Division of EMS and Trauma

July 2014

Rural EMS Assistance Fund Update

By: Amanda Roehrich, DEMST Grants Manager

On June 30, 2014 the grant cycle for the Rural EMS Assistance Fund ended. All requests for reimbursements have been processed and a progress report form will be distributed for you to complete shortly detailing your accomplishments and inadequacies in funding utilization.

As for the new grant cycle, we are still in the process of analyzing the applications and coming up with funding scenarios. Once this is complete, announcements will be made on our website and contracts will be mailed to the funded recipients. Due to the large amount of requests, this is a lengthy process and I thank you for your patience and look forward to another year of working with all of you.

LUCAS Device Distribution

By: Amanda Roehrich, DEMST Grants Manager

The distribution of Lucas devices continues for The Leona M. and Harry B. Helmsley Charitable Trust Grant. For those whose paperwork is complete and approved, a packet will be mailed which includes a check or an electronic payment advice for the equipment you will be receiving as well as a copy of the signed Notice of Grant Award. According to the Notice of Grant Award, these funds are to be used to pay Physio-Control, Inc. for the equipment you are receiving. Please remember that ownership and maintenance of this equipment belongs to the grantee and that the grantee is responsible for insuring the equipment on their policy. Do not use the equipment until proper training has occurred. There are several entities that have returned the contract to me but have not completed the paperwork for Physio-Control, Inc. If you have not received your device but it has been a while since you have sent paperwork, please contact me to find out what is needed.

Check it out...

As all EMS personnel should know - you need to be state licensed in order to work as an EMS provider in the state of North Dakota. Yes, even if you are Nationally Registered. Your state licensure period is two years and expires on June 30.

As you may note - June 30, 2014 has come and gone. You may want to check your North Dakota state license and verify it is still current as a great number of our EMS personnel have not yet relicensed with the state of North Dakota.

This chart shows the numbers as they currently stand as of July 25, 2014.

Level	Due 6/30/2014	Done	Remaining	% Done
State EMT	3	2	1	66.67%
AFAA	187	181	6	96.79%
EMR/FR	709	138	571	19.46%
EMT	529	183	346	34.59%
EMT-I/85	42	13	29	30.95%
Paramedic	130	52	78	40.00%

So We Didn't Respond

With rural EMS services facing heavier workloads and dwindling volunteer numbers, responding to calls can be difficult. However, by creating a call schedule, you can avoid numerous issues that can arise from not responding.

Yes, another ambulance service was eventually called after your non-response and the patient did get taken to the hospital and survived. The problem is that the patient is the one forgotten in the process.

That patient could be your friend or family member that has to sit at home with chest pain for an hour waiting for an ambulance to respond. Would you want your friend or family member having respiratory distress to get into a vehicle and drive themselves to a hospital after waiting too long and wondering if an ambulance will actually come?

Situations just like these have occurred in North Dakota.

When asked, ambulance managers have said they aren't sure how this could have happened. We have found that one of the major underlying reasons for a non-response is the lack of a call schedule. This is disquieting considering a call schedule is a requirement of licensure in North Dakota.

During the Rural EMS Improvement Project, eight characteristics of thriving ambulance services were outlined. Number five was an enforced call schedule. It is stated in The Rural Ambulance Service Leader's Survival Guide (2011) "using an 'all-call' system, where there is a no-call schedule and specific individuals are not designated to be on call, is not reliable, does not distribute call time responsibly, and does not distribute call opportunity fairly. While many services have operated with an 'all-call' system in the past, the difficulty in attracting and keeping volunteers today makes this an unreliable means of ensuring that 100 percent of all calls will be answered promptly. An 'all-call' system adds stress to volunteering when there are few active volunteers."

With an "all-call" system, there is a saying that rings true: When something is everybody's responsibility, it is nobody's responsibility. There are no actions to take because it was nobody and everybody's fault for the non-response. How can you ensure that this won't happen again when you are sticking to the same model?

Ask yourself the following questions:

1. Am I in compliance with all conditions of ambulance licensure? Maintaining a call schedule is a condition of ambulance licensure. If you do not maintain a schedule, you are not complying with all conditions of licensure. Many ambulances receive money from the state, which requires complying with all conditions of licensure as a condition of receiving this money.

2. Could my service be liable for a non-response without a call schedule? W. Ann Maggiore, JD, NREMT-P wrote in a JEMS article Patient Abandonment: What It Is and Isn't (2007) "Abandonment can also occur when the EMS system as a whole fails to respond to a patient's call for help." As taught in all the initial courses, negligence can be proven when four elements are present: 1. A duty to act, 2. A breach of that duty, 3. Damages, and 4. Cause.

The main reason cited by services for not using a call schedule is the threat by over-taxed volunteers of quitting. However, I believe you should give it a try. Services with dwindling rosters and steady or increased calls for service that have transitioned from an "all-call" system to a schedule have reportedly found it freeing. You may find that you will too.

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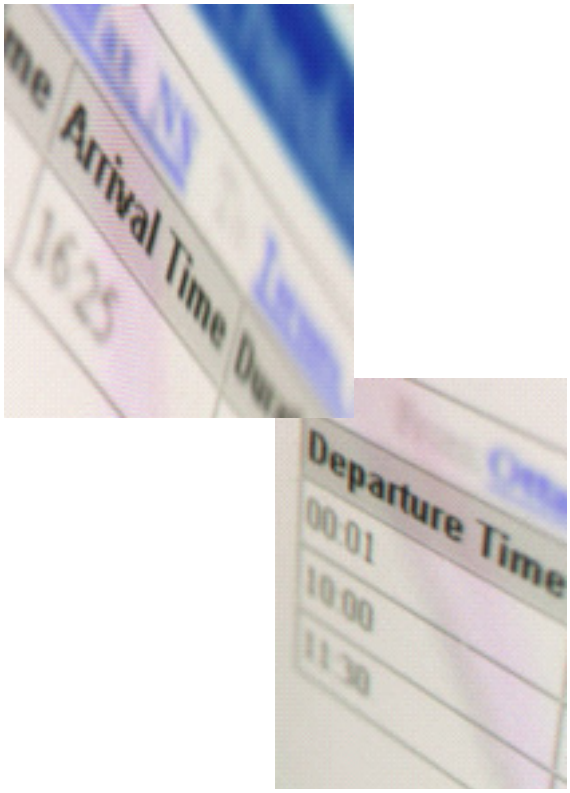

Hot Car Safety
By: Elizabeth Pihlaja, EMSC Coordinator

It seems like every few days a new story about a child dying in a hot car pops up online or on the news. Unfortunately, 17 children have died so far in 2014 after being left in hot cars; 44 children died in hot cars in 2013. While the majority of these tragedies have been unintentional (52% involved a child forgotten by a caregiver, 29% involved a child getting into a hot, unattended vehicle on their own), there are some easy things you can do to ensure your child's safety in a hot car. It's easy to think that this could never happen to your family, but the reality is that this situation has happened to people of all levels of income, education, and experience with children. Working these simple steps into your daily routine may help avoid a devastating incident.

Safe Kids USA uses the acronym ACT:

A – Avoid heatstroke related injury and death by never leaving your child alone in a car, not even for a brief run into the store. Also, make sure to lock your car when it's not in use, so children can't get in on their own and become trapped inside.

C – Create reminders by putting something you'll need during the day in the back seat, next to your child. This could be your phone, purse, or even a shoe. Additionally, you could put something baby-related in the passenger seat, like a stuffed animal, to remind yourself that your child is in the car.

T – Take action. If you see a child alone in a car, call 911. This one call could save a life.

For more information, please contact Elizabeth with the North Dakota EMS for Children program at epihlaja@nd.gov or 701.328.2953, or check out the following resources:

-Safe Kids Worldwide, www.safekids.org

-Parents Central, www.safercar.gov

-San Francisco State University: Heatstroke Deaths of Children in Vehicles, http://www.ggweather.com/heat/

Upcoming Dates to Remember:

EMS Advisory Council Meetings
October 23, 2014
10:00AM - 4:00PM CST
AV Rooms 210 - 212

EMSC Advisory Committee Meetings
September 4, 2014
December 4, 2014
All are scheduled for 12:00 CST
Capitol Building Resource Room / Teleconference

EMSC Events
St. Alexius & Kohl's Back to School Extravaganza;
Dykshoorn Park on Main Street Mandan
August 5, 2014
1:00 - 6:30PM

17th Annual ND State Trauma Conference
September 24 - 25, 2014
Fargo

See NDEMSA.org regarding the following events:

Leadership Course - Level III
October 18 - 19, 2014
Seven Seas, Mandan

Leadership Course - Level IV
December 13 - 14, 2014
Radisson, Bismarck

EMS Management Course #3
July 30, 2014
Comfort Inn, Bismarck

Meet The New Stroke/Cardiac Care Coordinator

By: Shila Thorson

Greetings, I would like to introduce myself. My name is Shila Thorson and I am the new State Stroke/ Cardiac Care Coordinator. I began this position at the end of April but my cardiac career began at Medcenter One (now Sanford Bismarck), where I worked as a CNA and Telemetry tech while attending the Medcenter One College of Nursing. Upon graduation, I transitioned to working on the telemetry unit as an RN. In 2012, I became board certified in Cardiac Vascular Nursing by the American Nurses Credentialing Center (ANCC). I am excited to use my cardiac-vascular experience to help improve the care of Stroke and STEMI patients across the state.

I grew up on a farm near New Salem, and currently live in Mandan. My husband, Ben, is a software developer at National Information Solutions Cooperative (NISC). We have a busy family of three kids. Grace is 5 and very excited about starting kindergarten and dance in the fall. Our second daughter, Sophie, is almost three and loves to be outdoors. Our son, Calvin, is one, loves to explore, and is always on the move. They definitely keep us on our toes.

We love to cook as a hobby. We are constantly trying different things and rarely use the same recipe twice. We are excited this year that we have a membership to a local CSA (Community Supported Agriculture) in which for purchasing a share we will receive fresh local produce weekly during the growing season.

I am enjoying the time I have spent in this role at the Division of EMS and Trauma. I am learning a lot from everyone I work with and am grateful for their patience as I make the transition. Everyone has been very welcoming and supportive. I am passionate about providing the best possible care to patients and aspire to build the best possible Stroke and Cardiac Systems of Care.

Shila Thorson and her family.

http://www.heart.org/HEARTORG/Affiliate/2014-North-Dakota-STEMI-Stroke-Conference_UCM_462162_Article.jsp

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http://ndhealth.gov/EPR/HP/hppconference/

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Trauma Designation Site visit
By: Ruth Hursman, State Trauma Coordinator

Every hospital with an emergency room that sees trauma patients, within North Dakota, has had at least one if not numerous, trauma designation site visits. Hospitals seeking trauma designation of Level I, Level II or Level III are required to have a site visit performed by a team from the American College of Surgeons. Facilities seeking Level IV or Level V trauma designation have a site visit performed by a team of people appointed by the Division of EMS and Trauma. This site visit team will typically include the State Trauma Coordinator, a Trauma Surgeon from a regional Level II facility and a Trauma Program Manager from a Level II facility. Occasionally the State Medical Director and/or the Emergency Medical Services for Children Coordinator will attend the visit as well.

Most site visits will start with the team sitting down with key hospital staff, introducing themselves and explaining the review process. During this time questions are typically asked by the reviewers related to the hospital, its organization and staffing guidelines. Discuss will be held on specific trauma protocols and policies that may be in place. The review team will typically ask very specifically about the educational expectations for staff such as ATLS and TNCC classes; along with things such as skills labs and assuring staff competencies. Assuring that all of the providers covering call for trauma patients in the emergency room have successfully completed and are current in ATLS is an extremely important expectation.

Next the review team will typically tour the hospital. This involves time in the emergency room, talking to staff and looking at available equipment and supplies. There is a very specific list of equipment essential for the care of trauma patients. The review team will be asking to see those supplies and equipment and assuring that it is in good working order.
From there the review team will typically attempt to visit with staff members in lab and radiology departments. While in these areas questions will be asked related to expected department response times for trauma code activations and about the availability of specific diagnostic testing and resources.

The bulk of the site visit time is spent on chart review and performance improvement. Trauma patient charts are reviewed looking specifically at documentation concerns as well as actual care concerns such as transfer out times; appropriateness of interventions performed or missed interventions. If the review team identifies an issue or concern, they will look to see if the facility's performance improvement audit also picked up this same issue. If the issue had been identified, the team will look to see how the issue was addressed and followed through on.
The process of assuring that concerns are identified and corrected is referred to as occurrence resolution or loop closure. It is essential and assures the review team that performance will be improved in the future. If concerns are noted during a site designation visit, it is typically related to the performance improvement process. Often times it is noted that the performance improvement process is fragmented. There may be good audit tools or tracking and trending but no follow through on issues identified. Poor documentation that issues were followed up on is a common problem. Sometimes it is noted that the audit tool being used is not capturing or identifying the necessary issues, although the remainder of the facility's process is intact. Site designation visits close with the review team asking any additional questions that were missed along the way, such as issues related to transfer agreements or the facility's involvement with injury prevention. The team spends a few minutes pooling their thoughts and generating a preliminary list of strengths and weaknesses which are shared with the facility during the exit interview.

Top 10 Most Frequently Identified Strengths:

1. Trauma coordinator (experienced, committed, organized)
2. EMS (relationship, partnership, demonstrated communication and teamwork)
3. Education (all nurses have TNCC, trauma updates, skills labs, scavenger hunts, competency days)
4. Emergency room (organization, equipment easy to locate, specific resources available)
5. CT scanner (used appropriately, does not delay transfers, PAC system, read times monitored)
6. Documentation (trauma flow sheet, peds assessment, completeness, repeated assessments)
7. Patient transfers (early activation of flight, transfers within 45-60 min, transfer times monitored)
8. Trauma Committee (strong structure, reviews all trauma cases, monthly, multidisciplinary)
9. Regional Trauma meetings (consistently participates, provider involvement, recommendations communicated)

~ Continued on page 6

Top 10 Most Frequently Identified Weaknesses:

1. Education (No system to assure ATLS compliance, no TNCC or trauma specific education)
2. Trauma Policies (unclear, don't reflect actual process)
3. Documentation (sporadic trauma flow sheet use, incomplete documentation)
4. Radiology (CT scan room lacks oxygen, suction; CT scans delaying transfers; read times too long or not being monitored)
5. Patient Transfers (LOS too long; transfers delayed due to diagnostic studies)
6. Transfer agreements (not updated or lacking)
7. Regional meetings (not attended, poorly attended, no provider attendance)
8. Midlevel chart review (not happening timely, lacking critical review of care)
9. Trauma Committee (lacks multidisciplinary, lacks documentation, meets infrequently)
10. Performance Improvement (lack indicators, lack indicators specific to patient outcomes, incomplete documentation of occurrence resolution, lack of provider involvement, lack of follow through on issues identified, lack of involvement of e-emergency, lack of clear goals and thresholds)

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http://www.ndhealth.gov/injury/Trainings/2014Conference/2014InjuryConfRegistrationBrochure.pdf

Community Paramedic Program Update
By: Ken Reed, Community Paramedic Coordinator

The pilot program continues to gain momentum as the first class of 8 Community Paramedics graduated from Hennepin Technical College and have begun their clinical phase. The 5 paramedics from FM Ambulance and 3 Paramedics from Rugby EMS are doing clinical rotations with a variety of primary health care and chronic disease providers/sites. The minimal 200 required clinical hours are designed to help the paramedics bridge their knowledge and experience into the care of chronic and non-emergent patients.

Paramedics from Billings County EMS and Bowman Ambulance are registering to begin their initial Community Paramedic class beginning in August. The Community Paramedic subcommittee of the ND EMS Advisory Council has not received any other proposals for pilot sites. We had hoped to involve more ND EMS agencies in the pilot program and we will continue to encourage our licensed ambulance providers to consider participation in the pilot program.

Other areas of activity include the continuing development of the administrative rules that will give legal recognition to Community Paramedics in North Dakota. We have also begun making overtures to third party payers like Blue Cross and Medicaid in hopes of securing potential reimbursement for the services provided by Community Paramedics. Representatives of the DEMST will be providing testimony before ND Legislative Health Services Committee at the end of July to update them on the progress of the pilot program.

If you want to know more, please contact Ken Reed, Community Paramedic Coordinator at kreed@nd.gov.

Things to Remember about Agency Licensure
By: Kelli Sears, State EMS Training Coordinator

October is quickly approaching and with that comes the lingering expiration date of ambulance service licensure for North Dakota. Let's take a few moments to review the licensing process and some tips to make the whole process quicker and easier.

Ambulance service licensure will expire at midnight on October 31st of this year. Renewal of this license is biennial and will have an October 31, 2016 expiration date. The license applications will be sent out to each ambulance service around the beginning of September to allow ample time for completion and submission. The application is also available online at http://www.ndhealth.gov/ems/forms.htm. Here you can fill the pdf application out online and print it when you are finished. Licensing fees are fifty dollars per headquarters station and fifty dollars per substation. Payments should be sent in with the license application.

The process of filling out the application can be simplified by having both vehicle rosters and personnel rosters updated in Big Picture as these areas of the application can be left blank if they are up to date in the database. This can be done at any time by the squad leader by logging into Big Picture. Squad leaders may also want to consider letting their medical director know that you will be asking them to renew their medical director agreement as part of the license renewal process. This will give you an opportunity to set up an appointment with the medical director to have this completed as well as discuss, before time is critical, any unforeseen medical director changes or issues that may come up.

Once you have completed and submitted the application to the Division of EMS and Trauma you will be receiving the new license in the mail. Adhesive copies of the license will be provided for each ambulance on your vehicle roster. These should be displayed in a conspicuous place in the patient compartment of each ambulance

Along with the licensing, keep in mind the rules, regulations, and potential site visit that come along with it. Some important things to keep in mind:

- Headquarters ambulance services must be available 24/7
- Ambulance services must maintain a file that identifies at least two qualified personnel on a written call schedule for each staffed ambulance
- Every ambulance run must be reported to the department through electronic patient care reporting
- Ambulance services must have a trauma transport plan in place
- Ambulance services must have current written protocols developed and signed by their medical director
- The time from dispatch to the time the ambulance is en route is not to exceed 10 minutes (at least 90% of the time)
- BLS and ALS Ambulance services have minimum equipment standards that must be met

Full detailed versions of the rules and regulations can be found on the Division of EMS and Trauma website at http://www.ndhealth.gov/ems/Training/statutes.html.

Ambulance licensure is just around the corner so this is just a friendly reminder so there are no surprises or added stress when the time comes. Please feel free to contact the Division of EMS and Trauma if you have questions or concerns about the ambulance relicensure process.

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ATLS Instructor Course held at St. Alexius
By: Ruth Hursman, Trauma Coordinator

Advanced Trauma Life Support (ATLS) is a course taught by physicians emphasizing the life-saving skills necessary for physicians, nurse practitioners, and physician's assistants for the severely injured patient. For the first time, an ATLS Instructor Course was held at St. Alexius Medical Center in Bismarck. Nine instructor hopefuls from around the state gathered with certified ATLS faculty to participate in the two-day event. They learned about adult learning principles and how to best facilitate the learning process of ATLS students. "ATLS is a course that truly has the ability to save a life" stated Randy Szlabick, MD, FACS Chairman of the North Dakota American College of Surgeons Committee on Trauma.

Facebook Roundup

- Spirit Lifeline helicopter pulled service from Dickinson, but Valley Med Flight has agreed to base a medical helicopter in Dickinson.
- Safety is always a priority. Great resources were shared on the death risk of children in hot cars, fireworks injuries, drowning, and having a severe weather plan.
- EMS Week was celebrated in May along with EMS for Children Day. A video of ND personnel talking about their experience was shared and reached over 2,500 people through Facebook. Tom and Elizabeth were also interviewed by Prairie Public and KFYR.
- A NHTSA report, Safety in Numbers, was shared that talks about how EMS data saves lives.
- http://www.nemsis.org/documents/SafetyInNumbers_EMS_May2014.pdf.
- Several articles were posted about North Dakota hospitals talking about the increased use of telemedicine as well as expansion projects that are going on to meet growing demands.
- A Critical Incident Stress Management Course is coming up August 18-21st. For more information, go to http://ndhealth.gov/EMS/pdfs/August2014.pdf.
- The ND HealthCare Emergency Preparedness Conference is August 21st in Bismarck. You can register at http://ndhealth.gov/EPR/HP/hppconference/.

You don't have to be a member on Facebook to view the division's Facebook page. Just type facebook.com/NDDEMST into your internet browser.

facebook

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