



Update from the Office of EMS

Volume XVII, Issue I

I hope this finds everyone enjoying the New Year!!! As I look back over the previous year, I am really pleased with the progress that we have made in EMS in Alabama. We still have lots of work left to do to make the system the best that it can possibly be. We are moving forward with a new streamlined ePCR that I think people will find more user friendly. We are continuing to move forward with the extension of the stroke system statewide. We will also be standing up the STEMI system statewide.

With all of these new things we must not lose focus on the reason we do what we do and that is the patient. I encourage each one of you to continue to keep abreast of the literature and to develop a personal learning plan. Don't be that person that does the bare minimum. Keep up with new technology and new ideas!!!

I am extremely proud of the job each one of you do each day and do not hesitate to contact me if needed.

William E. Crawford, M.D.,FACEP
State EMS Medical Director
Alabama Dept. of Public Health
Office of EMS



The National Continued Competency Program: The 'New' Recertification (NCCP)

In 2012, the NREMT introduced a new recertification model, the NCCP. Constructed using methodology similar to that of the American Board of Medical Specialty requirements, the new NCCP model streamlines the recertification process into three strategic categories of continuing education: National, Local, and Individual.

The NCCP offers numerous improvements that will impact EMS for the better for years to come. These changes allow a platform for evidence-based medicine to reach EMS professionals all over the country, give state and local agencies the freedom to dictate a portion of the national recertification requirements and provide a foundation for the EMS professional to embrace life-long learning.

The national component of the NCCP (the 'new' refresher) will constitute 50% of the new recertification requirements at each level and will replace the traditional DOT refresher. Topics will be updated every four years and will reflect current trends in evidence-based medicine, scope of practice changes, and position papers from numerous associations involved with EMS research. It will also serve to focus on those patient presentations that have a low frequency but high criticality.

The local component of the NCCP will constitute 25% of the new recertification requirements at each level. The requirement for these hours will be decided by local entities, including the state, region, or

agency. These topics can include, but are not limited to, state or local protocol changes, tasks that require remediation based on QA/QI and topics chosen from run reviews. The local component allows national recertification requirements to be adapted to the needs of the state and local agencies. Methods to provide current continuing education such as a monthly training, conferences, and in-service training will stay the same.

Finally, the individual component of the NCCP will constitute the last 25% of the new recertification requirements at each level. Within this component, an individual is free to take any EMS-related education. As a result of the new NCCP recertification model, the total continuing education hours needed to recertify a national EMS certification have been reduced for EMTs, AEMTs, and Paramedics.

States across the nation are beginning to implement this new recertification model. Please periodically check the NREMT's webpage and with your state EMS office for information on upcoming implementation in your state.

For more information on NCCP, please [click here](#). Also review the NREMT recertification brochures: [EMR](#), [EMT](#), [AEMT](#), and [Paramedic](#).

Individual Licensure Update

New National Registry Requirements

Provide Level	NCCR	LCCR	ICCR	Total
EMR	8	4	4	16
EMT	20	10	10	40
AEMT	25	12.5	12.5	50
Paramedic	30	15	15	60

ADPH OEMS requirements is under **“Local Continued Competency Requirements (LCCR)”**

NCCR: The National Registry will provide the topics associated with this section. For 2015 and 2016 you may use a tradition refresher to complete this section. Renewals starting in 2017 must meet the new NCCR requirements.

LCCR: ADPH OEMS Requirement, For renewals in 2015 a traditional 16 hour protocol certificate can be used to complete this section. For renewals in 2016 you must meet the new LCCR requirements listed below.

- 1) Acute Care* AND Protocol Education, ALL Levels – 6 Hours
- 2) Cardiopulmonary Resuscitation Education, All Levels – 4 Hours

*Acute Care is Trauma, Stroke, and STEMI System

NOTE: The additional AEMT 2.5 hours and Paramedic 5 hours can come from any EMS Related ConEd

ICCR: For renewals in 2015 and the future you can use any EMS related ConEd to complete this requirement.

The following information was released by the NREMT in the summer 2014 *The Registry*. The NREMT Board of Directors approved a re-entry pathway for Emergency Medical Technicians (EMT). The re-entry pathway provides an opportunity for EMTs to regain their NREMT Certification. The re-entry pathway requires that a previous Nationally Certified or state licensed EMT:

- 1) Provide documentation of successful EMT course completion; including transition course documentation if required*.
- 2) Provide documentation of prior National Certification at the EMT level.
- 3) Provide documentation of prior state licensure as an EMT (if not Nationally Certified).
- 4) Meet the eligibility requirements for National Certification.
- 5) Successfully complete an EMT psychomotor exam.
- 6) Successfully complete the NREMT cognitive examination.
- 7) *EMT courses not following the 2009 Education Standards must be accompanied by transition course documentation.

If you should have any questions please contact our office.

Stephen Wilson
Licensure Coordinator





What do Alabama Intermediates Need for Renewal?

First, if you are an Intermediate you will be able to maintain your intermediate license in Alabama!

If you are Nationally Registered you have one of two options, you can maintain your National Registry at the EMT level and Alabama will continue to license you at the Intermediate level, or you can let your National Registry lapse and we will continue to license you as an Intermediate. If you allow your Intermediate license to expire, whether Nationally Registered or not, you will not be able to obtain your Intermediate license back.

Intermediates should submit the following to the OEMS for the 2016 renewal (either option A or B):

Intermediates will need a total of 50 hours of continuing education.

Option A

36 hour DOT refresher course

6 hour Alabama Protocols/Acute Care Systems update

4 hour BLS Course

4 hours of EMS related con-ed

Option B

NCCR

25 hour National Continued Competency Requirements

(Intermediates will follow the same [brochure](#) as AEMT)

LCCR

12.5 hour Local Continued Competency Requirements

6 hour Alabama Protocol/Acute Care System update

4 hour BLS Course

2.5 hour EMS related con-ed

ICCR

12.5 hour Individual Continued Competency Requirements

12.5 hour EMS related con-ed

Alabama e-PCR Submission Requirements

Some e-PCR Points of Clarification:

1. It is a requirement to complete a patient care report on every emergency medical 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 168 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 the 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.





Transition Courses

The National Registry website indicates that all EMSPs need to complete a transition course to re-certify. The OEMS has determined that Alabama EMSPs will **NOT** have to take a transition course. The National Registry renewal application will ask “have you transitioned?” All EMSPs should respond “yes” to this question. This transition is in name only and all EMSPs should disregard any request to submit transition paperwork to the National Registry.

Training Officers Register Your Agency (the employer) on the NREMT Website!

Online re-certification allows:

- Certified EMS providers to document their continuing education using the NREMT website
- You to monitor the progress of their continuing education
- You to enter continuing education documentation for all providers at your agency
- Electronic verification of continuing education and skills.

Persons authorized to serve as a Training Officer by their employer (service) should register their agency on the NREMT website by following [these simple instructions](#). User guides for the online re-certification process can also be found [online](#).

Please note:

- Audits and verifications of agencies and Training Officers will be performed
- There is no fee to register your agency online, this program is a service provided by the NREMT.
- There are no additional fees to Nationally Certified providers who use the online system to document their continuing education. Current re-certification application fees using continuing education are: First Responder=\$10; EMT-Basic/Intermediate=\$15; EMT-Paramedic=\$20.

Licensure and Education Information

- All EMS students must be licensed by the State of Alabama at the previous level.
- Please remember the requirements as stated in the EMS Rules document under **420-2-1-.11 Licensed Provider Service Staffing** License Provider Services shall not allow EMSP to respond to a medical emergency with the intent to treat or transport a patient unless the EMSP are clean and appropriately dressed and wearing photo identification with the level of license, license number, and name of EMSP visible. The photo identification shall be displayed at all times unless extenuating circumstances prevent the photo identification from being available.

Ambulance Driver Qualifications

The requirements for all ambulance drivers are: a valid drivers' license, a current EVOC from an approved EMS course, a current approved CPR course, and a certificate of completion of an approved Emergency Medical Responder (EMR) course, or be a previously licensed EMSP. All EMSPs who drive an ambulance must maintain an initial approved EVOC course and a refresher every two (2) years. Alabama EVOC is still a requirement; you MUST have a current EVOC certificate in your personnel file.

Emergency Medical Responder (EMR) Course

The following are approved EMR Courses:

- EMS approved courses offered through your regional office, or
- A course approved by the Alabama Fire College which includes the Emergency Care Provider Course.





Compliance Issues			
Name	Rule/Protocol	Complaint	Action Taken
Glenn Bishop EMSP-Advanced #1300662	420-2-1-.29	Impaired EMSP	Suspension
Kristofer J. Davis EMSP-Basic #0900786	420-2-1-.29	Impaired EMSP	Suspension
John M. Goode EMSP-Basic #1500583	420-2-1-.30	Exceeding Scope of Practice	Suspension
Harrison C. Gray EMSP-Paramedic #1001055	420-2-1-.29	Impaired EMSP	Suspension
Alvia Holcomb EMSP-Paramedic #1300649	420-2-1-.28 420-2-1-.30 Protocols 1.01 & 1.05 Protocols 3.19 & 3.33	Responsibility of Patient Complaint/ Disciplinary Procedure	Suspension
Doyle H. Jeanes EMSP-Paramedic #9600043	420-2-1-.25 420-2-1-.30 Protocols 1.05 & 1.14 Protocols 3.15 & 3.29	Patient Care Issue Duty to Act	Suspension
Johnathan T. Mims EMSP-Paramedic #0800872	420-2-1-.29	Impaired EMSP	Suspension

Compliance Issues continued

Name	Rule/Protocol	Complaint	Action Taken
Brandon K. Pate EMSP-Basic #1100349	420-2-1-.29	Impaired EMSP	Suspension
James M. Phillips EMSP-Paramedic #1300079	420-2-1-.25 420-2-1-.30 Protocols 3.05, 3.13, & 3.33	Patient Care Issue Guilty of Misconduct	Suspension
Warren C. Sautter EMSP-Advanced #0800184	420-2-1-.29	Impaired EMSP	Suspension
Jason C. Scott EMSP-Paramedic #0016168	420-2-1-.25 420-2-1-.30	Patient Care Issue Falsification of Record Duty to Act	Suspension
Dallas C. Smith EMSP-Paramedic #0500332	420-2-1-.25 420-2-1-.30 Protocols 1.01, 1.05, 3.05, 5.07, & 5.29	Responsibility of Patient Guilty of Misconduct Falsification of Records	Suspension
Nicholas B. Watley EMSP-Advanced #1400017	420-2-1-.29	Impaired EMSP	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 October-December, 2015.

Adamsville Fire and Rescue	Pickens County Ambulance Svc
Air Evac EMS-Fayette	Ragland Rescue Service
Anniston EMS	Rocky Ridge Fire Department
Bessemer Fire Department	RPS-Jefferson
Birmingham Fire Department	RPS-Marion
Brookside Fire and Rescue	Shoals Ambulance-Jefferson
Concord Fire District	Sylvan Springs Fire Department
Fayette County EMS	Trussville Fire and Rescue
Forestdale Fire District	West Jefferson Fire and Rescue
Fultondale Fire and Rescue	Winterboro Vol Fire and Rescue
Goodwater Ambulance Service	
Indian Ford Fire District	
Irondale Fire District	
Marion County EMS	
Maytown Vol Fire Department	
Midfield Fire Department	
Minor Heights Fire District	
Morris Fire and Rescue	
Palmerdale Fire District	

Culture of Excellence

Corner Volunteer Fire and Rescue

Gardendale Fire and Rescue

Graysville Fire and Rescue

Homewood Fire and Rescue

Hueytown Fire and Rescue

McAdory Fire Department

McCalla Area Fire District

Mount Olive Fire and Rescue

US Steel



Intranasal Medications in Kids? Why Not...Everything Else Goes Up There!

Annalise Sorrentino MD, FAAP, FACEP

My last shift started with a three year old with a dog bite to the face, a ten year old with a forearm injury, and an anxious 16 year old who needed a lumbar puncture. When working with children and young adults, we are constantly looking for ways to make the emergency department visit more tolerable for all involved. There are two things that have helped me come closer to that goal. The first is having child life specialists. The second is intranasal medication delivery.

Initially created for local nasal effects, the use of intranasal medications have become a desired route for certain drugs when seeking a systemic effect. Some immunizations have found success using the intranasal method, and several other medications have followed suit, namely those used for sedation and analgesia. There are several benefits to using the intranasal route, including:

- High vascularization of the nasal mucosa
- Wide absorption area
- Avoidance of first pass metabolism by the GI or hepatic pathways
- Avoidance of IV placement
- High patient tolerance of the drug administration
- Quick onset of action¹.

The nasal fossa is divided into three parts: the vestibule, the cavity, and the turbinates (See Figure 1). The turbinates are classified into the inferior, middle, and superior. The main site for systemic drug entry is around the inferior turbinate due to its high surface area and vascularization.

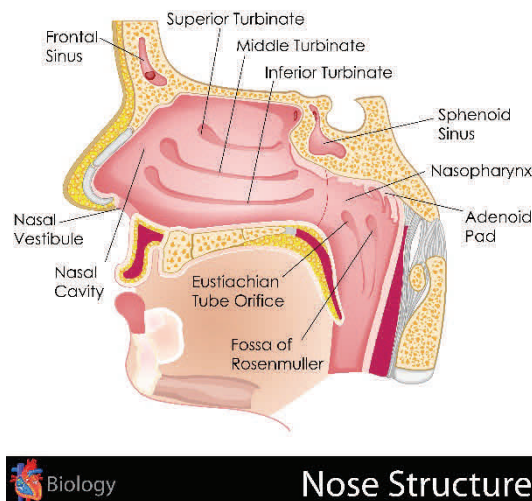


Figure 1: Nasal Anatomy (From IStock-Photo 2015.)

There are several factors that may play into the effectiveness of intranasal drug delivery including volume administered, particle diameter, spray administration, factors influencing the site of absorption (ex. other drugs such as phenylephrine), nasal blood flow, and mucociliary clearance and medical

Continued on next page.

conditions that affect it, and these things should be taken into account when administering intranasal medications². The best absorbed medications are those with low molecular weights, are highly lipophilic, and have no net charge at physiologic pH³.

Intranasal delivery has been used for several different purposes including vaccinations; treatment of certain conditions such as rhinosinusitis, seizures, migraines, and diabetes insipidus; use of antipsychotic medications⁴; and sedation and analgesia. For purposes of this article, we will focus on use for the latter. Two main classes of drugs have been used historically in intranasal administration: opioids and benzodiazepines (please see table 1 for dosing guidelines). More recently, other drugs such as ketamine and dexmedetomidine have also been studied.

Midazolam is a useful drug in pediatrics for the situations where you need anxiolysis and amnesia. It can be given in a variety of ways, and intranasal use has been widely studied. Doses ranging from 0.2 mg/kg to 0.5 mg/kg have been evaluated. Overall, its use has been shown to have a rapid onset of action, achieve adequate sedation, and is associated with high parent satisfaction. The one drawback that was consistently found was that it was more irritating than other routes of administration³. One study evaluated using intranasal lidocaine as a premedication, and found that its use helped prevent the burning that is often associated with the use of intranasal midazolam⁵. Further prospective studies have been done and preliminary data (ahead of publication) show similar results (I know this because one of our fellows did the study...watch for it! It's coming soon!!). Intranasal midazolam is a great choice when you are needing something to take the edge off, but analgesia is not your main focus. I find that it works best in situations where my analgesia is managed by other means, typically topical anesthetics and/or regional blocks. Its mild amnestic properties are also helpful when it comes to potential follow up.

Fentanyl is the ideal intranasal medication...highly lipophilic and low molecular weight. It has been shown to be more effective than intravenous morphine for pain reduction in long bone fractures³. It is overall very well tolerated and produces adequate analgesia. It has recently been compared with intranasal ketamine and found to be equally analgesic but with fewer side effects (mainly dizziness), although they were mild overall⁶. This is a great choice when you need analgesia quickly, and you don't know if you'll need an IV or if they need to be NPO. I use this routinely before getting imaging in my orthopedic patients.

Other agents for sedation and analgesia have also been assessed. (As a matter of full disclosure, I have never used either one of these medications in the intranasal route). Intranasal ketamine has been evaluated in the emergency department as well as in the pre-hospital setting. Doses ranging from 0.5 mg/kg to 9 mg/kg have been used with adequate sedation³. Further studies need to be done to best establish the ideal dose in the pediatric patient. Intranasal dexmedetomidine was evaluated in an observational study and showed good sedation and image quality when using it for sedation for computed tomography in children⁷.

Delivering intranasal medications can be done in a few different ways. The most basic is the drip method, but does require a patient child to achieve success. Probably the most widely used device is the mucosal atomizer device. It screw on to the top of your medication syringe and when you spray it into the nares, it rapidly distributes the particles after breaking them down into smaller ones that are more easily absorbed³ (See Figure 2).



Figure 2: Mucosal Atomization Device

(From <http://oto.sagepub.com/content/139/1/131/F1.expansion.html> Accessed 8/31/2015.)

Intranasal medication delivery can be a useful tool when dealing with children. Some tips that will allow for higher success include:

- Consider suctioning prior to administration if there is a lot of mucous present
- Use small volumes
- Use the highest concentration of medication available and do not dilute
- Use both nares to increase surface area

Intranasal meds are a quick, safe and relatively painless way to deliver analgesia and anxiolysis to pediatric patients. They are a great resource to have in your toolkit!

Continued on next page.

Table 1: Annalise's Cheat Sheet for Intranasal Drug Dosing

<u>Drug</u>	<u>Dose</u>	<u>Max</u>	<u>Analgesia</u>	<u>Anxiolysis</u>	<u>Amnesia</u>
Fentanyl	1 mcg/kg/dose	100 mcg	+	-	-
Midazolam	0.25 mg/kg/ dose	10 mg	-	+	+
Lidocaine 4%	0.5 mL		For use with intranasal midazolam		
Ketamine	Dosing ranges from 1 mg/kg to 9 mg/kg; most studies use 3 mg/kg, but one study found best results with 9 mg/kg ⁸ ; no routine recommendations exist currently		+	+	+
Dexmedetomidine	1-2 µg/kg ⁹		+	+	-

Table 2: When to Consider Using Intranasal Analgesia and Sedation

Laceration repair (works best in conjunction with local anesthesia)	Injuries due to animal bites (typically associated with a high level of anxiety)
To facilitate getting adequate imaging quickly (i.e. deformities or suspected fractures)	As a pre-medication for a regional block
Lumbar punctures	Procedures in younger children or those with developmental issues
Prepubertal genital exams	Abscess incision and drainage
Joint dislocations	Burn debridement or dressing
Patients who are NPO	Simple casting if any cast molding needed
CT or MRI imaging	Foreign body removal
Status epilepticus	

Continued on next page.

References:

- Fortuna A, et al. Intranasal Delivery of Systemic-Acting Drugs: Small-Molecules and Biomacromolecules. *European Journal of Pharmaceutics and Biopharmaceutics* 2014;88:8-27.
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- Filho EM, et al. Intranasal Dexmedetomidine for Sedation for Pediatric Computed Tomography Imaging. *J Pediatr* 2015;166:1313-1315.
- Tsze DS, et al. Intranasal Ketamine for Procedural Sedation in Pediatric Laceration Repair. *Ped Emerg Care* 2012;28:767-770.
- Yuen VM, et al. A Randomized Comparison of Two Intranasal Dexmedetomidine Doses for Premedication in Children. *Anaesthesia* 2012;67:1210-1216.



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 Vickie Turner

Provider Service Licenses—Call Stephen Wilson or Kembley Thomas

Individual Licenses—Call Stephen Wilson or Stephanie Smith

Individual Training or Testing—Call Stephen Wilson

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

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.

Newsletter Reminder

The newsletter is free to anyone as long as they have internet access to our web page (www.adph.org/ems). The newsletters can be found on the Newsletter page which is linked to the home page. All Alabama licensed EMSPs who have a **VALID** email address will receive notice when the newsletter has been published. Our licensure database is used to store your last submitted valid email address, but cannot accommodate unlicensed people. They will have to visit our website to view or download the newsletter.

If you are not getting our newsletter announcements via email, it is because your email address was illegible or in an incorrect format or you have changed it and not updated your information with our office. You can email any changes via emsinquiry@adph.state.al.us or call office staff at (334) 206-5383.

