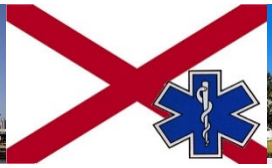
THE ALABAMA OFFICE OF EMERGENCY MEDICAL SERVICES




EMS QUARTERLY NEWSLETTER

From Mobile to Huntsville and Everywhere In-Between

Volume 17, Issue 1 – January - June 2024

ALABAMA CELEBRATES 50TH EMS WEEK.

William Elwin Crawford, MD, NRP, FACEP
EMS Medical Director, State of Alabama

I want to take this opportunity to say Thank You to all of the EMS providers as we kick off the 50th anniversary of EMS Week. I thank you for your dedication to our profession but most of all I thank you for your dedication to our patients.

The theme of this year's EMS Week is "Honoring our Past" while also looking forward to our future. There have been lots of folks who have made EMS great over the years and the list would be too long to even attempt to list.

I would like to honor two of my personal mentors. One is Ralph Howard who was the founder of Hale Co EMS and the longtime director of that service. He was always able to develop young people into competent EMS providers. I know that personally he took a wild-eyed young man and brought EMS into focus, and I still have that same passion for EMS even after thirty nine years. It is a testament to Ralph's commitment to EMS and sometimes his tough love that I still have the wonder and love for EMS even after all of these years.

The second person is Glenn Davis who is the Region 4 director. If you have ever practiced in the West Region, chances are you have been taught and mentored by Glenn. He is absolutely the most selfless person I have ever met and truly tries to serve his fellow man. I still lean on Glenn daily for advice and I can always count on him to give honest feedback. As we look to the future of EMS we would be wise to adopt the servant attitude that Glenn shows every day.

In closing I would once again say thank you for what you do each and every day.

Elwin Crawford, MD, FACEP

NOTES FROM THE DIRECTOR:
Alabama EMS History & 50th EMS Week
Jamie Gray, BS, AAS, NRP, TP-C
State EMS Director

As Alabama EMS celebrates the 50th EMS Week I wanted to take this opportunity to reflect upon where our profession came from and where it is going. The climate of society and medicine is an ever-changing arena in which EMS professionals strive every day to prevent death and promote health. Often, we do that at great cost to our own "normality." EMS is much more than a job. As I have said before, EMS is a calling. Where "normal" persons work to live in normal employment, EMS practitioners take on the unique lifestyle that is required by our profession.

Practicing in EMS is not easy at any level; from volunteer first responder to emergency department physician. It is demanding, very often thankless, emotionally expensive, and mentally and physically challenging. Our field practitioners risk life and limb for compensation that may be little or none (as volunteers) to moderate (as paid employees) but no amount of money could afford the benefits provided in the ditches at midnight to our citizens. Society can never adequately recompense people whose job it is to respond to cries for help, to bring calm and order into an inherently disorganized situation and to treat and transport them for the purpose of restoring comfort and healing. There simply is no treasure equivalent to that task.

Most experienced EMS practitioners have trouble reconciling what exactly brought them into the EMS profession, and some have trouble reconciling what keeps them in it. Likely the answer is as different as each individual who dedicates their time and effort in the performing of the EMS arts. Most, I would say, entered the field and stays in the field because they wish to help other people. Altruism has often been identified as the answer for both questions.

Altruism has brought excellent practitioners into EMS since its inception. Alabama EMS started in its present form about fifty years ago. Prior to that people often went to the hospitals as best they could. Private vehicles, taxis, tow trucks, hearse ambulances (often hearses were utilized for that while not being utilized in funerals because of the ability of the patient to lie down without difficulty) or simply on foot. Taxi drivers often had stories about delivering babies in their vehicles, and more than often carried bleeding and ill passengers to seek help. Police officers performed similarly with their patrol cars and often fire personnel did with their vehicles. One commonality was that a patient was very lucky if their caregiver had even rudimentary first aid training or any appropriate equipment for stabilization or bandaging. As the opportunity presented itself some of those persons elected to get trained in proper EMS techniques, and other people new to patient care joined them, and EMS in Alabama was born.

Alabama followed the same timeline as much of the rest of the nation in its development of EMS. Most EMS personnel are marginally aware of the role of "The White Paper" (*Accidental Death and Disability: The Neglected Disease of Modern Society*, 1966, National Academy of Science) in the birth of EMS. Only two years later, the first 9-1-1 call occurred on February 16, 1968, in the town of Haleyville, Alabama. True EMS began developing just prior to The White Paper in certain parts of the country, specifically Los Angeles, Miami and Tallahassee Florida and Maryland. EMS was first federalized in 1972 and the Department of Transportation developed the first training curricula in 1973. The same year the EMS Systems Act created funding for EMS development and mandated vehicle specifications.

NOTES FROM THE DIRECTOR (con't)

With federal funding the Alabama EMS Office was soon initiated, the first Director of which was Wyndol "Bob" Faggard, a federal employee of the United States Public Health Service, posted in Atlanta. Mr. Faggard took on the task of initiating the Alabama EMS System, the Alabama EMS Office and hiring the first staff. The decision was made to put EMS under the umbrella of the Alabama Department of Public Health. Initially some legislators wished to place EMS under the Alabama Department of Transportation, however the finalized law placed it under Public Health as it was a medical application rather than a matter of transportation. According to Art Harmon, one of the first staff members and first state employed OEMS Director, the Alabama Department of Public Health initially did not know how to fit EMS into their structure as their mission was primarily proactive and preventative in nature and EMS was a reactive response to emergency situations.

With the development of state regulated EMS in Alabama, housed in the Alabama Department of Public Health, hospitals were integrated into an EMS communication system (H.E.A.R. or Hospital Emergency Administrative Radio) that provided vehicle to hospital communication. The radios were VHF and operated to access the monitoring hospitals individually with use of a pulse-dial device. Each hospital had a four-digit code that would alert the hospital's console and allow the field crew to communicate the patient's information, generally when enroute to the emergency department. It's important to remember that this was years prior to the invention of cell phones. Some components of the H.E.A.R. system still exists. One example is Monroe County Hospital in Monroeville, Alabama. Their radio console remains monitoring, waiting for access, but it very infrequently used, with most crews calling their medical control recorded telephone line to communicate with the emergency department.

Similarly, to communications, the fifty years since EMS's inception have seen a multitude of developments and inventions. Advanced practice models, new medication formularies, technology advancements and transportation innovations. Alabama has remained proactive in EMS development. Our current system bears little resemblance to that of even a decade ago. We continue to provide more services to our citizens and the ability to do so requires more and more from our practitioners. Every patient interaction requires electronic documentation. More and more ambulance services turn to video surveillance of EMS activity to reduce liability, and for quality assurance and quality improvement. Our EMS System will continue to develop as innovations become available because our focus will always be the delivery of the best possible services to the citizens of Alabama.

So, as we progress into the future what should we strive for? Primarily I think we should look inward, develop ourselves to our highest potentials, and pride ourselves in delivering the best possible medical services. As a component of that we should attend to our own physical and emotional needs and to those of our colleagues. Ours is a messy business and we leave bits of ourselves and our innocence on every scene we visit. If we do not look after each other then nobody else is likely to do it. Secondly, as a component of our professionalism, we should not only reaffirm our own altruism, but look to the younger generation to inspire that tendency in those who will take the responsibilities for future EMS. We should endeavor to lead by example and inspire the coming generations to reach the point where they seek to practice altruism as we and our predecessors have done.

Every generation is different from the one before it. But despite what some components of society say about those that are younger, humans have always been the same. I think the need to reach out and help our fellow man is inborn and I choose to reach out and encourage the young to respect and join our service to humanity.

ACUTE HEALTH SYSTEMS UPDATE
Alice B Floyd, BSN, RN, EMT-P
Acute Health Systems Manager

Trauma System –

Along with other components of healthcare, the Alabama Trauma System (ATS) has had challenges over the past year. These challenges include a delay in moving the ATCC from an older building to their location in the Birmingham Regional EMS System (BREMSS) building. Shortly prior to the planned move a storm cause significant water damage, which delayed the transition several months. Some long-term issues that have affected the trauma system in both rural and urban areas include loss of trauma resources, ED staffing model changes, staff turnover, trauma center withdrawal from the system, and hospital redesignation or closure, etc. These situations can stress EMSP due to longer transport times and additional transfers. There is no quick fix for many of the issues facing the trauma system but there are ways to avoid major issues. Managers and owners should review and update mutual aid plans, if needed. EMSP should understand each system and know system entry criteria. EMSP should contact ATCC prior to leaving the scene when entering a patient into the trauma system, stroke system or STEMI system (in BREMSS).
More information can be found in current EMS Protocols posted at
https://www.alabamapublichealth.gov/ems/assets/10th.edition.protocols.pdf,

The Regional Trauma Plans are posted at
https://www.alabamapublichealth.gov/aths/regional-trauma-plans.html

The Stroke Plan is posted at
https://www.alabamapublichealth.gov/strokesystem/assets/stroke.plan.3.11.2024.pdf

Regional EMS Offices can be contacted at https://www.alabamapublichealth.gov/ems/education-and-testing.html for more information.

Stroke System –

The first in a series of six Regional Stroke Symposiums was conducted on April 14, 2023, in the BREMSS Region. The last in the series was held on July 18, 2024, in the West Region. Each EMS Region started Severity-Based Stroke Triage (SBST) routing a few months after their symposium and the West Region will soon do the same. Prior to the implementation of the 10th Edition Alabama EMS Patient Care Protocols in 2022, EMSP used FAST to assess for stroke. The initial stroke system plan was for all suspected stroke patients to be transferred to the closest available stroke center regardless of level. The updated Patient Care Protocols included Emergency Medical Stroke Assessment (EMSA), which is a severity-based stroke scale. With SBST routing, a patient entered into the stroke system by EMS with an EMSA score of 4 or greater, is less than 60 minutes from a thrombectomy-capable stroke center (TSC) and within a 3.5-hour window since last known well (LKW) time will be routed to a TSC. Based on stroke

assessment findings, LKW time, time/distance from **an available** TSC, there are many considerations in SBST. All EMSP are encouraged to contact TCC early for system entry. Most EMSP are probably comfortable with doing an EMSA, but if reminders or cues are needed, ATCC Communicators can and are willing to assist with reminders. Even though many patients entered in the stroke system are not diagnosed with stroke, they are frequently admitted with a neurological emergency.

TOPICS ON TRAUMA & CARES

Sara Matthews, RN
Acute Health Systems - Trauma Registrar, CARES Coordinator

Each year, approximately 350,000 persons in the United States experience out of hospital cardiac arrest (OHCA) or sudden death; approximately 90% of persons who experience an OHCA die. By population proportion, this is equivalent to approximately 5,251 persons in Alabama each year, or about fourteen persons per day. Nationally survival to discharge from the hospital remains very poor (approximately 10.4%) and likely the proportion is mirrored in Alabama. Medical science and emergency medical services have been researching OHCA for decades, yet survival remains very low. Historically, methods of data collection for OHCA have been insufficient, neither uniform nor reliable. The Cardiac Arrest Registry to Enhance Survival (CARES) was developed to answer this data collection insufficiency to assist communities determine standard outcome measures for out-of-hospital cardiac arrests to promote quality improvement efforts and benchmarking capabilities to improve care and increase survival.

To initiate the first inroads into the Alabama Statewide Cardiac System, Alabama implemented the use of CARES in 2019. CARES is voluntarily participated in by around ten EMS agencies in Alabama. Participation is generally driven by a Quality Assurance/Quality Improvement mindset and potentially positively impacts the participating agencies in many ways. Not the least of which is that they can compare their performance dynamics with the rest of the nation. Utilization of the CARES system requires the participation of hospitals in the participating agency's area of operation. The receiving hospital participates by entering the outcome data of events after the EMS agency's unit has delivered the patient and returned to service. The Alabama Office of EMS encourages transporting agencies to partner with their receiving hospitals to facilitate data entry into the CARES system. These partnerships will primarily serve Alabama Public Health by providing out of hospital cardiac arrest outcomes feedback. Secondarily the partnerships may serve to strengthen relationships between participating EMS agencies and their client hospitals and hold potential for improved business relationships between the two.

The next two pages of this newsletter contain some CARES information, which includes some nationwide 2023 Data Highlights. If you have any questions or comments, please do not hesitate to contact me at my office number (334-290-6241) or email (sara.matthews@adph.state.al.us).

Cardiac Arrest Registry to Enhance Survival (CARES)

CARES Cardiac Arrest Registry to Enhance Survival

EMORY WOODRUFF HEALTH SCIENCES CENTER

Benefits of CARES Participation

PERFORMANCE IMPROVEMENT

CARES helps communities measure and enhance their cardiac arrest survival rates.

ACCESS TO INFORMATION

Joining CARES grants access to crucial data for enhancing performance and saving lives.

EMS REGISTRY CONTRIBUTION

Contribute to one of the largest EMS registries worldwide, including patient outcome information from hospitals.

FACILITATING VITAL RESEARCH

CARES' comprehensive data supports crucial research, advancing cardiac arrest treatment and saving lives.

139,822

NON-TRAUMATIC, WORKED OHCAS WERE REPORTED TO CARES IN 2023.

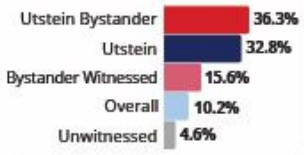
CARES covers a catchment area of more than 179 million, including 34 statewide registries and 42 community sites. More than 2,300 EMS agencies and over 2,500 hospitals participate nationwide.

For further information, please refer to the CARES homepage and explore our 2023 Annual Report.

2023 CARES Coverage

2023 Data Highlights

NON-TRAUMATIC ETIOLOGY SURVIVAL RATES



7.6 MINUTES

MEDIAN EMS RESPONSE TIME

11.7% OF PATIENTS WHO ARRESTED IN PUBLIC HAD A BYSTANDER APPLIED AED

*Rate excludes events that occurred in a private setting and/or were witnessed by a 911 Responder

41.2% OF PATIENTS RECEIVED BYSTANDER CPR

*Rate excludes events that occurred in a medical location and/or were witnessed by a 911 Responder

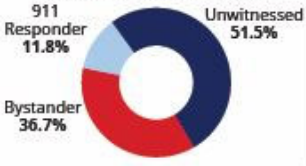
	FEMALE	MALE
MEDIAN AGE	65	65
BCPR	40.8%	41.4%
PUBLIC BCPR	43.2%	44.8%
PUBLIC AED USE	9.0%	12.4%
OVERALL SURVIVAL	9.5%	10.7%
RISK ADJUSTED OVERALL SURVIVAL	10.5%	9.5%
PEDIATRIC CASES	40%	60%

37% Female

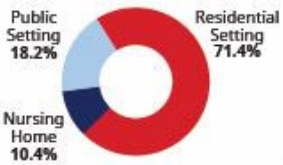
Overall Cases

63% Male

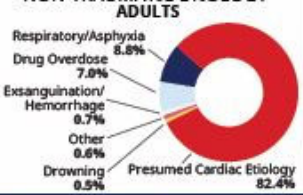
WHO WITNESSED THE ARREST



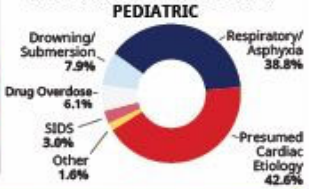
LOCATION OF ARREST



NON-TRAUMATIC ETIOLOGY ADULTS



NON-TRAUMATIC ETIOLOGY PEDIATRIC



More information is available at https://mycares.net @CARESRegistry Cardiac Arrest Registry to Enhance Survival (CARES)

Cardiac Arrest Registry to Enhance Survival (CARES)

CARES Cardiac Arrest Registry to Enhance Survival

EMORY WOODRUFF HEALTH SCIENCES CENTER

CARES CASE DEFINITION

An out-of-hospital cardiac arrest (OHCA) not caused by a traumatic event, where 911 responders attempt to resuscitate the person using CPR or a defibrillator. This includes patients who receive an AED (automated external defibrillator) shock by a bystander before the 911 responders arrive.

BYSTANDER

A person who is not part of the 911 response team and does not respond to the emergency in an official capacity.

911 RESPONDER

Emergency personnel who respond to a 911 call in an official capacity (i.e. First Responder or transport EMS).

BYSTANDER CPR RATE

The percentage of people who received CPR from a bystander after experiencing an out-of-hospital cardiac arrest that was not caused by a traumatic event. This rate excludes events that occurred in a medical location and/or were witnessed by a 911 Responder.

PUBLIC BYSTANDER AED RATE

The percentage of people who had an AED applied by a bystander following their arrest in a public location. This rate excludes events that occurred in a private setting and/or were witnessed by a 911 Responder.

Survival Rates

OVERALL SURVIVAL

- The percentage of people who survived among all CARES cases.

RISK-ADJUSTED SURVIVAL

- Risk-adjusted survival is a survival rate modified to account for various factors that may influence the outcome. This includes age, race/ethnicity, etiology of arrest, witnessed status, location of arrest, initial OHCA rhythm, bystander CPR, and whether the arrest was a 9-1-1 witnessed OHCA.

BYSTANDER WITNESSED SURVIVAL

- The percentage of people who survived among the subset of CARES cases that were witnessed by a bystander.

UNWITNESSED SURVIVAL

- The percentage of people who survived among the subset of CARES cases that were unwitnessed.

UTSTEIN SURVIVAL

- The percentage of people who survived among the subset of CARES cases that were both witnessed by a bystander and presented with a shockable rhythm.

UTSTEIN BYSTANDER SURVIVAL

- The percentage of people who survived among the subset of CARES cases that were witnessed by a bystander, presented with a shockable rhythm, and received some bystander intervention (CPR and/or AED application).

CARES DATA DICTIONARY 2023 CARES ANNUAL REPORT

More information is available at https://mycares.net @CARESRegistry Cardiac Arrest Registry to Enhance Survival (CARES)

FOCUS ON NEW STAFF:
Alabama Office of EMS
Jessica L. Winston
Administrative Support Assistant II

The Alabama Office of EMS is pleased to announce the new employment of Administrative Support Assistant II Jessica L. Winston.

Jessica began her career with the state of Alabama in 2020 when she was employed as a clerk in the Alabama Department of Finance. Within the first year she was promoted to Administrative Support Assistant I. She began her role with the Office of EMS in February of 2024 being promoted to the rank of Administrative Support Assistant II.

Jessica is a native of Wetumpka, Alabama and a 2001 graduate of Wetumpka High School. She reports that a particular passion in high school was her performance opportunities in the "Pride of the Tribe" Wetumpka High School Band where she played saxophone and rose to the rank of Captain of the Color Guard. Jessica left high school to attend Capps College where she earned a degree in Medical Assisting.

Jessica states that she loves reading, writing and "giving God His praise as much as possible." Her parents were foster parents, adopting four children, to give them a safe environment to grow in. Those children are Jessica's brothers, and a sister. Her parents subsequently passed away and Jessica received custody of her siblings. In addition, she has a son, Ladavion, who is fourteen years old at the time of this writing.

Jessica says that she always dreamed of working for the state. She considers herself a people person, working and interacting with people of different backgrounds, talking with them, and getting to know them. She reports that "You never know what someone is going through, so I try to be friendly." That attitude is of special use to our Office as Jessica's primary role is that of Receptionist. She not only answers the main telephone and directs incoming calls to the appropriate staff member, she greets the public at our front door and assists both visitors and callers with their questions and concerns.

Regarding working for the Office of EMS she states "I love working with the people of EMS and I am excited to be a part of the EMS family. Everyone here is helpful and I am excited to see what the future hold for me here.

The Alabama Office of EMS is proud and privileged to have a person of Jessica's character and ability working on our staff. We look forward to many years of working together to assist and serve the EMS field personnel who we license and the public at large.

FOCUS ON NEW STAFF:
Alabama Office of EMS
Timikel Robinson, BBA, MSM
OEMS Financial Manager

The Alabama Office of EMS wishes to announce the recent employment of Timikel Robinson as our new Office Financial Manager. Ms. Robinson has had a career track with the State of Alabama for over twenty years and began her tenure with OEMS in May 2024.

Ms. Robinson began her career as an Administrative Assistant in Industrial Relations. She has worked for various agencies since beginning her career and educated herself as a working student, topping with a master's degree in management. She worked at Alabama Medicaid for seven years and the Alabama Department of Public Health for over a decade. She states that since rejoining "the wonderful team at Public Health" she has recognized several employees she has worked with in the past, or crossed paths with at some point.

Ms. Robinson brings many years of administrative, supervisory, and managerial experience with her to her new position. Her duties will be the implementation and management of all financial aspects of the operation of the Alabama OEMS. Those duties include management of contracts, budgetary concerns, memoranda of understanding, and similar endeavors.

Ms. Robinson states that she is "looking forward to this new opportunity to work with a great department and a wonderful staff."

FOCUS ON NEW STAFF:
Alabama Office of EMS
Kezia M.Laster, MPH
Epidemiologist

The Alabama Office of EMS is pleased to announce the employment of Kezia Laster as an epidemiologist assigned to the Data Management & Analysis Section of our office. Kezia is tasked with statistical investigation of EMS dynamics reflected by data derived from electronic Patient Care Reports (e-PCRs) as well as data entered into the Acute Health Systems databases.

Kezia is a native of Montgomery, Alabama, having graduated from Jefferson Davis High School. She holds many interests that began in her childhood. Among them are ice skating, ballet (she performed with the Montgomery Ballet), astronomy, classical piano (playing from her early childhood through her college years) and competitive cheerleading.

Kezia attended Alabama State University, where she majored in Biology/Pre-Health and minored in chemistry. She was also an ASU Cheerleader throughout her undergraduate tenure there. She attended Mercer University in Georgia for her graduate studies. She initially attended the Mercer

University College of Pharmacy and served as a pharmacy intern at Emory University Hospital Inpatient Pharmacy. During her training she realized that as much as she loved caring for the needs of individual patients, she could positively affect the lives of larger numbers of people through the practice of public health. She then transferred to the Mercer University College of Health Professions to study epidemiology. While at the Mercer College of Health Professions she interned at the Mercer Center for Evaluation and Applied Research (CEAR) Program. Upon completion of the CEAR Program internship she earned certification in Program Evaluation.

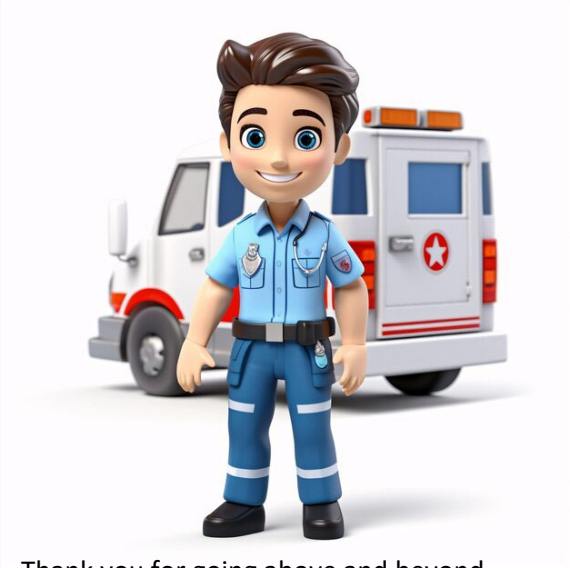
Kezia states that among the things she loves is spending time with her family, including her two daughters, who are sixteen years and two years old. She loves reading books, generally fiction but will throw some variation into the mix. She collects all things related to Jean-Michel Basquiat (American artist) and also collects Converse shoes. She retains her lifelong love of music and volunteering at animal shelters, having once aspired to become a veterinarian.

Among her favorite quotes she includes:

"What we must do is commit ourselves to some future that can include each other and to work toward that future with the particular strengths of our individual identities. And in order for us to do this, we must allow each other our differences at the same time as we recognize our sameness." – Audre Lorde

"Nobody ever figures out what life is all about, and it doesn't matter. Explore the world. Nearly everything is really interesting if you go into it deeply enough." – Richard P. Feynman

The Alabama Office of EMS welcomes Kezia into our work family and we look forward to many years of association, working together for improved health outcomes for the citizens of Alabama.



Thank you for going above and beyond the call in your service to the state of Alabama. There are currently more than 13,000 licensed personnel in Alabama, and we appreciate every one of you.

OEMS Lobby during 50th EMS Week

EMS DATA & REPORTING UPDATE

Gary L. Varner, MPH, NRP / Epidemiologist Senior
Kezia M. Laster, MPH / Epidemiologist
Data Management & Analysis Section

2023 Reporting Submission Dynamics

OFFICE OF EMS
DATA MANAGEMENT & ANALYSIS

Each year the Alabama Office of EMS receives hundreds of thousands of electronic Patient Care Reports. Each report is the story of an emergency response, not necessarily the story of one individual patient's care. Patient care circumstances may include transport, transfer of care (for transport), refusal of transport or other non-transport situation, handover of the patient to law enforcement, the inability to locate a patient at the scene of dispatch, or cancellation of your unit by personnel on the scene or by the dispatcher or other agency by radio. This does not even mention the potential scenarios occurring with patient who were found to be deceased.

In general, the EMS Repository (the EMS database receiving e-PCRs) receives one e-PCR every 15-30 seconds. Every response to a call for assistance of a potentially ill or injured patient should be documented with an e-PCR. Bear in mind that the responsibility of reporting lies with the crew members rather than the service. The service is responsible for providing a method of reporting and for oversight of the process of reporting – the responsibility of the actual reporting lies with the reporter of the crew. We at the OEMS have described the criteria as "If you receive a call and respond and drive off of the station parking lot, an e-PCR should be submitted, even if your unit is cancelled in the street in front of the station." This attention to reporting protects the individual crew members, and the service, from liability by documenting the cessation of response in a situation where a duty to act originally existed.

In 2023 the EMS Repository had 991,104 reports submitted. Of that number, approximately 5% of those reports failed to submit successfully. That does not sound like a lot, but it constitutes 49,065 reports. Any report that contains one or more errors due to rules violation will fail to submit. The failed reports are primarily due to a failure in the software platform's validation feature. That feature, which is required by NEMSIS, should accurately alert the reporter as to IF a rules violation has occurred (for example, if no protocol has been identified if a procedure has been indicated) and it should also tell the reporter WHAT the violation is, so that it can be corrected.

Alabama is unique in that we require and expect the EMS software vendors authorized to sell to, and service their products for, Alabama licensed Emergency Medical Provider Services, to submit their failed reports as well as their passing reports. The reasons for failure are recorded and the reports are filed in a secondary drive and marked as failing. They are not included in statistical analysis of field activity as they are flawed by not meeting the criteria of the Schematron business rules, and thus not comparable. Variations in failures occur between individuals, the types of medical issues/situations that occur between patients, and between software vendors. The basic issue of failure remains in the lack of efficiency and effectiveness of the software platform's validation feature. OEMS can provide a list of failure criteria experienced by any Emergency Medical Service Provider, and a count of each one encountered within any specified time frame. The best use is to identify issues frequently encountered by certain personnel for the purpose correcting the underlying reporting issue.

There are two rules validation levels: errors and warnings. One error is sufficient to fail a report submission. No number of warnings will fail a report. Warnings are set up in some software platforms (the free state software, for example) to act as reminders. One warning frequently asked about is *"Medications should be recorded, since a patient was treated".* Some patients that are treated and transported are not given medications, even oxygen, as it is not warranted. The warning fires if the patient is recorded as treated so that the reporter is reminded to list any medication that may have been administered. In the free state software (RESCUE) the message shows up on the screen in a colored font with an asterisk.

Note that the 2023 totals above represent "unique e-PCRs" which means that each report represents one situation or response. The EMS Repository holds versions of each report if more than one is submitted. This occurs if a report failed and was resubmitted after editing and errors were corrected. This also occurs if a report was edited for content and resubmitted, such as an addendum to the narrative was added. During 2023 considering all submission (of all versions) a total of 121,981 errors were encountered.

Although individual services have individual patterns of errors, some errors are more prevalent. One particularly prevalent error is *"Date/Time of Assessment should be no later than Transfer of EMS Patient Care Date/Time or Destination Patient Transfer of Care Date/Time"*. This may occur in the situation where vital signs are timed as taken a minute or so after the arrival at the hospital was recorded. This may be due to transfer of times from a Computer Aided Dispatch (CAD) system that independently submits times as recorded by the dispatcher versus the vital signs being timed by the EMS provider attending the patient. A secondary consideration is if a first responder rides in with the patient and does not correctly document the fact that care is continuing under the same agency or provider even though transported by a second agency. A third consideration may be with extended wall-times when vitals are measured after arrival at the ED while awaiting transfer of care to the facility RN's. A similar error may occur if the first response unit is on scene and a second arrives on scene and are doing simultaneous care and then the data is transferred electronically to the transport unit's computer to fill out the demographic data. This usually occurs when an engine first response sends data to the computer of the transport unit when both work the same department and have the same NEMSIS software platform.

Failure to submit is data that is lost to study. The Alabama Department of Public Health closely monitors the activities of Emergency Medical Provider Services and e-PCR data is studied heavily for its reflection of disease and injury patterns, toxicology patterns (opioid exposures, for example) emergency response dynamics and manpower studies. In addition, the reports themselves are the legal records of life-and-death interventions involving citizens of our state. Successful submission of an e-PCR to the Office of EMS means that any alteration of that record is accounted for, and each version of the record is available and guaranteed by the state's EMS regulatory agency. This assures that documents furnished to the judicial process, legislative process or executive process are guaranteed to be valid versions of what was submitted by the licensed personnel providing emergency care and the Emergency Medical Provider Service.

COMPLIANCE SECTION UPDATE –1st & 2nd QUARTER REPORT

Steven Stringer, BS, AAS, NRP, FP-C
Compliance Coordinator

So far in 2024 (January through June) our office has issued 9 license suspensions for EMSP impairment and 6 license suspensions for EMSP discipline issues.

The topic I would like to discuss in this newsletter is that of Death in the Field, which is outlined in the Provider Services Operational Guidelines in Section 18.03.

One of the heaviest responsibilities that an EMS crew has is that of deciding whether to withhold resuscitation. Withholding should be considered in cases of (1) Decapitation (2) Massive Crush of a Major Organ (3) Incineration (4) Rigor Mortis in a warm environment (5) Dependent Lividity (6) Decomposition (7) Pulseless and Apneic in a mass casualty situation and (8) Pulseless and Apneic with blunt trauma. If the decision to withhold resuscitation is considered, Online Medical Direction (OLMD) **MUST** be contacted to confirm the decision. There are also some considerations for various situations that are outlined in this section of the Provider Services Operations Guidelines. I would encourage every licensed individual to learn this guideline by heart, and to have a copy of the guidelines available on their unit.

That being said, remember this: DEATH IS ALWAYS A POOR OUTCOME. Death in the field, death during transport and death after arrival at the hospital are ALWAYS reviewable situations. In clinical practice it is called morbidity and mortality review. Physicians and hospitals routinely conduct peer review to evaluate the inevitability of death of patients, although that is sometimes conducted randomly. In EMS the review process is generally secondary to law enforcement investigations and ultimately secondary to tort litigation. Families very often resort to blaming EMS for the death of a loved one out of grief and anger.

The electronic patient care report (e-PCR) is the patient's medical chart in the prehospital environment. Medical charting not only contains WHAT we do, it contains our REASON for doing it. Most e-PCR charting accounts for measures taken in the care of the patient. In cases where NO measures will be taken (withholding resuscitation or refusal of care) the situation MUST be very carefully documented to account for the decisions of the EMS crew to take no measure of care.

Very often we will review e-PCRs that indicate that the patient was deceased in the field but without validation of suspicion of death by documentation of the situation where the patient was found, indicators of death that led the crew to decide to withhold resuscitation. The conversation with the OLMD must be fully documented and timed and an ECG should be recorded and filed.

My suggestion would be for each one of us who are put into the situation of deciding to withhold care to simply remember the patient is someone's family member and then visualize ourselves sitting in a courtroom witness stand with a plaintiff's attorney pointing his/her finger at us and saying, "Why did YOU decide the patient was DEAD?" That particular situation is only manageable with extensive documentation to back you up.

We are anticipating another excellent EMS Conference in Gulf Shores in 2024. As always, the opportunity to learn, relax, network, and earn CEU's will be coupled with exposure to new products and technology and other interesting activities – all within one of the most sought out vacation destinations in the United States. We invite you to join us. Visit ***alabamaemsconference.com*** for reservations, tickets, and information.

Monday Nov 11	Tuesday Nov 12	Wednesday Nov 13	Thursday Nov 14	Friday Nov 15
Vendor Set up	Pre Con: Jedi-Code Practices, Hemorrhage Heroes		Critical Care Blitz: 16 Hour Review	Cadaver Lab
Pre Con: TNCC, ENPC, AMLS	Conference Begins at 11:15- 17:15, Live SEMCC at 1	Conference from 0900-16:20	Conference 0900-1600	Critical Care Blitz: 16 Hour Review
Meet And Greet Registration at 1800	Casino Night at the Wharf	Family Night	Awards Night at the Hangout at 1800	IBSC onsite Testing

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