Developments of EMS Medical Direction During a Disaster in Texas

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OBJECTIVES

- Understand scope of practice as it pertains to EMS and other health personnel during a disaster
- Understand potential differences in scope of practice and skill of responders from different jurisdictions
- Understand Texas regulations concerning EMS Medical Direction and Medical Direction in a disaster
- Understand the different roles and issues for the local EMS Medical Director during a disaster
- Discuss Texas specific programs and initiatives for EMS during a disaster
SCOPE OF PRACTICE IN EMS

Dr. Craig Cooley
“SCOPE OF PRACTICE”

- Legal description
  - Distinguishes between licensed health care personnel and the lay public
  - Distinguishes between different licensed health care professionals
    - Exclusive or overlapping domains of practice
    - EMS—depends on definition of “pre-hospital”
      - May be written or interpreted narrowly
        - Paramedics in EDs
**SCOPE OF PRACTICE**

- Describes authority, *vested by a state*, in **licensed** individuals practicing within that state
  - Statute, rules, or regulations
  - Precedent
  - Licensure board interpretation
- Establishes which activities and procedures represent illegal activity if performed **without** a license
SURVEY

- How many Licensed Paramedics?
- How many Certified Paramedics?
**Certification**
- Time-limited recognition and use of a credential to an individual after verifying that he/she has met predetermined and standardized criteria
  - National Registry
  - Licensed before ABEM
  - USMLE before license
- **Statutory**—allows for government regulation when activity is not prohibited by law
  - Teachers, librarians

**Licensure**
- Time-limited government permission given to an individual to engage in a given activity after verification of predetermined and standardized criteria
  - Illegal to perform without approval
  - All EMS providers are functionally licensed
    - Nothing to do with “independence” of practice
Tasks and roles *legally* authorized to perform

**DOES NOT:**
- Define standard of care
- Establish a practice guideline or protocol
  - Protocols may “define” scope of practice
- Vary based on circumstances
- Regulate knowledge
## Scope of Practice

**1.** “Are/were you allowed to do it?”

**2.** Act of commission if unlicensed—criminal offense

**3.** Varies level to level, but NOT based on circumstances

**4.** From statute, rules, regulations, etc

**5.** Can’t really regulate knowledge through scope of practice

## Standard of Care

**1.** “Did you do the right thing and did you do it properly?”

**2.** Act of commission or omission may lead to civil liability (negligence)

**3.** Situational—depends on many variables

**4.** Determined by scope of practice, literature, expert witnesses and juries

**5.** Used to evaluate professional judgment
IF YOU’VE SEEN ONE EMS SYSTEM, YOU’VE SEEN ONE EMS SYSTEM
“PARAMEDIC”

- What does that mean?
- No universal definition
  - Varies by state and regions within Texas
    - Delegated authority (more later)
- Wide range of skills and training
  - Two providers standing next to each other may not have the same capabilities
  - Why??
SCOPE OF PRACTICE

- States highly variable
  - Listed in state law
    - May be constraining
  - Deferred to state level EMS authority
  - Combination of elements
    - Vague language

- Examples...
New York City!!...(actually, not NYC—FDNY does what it wants)

“New York State does not have a specific scope of practice document for the CFR/EMT/AEMT. Instead, in NYS, scope of practice for the CFR/EMT/AEMT is defined by curriculum, protocol, and physician medical direction at the EMS agency, region, and State levels. In order to determine whether a particular skill falls within the EMS provider's scope of practice, one would need to refer to the appropriate curriculum and protocol.”
“DELEGATED AUTHORITY”

- Only state with this
- EMS personnel work “under the physician’s license”
  - Hear this across the country—only really true here
  - “Paramedics can do heart surgery on the side of the road if their Medical Director allows it”
- Technically true, but reality is fuzzier
State law **does** define EMS levels with specific skills listed
- Very limited

No direct authority by DSHS to define scope of practice...

Texas Medical Board would have a say about the physician's license if extreme procedures were allowed
REALITY

- Combination of legal authority to practice with training, accepted standard of care, and local authority (Medical Director)
- Allows for systems to individualize to meet local needs
- Neighboring systems may have significant differences in capabilities of providers
An individual qualifies as an emergency medical technician if the individual is certified by the department as minimally proficient to perform emergency prehospital care that is necessary for basic life support and that includes cardiopulmonary resuscitation and the control of hemorrhaging.
An individual qualifies as an emergency medical technician-intermediate if the individual is certified by the department as minimally proficient to provide emergency prehospital care by initiating under medical supervision certain procedures, including intravenous therapy and **endotracheal** or esophageal intubation.
TEXAS PARAMEDIC

- An individual qualifies as an emergency medical technician-paramedic if the individual is certified by the department as minimally proficient to provide 
  advanced life support that includes initiation under medical supervision of certain procedures, including 
  intravenous therapy, endotracheal or esophageal intubation, electrical cardiac defibrillation or 
  cardioversion, and drug therapy.

- Licensed Paramedic
  - In addition, a licensed paramedic must complete a curriculum that includes college-level course work in 
    accordance with rules adopted by the board.
OTHER STATE DEFINITIONS

- Highly variable
  - EMT, EMT-I, EMT-CC, EMT-CT, EMT-P, etc
  - > 40 different “levels”
    - Even more if you count scope of practice and credentialing differences

- How do we fix this??
IS THERE A SOLUTION?
The National EMS Scope of Practice Model supports a system of licensure common in other allied health professions. Such a system offers the following benefits:

- establishes national standards for the minimum psychomotor skills and knowledge for EMS personnel;
- improves consistency among States’ scopes of practice;
- facilitates reciprocity;
- improves professional mobility;
- promotes consistency of EMS personnel titles;
- and improves the name recognition and public understanding of EMS personnel.
NATIONAL EMS SCOPE OF PRACTICE

- **Education**
  - *National EMS Education Standards*
- **Certification**
  - State level
  - National Registry
- **Licensure**
  - State level
- **Credentialed**
  - Medical Director
“...minimal terminal objectives for entry-level EMS personnel to achieve within the parameters outlined in the National EMS Scope of Practice Model.”

“Although educational programs must adhere to the Standards, its format will allow diverse implementation methods to meet local needs and evolving educational practices. The less prescriptive format of the Standards will also allow for ongoing revision of content consistent with scientific evidence and community standards of care.”
“Core Content defines the entire domain of out-of-hospital practice and identifies the universal body of knowledge and skills for emergency medical services providers who do not function as independent practitioners.”

“Core Content does not represent a minimum level of knowledge and competency. The National Scope of Practice Model will determine the minimum level of knowledge and competency for various levels of EMS providers.”
Floor capabilities for different levels
- Emergency Medical Responder (EMR)
- Emergency Medical Technician (EMT)
- AEMT (Advanced EMT)
- Paramedic
- Allows for more aggressive scope in different states
PARAMEDIC

- Combination of:
  - Education
    - *National EMS Education Standards*
  - State license
    - Combination of different elements
  - Certification
    - *National EMS Scope of Practice Model*
  - Credentialing
    - *National EMS Core Content*
ELECTMENTS REQUIRED

- Educated
  - Learned it
  - Paramedic school

- Certified
  - Passed it
  - National Registry
  - Or state test

- Licensed
  - Paid it
  - State requirements
    - At least 18 years old
    - Complete high school or GED certificate
    - Successful completion of a DSHS approved EMS training course
    - Submit EMS Personnel Certification Application and fee
    - Pass National Registry exam
    - Fingerprints

- Credentialed
  - Got it checked off
  - Medical Director
An individual may perform only those procedures for which they are educated, certified, licensed, AND credentialed.
I'm a Paramedic and I'm here to help!

RELEVANCE IN A DISASTER
FEDERAL PLAN

- No specific federal requirements
  - Refers to states
- Relies on adoption of the National Scope of Practice
  - Potential for variable capabilities of responders
  - Potential for confusion
“The terms “credentialed” and “credentialing” mean having provided, or providing, respectively, documentation that identifies personnel and authenticates and verifies the qualifications of such personnel by ensuring that such personnel possess a minimum common level of training, experience, physical and medical fitness, and capability appropriate for a particular position...”
FEMA PARAMEDIC CRITERIA

- **Completion of a state-approved paramedic program** based on NHTSA National Standard Curriculum*.
  - NHTSA National EMS Education Standards are a component of the EMS Education Agenda for the Future: A System Approach, a comprehensive plan for a national EMS education system.
  - The state equivalent to EMRs, EMTs, Advanced EMTs and paramedics are expected to transition to these educational standards as they are implemented.

- **Completion of the following courses/curricula:**
  1. ICS-100: Introduction to ICS.
  4. HazMat Awareness Training or equivalent basic instruction consistent with: ...

- **Ongoing, active participation with an EMS-providing entity, organization, or agency.**

- **Successful completion of a state-approved program at this level or NREMT certification at this level.**

- **Active status of legal authority** to function as a paramedic granted by a state, the District of Columbia, or U.S. territory.
STATE PLAN

- TDEM
- EMTF
  - Ambulance Strike Teams
  - AMBUS
  - MMU
- RAC (STRAC)
  - Regional coordination of assets
RESPONDERS

- Will have been vetted
  - Background check
  - “Credentialed” to respond and work at their level of state authority
  - Some understanding of ICS and disaster response plans
Variable medical capability
- May be credentialed for more or fewer skills than local system
- Increased confusion with “mixed” teams

Communication is key
- Discussion between local and sending EMS Medical Directors
EMS providers are not created equal

All formal responders will be licensed and authorized to see patients

- Beware of “self-responders”

Responders may have variable capabilities when treating patients

And with that...
EMS MEDICAL DIRECTION IN A DISASTER
WHAT IS AN EMS MEDICAL DIRECTOR?
Texas Health and Safety Code, Chapter 773

Sec. 773.007. SUPERVISION OF EMERGENCY PREHOSPITAL CARE. (a) The provision of advanced life support must be under medical supervision and a licensed physician's control. (b) The provision of basic life support may be under medical supervision and a licensed physician's control.

Sec. 773.0571. REQUIREMENTS FOR PROVIDER LICENSE. The department shall issue to an emergency medical services provider applicant a license that is valid for two years if the department is satisfied that: (6) the applicant employs a medical director; and

Sec. 773.114. SYSTEM REQUIREMENTS. (a) Each emergency medical services and trauma care system must have: (1) local or regional medical control for all field care and transportation, consistent with geographic and current communications capability; (2) triage, transport, and transfer protocols; and
Texas Occupations Code, Title 3, Subtitle B, Chapter 157

Sec. 157.001. GENERAL AUTHORITY OF PHYSICIAN TO DELEGATE.
(a) A physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate if, in the opinion of the delegating physician:
(1) the act:
   (A) can be properly and safely performed by the person to whom the medical act is delegated;
   (B) is performed in its customary manner; and
   (C) is not in violation of any other statute; and
(2) the person to whom the delegation is made does not represent to the public that the person is authorized to practice medicine.
(b) The delegating physician remains responsible for the medical acts of the person performing the delegated medical acts.

Sec. 157.003. EMERGENCY CARE. The authority to delegate medical acts to a properly qualified person as provided by this subchapter applies to emergency care provided by emergency medical personnel certified by the Texas Department of Health.
(4) **Delegated practice**—Permission given by a physician licensed by the board, either in person or by treatment protocols or standing orders to a specific prehospital provider to provide medical care.

(5) **Direct medical control**—Immediate and concurrent clinical direction either on-scene or via electronic communication from a physician licensed by the board and designated by the EMS medical director. If an EMS system does not have an EMS Medical Director, then such designation should be by a physician advisor, or in his or her absence, the director of the EMS system.

(12) **Protocols**—Written instructions providing prehospital personnel with a standardized approach to commonly encountered problems in the out-of-hospital setting, typically in regard to patient care. Protocols may include standing orders to be implemented prior to, or in lieu of, establishing communication with direct medical control.

(13) **Standing delegation orders**—Instructions or orders provided by the EMS medical director to EMS personnel, directing them to perform certain medical care in the absence of any communication with direct medical control.
Texas Administrative Code Title 22, Part 9, Chapter 197, Rule §197.3

(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/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.
Texas Administrative Code Title 22, Part 9, Chapter 197, Rule §197.3

(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;
Texas Administrative Code Title 22, Part 9, Chapter 197, Rule §197.3

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

(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;
(a) The EMS medical director shall assign the prehospital provider under his or her direction to a specific on-line communication resource by a predetermined policy.

(b) Specific local protocols shall define the circumstances under which on-line medical direction is required.

(c) A physician providing or delegating on-line medical direction ("on-line physician") shall be appropriately trained in the use of prehospital protocols.

(d) A physician providing or delegating on-line medical direction shall have personal expertise in the emergency care of ill and injured patients.

(e) A physician providing or delegating on-line medical direction for particular patients assumes responsibility for the appropriateness of prehospital care provided under his or her direction by EMS personnel.
Texas Administrative Code Title 22, Part 9, Chapter 197, §Rule 197.5

(a) Control at the scene of a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

(b) The prehospital provider on the scene is responsible for the management of the patient(s) and acts as the agent of the physician providing medical direction.

(c) If the patient's personal physician is present and assumes responsibility for the patient's care, the prehospital provider should defer to the orders of said physician unless those orders conflict with established protocols. The patient's personal physician shall document in his or her orders in a manner acceptable to the EMS system. The physician providing on-line medical direction shall be notified of the participation of the patient's personal physician.

(d) If the medical orders of the patient's personal physician conflict with system protocols, the personal physician shall be placed in communication with the physician providing on-line medical direction. If the personal physician and the on-line medical director cannot agree on treatment, the personal physician must either continue to provide direct patient care and accompany the patient to the hospital or must defer all remaining care to the on-line medical director.

(e) The system's medical director or on-line medical control shall assume responsibility for directing the activities of prehospital providers at any time the patient's personal physician is not in attendance.

(f) If an intervenor physician is present at the scene and has been satisfactorily identified as a licensed physician and has expressed his or her willingness to assume responsibility for care of the patient, the on-line physician should be contacted. Once the on-line physician is contacted, he or she is ultimately responsible for the care of the patient unless or until the on-line physician allows the intervenor physician to assume responsibility for the patient.

(g) The on-line physician has the option of managing the case exclusively, working with the intervenor physician, or allowing the intervenor physician to assume complete responsibility for the patient.

(h) If there is any disagreement between the intervenor physician and the on-line physician, the prehospital provider shall be responsible to the on-line physician and shall place the intervenor physician in contact with the on-line physician.

(i) If the intervenor physician is authorized to assume responsibility, all orders to the prehospital provider by the intervenor physician shall also be repeated to medical control for recordkeeping purposes.

(j) The intervenor physician must document his or her intervention in a manner acceptable to the local EMS.

(k) The decision of the intervenor physician not to accompany the patient to the hospital shall be made with the approval of the on-line physician.

(l) Nothing in this section implies that the prehospital provider can be required to deviate from standard protocols.
Texas Administrative Code Title 22, Part 9, Chapter 197, §Rule 197.6

(a) The medical director has the authority to design research projects and educational studies. Such studies should be approved by:

(1) EMS administrative officials; and

(2) an independent review panel if the project/study may have a differential impact on patient care.

(b) The results of the study should be made available through publications to the EMS community.
An EMS Medical Director in Texas:

- Delegates the practice of emergency care to EMS providers
  - Credentials and/or de-credentials each EMS provider providing care under his/her practice
- Remains responsible for that medical care
- Provides standing orders
- Provides real-time (on-line) direction to EMS providers
- Writes and maintains protocols for medical care
- Stays actively involved in and directs education and continuing education of EMS personnel
- Is responsible for the Quality Assurance / Performance Improvement of medical care of an EMS System
- Acts as a liaison between the EMS Administration and the local medical community
Some specifics:

- Determines any remediation needed for EMS providers
- Determines where EMS patients are transported (destination)
- Determines when a patient will not be transported
- Determines when a patient will be transported against his/her will
- Provides real time (on-scene or on-line) direction as needed
- Determines when other physicians on the scene of an emergency can provide direction to EMS personnel
SO....WHAT ABOUT DURING A DISASTER?

NAEMSP recommendations:

EMS should take the lead in local disaster medical response.

- Establish competency-based core curricula and regular training in disaster response
- Development of metrics to measure competency in disaster response
- Establish MOU’s / MOA’s for mutual aid
- Plan for licensure and liability issues
- EMS and EMS Medical Directors should participate in Unified Command structure
- Establish triage processes and training
- Have processes in place to increase scope of practice and decrease need for direct medical control
- EMS providers should have involvement in expanded community medical care roles
- Advocate for resiliency and recovery of EMS responders after a disaster
SO....WHAT ABOUT DURING A DISASTER?

- Triage
- Destination decisions – change?
- Altered treatment decisions / standards of care
- No transport / Altered transport
- No send / Delayed response
- Jurisdictional boundaries
- EMS functioning in alternate settings
- Altered scope of practice
- EMS participation in state response
- Responder health and safety
- Liability
Need to prioritize patients
  - Most good for the most patients
  - Which patients go where?
Which system to use?
  - START (Simple Triage and Rapid Transport)
  - MASS (Move, Assess, Sort, Send)
  - SALT (Sort, Assess, Life-saving interventions, Treatment/Transport)
ALTERED DISPATCH

- Increased front-end triage of calls
- Nursing hotlines
- Triage of call order
- Alternate resources sent
- Treat-and-release protocols
- No-send criteria
ALTERED TREATMENT DECISIONS / ALTERED STANDARD OF CARE

- Change in staffing of ambulances
- Change in protocols for treatment
  - Save resources
  - Save time
- Altered documentation requirements
- Alteration of transport vehicles
DESTINATION DECISIONS

- Closest appropriate facility
- Closest hospital vs. hospitals at a distance
- Utilizing all emergency departments
- Alternate Care Sites
  - Clinics
  - Shelters
  - Mobile medical units
ALTERNATE SETTINGS / ALTERED SCOPE OF PRACTICE

- Shelter care
- Alternate care sites
- Vaccination delivery

Photo by Jocelyn Augustino, FEMA

Photo by Chief David Almaguer, HFD
 RESPONDER HEALTH AND SAFETY / LIABILITY ISSUES

- PPE
- Vaccinations
- Pre- and post-incident health screenings
- Mental health support
- Deployment in austere environments
STATE RESPONSE / OUTSIDE JURISDICTIONAL BOUNDARIES

- Ambulance Strike Teams
- Ambulance Utilization Criteria
- ALS Buses
- Ambuses
- Mobile Medical Units
- Incident EMS Medical Directors
Institutes of Medicine

Recommendations for states to develop robust CSC plans and guidelines

Must include:

- Utilizing NIMS compliant ICS
- Adhering to ethical norms and principles
- Providing palliative care services
- Addressing the needs of at-risk populations
- Mobilizing mental health services
CRISIS STANDARDS OF CARE

- Establish consistent triggers and thresholds for CSC
- Modifying protocols
- Transferring protocols
- Authorization of the use of CSC protocols/plans
- Provide liability protection for providers
- Coordination of regional and state emergency operations and CSC planning
- Reimbursement issues
- Liability protection for altered modes of transportation and care
REFERENCES

- Texas Health and Safety Code, Chapter 773
- Texas Occupations Code, Title 3, Subtitle B, Chapter 157
- Texas Administrative Code Title 22, Part 9, Chapter 197