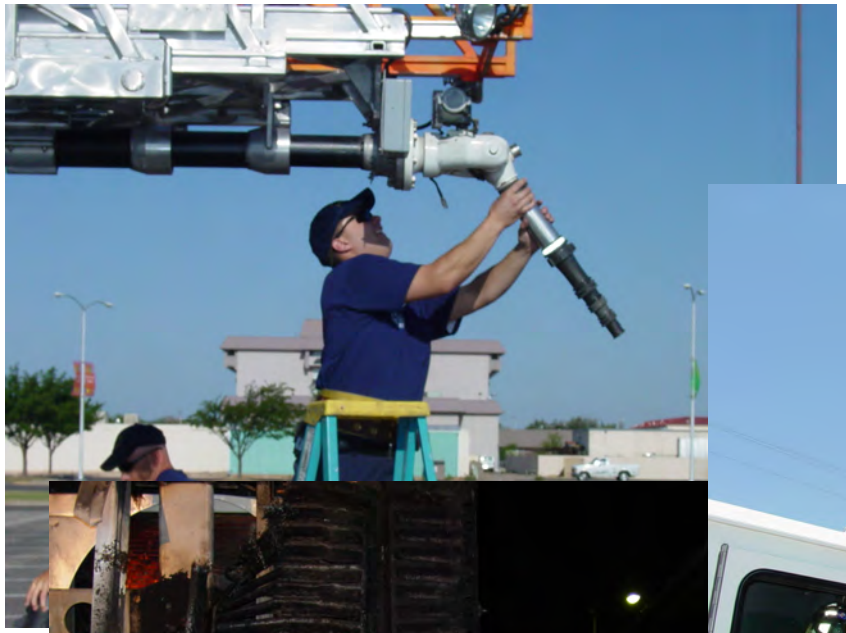

2024 TFCA ANNUAL CONFERENCE
LEADING INTO THE FUTURE
MARCH 19-22, 2024
WACO CONVENTION CENTER

A Fire Chief and a Medical Director Walk Into a Bar…

But first…a little context.

The best job in the world…



LUBBOCK FIRE•RESCUE LFD 1909


MORGAN'S POINT RESORT
LADDER COMPANY 61


ENGINE
61
FIRE
E61


MORGAN'S POINT
RESORT


TAKE10
MINUTES TO LEARN COMPRESSION ONLY CPR
MORGAN'S POINT RESORT FIRE
SQUAD
61


MORGAN'S POINT RESORT FIRE
EST.
1974
BATTALION
ENGINE
LADDER
SQUAD


HONDA


100
200
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EMT
624

A Fire Chief and a Medical Director Walk Into a Bar…

Option #1…

Or we can choose from these…or both!

- What should my EMS medical director be doing for me?
- What training should my medical director have?
- What should my org chart look like with my EMS doc?
- How comfortable are you with TAC 157? It doesn't matter for FROs right?
- Can something happen in our department like what happened to Elijah McLain?
- Lift assist calls = low liability as long as I'm just picking them up…
- Anything else you want to talk about…
  - EMS is 85% of what we do…
  - Is my NFIRS report an EMS report…
  - Why do I have 9 million NFIRS reports and 300 medical reports…

What should my medical director be doing for me?

Texas Administrative Code

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 157	EMERGENCY MEDICAL CARE
SUBCHAPTER B	EMERGENCY MEDICAL SERVICES PROVIDER LICENSES
RULE §157.11	Requirements for an EMS Provider License

(M) Completed Medical Director Information Form.

(N) Treatment and Transport Protocols and policies addressing the care to be provided to adult, pediatric, and neonatal patients, and as stated in Health and Safety Code §773.112(d), must be approved and signed by the medical director.

(O) A list of equipment as required on the EMS Provider initial and renewal application, with identifiable or legible serial numbers, supplies and medications; approved and signed by the medical director.

(60) Off-line medical direction - The licensed physician who provides approved protocols and medical supervision to the EMS personnel of a licensed EMS provider under the terms of the Medical Practices Act (Occupations Code, Chapters 151 - 165) and a rules promulgated by the Texas Medical Board (22 Texas Administrative Code, §197.3).

Texas Administrative Code

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 157	EMERGENCY MEDICAL CARE
SUBCHAPTER A	EMERGENCY MEDICAL SERVICES - PART A
RULE §157.2	Definitions

(a) An off-line medical director shall be:

(1) a physician licensed to practice in Texas and shall be registered as an EMS medical director with the Texas Department of State Health Services;

(2) familiar with the design and operation of EMS systems;

(3) experienced in prehospital emergency care and emergency management of ill and injured patients;

(4) actively involved in:

(A) the training and/or continuing education of EMS personnel, under his or her direct supervision, at their respective levels of certification;

(B) the medical audit, review, and critique of the performance of EMS personnel under his or her direct supervision;

(C) the administrative and legislative environments affecting regional and/or state prehospital EMS organizations;

(5) knowledgeable about local multi-casualty plans;

(6) familiar with dispatch and communications operations of prehospital emergency units; and

(7) knowledgeable about laws and regulations affecting local, regional, and state EMS operations.

(b) The off-line medical director shall be required to:

(1) approve the level of prehospital care which may be rendered locally by each of the EMS personnel employed by and/or volunteering with the EMS under the medical director's supervision, regardless of the level of state certification or licensure, before the certificant or licensee is permitted to provide such care to the public;

(2) establish and monitor compliance with field performance guidelines for EMS personnel;

(3) establish and monitor compliance with training guidelines which meet or exceed the minimum standards set forth in the Texas Department of State Health Services EMS certification regulations;

(4) develop, implement, and revise protocols and/or standing delegation orders, if appropriate, governing prehospital care and medical aspects of patient triage, transport, transfer, dispatch, extrication, rescue, and radio-telephone-telemetry communication by the EMS;

(5) direct an effective system audit and quality assurance program;

(6) determine standards and objectives for all medically related aspects of operation of the EMS including the inspection, evaluation, and approval of the system's performance specifications;

(7) function as the primary liaison between the EMS administration and the local medical community, ascertaining and being responsive to the needs of each;

(8) develop a letter or agreement or contract between the medical director(s) and the EMS administration outlining the specific responsibilities and authority of each. The agreement should describe the process or procedure by which a medical director may withdraw responsibility for EMS personnel for noncompliance with the Emergency Medical Services Act, the Health and Safety Code, Chapter 773, the rules adopted in this chapter, and/or accepted medical standards;

(9) take or recommend appropriate remedial or corrective measures for EMS personnel, in conjunction with local EMS administration, which may include, but are not limited to, counseling, retraining, testing, probation, and/or field preceptorship;

(10) suspend a certified EMS individual from medical care duties for due cause pending review and evaluation;

(11) establish the circumstances under which a patient might not be transported;

(12) establish the circumstances under which a patient may be transported against his or her will in accordance with state law, including approval of appropriate procedures, forms, and a review process;

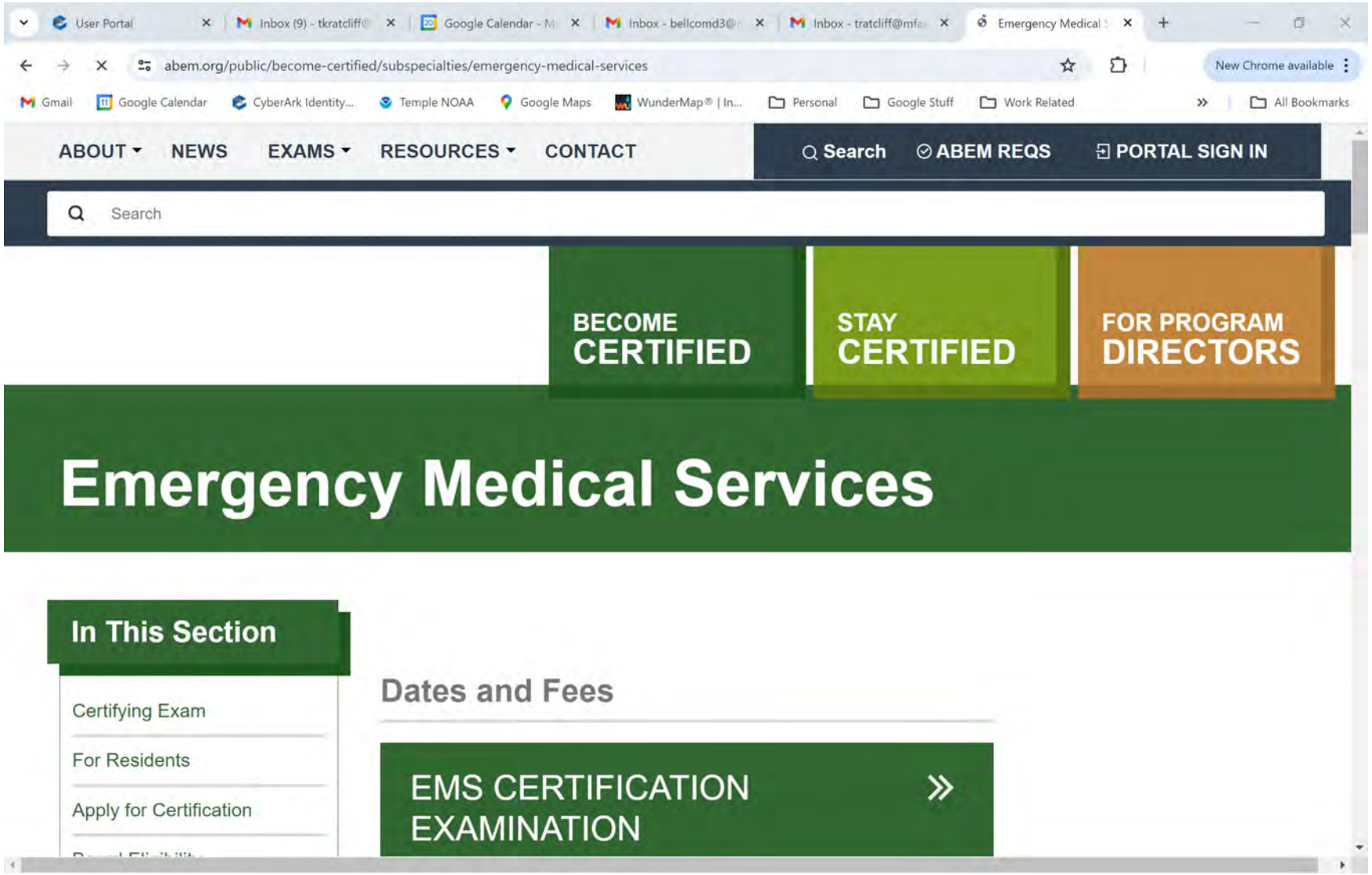
(13) establish criteria for selection of a patient's destination;

(14) develop and implement a comprehensive mechanism for management of patient care incidents, including patient complaints, allegations of substandard care, and deviations from established protocols and patient care standards;

(15) only approve care or activity that was provided at the time the medical director was employed, contracted or volunteering as a medical director;

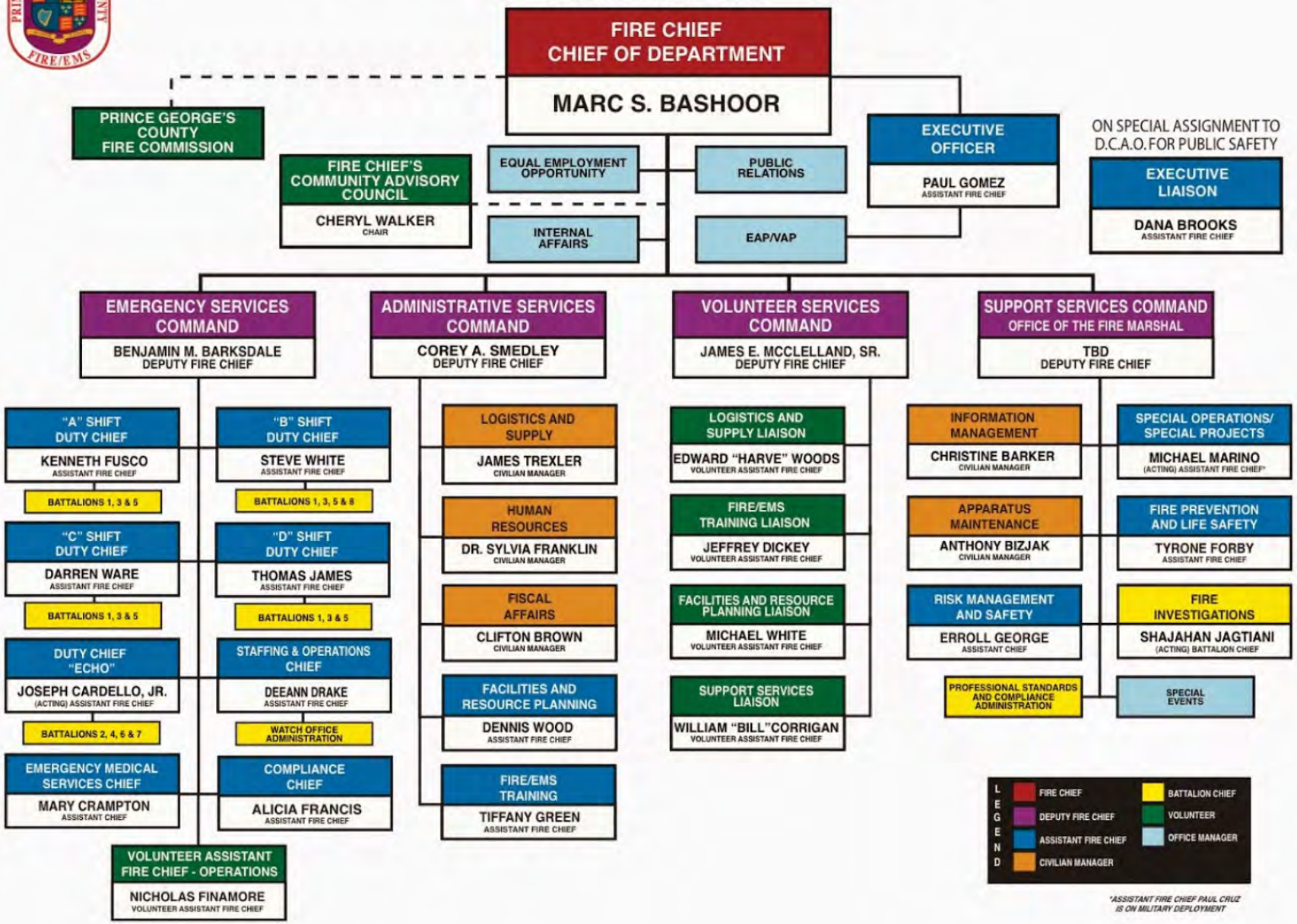
(16) notify the board at time of licensure registration under §166.1 of this title (relating to Physician Registration) of the physician's position as medical director and the names of all EMS providers for whom that physician holds the position of off-line medical director;

Training for my medical director?



PRINCE GEORGE'S COUNTY FIRE/EMS DEPARTMENT
ORGANIZATIONAL STRUCTURE

EFFECTIVE JANUARY 11, 2015



Does TAC 157 matter for FROs?

Does TAC 157 matter for FROs?

(e) Responsibilities of the FRO. During the license period the FRO's responsibilities shall include:

(1) assuring ongoing compliance with the terms of all EMS provider agreement(s);

(2) assuring the existence of and adherence to a quality assurance plan which shall, at a minimum, include:

(A) the standard of patient care and the medical director's protocols;

(B) pharmaceutical storage;

(C) readiness inspections;

(D) preventive maintenance of medical equipment and vehicles owned by the FRO;

(E) policies and procedures;

(F) complaint management; and

(G) patient care reporting and documentation;

Texas Administrative Code

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 157	EMERGENCY MEDICAL CARE
SUBCHAPTER B	EMERGENCY MEDICAL SERVICES PROVIDER LICENSES
RULE §157.14	Requirements for a First Responder Organization License

Does TAC 157 matter for FROs?

How is your QA/QI plan? Or to start, how good is your documentation?

Lessons Learned From EMS Documentation Legal Case Studies

(4 min read) Emergency Medical Service (EMS) documentation continues to be one of the most vexing challenges for EMS practitioners and agency leaders alike.

Doug Wolfberg, Founding Partner and Attorney at Law, Page, Wolfberg & Wirth
Nov 2, 2021

(4 min read) Emergency Medical Service (EMS) documentation continues to be one of the most vexing challenges for EMS practitioners and agency leaders alike. Good documentation is essential to reducing legal risk, ensuring proper and accurate reimbursement, collecting valid data, and maintaining agency compliance. Poor documentation can raise risks in all these areas for EMS agencies.

Paramedic gets 5 years in prison for Elijah McClain's death in rare case against medical responders

DENVER (AP) — A Colorado paramedic was sentenced Friday to five years in prison for the death of Elijah McClain in a rare prosecution of medical responders that has left officials rethinking how they treat people in police custody.

> Firefighters and officials from their union have criticized the state's prosecution of Cichuniec and said it was discouraging firefighters from becoming paramedics, decreasing the number of qualified personnel in emergencies and thereby putting lives at risk.
>
> "Convicting Pete for the death is not justice. It's the very definition of a scapegoat," said former Aurora Fire Lieutenant John Lauder, who recently retired after working with Cichuniec over two decades. "But for the grace of God, it could be us in jail. The result of this decision will have a negative impact on patient care throughout the nation. Will paramedics now be held be held responsible for outcomes beyond their control?"

“It’s just a **lift assist** call

1 – You run a ton (that’s a lot) of lift assist calls.

2 – We are missing things and need to be careful.

3 – Your documentation shall set you free.

So how many?

So how many?

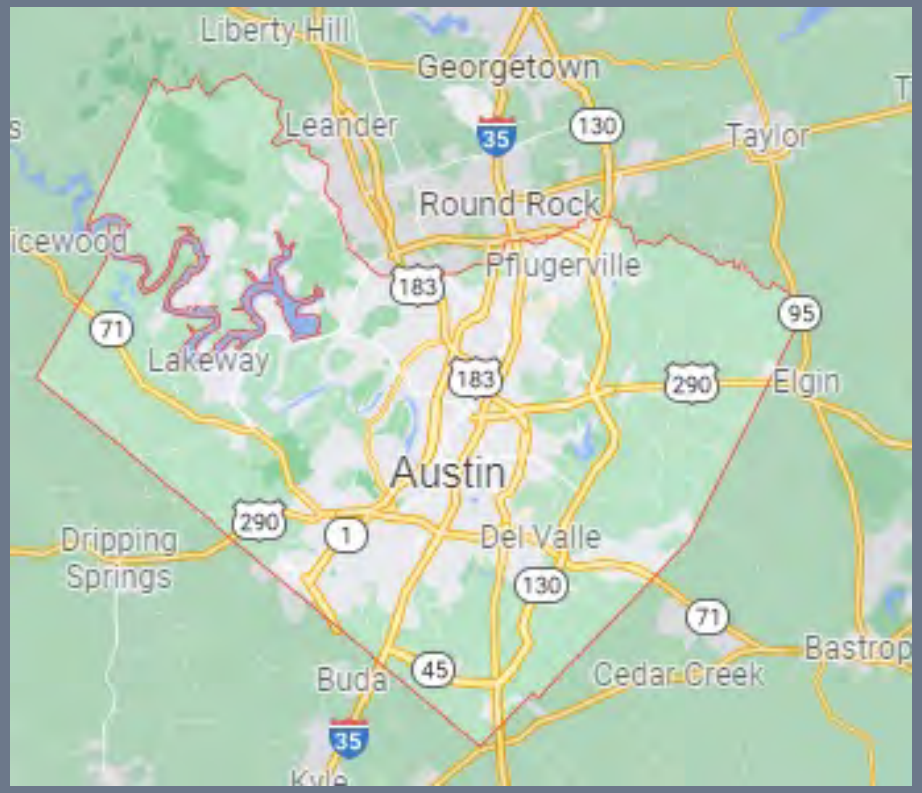
35.6 million estimated falls

8.4 million fall related injuries (10.2%)

So how many?

88

day



32250

year

A descriptive study of the "lift-assist" call

David C Cone [1], John Ahern, Christopher H Lee, Dorothy Baker, Terrence Murphy, Sandy Bogucki

Affiliations + expand

PMID: 22971148 DOI: 10.3109/10903127.2012.717168

Results: From 2004 through 2009, there were 1,087 LA responses (4.8% of EMS incidents) to 535 different addresses. Two-thirds of the LA calls (726; 66.8%) were to one-third of these addresses (174 addresses; 32.5%); 563 of the return calls to the same address occurred within 30 days after the index LA. For 214 of these return visits, it was possible to compare patient age and sex with those associated with the initial LA, revealing that 85% of return visits were likely for the same patients. Of these, 38.5% were for another LA/refusal of transport, 8.2% for falls and other injuries, and 47.3% for medical complaints. Hospital transport was required in 55.5% of these return visits. The EMS crews averaged 21.5 minutes out of service per LA call.

Conclusion: Lift-assist calls are associated with substantial subsequent utilization of EMS, and should trigger fall prevention and other safety interventions. Based on our data, these calls may be early indicators of medical problems that require more aggressive evaluation.

Prehosp Emerg Care. Sep-Oct 2017;21(5):556-562. doi: 10.1080/10903127.2017.1308607. Epub 2017 Apr 19.

Morbidity and Mortality Associated with Prehospital "Lift-assist" Calls

Lauren Leggatt, Kristine Van Aarsen, Melanie Columbus, Adam Dukelow, Michael Lewell, Matthew Davis, Shelley McLeod

PMID: 28422537 DOI: 10.1080/10903127.2017.1308607

Results: Of 42,055 EMS calls, 804 (1.9%) were LAs. These calls were for 414 individuals; 298 (72%) patients had 1 LA, and 116 (28%) patients had >1 LA call. There were 169 (21%) ED visits, 93 (11.6%) hospital admissions and 9 (1.1%) deaths within 14 days of a LA call. Patient age (p = 0.025) significantly predicted ED visit. Patient age (p = 0.006) and an Ambulance Call Record missing at least 1 vital sign (p = 0.038) significantly predicted hospital admission.

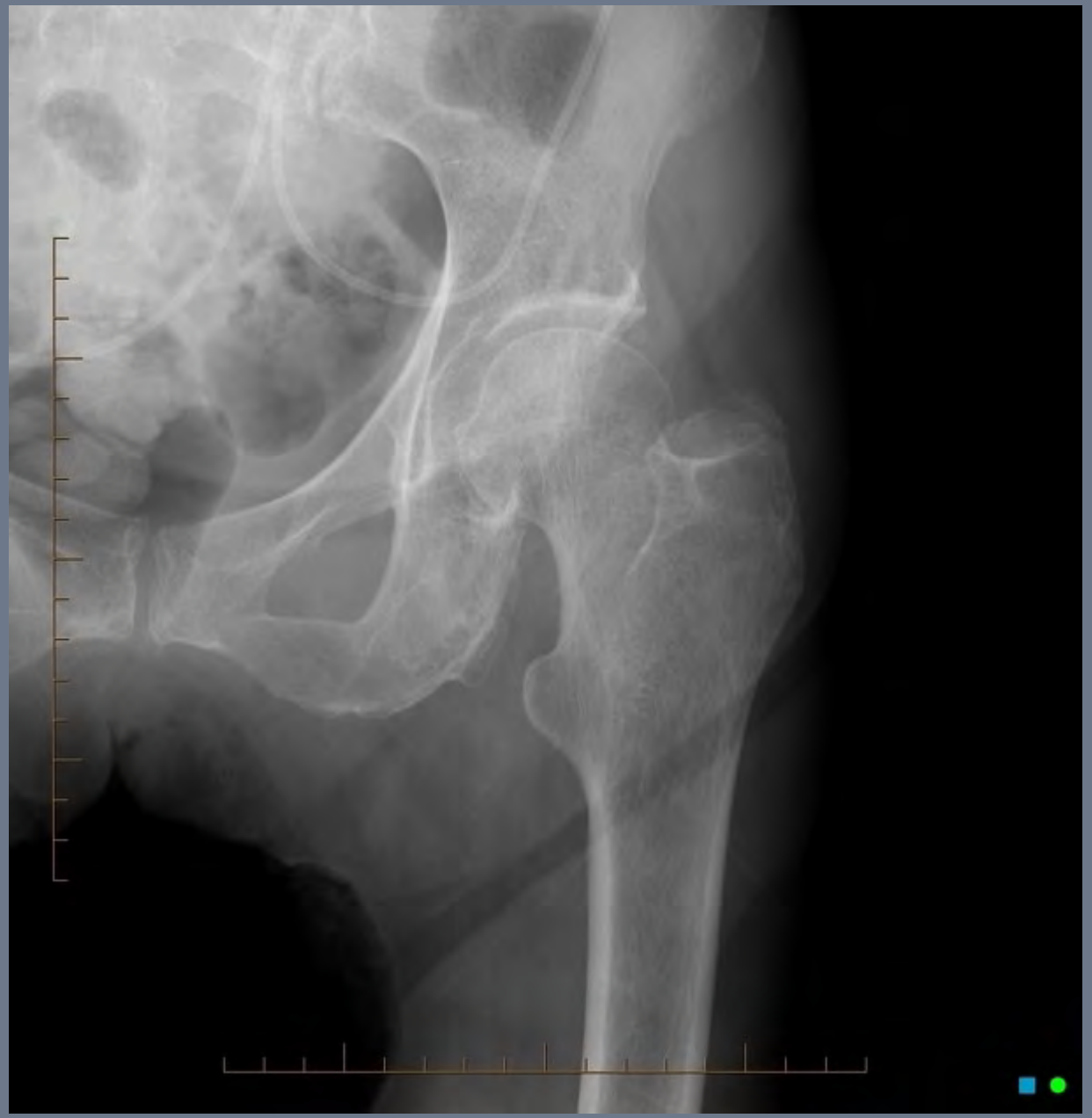
Conclusions: LA calls are associated with short-term morbidity and mortality. Patient age was found to be associated with these outcomes. These calls may be early indicators of problems requiring comprehensive medical evaluation and thus further factors associated with poor outcomes should be determined.

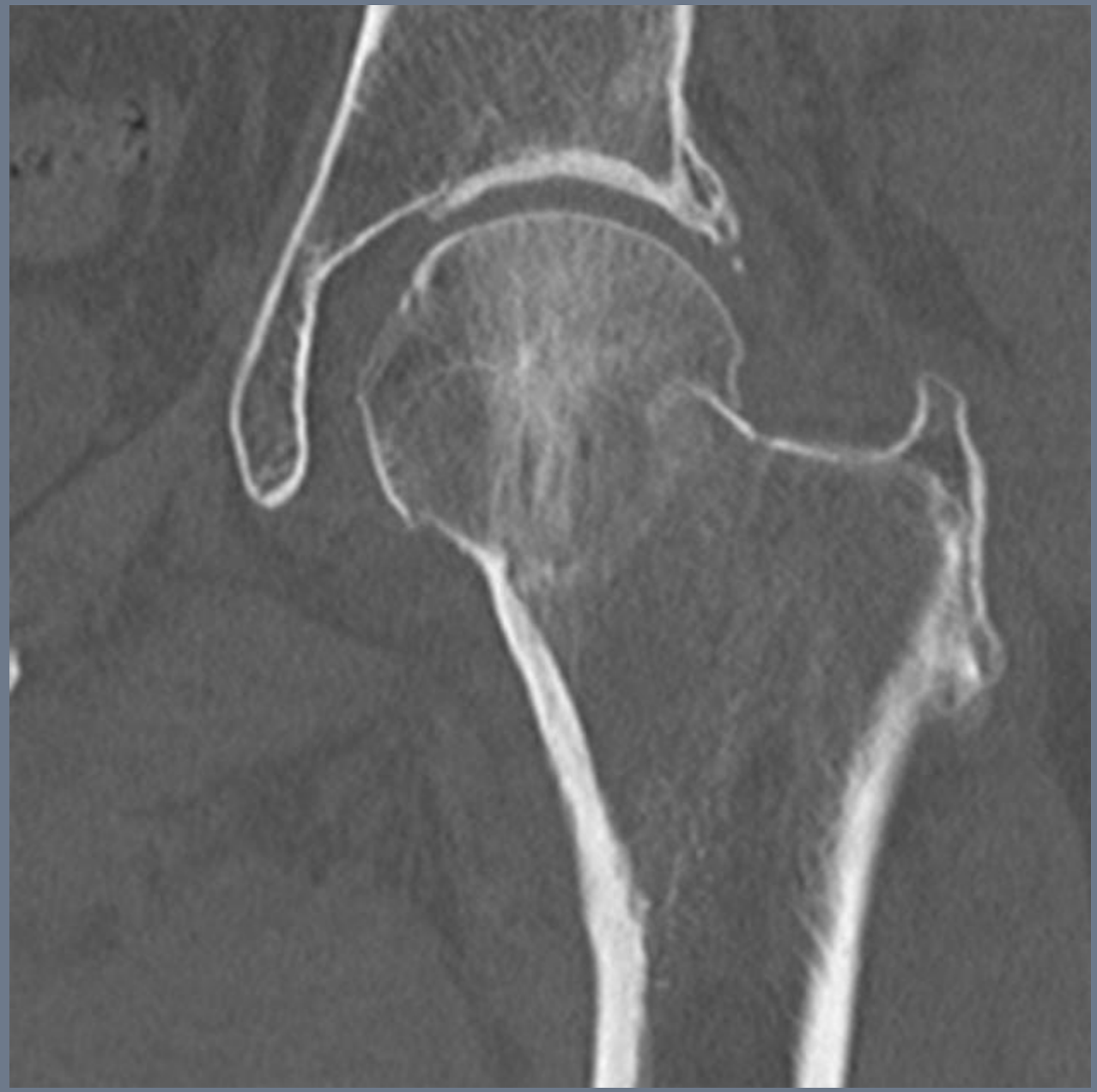
1 – You run a ton (that’s a lot) of lift assist calls.

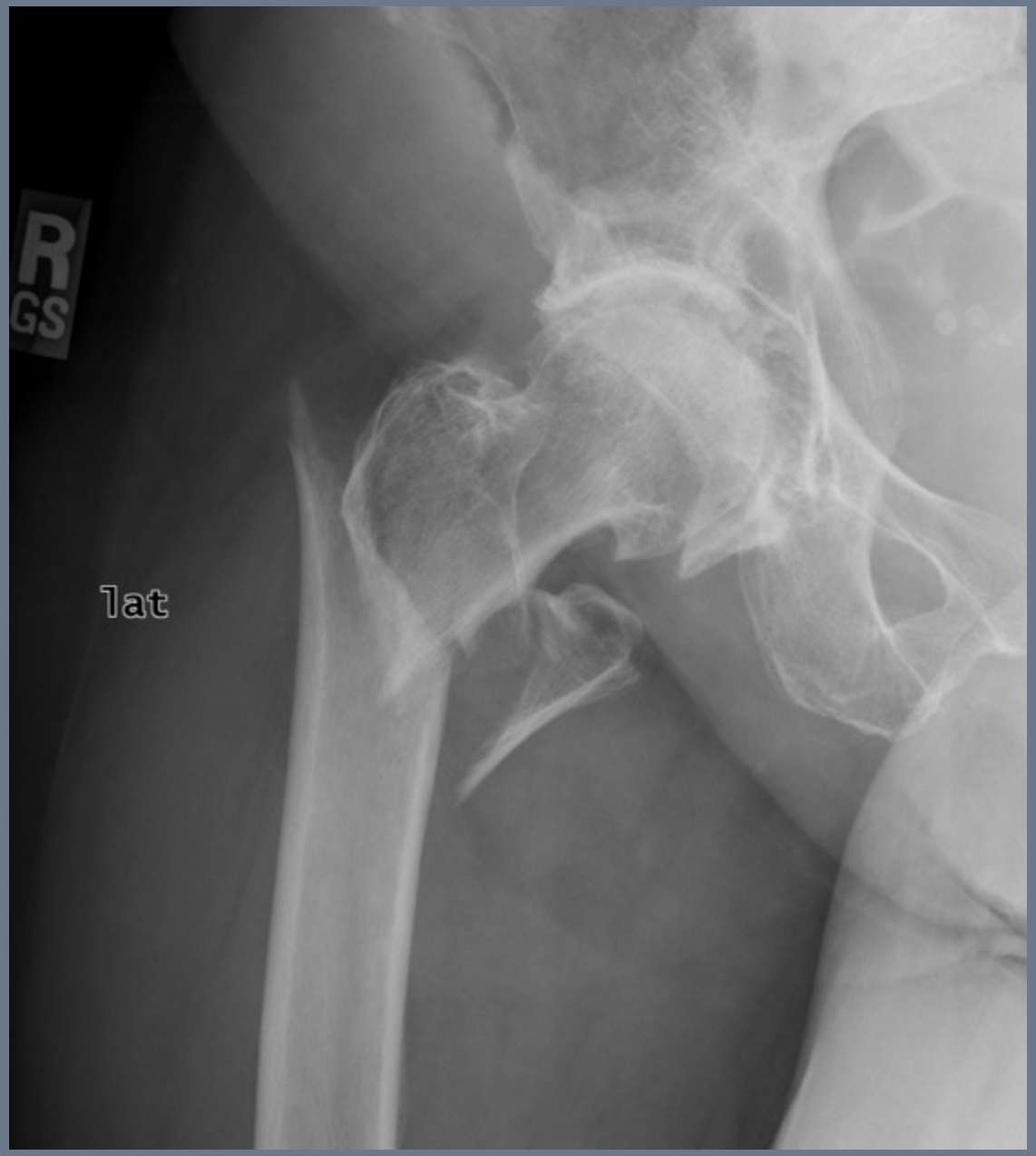
2 – We are missing things and need to be careful.

3 – Your documentation shall set you free.

What are we missing?



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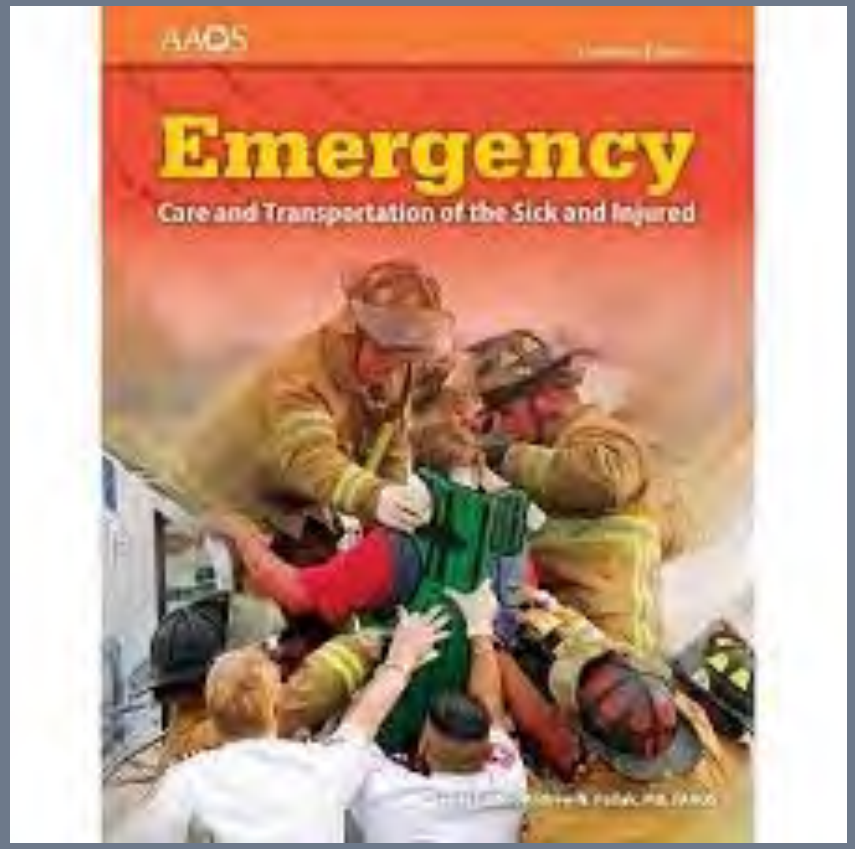


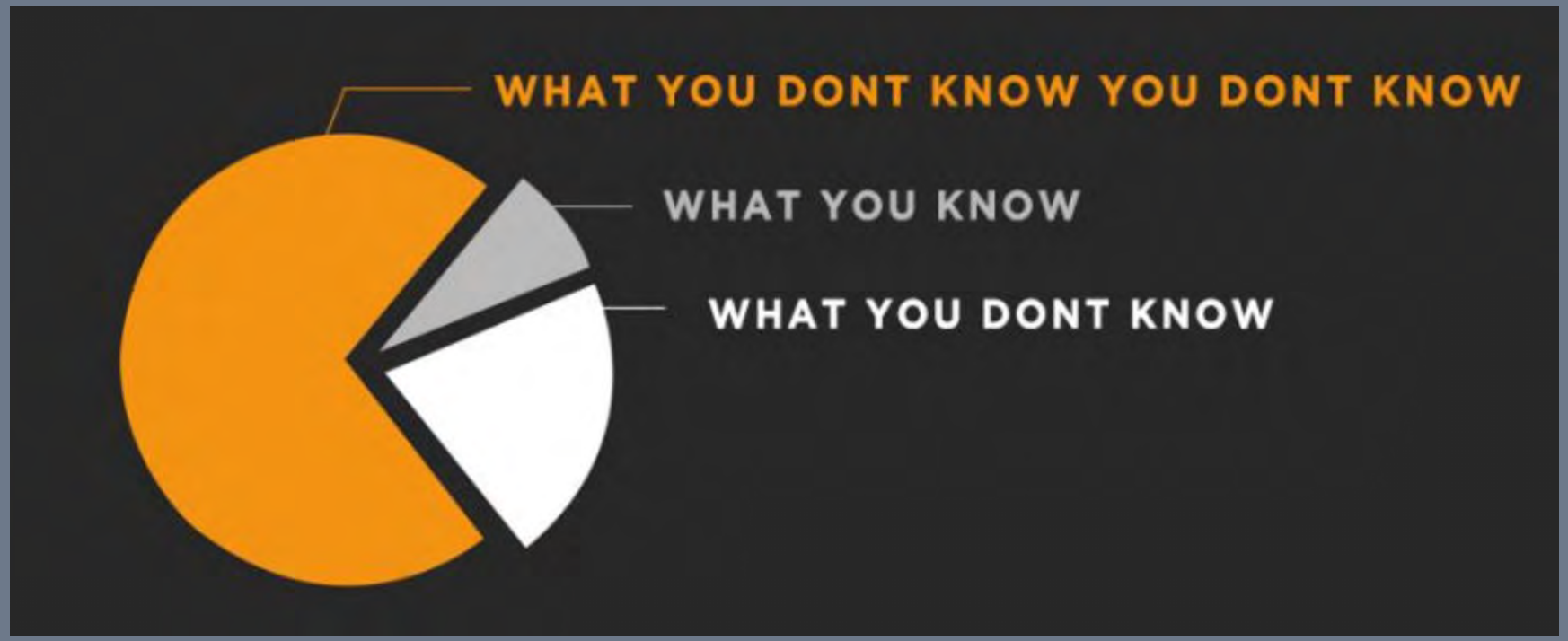
Older people don’t feel pain the same was as younger people.

Mental impairment can make communicating pain harder.

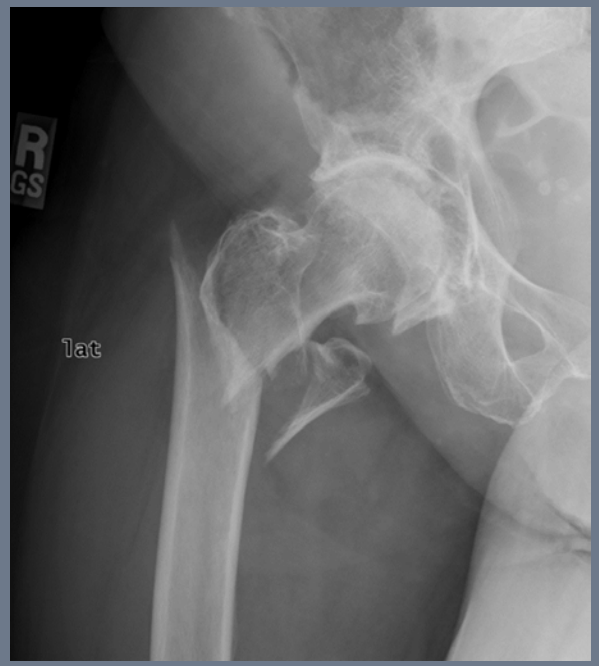
Medications can mask injuries and pain.

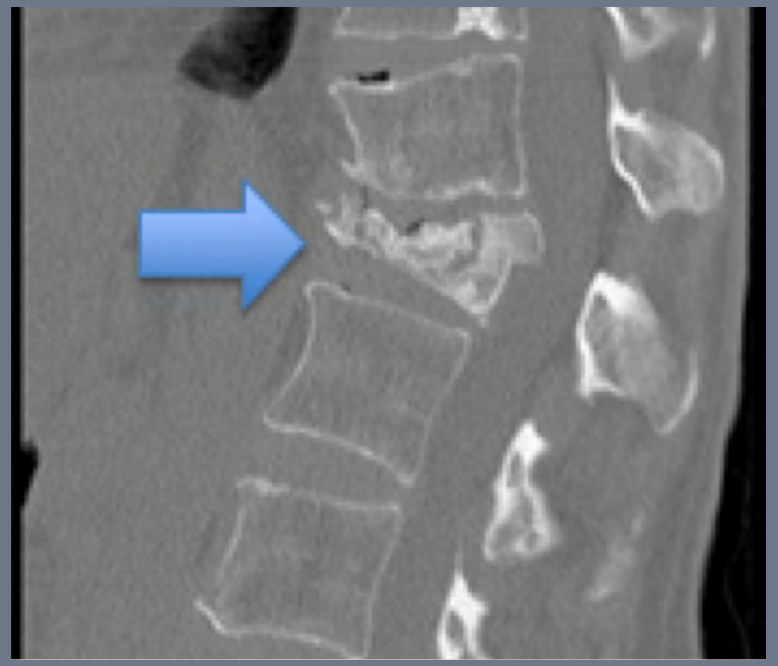
Older patients may pretend to be fine out of fear of being removed from their home.

The Organs of the Elderly Weep Softly

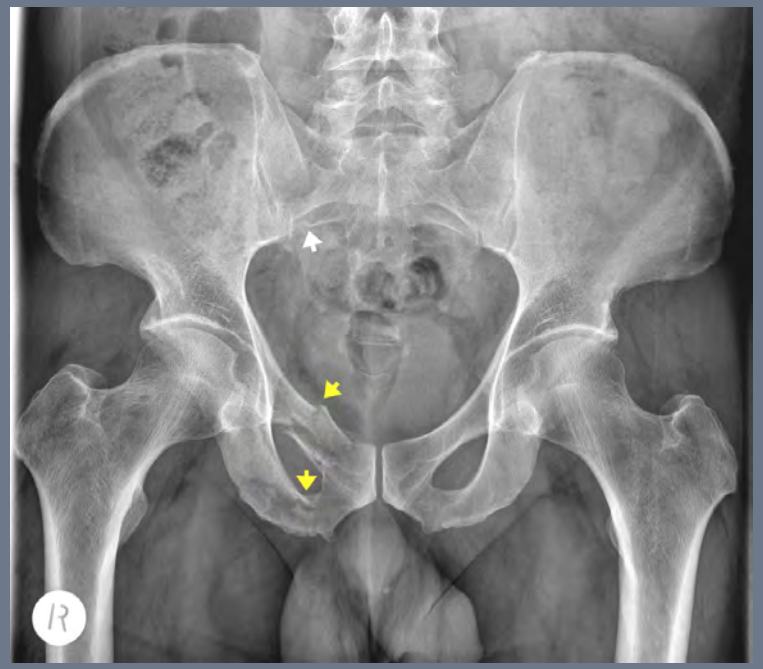

WHAT YOU DONT KNOW YOU DONT KNOW
WHAT YOU KNOW
WHAT YOU DONT KNOW

Things We Don't Find





Things We Don't Find



Things We Don't Check For

Morbidity and Mortality Associated with Prehospital "Lift-assist" Calls

Lauren Leggatt, MD, Kristine Van Aarsen, MSc, Melanie Columbus, PhD,

Of the ACRs examined, 113 (14.0%) were noted to be missing at least one vital sign. Regarding those charts with missing documentation, 28 (24.8%) were missing more than one vital sign and 44 (27.5%) of 160 calls were missing a blood glucose (BG) in diabetic patients. The most common vital signs missing was temperature, missing from documentation on 105 (13.0%) calls (Table 4). Of these missing vital signs and blood glucose omissions, only 15 (15.4%) and 3 (1.9%) were explained by patient refusal.

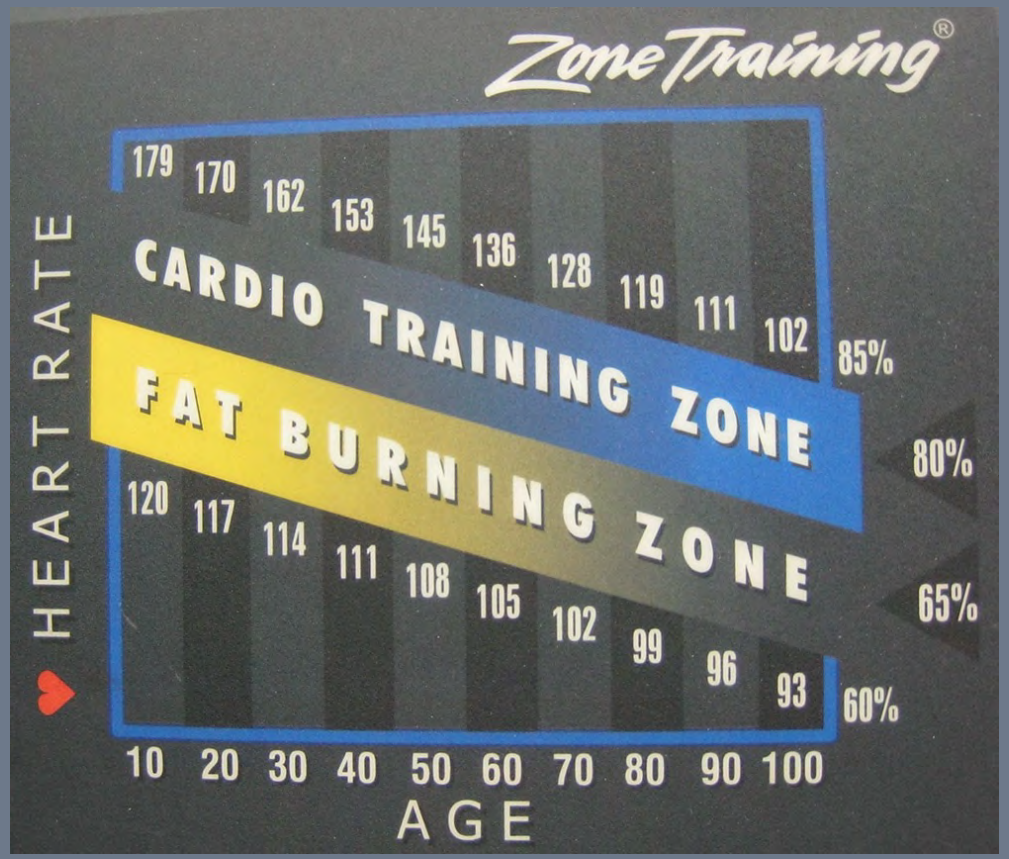
Table 3. Vital sign abnormalities in the lift assist population

Vital sign	Number (%) of calls
Bradycardia	14 (1.7)
Tachycardia	86 (10.7)
Hypotension	12 (1.5)
Hypertension	276 (34.3)
Extreme hypertension	16 (2.0)
Hypoxia	1 (0.1)
Extremes of temperature	49 (6.1)

Table 2. Discharge diagnosis sub-type of patients admitted to hospital within 14 days of LA call

Discharge Diagnosis	Number (%)
Infection	31 (33.3)
Fall	11 (11.8)
Cancer complication or new diagnosis of cancer	9 (9.7)
Fracture	8 (8.6)
Miscellaneous	34 (36.6)
Total	**93**


D6
67
MPH


ZoneTraining®
HEART RATE
179 170 162 153 145 136 128 119 111 102
CARDIO TRAINING ZONE
85%
80%
FAT BURNING ZONE
120 117 114 111 108 105 102 99 96 93
65%
60%
10 20 30 40 50 60 70 80 90 100
AGE


Xarelto
(rivaroxaban)
Tablets
10
Xa
15
Xa
20
Xa


Eliquis
(apixaban) tablets
5 mg
100 Tablets
NDC 0003-0894-31
(10 blister cards - 10 tablets in each blister card)
Eliquis®
(apixaban) tablets
5 mg
DISPENSE WITH MEDICATION GUIDE
Rx only
Bristol-Myers Squibb
Pfizer
60 Tablets
NDC 0003-0894-21
Eliquis®
(apixaban) tablets
5 mg
DISPENSE WITH MEDICATION GUIDE
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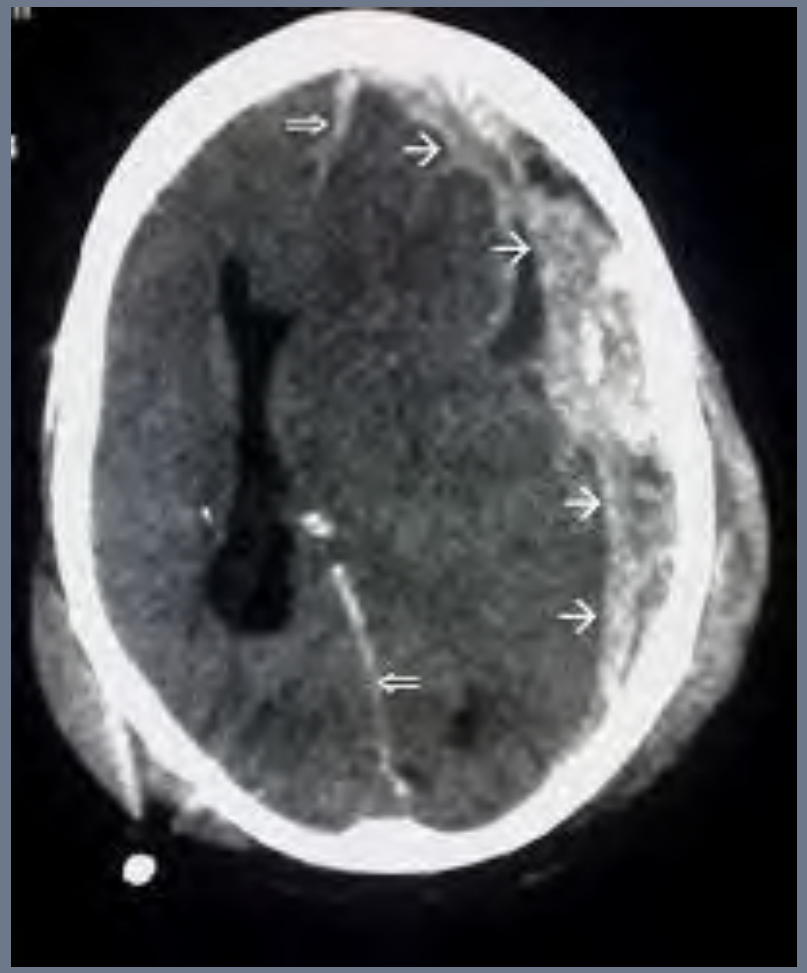
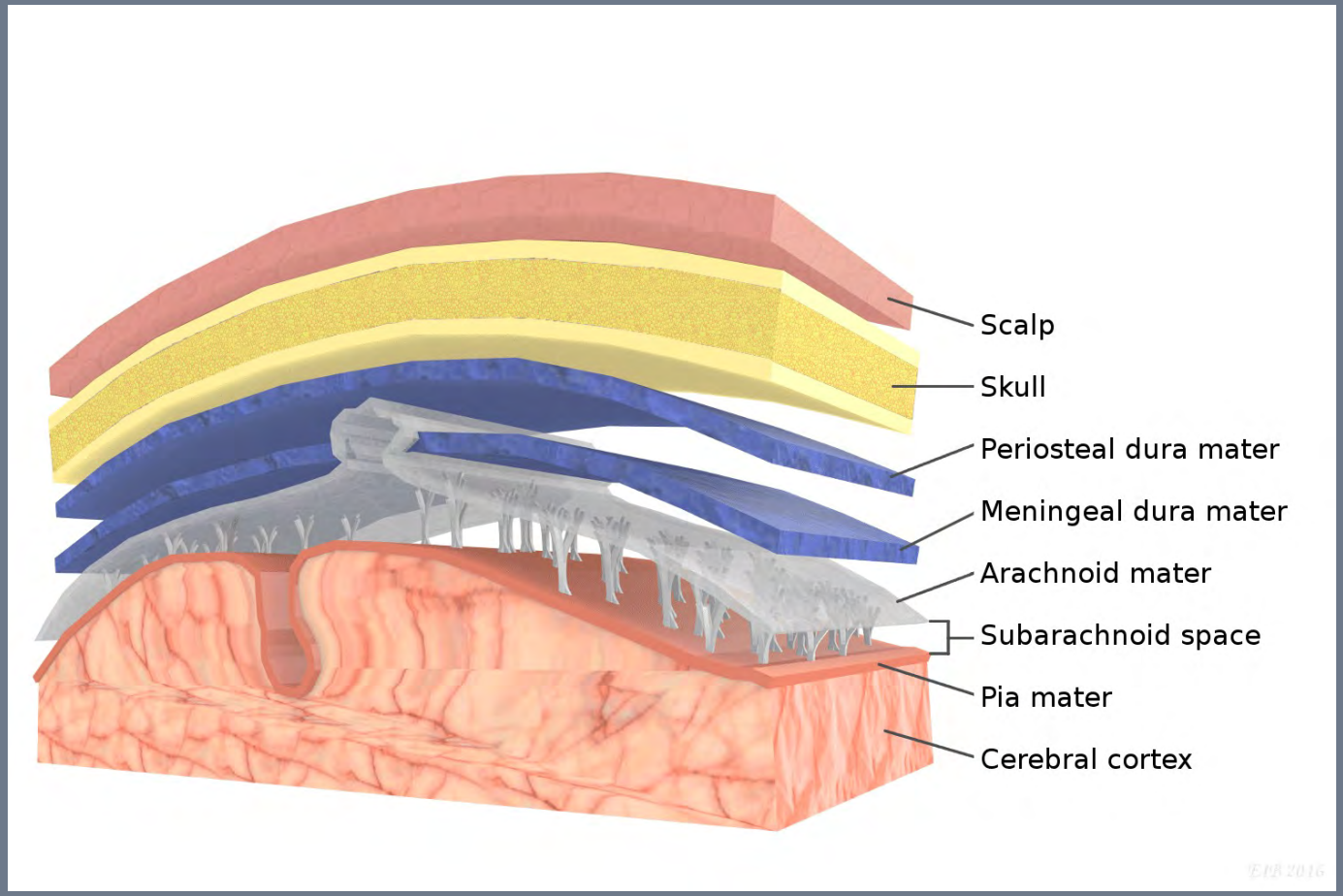
Pfizer




Scalp
Skull
Periosteal dura mater
Meningeal dura mater
Arachnoid mater
Subarachnoid space
Pia mater
Cerebral cortex

J Neurol Neurosurg Psychiatry. 1972 Oct; 35(5): 698–706.
doi: 10.1136/jnnp.35.5.698

Delayed traumatic intracerebral haemorrhage

Gopal Baratham and William G. Dennyson

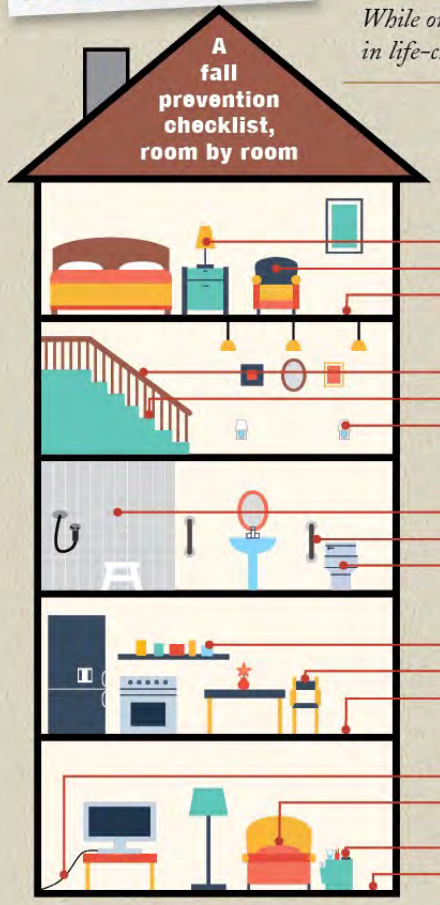
J Am Coll Emerg Physicians Open. 2020 Dec; 1(6): 1723–1728.
Published online 2020 Jul 22. doi: 10.1002/emp2.12198
PMCID: PMC7771793
PMID: 33392581

Development of a delayed chronic subdural hematoma 2 months after mild traumatic brain injury with a normal initial brain computed tomography: A case report

Michael Yih Chong Chia, MBBS[1]

Reduce your risk of falling at home

While one in three people over the age of 65 falls, often resulting in life-changing injuries, falls can happen to anyone.



Improve the safety of your home by following this step-by-step checklist.

BEDROOM

- ❑ Keep a light—a lamp, light switch or night-light—near your bed.
- ❑ Sit down to get dressed.
- ❑ Keep loose items off the floor.

STAIRS AND HALLWAYS

- ❑ Add handrails on both sides of the stairs.
- ❑ Install anti-slip strips on each stair.
- ❑ Install night-lights along the route from the bedroom to the bathroom.

BATHROOM

- ❑ Use a shower chair and handheld shower head while bathing.
- ❑ Install grab bars near toilet and shower.
- ❑ Put a riser seat on the toilet.

KITCHEN

- ❑ Move things so they're within easy reach.
- ❑ Use dining chairs that have armrests and no wheels.
- ❑ Don't clean with a high-gloss wax floor protector.

LIVING ROOM

- ❑ Move cords and other objects out of walkways.
- ❑ Use a cushion or a seat riser if your chair is too low to easily stand from.
- ❑ Keep frequently used items within reach.
- ❑ Remove throw rugs.

Good Samaritan Society®

For more information on health and well-being, visit good-sam.com/resources

SOURCES: https://nihseniorhealth.gov/falls/homesafety/01.html, http://www.mayoclinic.org/healthy-lifestyle/healthy-aging/in-depth/fall-prevention/art-20047358?pg=2

Ten years of EMS Fall Calls in a Community: An Opportunity for Injury Prevention Strategies

Carmen E. Quatman, MD, PhD,[1] Michael Mondor, BS, NRP,[2] Jodi Halweg, BS, NRP,[2] and Julie A. Switzer, MD[2]

Geriatric Orthopaedic Surgery & Rehabilitation | SAGE

Results:

Of the 38 237 EMS care responses in patients 60 years or older, 11.5% were related to falls. Fall calls increased by 268% over the past 10 years ($P = .0006$), yet the number of transports to the hospital significantly decreased over time ($P = .02$). Lift assists increased significantly ($P = .0003$), nearly doubling over the decade. At the same time, fall calls that did not result in transport to the hospital cost the community an estimated US$1.5 million over a 10-year period.

FLOORS: Look at the floor in each room.

Q: When you walk through a room, do you have to walk around furniture?

- ☐ Ask someone to move the furniture so your path is clear.

Q: Do you have throw rugs on the floor?

- ☐ Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.

Q: Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?

- ☐ Pick up things that are on the floor. Always keep objects off the floor.

Q: Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

BATHROOMS: Look at all your bathrooms.

Q: Is the tub or shower floor slippery?

- ☐ Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Q: Do you need some support when you get in and out of the tub or up from the toilet?

- ☐ Have grab bars put in next to and inside the tub and next to the toilet.

BEDROOMS: Look at all your bedrooms.

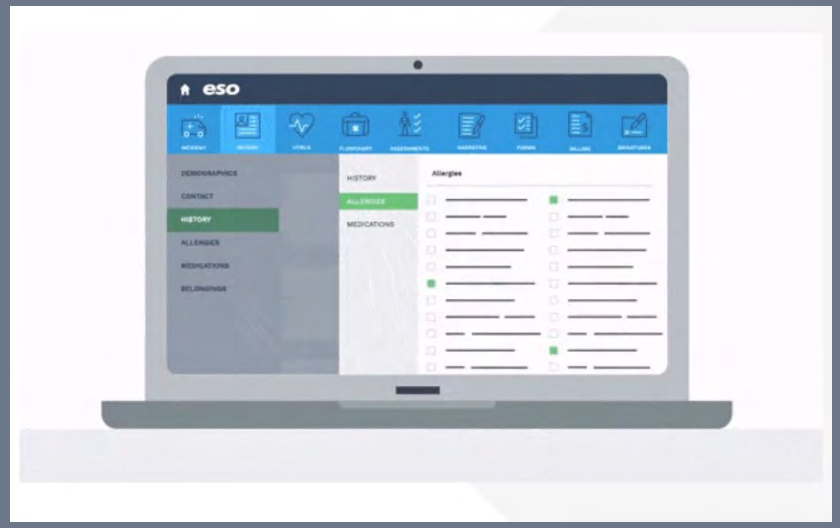
Q: Is the light near the bed hard to reach?

- ☐ Place a lamp close to the bed where it's easy to reach.

1 – You run a ton (that’s a lot) of lift assist calls.

2 – We are missing things and need to be careful.

3 – Your documentation shall set you free.


eso
DEMOGRAPHICS
CONTACT
HISTORY
ALLERGIES
MEDICATIONS
HISTORY
ALLERGIES
MEDICATIONS
Allergies

?

Things We Don't Document

?

1%

Things We Don't Document

1 %

Head, neck, back, hips.

Vital signs – FULL SET!

Neuro exam. Walk the patient.

Emergency plan for pt.

INFORMED refusal (what?)

Follow-up plan.

Caveat

LIFT ASSIST CHECKLIST

E | This checklist is intended to help the responder ensure that patients who are requesting a typically thought benign 'lift assist', get appropriate evaluation and advice on management and seeking care. First responders finding abnormal items below should strongly consider having an ambulance dispatched to assist or contact OLMC for advice. | E

STEP ONE – Physical Exam

- ❑ On arrival do what you can to help the patient be comfortable in the position found, i.e. pad head, move limbs, etc.
- ❑ Perform a good physical exam focusing on head, spine, pelvis, hips and extremities. Look for pain or deformity.
- ❑ If obvious injury found, stop and strongly encourage patient to be treated via normal protocol not lift assist.
- ❑ If no obvious injury, use an appropriate team lifting technique and get the patient up off of the ground to a chair or bed, etc.

STEP TWO – Medical History

- ❑ Get a good story about the fall, was this a slip and trip or did the patient have syncope and lose consciousness. Key clues for syncope include the patient not knowing what happened, not remembering hitting the ground or not being sure how long they have been on the floor. Any suspected syncope patient should be encouraged to be evaluated at the hospital.
- ❑ Get a good medical history, any concerning medical problems such as severe osteoporosis, recent surgery or other factors that would make a fall injury worse? Any recent illness that might cause falls such as not eating, diarrhea, etc.?
- ❑ Get a good medication history. Especially ask about blood thinning medications like Coumadin, Xarelto, Eliquis, etc. Any patient with a fall and a sudden stop or direct head trauma should be encouraged to be seen immediately in the ER. Ask about any 'new' medications or dosing changes, especially to BP, diabetes and sedating or pain medications.

STEP THREE – Vital Signs

- ❑ Obtain a full set of vital signs including BP, HR, RR and SaO2. If any concern about fever or infection, obtain a temperature as well.
- ❑ Blood sugar should be evaluated in patients with diabetes or patients with some component of altered mental status.
- ❑ End tidal CO2 should be checked in patients with any respiratory complaints or history of high CO2.
- ❑ 12-lead EKG should be obtained in any patient with chest pain or anginal equivalents or those with a 'story' sounding more like syncope.
- ❑ Orthostatic vital signs should be obtained in any patient with postural dizziness or history of volume losses or new medications that might affect blood pressure.
- ❑ Patients with abnormal vital signs for age should be strongly encouraged to allow transport and evaluation in the ER.

STEP FOUR – Capacity & Activities of Daily Living (ADLs)

- ❑ Make sure they have capacity to make a decision. Verify they are alert and oriented and ask some additional questions such as; 'How many quarters are in a dollar?', 'Can you count forward from zero by sevens?', 'Can you tell me the days of the week backwards starting with Sunday?' These questions help evaluate cognitive ability as well.
- ❑ If no injury has been detected and the patient normally can ambulate, ask them to walk a few steps with their normal assistive devices (cane, walker, etc.). Look for new or abnormal gait problems, unsteadiness, weakness. Any new deficits may be a sign of a stroke or other neurologic problem, they should be evaluated in the ER.
- ❑ Can the patient do their own ADLs and manage their own care at their normal baseline?

STEP FIVE – Evaluate Home Care Resources

- ❑ If there are family members or other caretakers present, involve them in the discussion and make sure everyone feels comfortable with the patient remaining at home.
- ❑ If no one else is present, verify that someone will be or can come to help the patient soon if they need assistance and someone to check on them.
- ❑ Ensure the patient has access to their phone (charged) or any medical alert devices they normally use.
- ❑ Perform a quick immediate home safety inspection looking for any slip, trip or lighting issues that can be rapidly remedied. Give the patient a pair of no slip socks if indicated.
- ❑ Offer transport one additional time and if declined obtain patient care refusal documentation.

C/O Dr. Bryan Everitt