



Update from the Office of EMS Volume XVV, Issue VIII

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



ITLS Trauma Competition

In honor of Dr. John Campbell's legacy, Alabama Chapter of the American College of Emergency Physicians, will sponsor and pay the entry cost of an Alabama three or four-person team to compete in the Trauma Competition at the ITLS International Trauma Conference. The conference will be held November 13-16, 2019 in Las Vegas, Nevada. Alabama ACEP has allotted \$2000, which will pay the entry fee for two three-person teams, one four-person team OR \$1000 each toward two four person teams. Additional costs will be the responsibility of the participants or their employers. We look forward to supporting the ITLS International Conference and encourage those interested to email Denise Louthain, Executive Director for ALACEP at dlouthain@seaems.com

Compliance Issues

Name	Rule/Protocol	Complaint	Action Taken
Joseph Bennett EMSP-Paramedic 0200024	420-2-1-.21	Documentation	Suspension
Erik Booker EMSP-Paramedic 1200515	420-2-1-.30	Patient Care Issues	Remediation
Michael Donelli EMSP-Paramedic 1300621	420-2-1-.20	Responsibility for the Patient	Remediation
Forrest Hale EMSP-EMT 1700868	420-2-1-.29	Standards of Conduct	Surrender
Calvin Hui EMSP-Paramedic 1300900	420-2-1-.29	Standards of Conduct	Suspension
James Hutson EMSP-Paramedic 0800295	420-2-1-.21	Documentation	Suspension
William Powell EMSP-EMT 9400160	420-2-1-.29	Standards of Conduct	Suspension
Jacob Steele EMSP-EMT 1700581	420-2-1-.29	Standards of Conduct	Suspension
Veronica Velazquez-Roque EMSP-EMT 1700747	420-2-1-.20	Responsibility for Patient	Remediation



Compliance Issues continued

Name	Rule/Protocol	Complaint	Action Taken
EMSP-Paramedic	420-2-1-.30	Impairment	Revoked
EMSP-Paramedic	420-2-1-.30	Impairment	Revoked
EMSP-Paramedic	420-2-1-.30	Impairment	Suspension
EMSP-Paramedic	420-2-1-.30	Impairment	Suspension
EMSP-Advanced	420-2-1-.30	Impairment	Revoked
EMSP-EMT	420-2-1-.30	Impairment	Suspension
EMSP-EMT	420-2-1-.30	Impairment	Suspension
Okaloosa Medflight 1103	420-2-1-.11	AHS Compliance	Probation





Provider Service Inspections

These inspections were completed April-June, 2019.

Advanced EMS	Cahaba Valley Fire-Shelby
Advantage Ambulance-Jefferson County	Calera Fire Department
AirEvac EMS, Inc.-Demopolis	Care Ambulance-Autauga
Alabama Fire College	Chelsea Fire and Rescue
Alabaster Fire Department	Cherokee EMS
Alexander City Fire Department	Cleburne Ambulance Service
AM/NS Calvert	Collins Chapel Fire & Rescue
Amserv EMS-Bibb County	Conecuh County EMS
Amstar EMS	D.W. McMillan EMS
AMVAC Chemical Corporation	Dauphin Island Fire and Rescue
Argo Fire District	Davis Lake Fire District
Arjenna Parabasic Transport, LLC	Demopolis Fire Rescue Department
ASAP EMS-Perry County	Elite Industrial Services
Ashville Fire District	Enterprise Fire
Athens-Limestone Ambulance Service	Enterprise Rescue
BASF Corporation	First Response
Brookwood Volunteer Fire Department	Floyd EMS
Cahaba Valley Fire-Birmingham	Gems Ambulance
	Goodwater Ambulance Service
	Greene County EMS

Provider Service Inspections continued

Greg's Ambulance Service	Lincoln Fire Department
Hale County EMS	MedTrans
Harpersville Fire District	Metro Health
Hartford Fire Rescue	Mobile County EMS
Haynes Ambulance-Bullock County	Mobile Fire Department
Haynes Ambulance-Coffee County	Moody Fire Department
Haynes Ambulance-Covington County	Montevallo Fire and Rescue Service
Haynes Ambulance-Macon County	Moulton Fire Department
Haynes Ambulance-Pike County	Newman's Medical Services, Inc.
Haynes LifeFlight-Pike County	North Shelby Fire District
Helena Fire Department	Northport Fire Rescue
Hillsboro Fire District	Northstar Paramedic Services
Hoover Fire Department-Jefferson County	Northstar-Talladega County
Hoover Fire Department-Shelby County	Odenville Fire Department
Indian Ford Fire District	Orange Beach Fire Rescue
Kellyton Fire & Rescue	Pelham Fire Department
LifeCare of Alabama-Tuscaloosa County	Pell City Fire Department
Lifeguard Ambulance Service- Mobile County	Prattville Fire Department
LifeSaver-Talladega County	ProgressiveHealth,LLC





Provider Service Inspections continued

RPS-Jefferson County

RPS-Shelby County

RPS-St. Clair

RPS-Talladega County

Ragland Fire Department

Riverside Fire Department

Samson EMS

Saraland Fire Rescue Department

Shoals Ambulance-Lauderdale
County

Shoals Ambulance-Shelby County

Slocomb EMS

Southeast Shelby County Rescue

Southern Emergency Medical

SouthFlight

Springville Fire Department

Steele Fire Department

Talladega Super Speedway

Troy Fire Department

Tuscaloosa County Sheriff's Office

Tuscaloosa Fire & Rescue Service

Vestavia Hills Fire Department

Westover Fire Department

Winterboro Fire Department

Culture of Excellence

Alabaster Fire
Department

Athens-Limestone
Ambulance Service

BASF Corporation

Brookwood Volunteer
Fire Department

Cahaba Valley Fire-
Shelby County

Cleburne Ambulance
Service

D.W. McMillan EMS

Enterprise Rescue

Goodwater Ambulance
Service

Kellyton Fire & Rescue

LifeSaver-Talladega
County

Orange Beach Fire
Rescue

Prattville Fire Department

RPS-Talladega County

Riverside Fire
Department

Saraland Fire Rescue
Department

SouthFlight

Springville Fire
Department

Steele Fire Department

Troy Fire Department

Tuscaloosa County
Sheriff's Office





EMSC Update

The inaugural equipment grant application process was a success. Twenty (20) services applied and will be receiving Pedi-Mate and Neo-Mate pediatric restraints in the next few months. The services that applied and were awarded are:

Baldwin EMS	Greenville Fire Department
Blount EMS	Hale County EMS
Chelsea Fire and Rescue	Headland Fire and Rescue
Dale EMS and Rescue	Highlands Medical Center
Dothan Ambulance Service	Lincoln Fire Rescue
East Alabama Fire District	North Shelby Fire District
Emergency Medical Transport	Orange Beach Fire and Rescue
Enterprise Rescue, Inc.	Regional Paramedical Services
Forestdale Fire District	Rocky Ridge Fire District
Geneva Rescue	Star of Life Services, Inc.

Please be on the lookout for the next equipment grant application announcement. We hope to outfit all of our services with pediatric restraints to allow you to transport our children safely.

Katherine Dixon Hert, BSBA
EMSC Program Manager

EMSC Good Call Awards

For EMSC Week this year, the EMSC Program put out a call to recognize our providers for Good Calls with pediatric patients. We had four nominees and all four were recognized at the EMSC Day event at Children's Hospital on May 22, 2019. Below are the stories about the nominees. We look forward to recognizing more of our providers in years to come.

On January 29, 2019, Daphne Fire Department Engine 3 responded for one seizing. The patient was brought to the fire station from the daycare next door. The patient was an 11-month-old boy who had been seizing uncontrollably. The parents later advised that the patient had been treated for a double ear infection for the past month. They had been advised that the patient had been running a fever of 101 while at daycare. The patient then began to seize. He would seize, have a brief moment of reprieve, then seize again. The engine crew, Lt. Luke Andrews, Firemedic Clint Smith, and Firefighter John Ellis, began to work to attempt to halt the seizures. Firemedic Smith established an IV in one arm and Lt. Andrews established a second line in the other arm. The patient was transported to the freestanding emergency department a few miles away. Unfortunately, the parents were told the patient was transported to a different facility. Upon their arrival, they were unable to find their child and no one was aware of his status. Once the parents were informed of the facility where their child was located, they traveled to meet him. Firemedic Smith accompanied the child to the freestanding emergency department and continued to provide ALS care. While en-route, one of the IV lines had become dislodged, leaving only one IV line. This was the IV that was utilized throughout the care of the patient. The freestanding ED contacted a flight crew to transport the patient to another facility. Upon the flight crew's arrival, Lt. Andrews greeted them and accompanied them to the patient. Firemedic Smith had, by this time, made contact with the parents and explained to them the situation and what was being done for their child. Lt. Andrews became instrumental in assisting the flight crew with securing an airway and ventilating the patient. The freestanding ED staff was unable to intubate the patient. Had Lt. Andrews not been on scene to assist with the flight crew their job would have been more difficult and cumbersome. Firemedic Smith was key in maintaining communication with the parents. The child was transported to a specialty center and released several days later. He had experienced a condition known as status epilepticus that had been brought on by an initial febrile seizure. The parents of the patient have expressed that, if not for the care and expedience of this crew, their child would not have survived this ordeal.





EMSC Good Call Awards continued

Ben Hughes is an outgoing, compassionate, dedicated flight nurse at University of South Alabama (USA) SouthFlight. He became a paramedic in 2009, and became a Registered nurse in 2013. He has transported over 350 critical patients over the last five years by air. He has multiple certifications including, certified emergency nurse as well as certified flight nurse.

On 8/16/2018, Ben and his partner responded to a single vehicle accident in which the car left the road at a high rate of speed, rolled several times and struck a tree. The patient was an 11 year old who was on his way to school. His sibling was driving and unfortunately succumbed to injuries prior to first responders arriving to the scene. The 11 year old was intubated using IV sedation/ paralysis medication on scene by the flight crew, required needle decompression due to a pneumothorax, and given blood products. Patient was transported to USA Health University Hospital (UH) and stabilized further before eventually being transferred to USA Children's and Women's. The patient arrived to UH at 8:29 am to the care of Dr. Brevard.

Ben's story was aired on WKRG TV 5's new series Smiles Behind the Shield.

EMSC Founder's Award

The Alabama EMSC Program also recognized Brent Dierking for his contributions to the program. He was part of the original group that applied for and was awarded the first Demonstration Grant for EMSC in the State of Alabama. He served as the Project Coordinator for the grant and was selected as the first paramedic from Alabama state to be sent to Children's National Medical Center in Washington, D.C. to attend the very first EMSC Training Program.

The Danger of “Narcan No Hauls”

Gary L. Varner, MPH, NRP
Senior Epidemiologist

Scenario:

You are a first response member of your local Emergency Medical Service. You arrive on the scene to find a patient non-responsive with bradypnea. Family members describe a history of opioid drug abuse associated with chronic pain after a car accident. A rapid physical assessment finds the patient to have pin-point pupils, moderate blood pressure and shallow respirations associated with the slow respiratory rate. After supplementing the patient’s ventilatory effort with a bag-valve-mask device and supplemental oxygen you elect to attempt to reverse the patient’s probable opioid toxicity with Narcan (naloxone). After administration of naloxone the patient returns to consciousness, first with confusion but then with lucidity and complaining of extreme pain in the areas injured in the accident. As you move the stretcher into the room you inform the patient of what just occurred and prepare to load him to transport him to the hospital. He looks at you and replies “Hey, I wasn’t trying to hurt myself, I am just in so much pain I took too much of my medication. I don’t want to go to the hospital.”

What should you do next?

Opioid deaths are primarily the result of lowered levels of consciousness and slowed respiratory rates. The CDC reported that 19.8 of every 100,000 Americans died of a drug overdose in 2017, with 67.8% of all overdose deaths being from opioids. Narcan (naloxone) has been available worldwide as a narcotic antidote since the 1960’s, but still the medical community struggles with consensus on what exactly is the optimum dose and regimen. According to the Emergency Medical Journal of The BMJ (formerly the British Medical Journal) the reason for the confusion is a combination of the proportion of opioid receptors undergoing binding of the drug molecules being uncertain in any case of opioid toxicity and the ability of naloxone to antagonistically bind those same receptors.[1] The key point we wish to outline here is that the pharmacodynamic effects of naloxone last for a briefer period than all but the shortest acting opioids, which has been evidenced in several studies; and that more and more American citizens have been suffering opioid toxicity every year.

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The physiological state of each patient also influences the proportional binding of receptors. The height and weight, age, genetics, body fat content, metabolism, renal and hepatic function, and hydration causes variance beyond simply the dose and quality of the opioid. Even the route that naloxone is administered can affect the uptake and duration. Different forms of opioids also vary in duration of effects. Heroin, for example, has a short half life (some studies suggest around 30 minutes, or shorter) but may have longer periods of effect than drugs like cocaine and methamphetamine. Other types of opioids have longer half-lives. Fentanyl, for instance, rates an elimination half-life of 8-10 hours. Naloxone, depending upon route of administration, has a half life of between 1-2 hours.

Every state and the District of Columbia, has adopted new laws to increase Narcan availability, generally geared toward making the drug more accessible. In Alabama and 40 other states, naloxone is available without a prescription. Pricing varies from about \$4,641 for an Evzio® auto-injector to \$35 for a pre-filled syringe and \$29 for a nasal atomizer. Although beneficial, the more common availability of Narcan may have the potential to cause laypeople in the community to consider the drug to be a substitute for emergency medical care. In preparation for this article no studies could be found on that subject, however, we must always remain cognizant of that possibility when dealing with patients who have experienced severe opioid toxicity and have been returned to consciousness following naloxone administration.

Anesthesiologists have long recognized that patients who have been narcotically sedated in a clinical setting and have had that sedation reversed by naloxone must be monitored for at least 1-2 hours in a hospital setting in case subsequent doses of naloxone are required to reverse resurging narcosis. Prehospital patients who have experienced out-of-hospital acute opioid poisoning requiring naloxone administration should logically also require at least 1-2 hours of clinical monitoring. Preexisting pathologies (such as those mentioned earlier, among others) can cause unexpected side effects of reversal and/or returning narcosis and may cause dangerous, or even deadly responses in some patients.[2] We should never assume that because the patient did not experience withdrawal symptoms with naloxone administration that the potential for problems are minimal.

Since the U.S. Department of Health and Human Services declared a public health emergency regarding opioids in 2017, the amount of investigation into every aspect of the problem has increased exponentially.

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An issue becoming evident nationally is that some number of overdose patients who are given naloxone in the prehospital environment are not being transported for hospital evaluation. The fact that laypeople can legally obtain and administer naloxone as part of the HHS plan to combat the opioid crises is one aspect of the problem and public information discouraging avoidance of emergency medical care after narcotic reversal is becoming more widespread. While the issue is currently under study in the State of Alabama, preliminary evidence suggests that up to 2-3% of EMS patients who are given naloxone (presumably when it is indicated) are being non-transported (sometimes called “no hauled”) due to patient refusal after a return to consciousness. Studies are currently looking into any contribution to overdose deaths that may occur in these situations. Any prehospital EMS provider with any length of time in service will immediately look at the situation in terms of professional liability.

So, going back to the scenario at the beginning of the article; what SHOULD you do next?

1. As we have outlined here; first recognize the potential danger of leaving a patient on scene when the possibility of narcosis resurgence exists. This danger should be explained at length to the patient. They should be informed that medical monitoring is required for an extended period so that narcosis resurgence can be professionally recognized and treated, and that a hospital is the best location for that monitoring to occur. When confronting an especially stubborn patient, some EMS personnel include statements such as “I cannot guarantee that you won’t die if I leave you here.” That statement is both fair and true.
2. If the patient continues to refuse you must ascertain his or her ability to make an informed decision. Considering that the patient is, in fact, under the influence of narcotic substances, even though consciousness has been returned, makes a courtroom defense of the EMS position for non-transport somewhat problematic. In the unknown probability that the patient’s decision to refuse transport against medical advice causes his or her demise, the family has an excellent position to present reasonable doubt regarding the patient’s decision-making abilities. We can certainly assure the patient’s ability to recognize person, place, time and situation; but we also must remember how that is ultimately going to present to a jury when the plaintiff’s attorney and expert witness outlines the neurological effects of narcotics.

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3. It is also true that a patient cannot be transported against their will. Two resources that should always be considered in this sort of case is law enforcement and medical control. Law enforcement should be involved in every case where narcotics are abused and arguably even accidentally taken to excess. It is legal in Alabama to get drunk in your own home without hazarding other citizens, however, it is not legal to overdose on narcotics in your own home, even when you are prescribed those medications. If law enforcement is not willing to intervene for refusal, then certainly medical control should be consulted before leaving the patient's side. Some physicians prefer to speak with patients personally in situations of this type. If the physician cannot convince the patient to allow transport (and at the least come in by private vehicle) then follow the physician's directions making sure that appropriate times, names and physician ID numbers are charted.
4. More than adequate (if not excessive) documentation of this situation cannot be over-emphasized. All (preferably multiple) efforts to convince the patient to allow transport should be quoted at length in the ePCR narrative. Indicators of the patient's consciousness and cognizance should likewise be described in exact detail. Use of family members to assist in encouraging compliance should be documented and names and phone numbers of those family members recorded. If the patient has refused, then a witness signature from law enforcement is preferable even when family members are present.

In summary let us begin by saying that this situation is a difficult one. Very few Alabama patients who are administered naloxone refuse treatment, but between 1 and 3 out of 100 have in the past few years (some prior to 2017) and the trend may increase in the coming years as naloxone becomes more familiar and common in our communities. Federal law states that a person has control over his or her healthcare. [3] At the same time a person must be able to make informed decisions, and if unable, the principle of implied consent must be used. The assistance of law enforcement personnel on scene should always be considered when interacting with a patient who has been exposed to any intoxicating substance, from both safety and legal perspectives. The absolute necessity for involvement of medical control and exact medical documentation for propriety and reduction of legal liability cannot be overemphasized.

SOURCES

1. Clarke, S.F., P.I. Dargan, and A.L. Jones, *Naloxone in opioid poisoning: walking the tightrope*. Emerg Med J, 2005. **22**(9): p. 612-6.
2. Kharasch, E.D., *Opioid Half-lives and Hemlines: The Long and Short of Fashion*. Anesthesiology, 2015. **122**(5): p. 969-70.
3. Teoli, D. and S. Ghassemzadeh, *Patient Self-Determination Act*, in *StatPearls*. 2019: Treasure Island (FL).

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 (emsis@adph.state.al.us).
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

A licensed EMSP shall perform his or her job duties and responsibilities in a manner that reflects the highest ethical and professional standards of conduct. Actions that are in violation of the standard of conduct will be considered misconduct and are subject to immediate disciplinary action, up to and including license revocation.

Please be reminded that, according to Rule 420-2-1-.28 (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, items listed in 420-2-1-.29 (2).

Also, be reminded that, according to Rule 420-2-1-.30 (6), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.