ALABAMA Emergency Medical Services

Update from the Office of EMS

Volume XVI, Issue III

The National Continued Competency Program: The 'New' Recertification (NCCP) from the NREMT Summer Newsletter

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.

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.

If you are a Nationally Registered EMT or Paramedic you will have to complete a 100 question self assessment tool exam prior to renewing your National Certification. This is a tool not a test, please use to examine your own weaknesses and improve upon them.

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

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Paramedic Scenario Psychomotor Exam and Psychomotor Competency Portfolio (PPCP) from the NREMT Summer Newsletter

The NREMT is changing the way it verifies psychomotor competency for National Registry Paramedic (NRP) certification. Several factors have come together prompting the NREMT to change its psychomotor examination. The first is a desire to ensure protection of the public by assessing psychomotor competency in a way that better simulates actual practice in a testing environment. The second factor is that EMS employers would like to be able to more quickly integrate newly certified providers into the workforce. Finally, the NREMT now requires that all paramedic candidates graduate from a Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredited paramedic program or one that holds a current Letter of Review (LoR) from the committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP). Scenario examinations allow the NREMT to incorporate essential attributes of team leadership along with scene and patient management, thus better reflecting actual out-of-hospital care as opposed to continuing to test 12 isolated skills.

The NREMT developed a portfolio of vital skills that each paramedic student will utilize to gain entry-level competence to qualify for the NRP certification examination. The program tracks each student's portfolio through the formative and summative phases of education in the laboratory, clinical ,and field internship settings. The completed portfolio provides a mass of evidence that documents a candidate's acquisition of psychomotor competency in the skills we currently evaluate on the 12-skill NRP psychomotor examination. All students who begin their paramedic program on or after August 1, 2016 are required to complete a portfolio that becomes a part of their permanent educational file and is a prerequisite to seeking NRP certification.

Beginning January 1, 2017, the NREMT will start testing Phase 1 of the new scenario psychomotor exam. In this phase, a total of six (6) skills will be tested, five (5) currently evaluated in the NRP psychomotor examination and one (1) scenario. This out-of-hospital scenario will reflect either a pediatric, geriatric, or adult patient. Each candidate will be provided with a trained paramedic partner and evaluated on his/her ability to manage a call, lead the team, effectively communication, and maintain professionalism throughout the simulated patient encounter.

Click on the following link to view best-practice documents and webinars that provide information on the development of student portfolios and scenarios. Please review and contact Todd Vreeland with any further questions.

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.

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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.

News from the State EMS Medical Director

Once again I write an article for the newsletter on drug shortages. We, in EMS, continue to struggle with drug shortages that affect our everyday practice. I certainly share your frustration.

As I write this article, there are different medicines that are now in short supply that may not have been in short supply only a few weeks ago. It seems that it is a moving target.

I know that vasopressin and epinephrine 1:10,000 are both in short supply. Most people can obtain epinephrine 1:1,000. If you can get the 1:1,000 concentration then you may have to mix 1 cc of this concentration with 9 cc's of normal saline to obtain a 1:10,000 mixture.

There may be instances in which you will need to use drugs that are not packaged in the manner that your EMSP are familiar with. Make sure that all EMSP are familiar with the packaging that is being used in order to reduce the likelihood of medication errors.

If you are having difficulty obtaining certain medications please forward that information to the OEMS with the contacts being Stephen Wilson or Hugh Hollon at 334-206-5383.

I appreciate your continued dedication to EMS and together we can work through these challenging issues. Please do not hesitate to contact me if you have questions.

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

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News from the Assistant State EMS Medical Director
tPA Protocol Update

With the growth of the state Stroke System, EMS has been called upon to care for and transport many more patients who are receiving thrombolytic therapy for ischemic stroke. Attached is an update to the Interfacilty Transfer Drug Course specifying treatment protocols for patients who have received tissue plasminogen activator, also known as tPA, for treatment of ischemic strokes. This protocol is for Interfacility Transfers only.

It is the responsibility of the individual EMS agency to disseminate this information to their EMS providers. Upon review to the satisfaction of each agency's Service Medical Director, Paramedics who are currently authorized with the ADPH OEMS Transfer Drug certification are authorized to utilize this interfacility treatment protocol.

If you have any questions, feel free to contact the ADPH Office of EMS at (334) 206-5383 or email Dr Sarah Nafziger, the Assistant State EMS Medical Director.

INTERFACILITY TRANSFER	JULY 2015
Stroke-IV tPA	

PURPOSE

To provide guidance for safe transport of patients who are receiving or have received intravenous tissue plasminogen activator (tPA) for treatment of ischemic stroke

HISTORY AND PHYSICAL EXAM

- Perform and Document initial neurologic exam
- Perform and Document vital signs prior to transport. If SBP>180 or DBP >105 discuss treatment of hypertension with sending hospital prior to transport and obtain necessary medications

KEY POINTS

- Verify and Document the time of initial IV tPA bolus and time of infusion completion.
- If IV tPA dose administration will continue en route, verify estimated time of completion and amount to be infused. Verify with the sending hospital that any excess tPA has been withdrawn from the tPA bottle and wasted so that the tPA bottle will be empty when the full dose is finished infusing. For example, if the total dose is 70 mg, there would be an extra 30cc in the tPA bottle that has to be withdrawn and wasted since a 100 mg bottle of tPA contains 100cc of fluid when reconstituted.
- At the completion of the tPA infusion, infuse 100cc of NS to flush the remaining tPA from the IV tubing so that the patient receives the full dose of tPA.
- Avoid unnecessary venipuncture or invasive procedures when possible due to increased risk of bleeding in patients receiving tPA
- Do not infuse other medications in the same IV where tPA is infusing
- Do not cycle blood pressure on the same arm where tPA is infusing
- Rarely, patients can have allergic reactions to tPA including but not limited to angioedema. If this happens, treat the patient according to the Allergic Reaction protocol
- If NIH stroke scale is documented at sending facility, note that on the patient's ePCR
- Stroke System: Notate ATCC Number on ePCR in the appropriate field. If patient has not already been entered into the stroke system, call ATCC and enter the patient into the stroke system. At completion of transport, notify ATCC and provide any needed information. If needed, ATCC can assist in obtaining OLMD for these patients.

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INTERFACILITY TRANSFER	JULY 2015
Stroke-IV tPA (continued)	

TREATMENT	DRUGS/PROCEDURES
• Oxygen to maintain pulse oximetry >95%. • Cardiac Monitor • Glucometer. If patient is hypoglycemic, treat using Hypoglycemia Protocol (3.21) It is preferable to use the blood glucose measurement obtained by the transferring hospital in order to avoid unnecessary delay. • Establish or maintain IV access. • Patient must remain NPO (nothing by mouth) including medications • The Paramedic is NOT authorized to give the *tPA* bolus but IS authorized to maintain the *tPA* infusion. *tPA* may only be given if ordered and started at the sending facility. • Monitor and document neurologic exam every 15 minutes. If patient develops worsened neurologic condition or if patient develops severe headache, acute hypertension, difficulty breathing, evidence of allergic reaction, or major bleeding then stop the *tPA* infusion (if still infusing) and contact OLMD. • Monitor and document vital signs every 15 minutes. If antihypertensive medications (*Labetalol*, *Nicardipine*, *Metoprolol*) are started or ordered at the sending facility, they may be continued for SBP>180 or DBP>105.	**EMT:** Not authorized **Advanced:** Not authorized **Intermediate:** Not authorized **Paramedic:** *Oxygen* Glucometer as needed Establish IV, Cardiac monitoring *tPA:* 0.9 mg/kg IV; not to exceed 90 mg total dose; administer 10% of the total dose as an initial IV bolus over 1 minute and the remainder infused over 60 minutes *Labetalol infusion:* 2mg/min and increase by 2 mg/min every 10 minutes to MAX 8 mg/min for goal SBP<180 and/or DBP<105. If SBP<140 or DBP<80 or HR<60, discontinue drip and call OLMD *Nicardipine infusion:* 2.5 mg/hr and increase by 2.5 mg/hr every 5 minutes to MAX 15 mg/hr until SBP<180 and/or DBP<105. If SBP<140 or DBP<80 or HR<60, discontinue drip and call OLMD *Metoprolol:* 5 mg IV, may repeat every 5 min to MAX 20 mg. Hold if SBP<140 or DBP<80 or HR<60

Compliance Issues			
Name	**Rule/Protocol**	**Complaint**	**Action Taken**
Kimberly R. Broyles EMSP-Paramedic #0600041	420-2-1-.30	Falsification of Records	Suspension
Cindi L. Burns EMSP-Paramedic #0300115	420-2-1-.30	Patient Care Issue	Suspension
Amanda L. Combs EMSP-Basic #1200034	420-2-1-.30	Falsification of Records Guilty of Misconduct	Suspension
Sussi J. Dalton EMSP-Basic #0900260	420-2-1-.30	Falsification of Records Guilty of Misconduct Exceeding Scope of License	Suspension
Teresa A. Faris EMSP-Advanced #1400555	420-2-1-.28 420-2-1-.30	Responsibility of Patient Falsification of Records Guilty of Misconduct	Suspension
Crystal D. Griffith EMSP-Basic #1001094	420-2-1-.30	Falsification of Records Guilty of Misconduct Exceeding Scope of License	Suspension
Brian Hatcher EMSP-Paramedic #9142807	420-2-1-.28 420-2-1-.30	Responsibility of Patient Falsification of Records Guilty of Misconduct Patient Care Issue	Suspension
Cori C. Kelley EMSP-Advanced #1300141	420-2-1-.30	Patient Care Issue	Suspension

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Compliance Issues continued			
Name	**Rule/Protocol**	**Complaint**	**Action Taken**
Gregory C. Lowery EMSP-Basic #0800590	420-2-1-.17 420-2-1-.30	Testing and Certification Requirements Guilty of Misconduct	Suspension
William C. Mosley EMSP-Paramedic #9041414	420-2-1-.30	Guilty of Misconduct Duty to Act	Suspension
Travis M. Peek EMSP-Paramedic #1000215	420-2-1-.30	Guilty of Misconduct	Suspension
Joel G. Pugh EMSP-Advanced #1400043	420-2-1-.29	Impaired EMSP	Suspension
Chasity N. Twilley EMSP-Basic #1400629	420-2-1-.30	Exceeding Scope of License	Suspension
Chad C. Walls EMSP-Paramedic #1100553	420-2-1-.29	Impaired EMSP	Suspension
Christopher L. Wright EMSP-Basic #0800515	420-2-1-.17 420-2-1-.30	Testing and Certification Requirements Guilty of Misconduct	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 April-June, 2015.

Athens-Limestone EMS

Calera Fire Department

Crossville Fire and Rescue

Cullman EMS

Dekalb Ambulance Service

Fort Payne Fire Department

Greg's Ambulance Service

Highland Medical Center Ambulance Service

Hillsboro Area Volunteer Fire and Rescue

Keller EMS-Colbert

Montevallo Fire and Rescue Service

North Lamar EMS

North Shelby Fire District

Phil Campbell Rescue Squad

Pleasant Bay Ambulance

RPS Cullman

Russellville Fire and Rescue

Scottsboro Fire Department

Southeast Shelby County Rescue

Shoals Ambulance-Lauderdale

Transcare Ambulance Service-Lamar

Westover Municipal Fire Department

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Culture of Excellence

Alexander City Fire Department

Emergency Medical Transport

Haynes Ambulance of Troy

Lafayette Fire and Rescue

Leeds Fire and Rescue

Moody Fire and Rescue

Odenville Fire and Rescue

Opelika Fire and Rescue

Riverside Fire and Rescue

RPS (Talladega)

Springville Fire and Rescue

Stillwaters Volunteer Fire and Rescue

Tallapoosa EMS

Valley EMS

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.

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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 Mark Jackson
Provider Service Licenses—Call Stephen Wilson or Stephanie Smith
Individual Licenses—Call Stephen Wilson or Kembley Thomas
Individual Training or Testing—Call Hugh Hollon
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.

Pediatric Prehospital Seizure Management

You are on duty in the ED, when a rescue unit calls and they would like orders for 3 year old child who is having their first seizure?

As you pull out your Alabama EMS Patient Care Protocols for reference, you recall that febrile seizures are the most common seizure disorder in children affecting 2-5% of children between the ages of 6 months and 5 years. You make sure to tell your nurses to get a rectal temperature and an accurate weight on the child (in kilograms) on arrival, but in the mean time you know you will need to help the EMS providers as their anxiety levels are likely high.

Pediatric prehospital seizure management is characterized by variability in care related to providers' infrequent exposure to children, difficulty maintaining skills, and limited knowledge of pediatrics. Prehospital providers may have more difficulty in rapidly obtaining intravenous access in children relative to adults, and the stress of managing critically ill children poses an added challenge. In attempt to help with some of their anxiety and stress, any information you can provide will be welcome.

You can estimate the child's weight as 15 kg, based on prior PALS training. You ask that the providers begin timing the seizure as you know most febrile seizures are short lived and self-limited. A true simple febrile seizure lasts less than 15 minutes and is characterized as generalized tonic-clonic in nature. You quickly think about other common causes of pediatric seizures and your list includes:

Febrile seizures
Ingestions or toxins
Head injury and/or child abuse
Infections, particularly meningitis
Prior history of seizure (has the patient missed doses of their medication?)

The Alabama EMS Patient Care Protocol for Seizures (3.30) recommends obtaining an IV, but this may be difficult in the pediatric patient. Encourage the EMS personnel to move forward with obtaining a finger-stick glucose and treat according to the Hypoglycemia Protocol (3.21) if it is less than 60 mg/dL (4 cc/kg of D25 IV or 0.5 mg glucagon IM with online medical direction). If the patient continues to have a seizure for greater than 5 minutes, use medications to stop the seizure as described in the protocol (these will need online medical direction). Recent studies suggest that non-IV routes may be the best option in pediatrics with one study showing that IM midazolam was not inferior to IV diazepam. So when the call comes consider your options: midazolam 0.2 mg/kg IM maybe as good as an option as diazepam 0.1 mg/kg IV. Recent literature also indicates that IN midazolam (0.2 mg/kg) is preferred over PR diazepam.

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Once the patient arrives in your ED, your work is just beginning, or really it may be done if you determine this is a simple febrile seizure. This is a seizure accompanied by fever (before, during or after) 100.4° F or 38 C, without central nervous system infection, metabolic disturbance or history of previous seizure disorder. For a simple febrile seizure no routine labs, EEG, CT scan, or referral to a neurologist is necessary. A lumbar puncture is not necessary if the patient is fully immunized and has not been pretreated with antibiotics. Locating the source of the fever (maybe a viral infection) and ensuring the child returns to a normal baseline is necessary. Nearly all of these children may be safely discharged after educating the families about febrile seizures.

Seizure Medication Choices:
No IV - Midazolam 0.2 mg/kg IN/IM (may also be given buccal)

IV – Midazolam 0.1 mg/kg over 30 sec
Diazepam 0.1 mg/kg over 30 sec
Lorazepam 0.1 mg/kg over 30 sec

PR - Diazepam 0.5 mg/kg

Hypoglycemia (glucose < 60 in pediatrics):
D25W: IV 2-4 cc/kg
Glucagon: IM 0.5 mg (Will need on-line medical direction)

The Alabama EMS for Children (EMSC) program is here to help. Please contact us if you would like to more information on how you can be the children's champion for your hospital.

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Katherine Hert
Alabama EMSC Project Director
Katherine.Hert@adph.state.al.us

1. Silbergleit R, Durkalski V, Lowenstein D, et al. "Intramuscular versus intravenous therapy for prehospital status epilepticus", N Engl J Med. 2012;366(7)591-600.
2. Carey JM, Shah MI "Pediatric Prehospital Seizure Management" Clinical Pediatric Emergency Medicine. 2014;15(1)59-66.
Subcommittee on Febrile Seizures. "Clinical Practice Guideline-Febrile Seizures: Guideline for the Neurodiagnostic Evaluation of the Child with a simple febrile seizure." Pediatrics 2011;127:389-394.