?

## DOCUMENTATION

Even if you “do everything right” on a call – documentation will always be what protects you if your actions are ever called into question. Our best recommendation is that you describe the fact that you asked questions (the same as above or similar) of the patient and that you document his answers. You should always include a description of persons on scene and witnessing your interaction with the patient, most preferably law enforcement or fire personnel, but at least a friend or relative. In his March 14, 2015 JEMS article “Pro Bono: Documenting Patient Refusals”, EMS Attorney Douglas Wolfberg advocates that documenting a refusal is more than simply obtaining a signature. The patient must be INFORMED of the possible risks of refusing care. Mr. Wolfberg states that as a defense attorney for EMS he would rather have a narrative detailing the risks and consequences that were disclosed to the refusing patient than a simple signature with no documentation of the risks discussed. He strongly advises that EMS providers do both, but his example illustrates the importance of good documentation.

Mr. Wolfberg explains that a patient experiencing a symptom which is reasonably suggestive of a serious problem, and who refuses treatment and transport, should be advised of the worst case scenario. For example, a patient experiencing chest pain should be warned that it could actually be a heart attack and that it could possibly result in death if left untreated.





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He calls this “the duty to terrify.” If the patient has a possible fractured toe, however, using the risk of death to discourage refusal would be unreasonable. A good refusal narrative should document that multiple alternatives were given, such as traveling to the E.D., or physician’s office by private vehicle. The report writer should always document the measures that EMS employed to exercise due diligence in consideration of the patient’s health.

#### FUNCTIONAL APPROACH

My personal suggestion is that IF you allow a patient to refuse treatment and transport and you end up doing LESS documentation than if the patient accepted treatment and transport, you are NOT documenting correctly. Even with a good refusal form (the link to Mr. Wolfberg’s is included below) is utilized; more than adequate narrative documentation is necessary for optimum protection.

Our office advocates that when EMS providers write narratives and complete documentation – they should do so as though they were writing it for a plaintiff’s attorney and as if it would be scrutinized in a court of law. It is not unreasonable to anticipate that it may (that is MY duty to terrify).

#### CONCLUSION

EMS is never completely straightforward. Many times people must be diagnosed with technology only available to physicians and in hospitals. EMS providers must “always expect the worst” in order to adequately protect and support our patients.

Visit Mr. Wolfberg’s site, [www.pwwemslaw.com](http://www.pwwemslaw.com) . Resources include free attorney reviewed forms and a free EMS law library access.

<https://www.pwwemslaw.com/sites/default/files/forms/patient-refusal-documentation/pww-model-patient-informed-decisionmaking-refusal-form.pdf>



# EMS

The Red-Headed  
Stepchildren of  
Medicine

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***As America continues its decades-long increasing trend towards greater obesity, ambulance EMS personnel often find themselves calling fire departments for lifting assistance. The great thing about firefighters is that they always find a way to lift the patient, no matter how heavy.***





## **Alabama e-PCR Submission Requirements**

### **Some e-PCR Points of Clarification:**

1. It is a requirement to complete a patient care report on every response. This office is already monitoring submission rates and comparative data suggests that many agencies are not reporting all runs as required. Please submit all required runs to avoid noncompliance.
2. Each record must be submitted electronically within 72 hours or less. The goal is to eventually narrow that down to within 24 hours. The 24 hour reporting allows Public Health to monitor surveillance trends as required by the Federal emergency preparedness guidelines.
3. Our IT staff is always available to assist you with your e-PCR needs. If you need assistance, you may call Chris or Lori at 334-206- 5383. You may get a voice recording depending on the call volume. They will eventually get back to you. If you do not hear from them within a reasonable time, you may wish to [email](#) them.
4. Collecting and importing data is paramount only to reporting reliable data. Reliable data is accurate and contains no errors. When one looks for shortcuts and/or skips data entry in areas that has been discovered to have no validation rules, it dilutes the integrity of the data, not to mention falsifies a legal document. Please make sure you enter data accurately.
5. As of January 1, 2017, Alabama began transitioning to NEMSIS version 3.x data. We will also continue to accept NEMSIS version 2.0 data until December 31, 2017. Alabama will be a NEMSIS version 3.4 compliant state beginning January 1, 2018.

## **General Information**

### **Do You Have Questions for OEMS Staff?**

This is another reminder to those of you calling our office (334) 206-5383:

Complaints, Investigations, and Inspections —Call Jamie Gray

Licensure —Call Stephanie Smith, Kembley Thomas, or Vickie Turner

Individual Training or Testing—Call Chris Hutto

EMS for Children, Website, and Social Media—Call Katherine Dixon Hert

EMS Data/NEMSIS – Call Gary Varner

### **Requests for Information from Regional Offices**

The Office of EMS would like to request that you comply with any request for information from your regional office. Some Directors are still having issues receiving information and data as requested by the State office. We would greatly appreciate your cooperation and compliance.

### **Reporting Requirements**

Please be reminded that, according to Rule 420-2-1-.07 (6h), All licensed provider services shall provide notification and written documentation within three working days to the OEMS regarding any protocol or rule violation, which includes but not limited to, according to 420-2-1-.30 (8), anyone guilty of misconduct or has committed a serious and material violation of these rules; has been convicted of a crime.

Also be reminded that, according to Rule 420-2-1-.29 (7), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.





## **Update from the Office of EMS Volume XVIII, Issue VIII**

### **From the Director**

It's that time of year again, schools back in and everyone is busy! It seems in EMS we are always busy and presented with new challenges all the time and in my opinion this is great, because if EMS is not moving then we are not growing as a profession. I want to advance and move EMS forward in the state of Alabama and the nation and we must maintain an open mind and be willing to explore new ideas to accomplish this goal. A few of the things we are currently working on are our Critical Care Protocols, which will be used as guideline for Critical Care crews to utilize for treating some of the sickest patients in the out-of-hospital setting. A group of Critical Care providers have been working to put these protocols together and the OEMS is very grateful for their efforts.

We have also partnered with the Alabama 911 Board to create a set of Emergency Medical Dispatch protocols. These EMD protocols have been adopted by the Alabama 911 Board and Alabama Department of Public Health Office of EMS. We encourage all EMS services dispatching themselves to take the course and become EMD certified. If you are being dispatched by 911, and they are not already EMD certified, encourage them to take the course and become certified. The bottom line is anyone who is taking calls and dispatching EMS should be EMD certified.

Many of you have questions about the EMS compact (REPLICA). Currently it is a work in progress. The commissioners are working to develop a set of rules to govern the commission. Once the rules are developed, we will have a much clearer picture of what will and will not be allowed. We currently have 16 states as part of the compact. Alabama was the 11<sup>th</sup> state to join and I was appointed the inaugural Treasurer for the commission and serve as a member of the executive committee. If you have any question about the compact, contact me at the office.

As the school year begins, I hope everyone stays safe and as always if anyone needs assistance from me or my staff, please contact the office.

Stephen Wilson  
Acting Director





## Compliance Issues continued

EMSP-Paramedic	420-2-1-.29	Impairment	Suspension
EMSP-Paramedic	420-2-1-.29	Impairment	Suspension
EMSP-Paramedic	420-2-1-.29	Impairment	Suspension
EMSP-Paramedic		Patient Care Issues	No Violation Found
EMSP-Paramedic		Patient Care Issues	No Violation Found
EMSP-Paramedic		Patient Care Issues	No Violation Found
EMSP-Paramedic		Patient Transport Issues	No Violation Found
Provider Service		Non-Compliant Equipment	No Violation Found
Provider Service		Mechanical Issues	Inspected/ Corrected
Provider Service		Mechanical Issues	Inspected/ Corrected
Provider Service		Inappropriate Transport	No Violation Found
Provider Service		No Coverage	No Violation Found
Provider Service		Inappropriate Transport	No Violation Found





## **Provider Service Inspections**

These inspections were completed April-June, 2018.

Adamsville Fire and Rescue

Advanced EMS

Advantage EMS

Air Evac EMS-Demopolis

Alabaster Fire Department

Alexander City Fire Department

Amstar EMS-Marengo

Argo Fire and Rescue

Arjenna Parabolic Transport

ASAP Ambulance-Escambia

ASAP Ambulance-Monroe

ASAP Ambulance-Sumter

Ashville Fire and Rescue

Atmore Ambulance

Baptist Lifeflight

Birmingham Fire and Rescue

Cahaba Valley Fire-Jefferson

Cahaba Valley Fire-Shelby

Calera Fire Department

Care Ambulance-Macon

Chelsea Fire and Rescue

Childersburg Ambulance Service

Choctaw County Ambulance  
Service

Conecuh County EMS

Corner Volunteer Fire and  
Rescue

DW McMillan EMS

Daphne Fire Department

Directorate of Public Safety

Emergency Medical Transport

First Response-Decatur

Forestdale Fire District

Fort Rucker EMS

Fultondale Fire and Rescue

Gardendale Fire and Rescue

GEMS

Graysville Fire and Rescue

Greenville Fire

Hale County EMS

# **Provider Service Inspections**

## **continued**

Harpersville Fire Department	New Site Volunteer and Ambulance Service
Haynes Ambulance-Bullock	Newman's Ambulance Service
Haynes Ambulance-Covington	North Shelby Fire Department
Haynes Ambulance-Elmore	Northstar Paramedic Services-Jefferson
Haynes Ambulance-Montgomery	Northstar Paramedic Services-Talladega
Homewood Fire and Rescue	Opportunity EMS
Hoover Fire Department-Jefferson	Ozark EMS
Hoover Fire Department-Shelby	Ozark Fire
Kimberly Fire and Rescue	Palmerdale Fire District
LifeCare of Alabama-Jefferson	Pelham Fire Department
Lifeguard Ambulance Service-Escambia	Pell City Fire and Rescue Service
Lifeguard Ambulance Service-Jefferson	Ragland Rescue Service
Lifeguard DBA Medstar-Baldwin	Riverside Fire and Rescue
Lincoln Fire and Rescue	RPS-Shelby
McAdory Fire Department	Samson Volunteer Rescue
McCalla Area Fire District	Saraland Fire Rescue Department
Medcare EMS-Wilcox	Simmons EMS
Mobile County EMS	Southeast Shelby County Rescue
Montevallo Fire and Rescue	
Mount Olive Fire and Rescue	





## **Provider Service Inspections continued**

Southern Ambulance Transport

Springville Fire and Rescue

Sylacauga Ambulance Service

Tallapoosa EMS

Tarrant Fire and Rescue

Troy Fire

Vestavia Hills Fire Department

Warrior Fire Department

Westover Municipal Fire

Department

# Culture of Excellence

Air Evac EMS-Demopolis

D.W. McMillan EMS

Lifeguard Ambulance Service-Escambia

Lincoln Fire and Rescue

Mobile County EMS

Saraland Fire Rescue Department

Sylacauga Ambulance Service





## **Thrombolytic Checklist for Stroke**

Emergency medical services personnel (EMSP) are a critical component in stroke care. Early recognition and treatment of stroke offers more opportunity for treatment, which may save lives and reduce the long-term effects of stroke. Treatment for acute ischemic stroke, the most common type of stroke, may include tPA (tissue plasminogen activator) administration and/or mechanical thrombectomy, if certain criteria are met.

The Stroke Thrombolytic Checklist in the Emergency Medical Service (EMS) Protocols was revised in the recent protocol update. The changes were made based on suggestions from stroke care professionals and EMS Regional Directors. The checklist should be completed for any patient suspect of, or presenting with, acute stroke symptoms. A copy of the completed form should be left with the patient at the stroke center.

The Alabama Trauma Communications Center (ATCC) needs specific information to enter the patient into the Alabama Stroke System. As the EMSP completes the Thrombolytic Checklist for Stroke, the information for ATCC is documented which allows for a rapid report and Stroke System entry.

Stroke centers are trying to reduce door-to-needle times for tPA administration; therefore, time is critical and EMSP can help. A very important section of the thrombolytic checklist for hospital staff is the "Historian Cell Phone #." If possible, the EMSP should collect the cell phone or historian contact information before leaving the scene. Current contact information provides a mechanism for stroke center staff to verify or collect additional information if needed.

For convenience, the Office of OEMS printed note pads of the revised Thrombolytic Checklist for Stroke and provided them to the EMS Regional Offices for further distribution. Providers may print their own copies from the [EMS Protocols Ninth Edition 2018](#) (Page 132) instead of using the pre-printed notepads.

Alice Floyd, BSN, RN  
Acute Health System Manager

## **Education Division Update**

The Education Division has been very busy as of late. The top priorities for us right now are National Registry test coordination and administration, writing rules for this office to regulate EMS education, and we have begun visiting schools to talk to EMS students.

It is that time of the year again when we are in the midst of EMS certification testing. Students, please keep in mind that at EVERY National Registry test you will have to leave your cell phones, smart watches, and/or tablets in your vehicles. It is against NR policy for you to have any of these devices on hand during the test. Also, it would help the test administrators greatly if you would have your Pre Authorization To Test (PATT) number on hand when you arrive at the site to take your psychomotor exam. You have to have this number for the scoring sheet.

We are very close to having a final draft of the EMS Education Rules. These rules are being drafted by a committee comprised of EMS educators, regional representatives, and the OEMS. Once approved, these rules will permit the OEMS to regulate all EMS education statewide. We have been working very closely with our regional and educational partners, and we are very proud of the work that has gone into this document.

After hearing that there are many in the state that are unsure about how the OEMS, the regions, the ATC, and the Alabama EMS system in general mesh together, the OEMS staff created a powerpoint slide show to help explain all of this. OEMS staff has been out and about presenting this material to EMS classes. If your class has not been offered this opportunity, please ask your instructor to contact us so that we may be able to set up a presentation for you.

Please remember that the education you have received is no good if it isn't combined with common sense and professionalism. You may know your stuff, but it doesn't help anyone if you can't apply it in a professional manner.

Please remember, too, that all services are responsible for making sure your providers and new hires have taken a protocol course. The Office of EMS will only ask for proof of protocols if the provider completed their education in a different state.

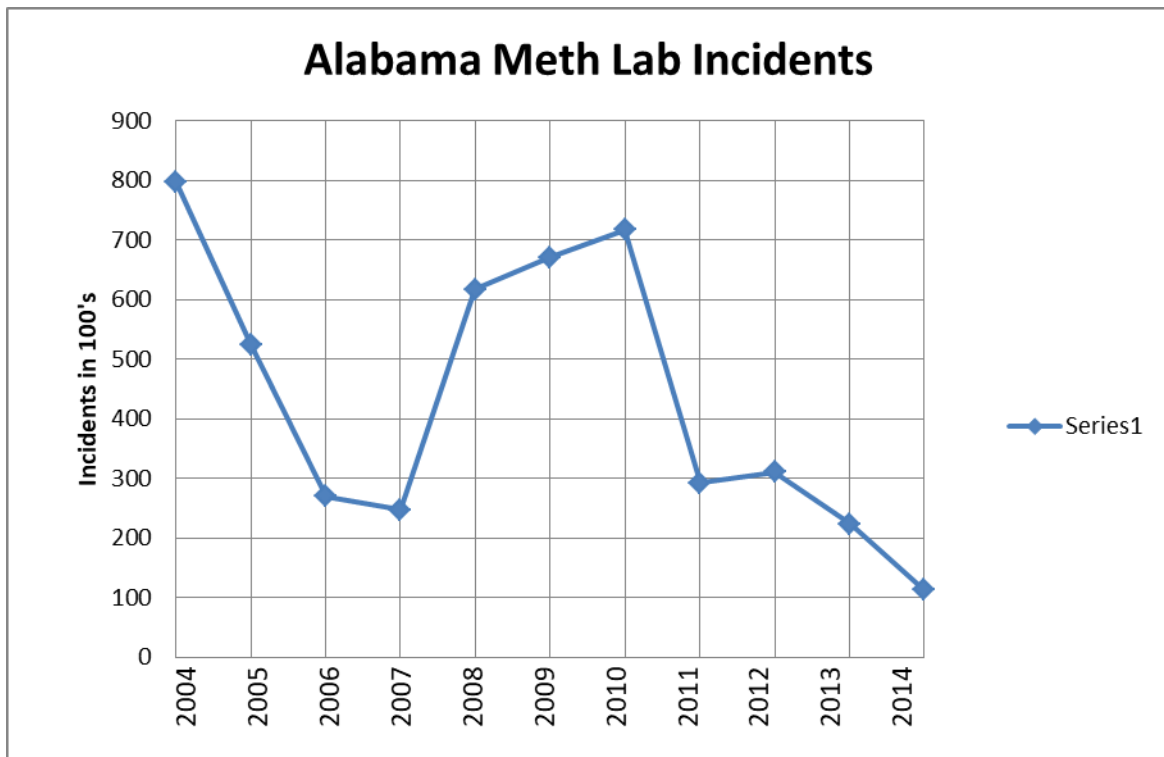
Chris Hutto, MBA, NRP  
Education Coordinator





## A Moment for Methamphetamine

United States Drug Enforcement Administration (DEA) data indicates that incidents involving methamphetamine labs (typically hidden or “clandestine” labs using common materials for generation of the drug) have generally fallen over the past 14 years (below note statistics from 2004-2014).



Between the years of 2004 and 2014 Alabama methamphetamine incidents accounted for 1.2% to 7.0% (average 3.4%) of methamphetamine incidents within the 50 states. Methamphetamine manufacture and use in Alabama remains a significant problem. The true number of existing labs is unknown and can only be estimated by counting the number of clandestine lab incidents recorded by public safety officials. Black market dynamics change with the evolution of the technology of manufacture, consumer demand and law enforcement techniques. Everyone in Alabama EMS has probably answered methamphetamine abusers; sometimes referred to as *tweakers*, *speed freaks*, *sketchers* and *meth heads*. This article seeks to report and explain some of the history and dynamics surrounding methamphetamine manufacture and abuse.

The German writer Norman Ohler, in his 2017 book *Blitzed: Drugs in the Third Reich* (Houghton Mifflin Harcourt, Boston, ISBN 9781328663795 (hardcover)) describes that drugs played a pivotal role in Nazi Germany in the late 1930's and into the years of World War II. Hitler himself was reportedly taking 74 separate drugs, including powerful opioid (the precursor to Oxycodone) and the first generation of methamphetamine in a pharmaceutical form (over the counter) then called “Pervitin.”



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Many Germans of the time took the drug to boost confidence, energy and attitude. It is said that the drug became as ubiquitous as coffee and was considered in much the same way. Housewives even ate Previtin-laced chocolates to allow them to work quickly and efficiently and to lose weight. The German Army distributed the chemical to its troops during the war to assist with the physical rigors of warfare.

Dr. Fritz Hauschild, a chemist for the Berlin-based Temmler pharmaceutical company, developed what was first called methyl-amphetamine in 1937. The company initially hoped to use his discovery to rival the American soft drink Coca Cola which was becoming popular in Germany and which famously initially contained approximately 1.3 milligrams of cocaine per ounce until 1903. At that time Coca Cola began using coca leaves from which the cocaine had been partially extracted and even today uses coca leaves which have the entirety of the cocaine extracted by the Stepan Company who then sells the extraction to the Mallinckrodt Pharmaceutical Company for production of cocaine products for medicinal purposes. Coca Cola was popular in Germany and, in fact, the Fanta line of soft drinks was developed by German Coca Cola manufacturers after trade embargos with the United States were initiated at the onset of World War II and prevented delivery of the original formula components.

SIDENOTE: If a soft drink was allowed to contain the original dose of cocaine of historic Coca-Cola, the amount in a 20 ounce bottle would be 26 milligrams, which is about one third to one half of an average “line” of cocaine and would cost about \$5.00 to \$6.00 per bottle (at cost) and probably would sell for much more. Cocaine has consistently cost about \$15,000 per kilogram (\$150.00 per gram) for the past few years. Woody, C. (2016, Oct 13) Cocaine prices in the US have barely moved in decades – here’s how cartels distort the market. *Business Insider Magazine*, Retrieved from <http://www.businessinsider.com/how-much-does-cocaine-cost-in-the-us-2016-10>

According to the National Institute on Drug Abuse methamphetamine is a habit forming stimulant that increases natural dopamine in the brain, intensifying reinforcement of rewarding behaviors as well as motivation and body movement. It is found in white powder form, sometimes formed into pills, or in a crystal form that resembles broken glass. It is chemically similar to the pharmaceutical amphetamine which is used to treat attention deficit hyperactivity disorder (ADHD) and the sleep disorder narcolepsy. It is known by the common names chalk, crank, crystal, ice, meth and speed. The routes used for drug intake are inhaling/smoking, swallowing (pill), snorting or injecting (dissolved in water or alcohol). The “high” of the drug initiates quickly but also fades quickly, which often results in repeated doses. A “binge and crash” pattern typically results causing some to binge in the form of a “run” where they give up food and sleep and continue to take the drug for hours or up to several days at a time.





Continued from page 16

The price of methamphetamine is approximately half that of cocaine, about \$80 per gram, and is classically sold as “an 8-ball” (an eighth of an ounce) which is 3.5 grams for about \$200.00.

The National Institute of Drug Abuse cites that manufacturers (here and in Mexico) actually make most of the illicit methamphetamine found on the streets of America in what are termed “superlabs” and are actually industrial in nature. As a low-cost alternative many practitioners of illicit drug culture will make the drug in small clandestine (secret) labs with inexpensive over-the-counter ingredients and common chemicals. One of the more well-known ingredients is pseudoephedrine and similar chemicals found in over-the-counter cold and decongestant medications. This illicit use of decongestants is the reason why the law requires stores to keep them behind the counter and keep records of sales to individuals and also to prohibit the sale of unusually large amounts or repeated amounts of them to individuals.

The nature of methamphetamine abuse lends itself to chronic, hopeless addiction. There is no way to quantify exposure frequency of methamphetamine to addiction development, however, methamphetamine is considered very highly addictive. The effects of methamphetamine make the user feel euphoria which drives repeated use. Use also prevents withdrawal from the drug which causes the consumer to lose the choice of whether or not to use the drug. As the cost of methamphetamine is significant, criminal activity (theft, etc.) often is associated with generation of drug purchase money. Physiologic damage of the central nervous system, specifically that of the limbic system, results in lack of impulse control, paranoia, extreme lack of empathy, and elicits extreme flagrant dishonesty and, thus, promotes a tendency toward criminal activity especially to purchase the drug. Meth addiction is generally medically recognizable by severe facial lesions (acne) worsened by scratching in an instinctive effort to lessen skin irritation, severe gingival and tooth disease (“meth mouth”) resulting in tooth loss and collaterally with the drug's tendency to cause weight loss, causes the addict to exhibit an emaciated image of their former selves. Severe yearning for the drug results in diminished social support by family as addicts are avoided due to the tendency to lie to and steal from loved ones. Neurological and organic damage also results in impaired physical functioning and diminishment of the quality of interpersonal relationships. Recovery rates among methamphetamine addicts are generally low, as is quality of life and life expectancy. Graduation to intravenous abuse of the drug (“slamming”) generally signals loss of recoverability.

SIDENOTE: Visit this CBS NEWS site to see more physical effects of meth use described above. <https://www.cbsnews.com/pictures/meths-devastating-effects-before-and-after/>

Continued from page 17

When working in Alabama EMS, or in any other state, we sometimes go into areas that are renowned for criminal activity. If that criminal activity involves the presence of clandestine methamphetamine labs then exposure to hazardous materials may be possible. In addition to cold medicines and decongestants, methamphetamine labs utilize many caustic and flammable materials. If you answer a residence or other building and observe what you consider to be an unusual amount of collection of these chemicals, you should use caution and consider reporting it to the fire service or law enforcement. The laundry list includes but is not limited to acetone, alcohol (isopropyl, rubbing) toluene (brake cleaner) ether (starting fluid spray) sulfuric acid (drain cleaner) coffee filters (especially if stained with red chemicals) iodine (usually veterinary products) salt (rock or table) batteries (lithium) small propane tank (used to steal anhydrous ammonia from farming operations and store it) lye, matches (red phosphorus) dishes (Pyrex or Corningware) and muriatic acid. Of course, many of these chemicals are hazardous, are fire accelerants, and are generally not considered unquestionable if found all in one place. Fire departments would approach an active lab for the purpose of neutralization and removal of the chemical components.

SIDENOTE: If a residence is recorded to have been associated with a meth lab it is placed in the DEA's National Clandestine Laboratory Register. Anyone can review any state's meth lab history by street address by going to this site on the DEA's webpage: <https://www.dea.gov/clan-lab/clan-lab.shtml>

In conclusion we can summarize by pointing out that persons under the influence of meth, and attempting to manufacture meth while under the influence of the drug make for the worst case scenario. Multiple incidents of persons stealing ingredients inside large stores (usually Wal-Marts) and attempting to cook the meth in the store have been recorded in recent years. Shoplifters have been caught with small portable devices (shake and bake labs) accumulating ingredients and actually cooking the meth while walking around in the store. The high risk of fire and explosions in these endeavors associated with the high risk taking tendencies of the practitioners should make all of us in EMS a little more observant when placed in situations with high index of suspicion for meth.

Gary L. Varner, MPH, NRP  
Senior Epidemiologist





## WHAT DO “THEY” DO WITH THAT DATA?

The goal of the ADPH Office of Emergency Medical Services (OEMS) is to capture data on every single response made by licensed EMS services in the State of Alabama. Submission of Electronic Patient Care Report (EPCR) data is a condition of Alabama licensure for EMS services and departments operating in our state. If a vehicle is contacted by their dispatch and placed on a call for the purpose of patient care and/or transport, an EPCR should be initiated (sometime during the process) to record the call – no matter what the disposition (outcome) of the call eventually is.

Ideally the Data Management and Analysis Section of the OEMS should be able to track every patient care dispatch, every patient care encounter, and every patient transport for each licensed EMS service or department AND for each licensed personnel recorded for that dispatch since the mid-2000’s and into the foreseeable future. Oversight (and quality assurance and improvement) is simply not possible if true and complete evaluation of performance is not available. And the only true availability of that information is through data collection.

Data collection is an aspect of EMS (for lack of more exact and socially acceptable terms) that can be said to be “an unappreciated endeavor.” The entire process of data collection; from acquisition of equipment, acquisition and maintenance of reporting software (packaged with other software, like billing and stocking software, stand alone or State supported) development and enforcement of company or department procedures for patient care reporting and service/department management of submissions uploads is considered by most in EMS to be too problematic, time-consuming and expensive to be worthwhile. Nothing could be farther from the truth.

The writing of an EPCR provides a permanent record of your patient care activities.

- Its most frequent role is to evidence your story of patient care (the patient care history) so that it can be used for billing purposes to qualify the charges that your service or department seek from third party payers (insurance companies) or personally from uninsured patients.
- Its most prominent role is to record data that is used to evaluate performance. Out of chute times, response times, scene times, transport times; dispositions (cancellations, refusals, transport decisions, other units on scene, etc.) and any and all evaluations, findings and procedures performed.

Continued from page 19

- Its most important role is to protect the ambulance crew from liability. The old axiom being “If it wasn’t written down then it wasn’t done (or didn’t happen).” Liability (accountability) is generally incurred by EMS crews, either directly or indirectly, in the attempt to prove negligence. Negligence is proven by determining that a duty to act existed and that the negligent party disregarded that duty to act in some way and an injury resulted. Disregard for duty is generally divided into doing something that others would not have, or not doing something that others would do, given the same situation and training (reasonable man test). The written record not only serves to support the claims of the “EMS accused” but is extremely useful (if wholly written and complete) if the case is raised months or years after the incident.
- As it becomes part of the patient’s permanent hospital record, the EPCR also serves as a record of interventions in the field performed under verbal or protocol orders that can be compared with the patient’s health outcome. In this way, as a clinical treatment record, it records performance, protects from liability, and speaks to the total ability of the Emergency Medical Services System, both in Alabama and nationally.

Specifically in Alabama your EPCR data is used for the following purposes among others:

- It is forwarded to the National Emergency Medical Services Information System. The data is utilized to evaluate the EMS System nationwide, guiding the future development of EMS nationally and providing a platform upon which cost-benefit analysis can be performed. Alabama is on the leading edge of states reporting Version 3 data (60% of U.S. states and territories report in some aspect of the Version 3 format) and we anticipate progressive evolution of the national reporting system as EMS marches into the future.
- The Alabama Law Enforcement Agency (ALEA) requests verification and validation of traffic death information for the Fatality Analysis Reporting System (FARS) reports sent to the National Highway Traffic Safety Administration (NHTSA). That review is conducted from EMS data bimonthly by the OEMS Data Management and Analysis Section.
- The command structure of the Alabama Department of Public Health depends upon accurate and adequate reporting of EMS data.
  - Investigations of infectious diseases often rely upon collateral EMS data to determine areas of the state that utilize EMS for treatment and transport of diseases of interest.





Continued from page 20

- Toxicological investigations and surveillance programs also heavily rely upon EMS data. Currently the opioid crises in Alabama is frequently studied by Alabama Department of Public Health and Centers for Disease Control by evaluation of naloxone (Narcan®) administration by Alabama EMS personnel as well as their reports of the drug being administered prior to their arrival by police and fire first responders.
- Provider Standards (who license healthcare facilities) often rely upon EPCRs generated during EMS runs associated with complaints regarding healthcare facility operations.
- The State Committee of Public Health (SCPH) and the State Emergency Medical Control Committee (SEMCC) both rely upon EMS data to evaluate the performance and outcomes of Enhanced Protocols Procedures performed under licensure by EMS services and departments. These committees are comprised of the lead physicians of the state and both directly and indirectly control the operation and development of EMS in Alabama.
- Review of the Alabama Trauma System and Alabama Stroke System (and moving forward, the Alabama STEMI System) all often rely upon data supplied by EMS field personnel to verify dynamics and supplement information supplied by hospitals and trauma centers.
- Most directly the Office of EMS uses EMS data to investigate complaints of varying natures that are lodged against EMS services and providers. Any evaluation of field performance is supplemented by review of associated EMS data.

In conclusion we can say that EMS reporting is not only here to stay, but becomes more important in the healthcare process in Alabama and the United States every day. Alabama EMS personnel are directly responsible for reporting the run dynamics of their calls as a condition of their licensure in Alabama. Licensed EMS services and departments are responsible to their licensed personnel (paid or volunteer) to provide a platform upon which the required reporting can consistently and procedurally occur. Alabama EMS personnel should invest themselves in the accurate recording and reporting of data for reasons of both professionalism and avoidance of personal and professional liability in potential criminal and tort proceedings.

Gary L. Varner, MPH, NRP  
Senior Epidemiologist

## Alabama e-PCR Submission Requirements

### Some e-PCR Points of Clarification:

1. It is a requirement to complete a patient care report on every response. This office is already monitoring submission rates and comparative data suggests that many agencies are not reporting all runs as required. Please submit all required runs to avoid noncompliance.
2. Each record must be submitted electronically within 72 hours or less. The goal is to eventually narrow that down to within 24 hours. The 24 hour reporting allows Public Health to monitor surveillance trends as required by the Federal emergency preparedness guidelines.
3. Our IT staff is always available to assist you with your e-PCR needs. If you need assistance, you may call Chris or Lori at 334-206- 5383. You may get a voice recording depending on the call volume. They will eventually get back to you. If you do not hear from them within a reasonable time, you may wish to [email](#) them.
4. Collecting and importing data is paramount only to reporting reliable data. Reliable data is accurate and contains no errors. When one looks for shortcuts and/or skips data entry in areas that has been discovered to have no validation rules, it dilutes the integrity of the data, not to mention falsifies a legal document. Please make sure you enter data accurately.
5. Alabama became a NEMSIS version 3.4 compliant state beginning January 1, 2018.





## **General Information**

### **Do You Have Questions for OEMS Staff?**

This is another reminder to those of you calling our office (334) 206-5383:

Complaints, Investigations, and Inspections —Call Jamie Gray

Licensure —Call Stephanie Smith, Kembley Thomas, or Vickie Turner

Individual Training or Testing—Call Chris Hutto

EMS for Children, Website, and Social Media—Call Katherine Dixon Hert

EMS Data/NEMSIS – Call Gary Varner

### **Requests for Information from Regional Offices**

The Office of EMS would like to request that you comply with any request for information from your regional office. Some Directors are still having issues receiving information and data as requested by the State office. We would greatly appreciate your cooperation and compliance.

### **Reporting Requirements**

Please be reminded that, according to Rule 420-2-1-.07 (6h), All licensed provider services shall provide notification and written documentation within three working days to the OEMS regarding any protocol or rule violation, which includes but not limited to, according to 420-2-1-.30 (8), anyone guilty of misconduct or has committed a serious and material violation of these rules; has been convicted of a crime.

Also be reminded that, according to Rule 420-2-1-.29 (7), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.





## **Update from the Office of EMS Volume XVIII, Issue VX**

### **From the State EMS Medical Director**

Our OEMS staff and I have had the opportunity to get out over the last several weeks and visit two different EMS venues within our state. We visited East Alabama EMS' conference in Oxford and it was very interesting to hear different speakers delivering talks dealing with leadership and management issues. We also visited the Alabama Ambulance Association/ Alabama EMS Association conference in Orange Beach. It was interesting to hear the feedback from those participating in the clinical track lectures. These were well received and people took home ideas to improve their patient care.

Getting out and visiting the different EMS stakeholders in our state is the most enjoyable part of my job. I always enjoy listening to different viewpoints and always am reminded that people throughout our EMS profession in Alabama are truly trying to make our system better. We will never have a perfect system but, as we all work together, our system will continue to improve.

I certainly appreciate the opportunity to serve as your Alabama EMS Medical Director!! Don't hesitate to let me know if I can help you in any way.

Dr. William E. Crawford  
State EMS Medical Director





## **Provider Service Inspections**

These inspections were completed July-October, 2018.

Adamsville Fire and Rescue	Care Ambulance-Lowndes
Advantage EMS-Etowah	Center Point Fire and Rescue
Air Evac EMS, Inc-Fayette	Cherokee EMS
Air Evac EMS, Inc.-Cullman	City of Slocomb EMS
A-Med Ambulance Service	Clayton Fire and Rescue
AMNS Calvert	Cleburne County EMS
AMVAC Chemical Corporation	Clio Rescue Squad
Anniston Fire Rescue	Concord Fire District
Arab Fire Rescue	Cordova Volunteer Fire Dept
ASAP EMS-Clarke	Corner Volunteer Fire & Rescue
ASAP EMS-Perry	Cullman EMS
ASAP EMS-Washington	Cullman Fire Rescue
Athens Limestone EMS	Decatur Fire and Rescue
Atalla Fire and Rescue	Dothan Ambulance Service
Baker Hill Fire and Rescue	Dothan Fire
BASF Corporation	Elite Industrial Services
Birminghamport Fire Department	Eufaula Rescue Squad
Brookside Fire Rescue	Fayette County EMS
Care Ambulance-Autauga	Floyd EMS
Care Ambulance-Dallas	Forestdale Fire District

# **Provider Service Inspections**

## **continued**

Fultondale Fire and Rescue	Lifeguard Ambulance Service-Jefferson
Gadsden Fire Department	Lifeguard Ambulance Service-Mobile
Gallant Volunteer Fire Dept	Lifeguard Ambulance Service-Morgan
Gantt Rescue Squad	LifeSaver 2-Etowah
Gardendale Fire and Rescue	LifeSaver 4-Talladega
Geneva Rescue Squad	Louisville Fire and Rescue
Goodwater Ambulance Service	Madison Fire and Rescue
Graysville Fire and Rescue	Marion County EMS
Greg's Ambulance Service	Marshall Health System-Boaz
Hartford Fire Rescue	MedStar
Haynes Ambulance-Pike	Midfield Fire Department
HEMSI	Minor Heights Fire District
Hillsboro Area Vol Fire Rescue	Mobile Fire Rescue Department
Homewood Fire and Rescue	Mount Olive Fire & Rescue District
Hueytown Fire and Rescue	Mountain Brook Fire Dept
Huntsville Fire and Rescue	Mud Tavern VFR
Huntsville Medflight	Nixon Chapel VFD
Irondale Fire Department	North Baldwin EMS
Jefferson County Sheriff's Office	
Kellyton Fire and Rescue	
Kimberly Fire and Rescue	
LifeCare of Alabama-Jefferson	





## **Provider Service Inspections continued**

Northstar Paramedic Services-  
Jefferson

Northstar Paramedic Services-  
Talladega

Pleasant Grove Fire and Rescue  
Service

Prattville Fire Department

Rainbow City Fire and Rescue

Regional Air Medical Services-  
Walker

Rehobeth Rescue

RPS-Cullman

RPS-Marion

RPS-Walker

RPS-Winston

Samaritan EMS-Arab

Samaritan EMS-Morgan

SAVES Fire and Rescue

Shoals Ambulance-Jefferson

Shoals Ambulance-Lauderdale

Southflight

Southside Fire Department

Sylvan Springs Fire Department

Tarrant Fire Rescue

U.S. Steel

Vestavia Hills Fire Department

Vinemont Providence Fire  
Department

Warrior Fire Department

West Jefferson Fire and Rescue

Wicksburg Fire Rescue

Winterboro VFD

# Culture of Excellence

Brookside Fire Department

Cleburne EMS

HEMSI

Lifesaver-Etowah County

Samaritan EMS

Trussville Fire Department

West Jefferson Fire Department





**American College of Surgeons  
Committee on Trauma  
Alabama Trauma System Consultation**

Representatives of the American College of Surgeons (ACS) Committee on Trauma, came to Montgomery the week of September 10-14 to evaluate the Alabama Trauma System (ATS) at the request of ATS stakeholders. The consultation was made possible by support from the following partner agencies: Alabama Department of Public Health, Alabama Hospital Association, Children's of Alabama, the Healthcare Authority of the City of Huntsville doing business as HH Health System, the UAB Health System, and USA Health University Hospital.

As a result of this ACS assessment, trauma leadership will develop a consultative report for Alabama that will guide future systems development tailored to meet Alabama's specific needs.



Alice Floyd, BSN, RN  
Acute Health System Manager

## Regional Office Update

Many of you may know about the Office of EMS in Montgomery, located downtown in the RSA Tower. Most of us either know of its location or have been there in person. But I would venture to say that many of our EMS providers do not know about their local EMS regional office. I can remember attending a regional meeting in my area over a decade ago and not truly understanding what I was witnessing. It was overtime for me to attend the meeting so I did; I wish I had paid more attention at the time. I would have developed a better understanding of how the EMS system works in our state. I began to work for a regional office over two years ago and have learned considerably more about the EMS system. This knowledge that has become indispensable in my career as an EMS provider. I have learned how our acute healthcare systems function and how the regions play a role in our daily operations. There are services provided and oversee that happens by our regional offices that many of us may never know about. I wanted to take some time and help our providers understand a little more about these extensions of the Office of EMS.

There are six regional offices located throughout the state of Alabama. Each office covers a specific amount of territory based off of counties. Each of the regional offices employs personnel for various tasks. These tasks range from being a liaison with the Alabama Trauma Communications Center (ATCC) to continuing education coordinators. Each of the regional offices has a director who stays in contact with the Office of EMS. They have regular meetings that cover a myriad of subjects from daily operations to protocols and policies.

The main objective and goal of the regional offices is training. The offices provide courses to help you in your career and to assist you in keeping your certifications current. Most of the offices will offer refresher courses each year and protocol training to keep you current. All of your “alphabet” course (ACLS, PALS, ITLS, BLS, ETC.) are usually offered by your regional office. Our goal in training is to keep you working on the front lines, making a difference in your community, call after call.

The regional office can be one of the best assets in your arsenal. They can answer questions and provide guidance in your endeavor to become a better provider. Like you, they remain on call on a 24-7 basis. If you ever have any questions or complaints, never hesitate to call your regional office.

Lamar Green  
Field Coordinator  
Alabama Gulf EMS Systems (AGEMSS)







## EMS for Children Update

### What is Pediatric Emergency Care Coordinator (PECC) and why do we need them?

Based on the results from the EMS service survey performed in 2017, only 21.4% of our services have someone identified as a PECC. With an additional 30% planning on establishing that position or adding duties to a current provider, I thought it would be helpful to address the PECC.

The duties of a PECC as established by the Federal EMSC Program include:

- Ensuring that the pediatric perspective is included in the development of EMS protocols;
- Ensuring that fellow providers follow pediatric clinical-practice guidelines and protocols;
- Promoting pediatric continuing education opportunities;
- Overseeing pediatric process improvement;
- Ensuring the availability of pediatric medications, equipment, and supplies;
- Promoting agency participation in pediatric prevention programs;
- Promoting agency participation in pediatric research efforts; interacting with the ED PECC; and
- Promoting family centered care at the agency level.

The PECC:

- Does NOT have to be a separate position.
- It can be an individual already in place who assumes this role as part of their existing duties.
- The individual may be a member of your agency, or work at a county or regional level and serve more than one agency.

This is not meant to place an undue burden on our providers and agencies rather to help promote pediatric care at the pre-hospital level.

On the next page, I've included a graphic representation of the survey responses to this question. This information is inclusive of all 126 services that were selected to respond to the survey. While I know this doesn't represent all 309 active licensed services, the National EMSC Data Analysis Resource Center felt that the 126 agencies in the sample were representative of the state as a whole. If your agency was not in the sample and you have a provider who is performing the duties of a PECC or are interested in more information, please let me know. I will be happy to work with you to implement these very important duties as we continue to promote pediatric care in EMS.

Katherine Dixon Hert, BSBA  
EMSC Program Manager

# Pediatric Emergency Care Coordinator (PECC) Overview

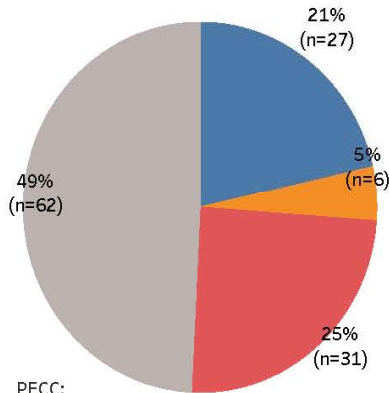
Highest Licensure:  
All

Annual 911 Pediatric Call Volume:  
All

Urbanicity:  
All

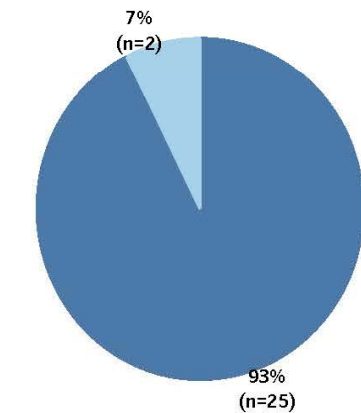
Percent of Agencies Shown:  
**126/126 (100%)**

## Pediatric Emergency Care Coordinator



PECC:  
■ Has a PECC  
■ Plans to Add a PECC  
■ Interested in a PECC  
■ No PECC

## PECC by Type:



■ PECC Oversees Agency  
■ PECC Oversees Multiple Agencies

## Reported PECC Duties:

PECC Type:  
All

	% Have
Ensures that the pediatric perspective is included in the development of EMS protocols	81%
Ensures that fellow providers follow pediatric clinical practice guidelines and/or protocols	100%
Promotes pediatric continuing education opportunities	100%
Oversees pediatric process improvement initiatives	81%
Ensures the availability of pediatric medications, equipment, and supplies	96%
Promotes agency participation in pediatric prevention programs	67%
Coordinates with the emergency department pediatric emergency care coordinator	41%
Promotes family-centered care	44%
Promotes agency participation in pediatric research efforts	44%
Other activities	41%





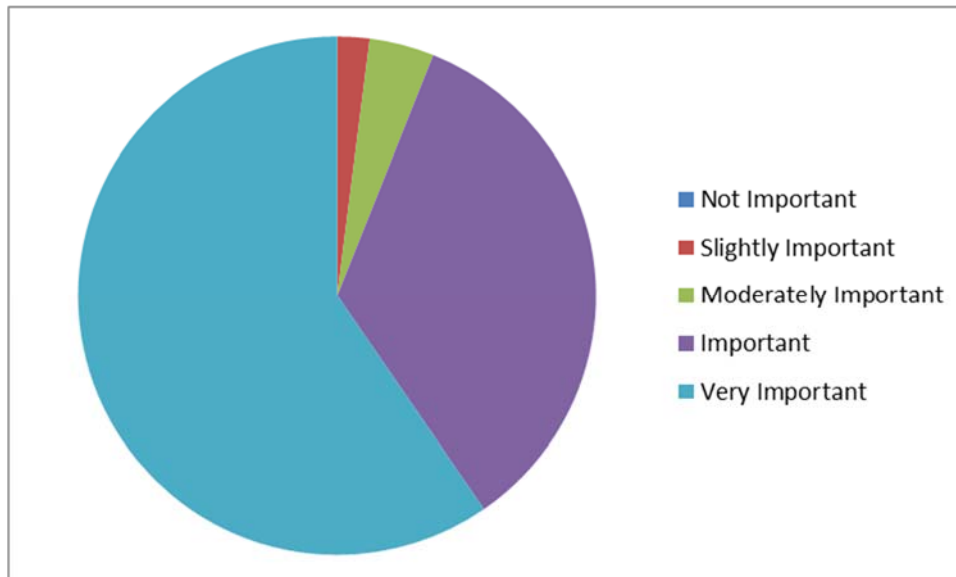
## Emergency Department Physician Opinions of Prehospital EMS in Alabama

In early summer of 2018 the Data Management and Analysis Section of the Office of EMS fielded a 10 question survey to the greater than 800 physicians who have a MDPID or Medical Direction Physician Identification Number. The questions were designed to investigate the opinions of actively working physicians regarding the importance of observations and documentation of prehospital EMS.

We received approximately 20% response from those still active, which is considered about normal for email surveys. Email survey response has diminished over the decades since its invention. Let's face facts – nobody likes to take surveys. We purposefully limited our selection to 100 respondents. It turns out that we only received about 100 responses. That many responses are statistically viable to represent the entire actively working population of physicians in Alabama. Among the many possible reasons for lack of response includes old email addresses, recipient's spam folders and disinclination to respond to surveys, previously discussed.

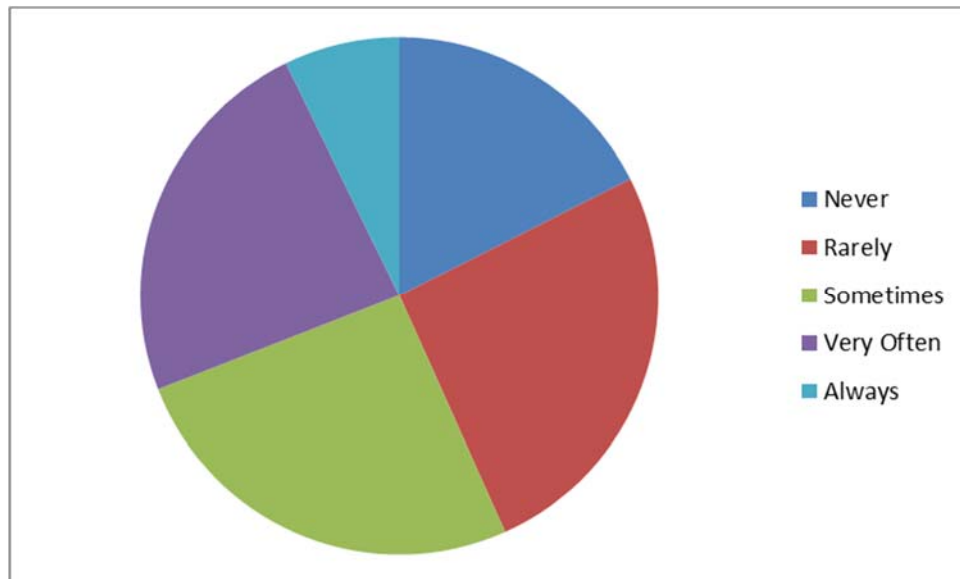
Below we will cite each question, demonstrate the response graphically and discuss the possible meaning of the responses. The response colors start at 12 o'clock and continue clockwise.

**Question 1: As a physician how important to your process of patient assessment and treatment do you consider the observations of prehospital EMS personnel (EMTs, AEMTs, IEMTs, Paramedics) to be?**



Q1 Analysis: It is noteworthy that 0.0% responded “not important.” Only 6.0% identified as either slightly or moderately important and we should remember that the concept of importance is subjective among individuals, similar to the 1-10 scale for pain is among our patients. Most significant is the fact that 93.9% considered it to be important or very important (34.3 and 59.6 percent respectively). Implication: Almost all physicians feel that prehospital EMS observations are significantly important to their process of patient assessment.

**Question 2: While working in your Emergency Department, how often do you receive a written prehospital EMS patient care report from the EMS crews that deliver your patients?**



Q2 Analysis: 17.5% of the physician respondents reported that they “never” receive a written prehospital EMS PCR. Conversely 7.2% report that they “always” receive one. About a quarter of the respondents report “rarely” (25.7%) and about the same proportions report “sometimes” and “very often” (25.7 and 23.7 percent respectively). EPCRs have made leaving a report copy at the ED a bit more difficult compared with the days of pre-EPCR written reports. It is important to remember that 420-2-2-.13 Patient Care Reporting section of the Alabama EMS Rules (2017 version in force) states that each EMS Provider (individual licensee) is responsible for completing an electronic Patient Care Report and submitting it to his/her EMS Provider Service. In turn the Provider Service is responsible for delivering copies of the PCR to the receiving facility either at the time of delivery of the patient or as soon as possible thereafter, not to exceed 24 hours.

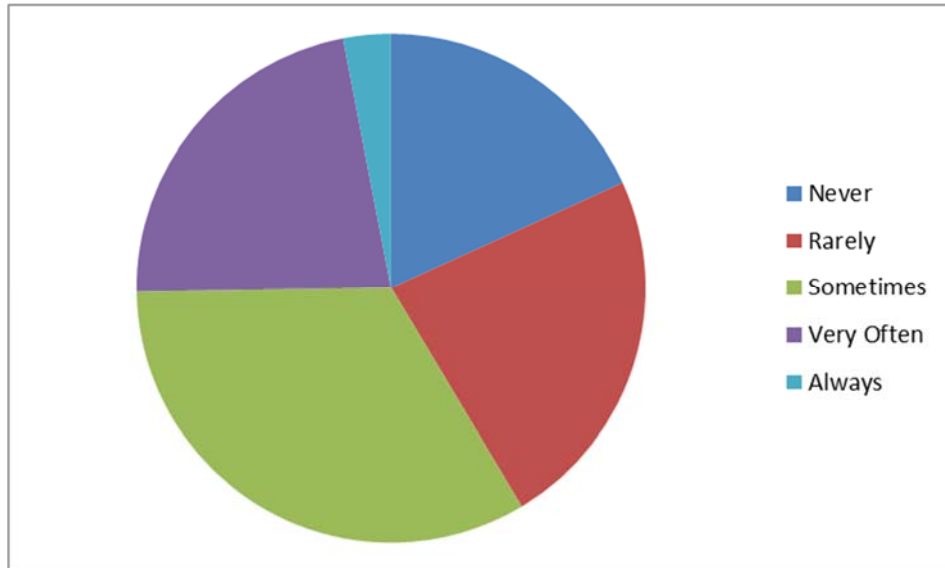
Incidentally, the Office of EMS is in the process of developing an automatic system whereby emailed copies of the ePCR is sent to each hospital at the time the ePCR is submitted. That system should be in place within the next 12-18 months.

Delivery of a copy of the entire patient care report with the patient is certainly desirable but sometimes not achievable. Time constraint during patient transport or patient care activity often prevents completion of the ePCR by the time of arrival. Crews are often not able to stand by at the receiving facility (the term “wall time” has come into use to describe this lag time) to complete the ePCR and must return to service. It is noteworthy that the crews also sometimes do not take advantage of facility forced “wall time” (sometimes taking an hour or more) to complete charting when the ED is unable to accept the patient. Questions 3 and 4 were designed to investigate the importance of the PCR copy to the receiving physicians.



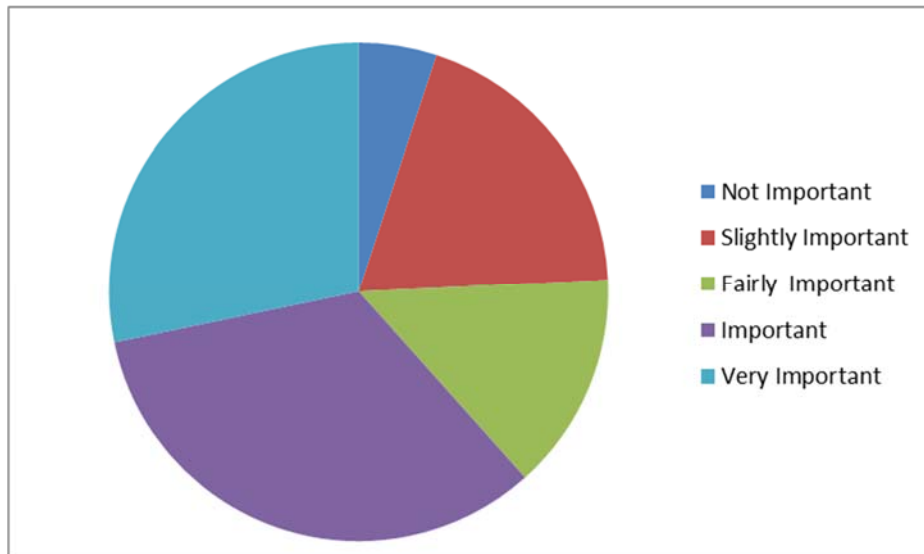


**Question 3: While working in your Emergency Department, how often do you rely upon written prehospital EMS patient care reports for information to base your patient care decisions upon?**



Q3 Analysis: First note that 58.5% steadily use written PCRs to formulate their patient care decisions. A third of the respondents (33.3%) stated that they “sometimes” used the written copy and 22.2% stated that they did so “very often.” Additionally 3.0% stated that they “always” use the PCR copy. A further 23.2% stated that although they do so “rarely,” they do sometimes do it. While 18.1% state they never use the PCR copy in their patient care decisions remember that 17.5% reported that they “never” receive a PCR copy. The study cannot account for how much not receiving a PCR contributes to never using one to make decisions but the proportions are certainly comparable. We can use these responses and say with some certainty that 81.7% of Emergency Department physicians use the PCR copy in the appropriate circumstances.

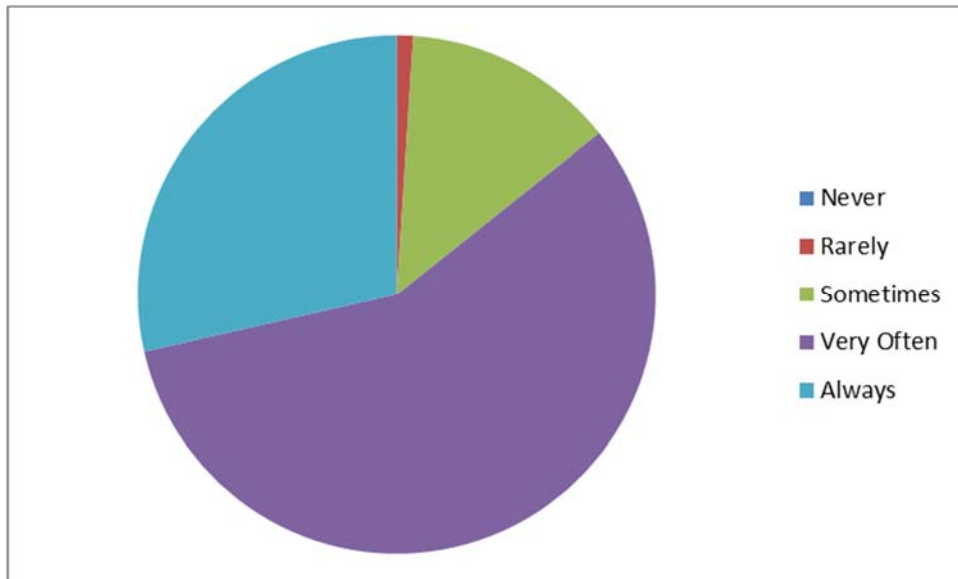
**Question 4: While working in your Emergency Department, how important would you say that it is to receive a written prehospital EMS patient care report from the EMS crews that deliver your patients?**



Q4 Analysis: Notice 94.9% of responding physicians consider the written PCR to be important at some level, with 61.6% considering it important or very important (33.3 and 28.3 percent respectively).

The patient care report copy is important for several reasons. We have discussed how they are used by the physician to assist in the patient care process and indirectly they record the observations of the crews in the field. They also are considered a legal document and should be made a part of the patient's medical records. If legal action for any reason occurs surrounding the patient's medical care both the plaintiff and defense attorneys will copy the entirety of the hospital's medical records for expert review. They will also subpoena or request an ePCR copy from the OEMS. If one is not available from the repository the absence can be interpreted in whatever manner necessary to meet the goal of the individual attorney. If a completed ePCR is available from OEMS and a partial one (or none) is available in the hospital records that also can become a leverage tool to one or the other's case.

**Question 5: While working in your Emergency Department, how often do you rely upon "face-to-face" verbal/oral prehospital EMS patient care reports for information to base your patient care decisions upon?**



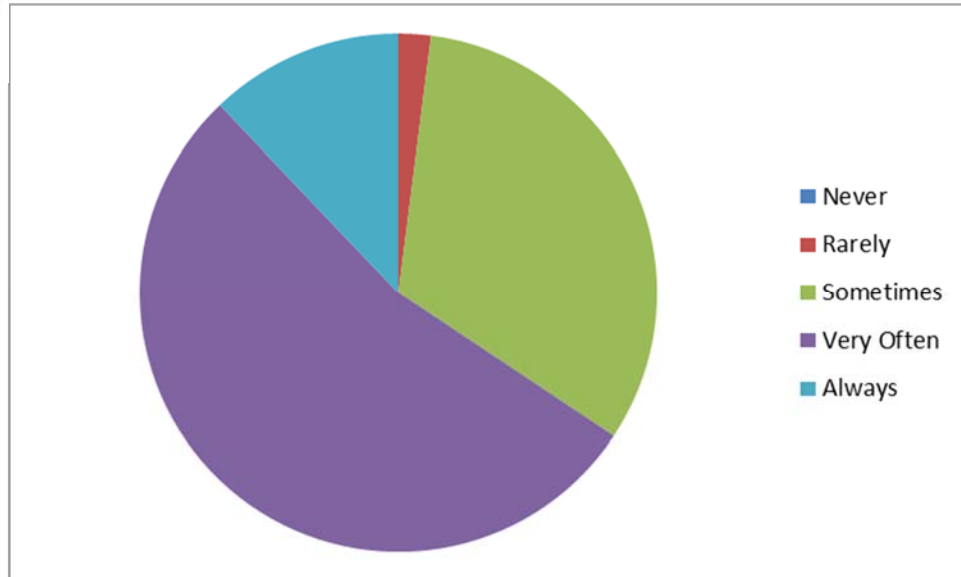
Q5 Analysis: First, 0.0% of the responding physicians reported that they "never" use face-to-face reports to assist them in their patient care decisions. This actually supports the hypothesis that written reports are not used as much as they could be because they are not always available at delivery. Additionally only 1.0% reported relying upon live interaction "rarely." Virtually 99% of respondents report that the interaction is used procedurally when necessary and 85.7% report significantly frequent use of the report information from prehospital EMS.

After identifying the fact that prehospital EMS report (written and verbal) is considered important to Emergency Department physicians. How often does the physician receive verbal report from field crews and how well do they perform that task?



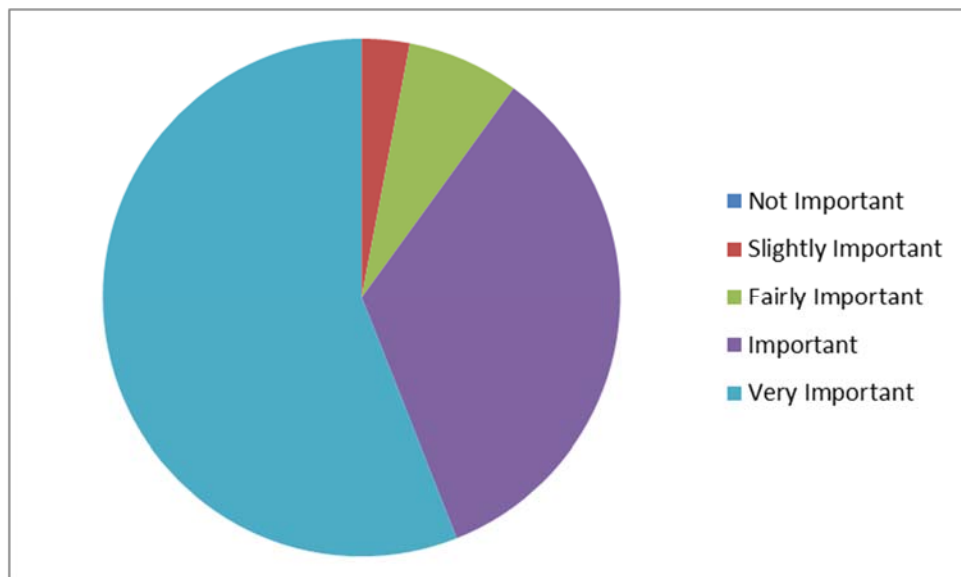


**Question 6: While working in your Emergency Department, how often do you receive a “face-to-face” verbal/oral prehospital EMS patient care report from the EMS crews that deliver your patients?**



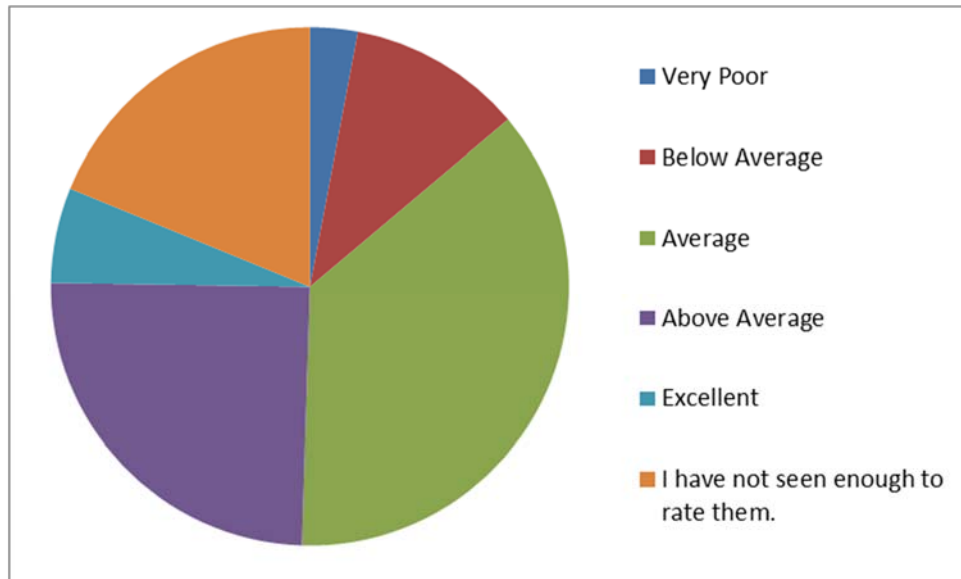
Q6 Analysis: No physician reported that he/she “never” received verbal EMS reports and only 2% reported it as a rare occurrence. “Sometimes” to “Always” comprised 98% of answers. Frequency likely has to do with the culture within the ED. Nurse availability, severity of patient condition and physician availability could all impact the frequency for direct physician contact. Face-to-face report with a physician is reported in 100% of respondents and 100% of respondents use the information to make decisions (see Question 5).

**Question 7: While working in your Emergency Department, how important would you say that it is to receive a "face-to-face" verbal/oral prehospital EMS patient care report from the EMS crews that deliver your patients?**



Q7 Analysis: No physician reported that verbal EMS reports as “not important.” Only 3.0% reported that verbal report was “slightly important.” The vast majority (90.0%) reported the verbal report to be meaningfully important and 56.0% reported it to be “very important.” Previous questions have established possible rationale as to why they perceive the face-to-face reports as important. Subsequent questions will establish the level of efficiency and effectiveness with which EMS reporting is viewed.

**Question 8: In your experience as a physician working in an Emergency Department setting, how would you describe the overall quality of written communication in Patient Care Reports given you by EMS Crews?**



Q8 Analysis: 19.4% of physicians reported that they had not seen enough written documentation by EMS crews to judge their quality. The majority (69.4%) considered the quality of documentation to be average, above average or excellent. Only 14.3% considered the quality to be “below average” or “poor.” The quality evaluation of written communication is very telling. Further research is warranted to determine exactly what aspects of EMS documentation are lacking to that 14.3% of those physicians who have seen an adequate number of prehospital written reports would consider them substandard. Further we need to determine if those evaluations are coming from the State of Alabama in total or just from specific areas. We also need to determine why almost 20% of the respondents, who are obviously experienced Alabama ED physicians, have not seen an adequate number of written PCRs.

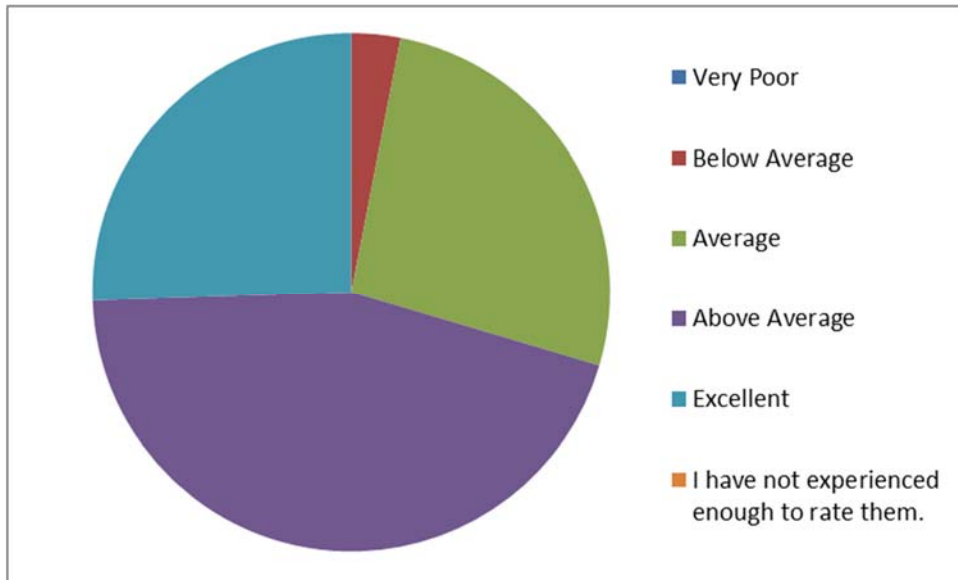
In comparison, the face-to-face verbal prehospital report seem to be much more familiar to the average Alabama ED physician, as eluded to in the above question responses. We investigated the impression of quality by receiving physicians for verbal communication by prehospital EMS crews in Question 9.





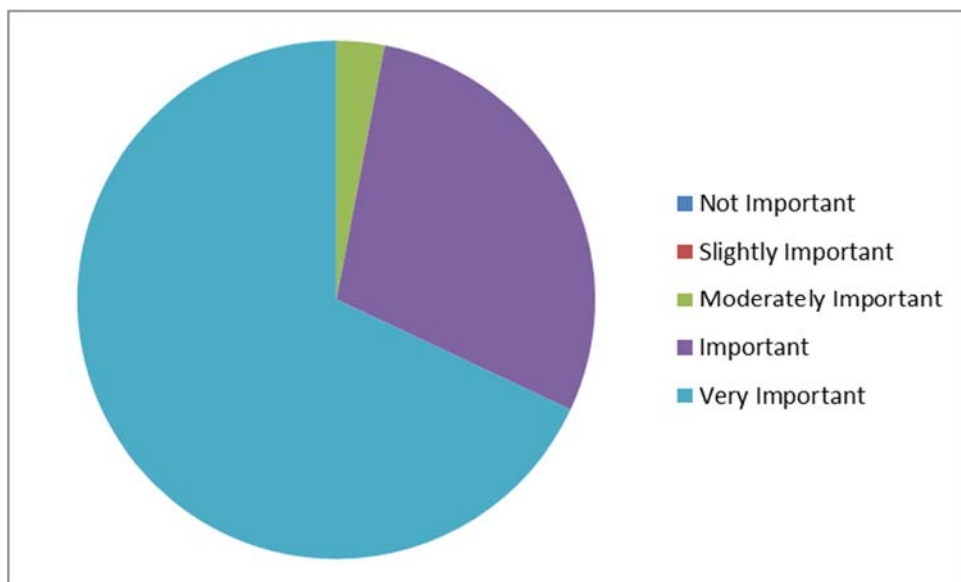


**Question 9: In your experience as a physician working in an Emergency Department setting, how would you describe the overall quality of "face-to-face" oral/verbal communication in Patient Care Reports given you by EMS Crews?**



Q9 Analysis: 0.0% of respondents graded the quality of their interaction to be “very poor” and only 2.0% reported that they had not received enough verbal reports to rate them. Similarly, 3.0% reported the quality of their interaction with prehospital crews to be “below average.” The vast majority (95.0%) reported the quality of their face-to-face report encounters to be “average, above average” or “excellent.” It is noteworthy that 25.0% of physicians reported the quality of interaction to be “excellent.”

**Question 10: In your role as a physician working in Emergency Department settings, how important do you consider the roles and operations of the EMS crews to your practice?**



Q10 Analysis: Prehospital EMS often questions itself, as it should, to promote quality improvement. The overall usefulness of EMS is sometimes questioned by society, particularly uninformed politicians, in reference to costs of services provided to constituents. Study respondents were asked to evaluate the importance of prehospital EMS in their practice of medicine. 0.0% reported that prehospital EMS was “not important” or even “slightly important.” Only 3.0% reported that it was “moderately important.” A resounding majority (97.0%) reported that prehospital EMS was “important” or “very important,” and on the whole 68.0% reported its value to be “very important.” This category represents the greatest proportion of any question at the highest qualitative rating.

## **SUMMARY**

The purpose of prehospital EMS is to identify the ill and injured patient, to evaluate, efficiently and effectively treat and transport, and effectively transfer the care of that patient to a physician under whose license the crew operates. Prehospital crews are technically the eyes, ears and hands of the physician in the field, working with him or her to perform optimum patient care in the continuum of the EMS call.

There is no doubt that the respondent physicians in this study rely upon prehospital EMS – with whom they partner and for whom they take ultimate responsibility. Sometimes we think that it is the service or department physician that we practice under, and that is true to a point. Legally we transition at some point, especially if we get orders, to the service of the receiving physician via the doctrine of the “borrowed servant principle.” Whereas our employer’s medical director may know us, we transiently work under the auspice of other physicians that do not. In order to promote these physicians to have confidence in us we must remain ever competent, functioning and professional. The essence of our abilities are often most evident in the way we communicate with others.

Writing great documentation will probably never be as easy to sell to the average prehospital crew as the thrill of getting the IV on the first stick, the expert tubing of the glottis on the first attempt and well under the time limit, or a successful defibrillation. The ability to professionally give a verbal patient care report is one of the best ways to gain the confidence of a receiving physician or nursing staff. The same is true but less evident with our written report. As we have seen the written report serves the physicians that we work under and it promotes the continuum of patient care. It is most often appreciated, if performed well, in a court of law or investigative process. Many an experienced prehospital EMS professional has walked from America’s courtrooms thinking “Boy I am glad I wrote that well.” Conversely others have regretted documentation shortcuts and lack of diligence.

All of us, no matter our particular niche in EMS, should strive for improvement and professionalism. Only thought and effort will facilitate those goals.

Gary L. Varner, MPH, NRP  
Senior Epidemiologist / State EMS Data Manager





## Alabama e-PCR Submission Requirements

### Some e-PCR Points of Clarification:

1. It is a requirement to complete a patient care report on every response. This office is already monitoring submission rates and comparative data suggests that many agencies are not reporting all runs as required. Please submit all required runs to avoid noncompliance.
2. Each record must be submitted electronically within 72 hours or less. The goal is to eventually narrow that down to within 24 hours. The 24 hour reporting allows Public Health to monitor surveillance trends as required by the Federal emergency preparedness guidelines.
3. Our IT staff is always available to assist you with your e-PCR needs. If you need assistance, you may call Chris or Lori at 334-206- 5383. You may get a voice recording depending on the call volume. They will eventually get back to you. If you do not hear from them within a reasonable time, you may wish to [email](#) them.
4. Collecting and importing data is paramount only to reporting reliable data. Reliable data is accurate and contains no errors. When one looks for shortcuts and/or skips data entry in areas that has been discovered to have no validation rules, it dilutes the integrity of the data, not to mention falsifies a legal document. Please make sure you enter data accurately.
5. Alabama became a NEMSIS version 3.4 compliant state beginning January 1, 2018.

## **General Information**

### **Do You Have Questions for OEMS Staff?**

This is another reminder to those of you calling our office (334) 206-5383:

Complaints, Investigations, and Inspections —Call Jamie Gray

Licensure —Call Stephanie Smith, Kembley Thomas, or Vickie Turner

Individual Training or Testing—Call Chris Hutto

EMS for Children, Website, and Social Media—Call Katherine Dixon Hert

EMS Data/NEMSIS – Call Gary Varner

### **Requests for Information from Regional Offices**

The Office of EMS would like to request that you comply with any request for information from your regional office. Some Directors are still having issues receiving information and data as requested by the State office. We would greatly appreciate your cooperation and compliance.

### **Reporting Requirements**

Please be reminded that, according to Rule 420-2-1-.07 (6h), All licensed provider services shall provide notification and written documentation within three working days to the OEMS regarding any protocol or rule violation, which includes but not limited to, according to 420-2-1-.30 (8), anyone guilty of misconduct or has committed a serious and material violation of these rules; has been convicted of a crime.

Also be reminded that, according to Rule 420-2-1-.29 (7), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.





## **Update from the Office of EMS Volume XVIII, Issue VX**

### **From the State EMS Director**

As we begin a new year in the Office of EMS (OEMS), I am excited to see all of the changes that are taking place. Currently, we are in the process of updating the EMS Rules. They are in the public comment phase now and should be finalized in the next sixty days. We are also in the final stages of working on the new Critical Care Protocols that should be finalized next month. I would like to recognize three Critical Care Paramedics who have put a tremendous amount of effort into working on this document: Wes Kelley with Haynes Life Flight, Chad Jones and Kenneth Hanak with Med-Star Air Care One.

With a new year brings about renewal time for individual licenses, from now until March 31, 2019, so check and see when your EMSP license expires. If you have any questions about your renewal, please call our office and we will help you.

I continue to stay engaged at the national level in many ways. One is by attending the National Association of EMS Official's meeting each year, regional meetings, and other meetings held by the organization. During these meetings, our staff is able to network with staff from other state EMS offices and learn what the issues are and what works best in other states. These meeting also give us an opportunity to network with our federal partners like the National Highway Traffic Safety Administration Office of EMS, The Department of Defense, Department of Homeland Security, National Registry of EMTs, and the International Board of Specialty Certifications.

This time next year we should be in our new location in Prattville! We will be moving into a new building that is currently being constructed in Prattville near Legends Drive. By January 2020, we should be in our new location along with the Center for Emergency Preparedness and the Office of Radiation Control.

I want to thank you for all that you do as we continue to provide great emergency medical care to the citizen of the state of Alabama!

Stephen Wilson  
State EMS Director

## **From the State EMS Medical Director**

I want to take this opportunity to comment on a few things. First, I encourage everyone to make a conscious effort to enter those patients into the trauma and stroke systems that meet the criteria for entry. If we ever have an opportunity to fund these systems, the funding will be driven by data. Let's get credit for what we really do!

Second, take every opportunity to educate people about what we really do. I have found that in many cases the public has a very limited understanding of what we really do in EMS. Many times they have no idea of the life saving equipment and pharmacological agents we use. There is certainly a limited knowledge, from the public, of how much initial and continuing education we must undergo. Buildup and talk up our profession!

Third, it is now the time that many of us are renewing our national registry certification and our state license. I want to remind everyone that it is YOUR responsibility to make sure your renewals are completed. It is not your chief, training officer, or supervisor's responsibility. I too am renewing my registry this year for my paramedic certification and it will be me that makes sure this is done! Don't let all of your training go to waste by forgetting to renew.

Please let myself or the OEMS staff know if we can assist you in any way.

Dr. William E. Crawford  
State EMS Medical Director





## Compliance Issues

Name	Rule/Protocol	Complaint	Action Taken
Amanda Daniels Paramedic #9900585	420-2-1-.30	Patient Care Issues	Remediation
Parke Edwards AEMT #0100690	420-2-1-.30	Patient Care Issues	Remediation
Michael Matarrese AEMT #1700401	420-2-1-.17	Falsification of Documentation	Suspension
EMSP-AEMT	420-2-1-.29	Impairment	Revoked
EMSP-EMT	420-2-1-.29	Impairment	Suspension
EMSP-EMT	420-2-1-.29	Impairment	Suspension
EMSP-EMT	420-2-1-.29	Impairment	Suspension
EMSP-EMT	420-2-1-.29	Impairment	Suspension
EMSP-Paramedic	420-2-1-.29	Impairment	Revoked
EMSP-Paramedic	420-2-1-.29	Impairment	Suspension

# **Provider Service Inspections**

These inspections were completed October-December, 2018.

Air Evac-Fayette County  
Cordova Fire Department  
Crossville Fire Rescue  
East Alabama Fire District  
Fayette EMS  
Gulf Shores Fire Rescue  
Haynes Ambulance-Macon County  
International Paper  
Lamar Ambulance Service  
Marion EMS  
North Lamar EMS  
Orange Beach Fire Rescue  
Regional Air Medical Services  
RPS-Marion County  
RPS-Walker County  
RPS-Winston County  
Sumiton Fire and Rescue Service







# **Culture of Excellence**

Gulf Shores Fire Rescue

Regional Air Medical Services

RPS-Marion County

RPS-Walker County

RPS-Winston County

## Regional Office Updates

For anyone in need of Alabama State EMS Protocol training, please visit [www.bremss.org](http://www.bremss.org) to access electronic training. You may find the training under the Education tab. Once you have completed the training, you will need to complete the exam and pass with at least a 70% in order to receive your completion certificate.

Michael Minor, BBA, NRP  
Executive Director  
Birmingham Regional EMS System

In 1978, the National Association of Emergency Medical Technicians adopted the “EMT Oath”. Part of the oath reads, “I will follow that regimen which, according to my ability and judgment, I consider for the benefit of patients and abstain from whatever is deleterious and mischievous, nor shall I suggest any such counsel.” We have all attended EMT courses. We have spent the grueling hours of study and rotations. Many of us have worked full time jobs and supported families while attending school. We remember the sleepless nights, the exams, the charting, and the NREMT testing. We have lived through countless changes in our young profession. I recall being advised in paramedic school that we would more than likely never utilize 12-lead ECG in the field. Now we utilize this skill as a basic part of our assessment. Some of our ranks even remember answering calls in a hearse out of the funeral home or when the Lifepak 5 was cutting edge technology.

We have been witness to the birth of a new life and, in the very next call, become witness to the passing of it. We have held patients whom we know we will not revive, regardless of efforts. We have borne the burden of telling a parent their child is gone. We have held the hand of the spouse when we tell them their loved one has passed away. We have seen the worst of humanity and its best all while wearing the Star of Life.

We took an oath to do all we do for the benefit of the patient. Sometimes we become jaded or so overcome with the loss and devastation we witness that we forget this simple promise. We are the patient advocate. That is the sum of all we do and the core of our being. We are the guardians of life and the wounded healers. It is simple to become so frustrated with paperwork, administration, rules, and regulations that we forget this simple promise: we are the patient advocate. Not for money, not for fame, not for glory, but for those who cry out for help in their darkest hour. Some of us have forgotten this oath. We have become so enamored with everything else that we forget why we pinned the Star of Life on our chest in the first place. Jocko Willink once said, “Basically, if you’re not looking at yourself with a critical eye, you are not going to reach your potential.” We have some of the best providers in the country, but we can always be better. Let’s look at ourselves with a critical eye. Let’s begin to remember why we started this profession in the first place. It is an honor to work beside each of you and for the ones who need us most. Let us never forget that.

Lamar Green  
Field Coordinator  
Alabama Gulf EMS Systems (AGEMSS)





## **EMS for Children Update**

### **EMS Recognition Program**

The Alabama EMSC Program wants to establish a recognition program in conjunction with EMSC Day in May. We are looking for providers who have made the right call in an emergent situation with a pediatric patient. While we want to always recognize our providers who have a positive outcome with a critical patient, this recognition program is going to focus on the everyday emergencies our providers see.

Please send your nominations along with a description of the call and the outcome, if known, to Katherine Hert ([katherine.hert@adph.state.al.us](mailto:katherine.hert@adph.state.al.us)) by March 29, 2019. The nominations will be evaluated by a workgroup of the Alabama EMSC Advisory Board and will be announced in conjunction with a continuing education opportunity at Children's Hospital on EMSC Day (May 22, 2019).

### **Equipment Grant Opportunity**

The Alabama EMSC Program budgeted additional funding in the grant this year to assist providers in purchasing pediatric restraints. An equipment grant application will be distributed in February to each service. The application due date will be March 8, 2019 with an award announcement date of April 1, 2019. The equipment available will be the Ferno PediMate and NeoMate. The applications will be reviewed by a workgroup of the Alabama EMSC Advisory Board and will be evaluated on need based on income and expenses and the ability to participate in a fund match program. If you have any questions, please contact Katherine Hert ([katherine.hert@adph.state.al.us](mailto:katherine.hert@adph.state.al.us)).

Katherine Dixon Hert, BSBA  
EMSC Program Manager

# Alabama e-PCR Submission Requirements

## Some e-PCR Points of Clarification:

1. It is a requirement to complete a patient care report on every response. This office is already monitoring submission rates and comparative data suggests that many agencies are not reporting all runs as required. Please submit all required runs to avoid noncompliance.
2. Each record must be submitted electronically within 72 hours or less. The goal is to eventually narrow that down to within 24 hours. The 24 hour reporting allows Public Health to monitor surveillance trends as required by the Federal emergency preparedness guidelines.
3. Our IT staff is always available to assist you with your e-PCR needs. If you need assistance, you may call Chris or Lori at 334-206- 5383. You may get a voice recording depending on the call volume. They will eventually get back to you. If you do not hear from them within a reasonable time, you may wish to [email](#) them.
4. Collecting and importing data is paramount only to reporting reliable data. Reliable data is accurate and contains no errors. When one looks for shortcuts and/or skips data entry in areas that has been discovered to have no validation rules, it dilutes the integrity of the data, not to mention falsifies a legal document. Please make sure you enter data accurately.
5. Alabama became a NEMSIS version 3.4 compliant state beginning January 1, 2018.





## **General Information**

### **Do You Have Questions for OEMS Staff?**

This is another reminder to those of you calling our office (334) 206-5383:

Complaints, Investigations, and Inspections —Call Jamie Gray

Licensure —Call Stephanie Smith, Kembley Thomas, or Vickie Turner

Individual Training or Testing—Call Chris Hutto

EMS for Children, Website, and Social Media—Call Katherine Dixon Hert

EMS Data/NEMSIS – Call Gary Varner

### **Requests for Information from Regional Offices**

The Office of EMS would like to request that you comply with any request for information from your regional office. Some Directors are still having issues receiving information and data as requested by the State office. We would greatly appreciate your cooperation and compliance.

### **Reporting Requirements**

Please be reminded that, according to Rule 420-2-1-.07 (6h), All licensed provider services shall provide notification and written documentation within three working days to the OEMS regarding any protocol or rule violation, which includes but not limited to, according to 420-2-1-.30 (8), anyone guilty of misconduct or has committed a serious and material violation of these rules; has been convicted of a crime.

Also be reminded that, according to Rule 420-2-1-.29 (7), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.