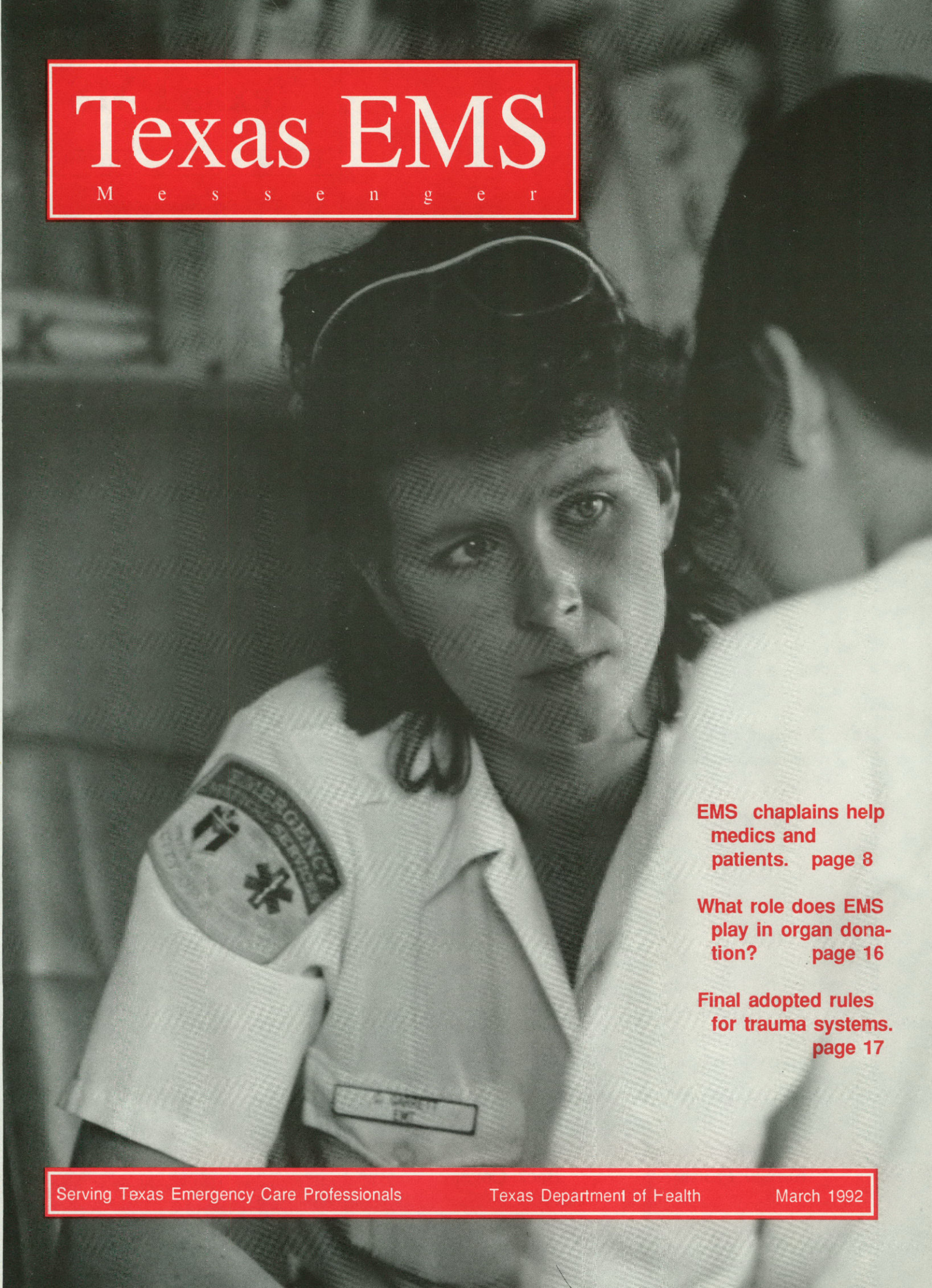
Texas EMS

Messenger



EMS chaplains help medics and patients. page 8

What role does EMS play in organ donation? page 16

Final adopted rules for trauma systems. page 17

Serving Texas Emergency Care Professionals | Texas Department of Health | March 1992

About this issue

COVER PHOTO: Dealing with children during a call takes a special understanding and patience. Sally Muir took this photo of Austin EMS medic Cheryl Garrett and her small patient.

Departments

Texas EMS
M e s s e n g e r

March 1992 Vol. 13 No. 2

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From This Side

Gene Weatherall
Chief
Bureau of
Emergency
Management

Critical Incident Stress Debriefing training comes to Texas June 25 - 28

We are extremely fortunate to have been able to schedule Dr. Jeffrey Mitchell to do training in Austin on Critical Incident Stress Debriefing. Dr. Mitchell will conduct the training on June 25 through June 28. We have an advertisement with additional information on page 30.

The days of the tough macho EMS types are over. In recent years we have become more enlightened regarding the need for methods of dealing with the stress of emergency medical service. I am certain that those of you from the old school can think of many situations in which we could have used some assistance. The incident that sticks in my mind is the time we found a brand new EMT sitting on the ambulance dock of the hospital crying after an unsuccessful CPR call. It wasn't until later that we realized that this call was the first time this new EMT had witnessed, much less worked on, a cardiac arrest patient. Had we been more sensitive to this situation we could possibly have arranged a debriefing of this call for this new EMT. There is no doubt that it was warranted.

The purpose of the training in Critical Incident Stress Debriefing is to establish a statewide network of CISD teams. Through this network we will be able to provide assistance to EMS firms around the state. Recently there have been situations in which teams from out of state were called in to provide asssistance. I hope you can schedule the time to attend one of the workshops by Dr. Mitchell. I have attended his basic CISD course and I can personally tell you that he is one of the best instructors I have ever seen. In addition to advanced training as a mental health professional, Dr. Mitchell started his career as a firefighter and EMT. Therefore, he can speak to these issues with first-hand experience. You know what they say about experience - it is the best teacher.

Speaking of experience, we need some assistance from some of you more experienced EMS people. The other day I was telling a younger member of our profession about the "old" days and during this discussion I brought up the hand pump suction. You know the one. In the early days of ambulance inspection you could buy it at the local hardware store. It was basically a jar with a bulb suction. The person I was talking to had never heard of this type of suction unit. This led to a discussion of other pieces of equipment from former days that are no longer around. We decided that what we need to do is start a collection to ensure that we retain some of these items until the time that we can construct an EMS museum. If anyone has one of these original glass bulb suction devices we would appreciate it if you could send us one to share with the younger generation of EMS. If anyone has started a collection of old EMS items we would like to know about it so that we can help to retain some of our EMS history.

EMS Week
May 10 - 16, 1992

Emergency Medical Service - It starts with you

Sponsored by Texas Department of Health and
American College of Emergency Physicians

Local and Regional EMS News

Rural EMS service in Brownwood opens

Heart of Texas EMS in Brownwood held its Grand Opening on November 17, 1991. Early Chamber of Commerce sponsored the celebration and Heart of Texas EMS President June Geigsby cut the red ribbon held by the Brown County Sheriff and Brownwood Chief of Police. Heart of Texas EMS serves six West Texas counties.

Breech baby delivered by Idalou EMS volunteers

David Moore and his crew of Idalou EMS paramedics Joan Yearwood and Darrell Foster and EMT Russ Perkins delivered a baby in October who was worth all the trouble that he caused. "I've visited with him and his mother, and he's a good-natured little kid," said Moore. Now. But last October, moments after Moore did a doctor-ordered episiotomy to free the infant's head, the little boy's Apgar score was 0, and he was pulseless and apneic.

The crew had just come off a call and happened to be standing beside their vehicle, instead of on call at their workplaces, so they were enroute within one minute of being dispatched to the OB emergency. At the scene three minutes later, the medics and a midwife had a baby who just "kicked the door down," in Moore's words. The child's feet began to deliver, then the body delivered, but the infant's head would not deliver.

The midwife attempted to maintain an airway with her hand, but the baby showed signs of stress and began to turn blue. Dr. Priscilla Carter, the on-line ER physician at University Medical Center in Lubbock, ordered an immediate mid-line episiotomy. One paramedic had the telephone during the procedure, one prepared the equipment, and one performed the episiotomy to deliver a 10 lb., 3 oz. boy, said Moore. The crew, mom, and baby were on their way to the hospital within ten minutes of the ambulance's arrival at the scene, and enroute the medics suctioned and intubated the tiny infant.

As they arrived at the hospital another 15 minutes later, the baby's pulse was 120, he had agonal respirations, and his color had returned. "The neurologist could find no deficits in the baby," said Moore, "and the baby stayed in the neonatal ICU at University Medical Center for about a week."

"I've been doing EMS for about ten years," said Moore, who became a paramedic in 1984, "and I've always gotten there after the baby delivered or transported the mother to the hospital before the baby was born. I've always been able to outrun them." So now Moore has a delivery to his credit and the mom's going to nursing school.

Idalou EMS, an MICU service just outside of Lubbock, has 12 medics.

Local and Regional EMS News

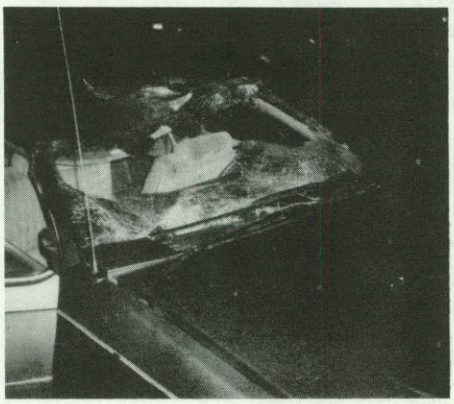
Ready Teddy goes to Ballinger

Ballinger Elementary School students got a visit from TDH's EMS mascot, Ready Teddy, in December. "Look at those faces," said Bob McDaniel of Ballinger EMS, of the photo taken by *The Ballinger Ledger's* Bill Foster, "a tremendous success!!" Ready, a popular EMS visitor in West Texas, talked to 640 kids about EMS and injury prevention during his Ballinger tour.

In 1991 our furry friend visited 42 Texas towns and more than 40,000 kids. You can reserve a bear suit for your public education activities from the Austin central office or from regional EMS offices in Arlington, Uvalde, Canyon, or Houston.

Saved by the belt in Caldwell County

Paramedic Cheryl Watson, Lockhart EMS director, worked a vehicle/horse crash late last year and nominated the survivors for the Texas Safety Belt Survivors' Club. Cheryl submitted this photo of the car (note the crumpled roof and shattered windshield) with her nomination.



If you know of someone whose seatbelt helped them escape serious injury in a car crash, call TDH's Steve Anderson at 1-800-252-8255 and tell him. Steve sends a certificate and a bag of goodies to crash survivors "saved by the belt."

EMS Providers Must Show Operational Policies During Regular or Spot Inspections

EMS rule section 157.11 requires all providers to have current operational policies by January 1, 1992. Time is up! The EMS/Trauma System Development program has sample policies that you may request by calling Paul Tabor at 512/458-7550. Providers will be expected to show their policies during any spot inspections after January 1, 1992.

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C. Total Paid and/or Requested Circulation (Sum of 10B1 and 10B2)	3,225	3,291
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	2,750	3,187
E. Total Distribution (Sum of C and D)	5,975	7,228
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Signature and Title of Editor, Publisher, Business Manager, or Owner
Alana S. Mallard

PS Form 3526, January 1991 (See instructions on reverse)

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In Texas in 1990, 357 children younger than one year died. 302 died of Sudden Infant Death Syndrome; homicides claimed 19; 8 choked on food; and 28 died of some other object causing obstruction or suffocation.

EMS Management of Sudden Infant Death Syndrome

by Linda G. Prentice, MD

Sudden Infant Death Syndrome, or SIDS, the sudden and unexpected death of apparently healthy babies, is the major cause of death of infants in Texas between the ages of one month and one year. About one in 1,000 babies in Texas dies each year from SIDS. It occurs almost twice as frequently in black babies and occurs more frequently in the winter months. It frequently occurs during sleep.

The cause of this syndrome remains obscure. Victims typically have been healthy prior to death. SIDS cannot be predicted or prevented. Certain risk factors may increase the chances of an infant dying of SIDS: prenatal drug use or smoking by the mother, exposure of the child to smoke, severe anemia during pregnancy, unresolved apnea of prematurity, and resuscitation at birth. However, most babies dying of SIDS have no known predisposing risk factors.

EMS personnel are often the first official people on the scene following the discovery of an infant who dies of SIDS. The action of EMS personnel can have a decisive effect on the later adjustment of the family to the death of their infant.

Information gathered by the EMT may aid the pathologist in differentiating SIDS from other causes of death. If an infant has been dead several hours, the discoloration of lividity may mimic child abuse. The EMT should make no assumptions about the cause of death. Considering that 302 of 352 infant deaths in Texas in 1990 were caused by SIDS, the cause of death is most likely to be SIDS. However, only an autopsy can conclusively determine if an infant's death is due to SIDS.

Family's and Caretaker's Response

Reaction may range from numbness to hysteria. Feelings of guilt may be lifelong. A caretaker may feel that she was negligent. A family member sleeping with the baby may fear they have suffocated the baby, although babies have remarkable ability to squirm and turn their heads. One parent may blame another for the infant's death. Siblings may feel that their hostile feelings toward the baby "magically" caused the baby's death. The

parents or caretaker of the infant cling to the hope that the EMT can do something to save the infant, even though the child may be obviously dead.

The EMT as the First Responder

Medical Support Administer CPR regardless of how the infant appears. Assess family members for possible shock. Transport the baby to a medical facility immediately. If the infant is pronounced dead at home by a proper authority, remain with the body until it is removed from the home.

Psychological Support Discuss with the family the possibility of SIDS and prepare them that an autopsy may be requested by a medical examiner and that the death scene investigation will be done. Encourage the family or caretaker to call a relative, friend, or neighbor to be with them and the remaining children in the home. Allow parents to touch the infant and to accompany the infant to the hospital. Remind the survivors that their physician or local health department will be able to tell them more about SIDS and may have the name of a local support group.

Observation of the Scene Observations must be recorded by the first responder. Sensitive, nonjudgmental questions must be asked of the family or caretakers. A death scene protocol is available from the Texas Department of Health which lists information to be recorded concerning conditions in the home, position and description of the body, clothing and bedding.

Reactions of the First Responder Feelings of anger and depression are natural reactions to dealing with the unexplainable death of an infant. EMTs who have responded to a child dying of SIDS may need to talk about the experience to an informed listener or counselor.

Dr. Prentice, MD, is the Director of Texas Department of Health's Division of Child Health.

Death Scene Protocol

Texas Department of Health makes available a 23-page death scene and coroner investigation protocol for suspected Sudden Infant Death Syndrome cases. Responding emergency medical services personnel should document their observations at the death scene for a possible later investigation by the coroner or medical examiner.

Death investigators typically need EMS personnel to document these types of observations:

- Where was the infant found?
  - Infant's bedroom? parent's bedroom? other?
- At what sleeping site was the infant found?
  - Adult bed? bassinet? bean bag? car bed or seat? conventional mattress? couch? crib? floor? water mattress? other?
- Was the deceased infant moved?
  - From where to where? by whom? for what reason?
- What was the infant's general appearance when found unresponsive?
  - On stomach? on side? on back? other?
  - Face up? face to side? face down?
  - Head tilted left? tilted right? neutral?
  - Neck flexed forward? flexed backward? neutral?
- Was the infant sweaty?
- Was the infant clothed? Was bedding over or under the infant?
  - Clothing intact? partially clothed? unclothed? List clothing and transport it with the infant.
- Was the clothing or bedding soiled?
  - By blood? mucus? food? vomitus? urine? feces? other?
- Was the infant wearing a diaper?
  - Cloth? disposable? other?
- What was the diaper's condition?
  - Dry? urine? feces? blood? foreign material? removed? other?
- Were objects found with the infant?
  - List them.
- In what condition was the infant's body?
  - Rigor mortis? lividity consistent with infant's position when found unresponsive? body warm to touch?
- What about the infant's mouth and nostrils?
  - Occluded? secretions? vomitus? blood? foreign objects? other?
- Was there evidence of trauma?
  - Abrasions? bruises? fractures? lacerations? other?
- Record type of attempted resuscitation, where it occurred, and duration of attempts.
  - Mouth to mouth? bag/mask? oral airway? intubation? cardiac compression? IV meds? intracardiac meds? intraosseous lines? initial cardiac rhythm recorded? cardiac rhythm restored?
- Any observations that responding medics can make about the environment where the infant was found may also important.
  - Room temperature? quality of housing? source of heating?

An Idea Whose Time Has Come

EMS Chaplains

By Dave Fair

Imagine the following two scenarios:

"Unit 3200 to Medevac base. This is going to be a DOS. Notify the Chaplain. We need his assistance at this location."

"Unit 3214 to Medevac base. We are enroute to the hospital. The Chaplain will be driving the wife in her vehicle."

Chaplain? In EMS? Why not? For decades fire departments have had chaplains. In more recent years, police chaplains have come of age. Now, a handful of EMS providers have broken new ground with EMS chaplains.

Traditionally, chaplains have mostly been nonpaid volunteers in all public services. EMS is no different, even when the provider is a for-profit organization.

Although requirements and guidelines for EMS chaplains differ from service to service, most chaplains are ordained clergy and many are pastors of their own churches. Although chaplains are present to offer support, not evangelize, their churches consider the position as an outreach and do not mind the pastor spending a reasonable amount of time in the field.

Medevac EMS in Brownwood, Texas, is one of the pioneers in EMS chaplaincy. The program is in its second year, and has three chaplains on staff. Although experience in the EMS profession is not required, two of the Medevac chaplains are EMTs.

This listing of EMS chaplain duties is written for Brownwood's program but the duties can be modified, to fit any EMS provider's situation.

Under the Brownwood plan, the chaplain is on call via radio or pager, or is on duty and rides out as the third person on the ambulance, and:

1. Provides comfort to family members at DOS locations, and assists with making arrangements if requested.
2. Provides reassurance and support to family members of seriously ill or injured patients at the scene or at the hospital.
3. Provides reassurance and support to the patient when appropriate.
4. Assists at the scene with equipment, packaging, crowd control, or other similar duties.
5. Drives family members to the hospital when appropriate.
6. Counsels patients or family members as a follow-up.
7. Makes referrals to mental health professionals when needed.
8. Provides stress management training for all EMS personnel.
9. Conducts defusings or Critical Incident Stress Debriefing of EMS personnel.
10. Networks with police, fire and hospital chaplains.

It is important to remember that the chaplain is God's representative. However, in an EMS emergency, the chaplain's role is to provide support and comfort. With patients coming from so many cultural backgrounds, the chaplain must realize that crisis service extends to people of all faiths or no faith. The chaplain must be careful not to attempt to push particular religious beliefs on a patient or family.

Medevac's EMS chaplains simply identify themselves and ask how they can be of assistance. Usually the response

indicates to the chaplain whether to provide general support or some type of spiritual help.

The EMS chaplain should wear the same uniform as regular EMS crew members with religious symbols worn on the epaulets in place of rank insignia. These will be crosses, Stars of David, or whatever the background of the chaplain. The name tag should clearly identify the person as an EMS chaplain.

What about special training for the chaplain? Medevac chaplains, for the most part, are EMTs, although their primary role is not in that capacity.

Non-EMT chaplains should learn the location of all equipment on the units and be instructed in other areas where they might be of assistance, such as traffic control and crowd control taught by local police. Chaplains should also have special training in emotional crisis intervention skills, including suicide intervention. Grief counseling training is also necessary.

In Brownwood, when the EMS chaplain arrives at the hospital on a unit where the crew is working a code, the chaplain stays in or near the trauma room. If the emergency physician calls the code, the chaplain usually accompanies the doctor to the waiting room to give the death notification to the family.

Although most chaplains serve strictly as volunteers and will not accept payment for services, it is appropriate for the EMS provider to supply uniforms and needed equipment such as radios and pagers. Some chaplains may decide to become EMTs. This doubles their effectiveness, as they can provide a wider range of assistance to the regular EMS field crew, especially in multi-casualty incidents. In some situations, the chaplain may drive the ambulance to the hospital, especially when a critical patient needs two attendants.

A plus for the EMS chaplain's program is help with stress management. Defusing can be conducted almost immediately and the chaplain is usually a member, or, in some cases, the leader of the area CISD team.

How do you start an EMS chaplaincy program in your community?

Contact the local ministerial alliance or similar group for names and addresses of area ministers. Send letters inviting them to a meeting to discuss the program. Furnish refreshments.

An EMS chaplain from another provider can explain the program and answer questions. Then plan a future training session for the ministers wanting to participate. Usually eight hours of training and orientation is needed. In addition, field training is provided by the EMS crews when the chaplain rides out.

On call and duty schedules will depend on the provider, the size of the community and the number of ministers in the program.

What is the public's reaction to EMS chaplains? "Great!" say Medevac personnel. Family members and patients alike welcome any ray of sunshine and the chaplains provide a positive role of reassurance and support.

EMS personnel here have readily accepted the chaplain program. Not only does it provide an extra pair of hands, but it relieves the crew to deal strictly with the patient, while the chaplain deals with family and bystanders.

Brownwood, Texas, and Medevac EMS are proof that the EMS chaplaincy is an idea whose time has come.

For information on starting an EMS chaplaincy program, contact Chaplain Dave Fair, P.O. Box 1059, Brownwood, Texas 76804 (915) 643-2518.

Dave Fair is an EMT and serves as Senior Chaplain for Medevac EMS in Brownwood, Texas. He is President of the Brownwood Police Chaplains Corps. Fair was team leader for the CISD of the Killeen, Texas police department following the Luby's massacre in October, 1991. Fair is President and Senior Consultant for the Code 3 Associates who work in the area of Emergency Service Stress Management.

By Alana S. Mallard

Fifty-two emergency medical services groups receive state funds to improve city and county lifesaving response

Texas Department of Health announced grants totaling $225,925 awarded to 52 local agencies that provide prehospital emergency health care in their communities. The agencies include volunteer fire departments, volunteer EMS, rural hospitals, EMS first responder groups, and city and county EMS groups.

"State lawmakers gave this money to the health department during the 72nd Regular Session specifically for the improvement of local prehospital medical care," said Dr. Robert MacLean, acting commissioner of the Texas Department of Health. "This is the first time since 1980 we have been able to help local communities buy medical equipment for their ambulances."

Most of the money will be used to match local funds to purchase ambulance and medical equipment such as defibrillators. Training equipment will also be purchased.

Dr. MacLean said that last year the health department gave similar EMS grants to 14 local agencies, but certain rules prevented the purchase of equipment. "In many rural EMS systems, purchasing equipment is the costliest part of their operation," he said. "When the health department helps with this major expense, then local funding can be used for other EMS needs, such as recruiting and training emergency medical technicians and paramedics."

A total of 79 proposals requesting $844,000 was received by the health department's Bureau of Emergency Management.

Beginning in April, the health department will accept grant applications for an additional $250,000 available for local EMS grants. The Bureau of Emergency Management and The University of Texas announced a March 28 grantwriting seminar for EMS personnel to help services request funds from the health department and other sources.

Local Projects List

Anson General Hospital, Jones county, $1,800 to purchase ambulance equipment, including two stretchers and a portable oxygen and suction unit.

Argyle Fire Department, Denton county, $3,885 to purchase an automated external defibrillator.

Bastrop County, $6,153 to purchase communications equipment.

Beasley Fire Department, Fort Bend county, $2,500 to purchase an automated external defibrillator.

Blue Mound Fire Rescue, Tarrant county, $9,850 for EMT and Paramedic certification training.

Bosque County Rural Association, $9,500 for ECA and EMT certification training.

City of Keene EMS, Johnson county, $7,867 to purchase communications equipment, including radios, pagers, and a base station.

City of Knox City, Knox county, $2,500 to purchase an automated external defibrillator.

City of Walnut Springs, Bosque county, $2,800 for ECA training, including the purchase of textbooks and EMS course coordinator professional fees. The newly-organized EMS group will receive technical assistance from the health department in starting up its prehospital emergency medical care organization.

Collingsworth Volunteer Ambulance Service, Collingsworth county, $334 to purchase two oxygen regulators.

Community Volunteer Fire Department in Alief, Harris county, $4,500 to purchase an automated external defibrillator.

Crockett County EMS, $5,467 for EMT-Intermediate and Basic Trauma Life Support certification training.

Cypress Creek EMS in Houston, Harris county, $456 to purchase an emergency childbirth training manikin.

Denver City EMS, Yoakum county, $3,604 to purchase training equipment and materials and to conduct EMS continuing education certification classes.

Dickens County EMS, $5,000 to purchase an advanced life support heart monitor and defibrillator.

Emergency Medical First Responders, Inc., in Anderson, Grimes county, $7,112 to purchase basic life support medical equipment. The newly-organized first responder group will receive technical assistance from the health department.

Emergicare, Inc., in Brownfield, Terry county, $1,925 to purchase two adult CPR training manikins, two infant CPR training manikins, and certification training for two EMT Instructors.

Fannin County Ambulance Service, $3,400 to purchase an automated external defibrillator.

Hall County EMS, $3,500 to purchase training equipment, including a trauma simulator manikin, textbooks, and videos.

Hemphill County EMS, $5,670 to purchase training equipment and an advanced life support heart monitor and defibrillator.

Hereford EMS, in Deaf Smith county, $4,230 to purchase an advanced life support heart monitor and defibrillator.

Iraan Fire Department, Pecos county, $5,225 for EMT and EMT-Intermediate certification training.

Kerrville Fire Department, Kerr county, $4,600 for EMT certification training.

Levelland EMS, Hockley county, $1,850 for a CPR training manikin set including adult, child, and infant manikins.

Life Care EMS in Weatherford, Parker county, $2,738 to purchase ambulance medical equipment, including a mechanical resuscitator.

Live Oak County Volunteer EMS, $5,308 to pay tuition costs of ECA and Paramedic certification training.

Live Oak Volunteer Fire Department, Bexar County, $4,215 to purchase CPR manikin materials and an automated external defibrillator.

(continued on page 12)

Local Projects List

Lolita Volunteer Fire Department and Ambulance, Jackson county, $3,023 to purchase basic and advanced life support medical equipment.

Luling EMS, Caldwell county received $6,570 to purchase an advanced life support heart monitor and defibrillator.

Marble Falls Area EMS, Burnet county, $8,470 to purchase an advanced life support heart monitor and defibrillator and an automated external defibrillator.

Mathis Police Department, San Patricio, $2,300 for emergency medical dispatch training for 9-1-1 dispatchers.

Maypearl Volunteer Fire Department and EMS, Ellis county, $3,000 to purchase an automated external defibrillator.

McDonald Observatory First Responders in Fort Davis, Jeff Davis county, $1,209 for advanced life support medical equipment.

Memorial Hospital in Dumas, Moore county, $7,366 to conduct EMT and EMT-Intermediate certification training.

Mills County EMS, $9,782 to conduct certification training for ECAs, Emergency Medical Dispatchers, and EMS examiners; to purchase communications and medical equipment; and to purchase an automated external defibrillator.

New Braunfels Fire Department, Comal county, $5,000 to conduct Basic Trauma Life Support certification training.

Nocona General Hospital EMS, Montague county, $3,535 to purchase EMS training equipment.

North Blanco County EMS, $3,690 to purchase EMT training materials, including textbooks and videos, and to pay EMS coordinator and instructor fees.

Palo Pinto General Hospital, Mineral Wells, Palo Pinto county, $11,500 to conduct CPR training for the public and Basic Trauma Life Support, ECA, EMT, EMT-Intermediate, and Paramedic certification training.

Panhandle EMS System based in Amarillo, $2,705 to purchase training equipment including two adult CPR training manikins and three infant CPR training manikins.

Rains County Rural Fire Protection District, $2,201 to purchase EMS training equipment, including videos and a CPR training manikin.

Ralls Ambulance Service, Crosby county, $977 to purchase CPR and IV therapy training equipment.

Round Rock Fire Department, Williamson county, $2,460 to purchase a semi-automated defibrillator.

Russell Ambulance Service in Winnsboro, Wood county, $2,500 to purchase an automated external defibrillator.

St. Jo Volunteer Fire Department, Montague county, $3,498 to purchase an automatic external defibrillator.

Stinnett EMS, Hutchinson county, $1,800 to pay tuition costs of EMT-Intermediate certification training.

Temple Fire Department, Bell county, $8,500 for Emergency Medical Dispatch training and to purchase Emergency Medical Dispatch materials, including a computer software program and license.

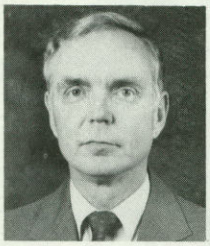
Texline Volunteer Fire and Rescue, Dallam county, $6,500 to purchase a used ambulance.

Vernon Fire Department and Ambulance Service, Wilbarger county, $3,750 to purchase an automated external defibrillator and a training simulator.

Volente Volunteer Fire Department, Williamson county, $800 to purchase an advanced life support training manikin with a defibrillator training torso.

Wild Peach Volunteer Fire Department, Brazoria county, $6,050 to purchase medical equipment and to pay tuition costs for ECA, EMT, and EMT-Intermediate certification training.

Windthorst Volunteer Fire Department, Archer county, $2,750 for EMT certification training.



from the Commissioner

Emergency Medical Services is observing its silver anniversary in Texas this year, and a special congratulations goes out to all the men and women in the program across the state who are dedicated to relieving suffering and saving lives.

Twenty-five years ago Texas received its first federal money for "ambulance training." Today, Texas EMS responds to more than a million emergency calls a year.

The EMS Division began as the Civil Defense and Traffic Safety Division in 1967, when ambulance inspection was moved out of the hospital licensing program. Today, our Division of Emergency Medical Services, in the Bureau of Emergency Management, employs 60 people in the central office, with more than 40 staff members in regional offices throughout the state.

These employees are responsible for certifying about 12,000 Texas EMS personnel each year to be sure only qualified, well-trained workers care for seriously injured and ill Texans whose lives depend on help from EMS. They also ensure that some 1,250 EMS organizations meet state standards requiring appropriate training, vehicles and medical equipment.

We were reminded of the importance and responsiveness of EMS during the recent tragedy in Killeen, the largest mass shooting in the country. All EMS organizations in the area responded and spent long, hard hours helping victims at the scene of the emergency.

Our hats are off to all the EMS personnel who routinely provide prompt and efficient medical services to the acutely sick or injured in Texas.

Robert A. MacLean

Health Department Praises Local EMS Activities

Texas Department of Health Acting Commissioner Robert A. MacLean, MD, praised Texas EMS and featured our 25th anniversary in his regular column in the *Texas Health Bulletin*, November-December, 1991, issue. Dr. MacLean worked closely with EMS when he directed the City of Houston Health Department.

EMS representatives from Fort Hood, Belton, Killeen, Harker Heights and Copperas Cove attended the January 25 Texas Board of Health meeting. Chairman Ron Anderson, MD, led the board members in commending "each organization and individual who responded to the Killeen shootings and who helped save the lives of many of the victims."


ONE
MOMENT
is all
it takes
Take a
moment to
POISONPROO

Certification News

Critical subscale failures must retake entire exam

A candidate who fails one or more critical subscales on the paramedic or intermediate exam and retests after April 15, 1992, will be required to retake the entire written exam as the retest. The process of retaking the entire retest exam has been in effect for emergency care attendants and emergency medical technicians for many years.

The Texas EMS Advisory Council gave full support to this policy during the December 6, 1991, meeting. See the January/February 1992 issue of the *Texas EMS Messenger* for further explanation.

EMT and ECA Certification Review Committee begins work

The Certification Review Committee reviews content from the exam databases for all four levels. A new review committee was established to concentrate on the EMT and ECA databases. The objectives of this new group are the same as the original group: 1) Review the databases for medical accuracy, clarity, and occupational relevance; 2) Review the examination blueprints for areas needing more questions; and 3) Write new pilot questions for both databases.

Members of this new committee are Mark Reger, Larry Croy, Kay Allen, Randy Bertin, Ralph Hendricks, Bob McMullen, Gene Gandy, and David Rives. This committee meets quarterly in Austin. This ongoing process will help ensure an up-to-date examination that is fair to students. The EMS community is encouraged to provide feedback to the EMS Certification Program. Written comments may be sent to the Bureau of Emergency Management, 1100 W. 49th Street, Austin, Texas 78756.

Debbie Bradford and Richard Best contributed to this article. Jim Zukowski, EdD, serves as the Certification Program's education consultant.

Thank You

The Certification Program would like to recognize those persons who have graciously given their time and assistance in the development of the new State Certification Examinations to begin April 15th.

Examination Review Committee
R. Donovan Butter, DO, Carol Goodykoontz, George Hatch, Sunnee Rakowitz, John Rinard, Eddie Callender, and James Davis.

Certification Review Committee
R. Donovan Butter, DO, Michael P. Wainscott, MD, Mark Reger, Donald Gordon, MD, James M. Atkins, MD, J. Thomas Ward, MD, Salvador Robles, Joe Linstrom, Jerry Rhodes, Bryan Bledsoe, DO, and Larry Croy.

Paramedic exam blueprint available

In the August issue of the *Texas EMS Messenger*, the new blueprint for the paramedic exam was introduced. Since the next series of exams will begin April 15, we review here the changes made to the blueprint.

The subscale outline and the number of exam questions per subscale are similar to the existing blueprint. Anatomy and physiology of the entire body areas incorporated into Subscale 1, instead of testing anatomy and physiology in each subscale. With this revision, relevant clinical situations will be tested under each of the other subscales, and only a certain total percentage will be allotted for anatomy and physiology throughout the entire exam. Also, rescue was moved to Subscale 6, where the content is more appropriate. Medical, Subscale 4, received five additional questions, which were removed primarily from Cardiovascular, Subscale 3. Finally, two drugs commonly used in the field - albuterol (Ventolin) and nifedipine (Procardia) - will be added to the list of drugs on which paramedics may be tested.

The paramedic blueprint and DOT content outline is available for $2 from Texas Department of Health.

If you would like a copy of the blueprint, send your request with $2.00 to:

Texas Department of Health
Bureau of Emergency Management
Certification Program
1100 W. 49th Street
Austin, Texas 78756-3199

Note Fund 2A284/160 on check

2A284/160

Name _____

Address _____

City/State/Zip _____

by Marsha H. Exley

The role of EMS in organ donation

On November 30, 1991, there were 1,209 Texans on the national waiting list for organ transplantation according to the United Network for Organ Sharing. Nationally, 24,367 people wait for organs.

In response to the most recent Gallop Survey of public opinion about organ donation, 89 percent of the American public would donate the organs of their loved one in the event of death. More than 94 percent of Americans have some knowledge of organ donation, according to this same poll. Most people assume that the driver license is the mechanism by which one's wishes may be made known. Yet, in fewer than one percent of actual organ retrievals is the driver license the impetus to approach the family for donor consent.

Texas lawmakers recently passed House Bill 271 to make Texas one of only a few states to mandate that an anatomical gift indicated by a donor card or driver license "shall be honored without obtaining the consent of any other person" (Sec. 692-014.b). While the legality of a signed donor card or driver license is not new, House Bill 271 provides new vigor to the concept of patient self-determination in terms of donation. In the past, hospital personnel have left the critical decision about organ or tissue donation up to the family of the deceased.

Although House Bill 271 became effective September 1, 1991, many hospitals have hesitated to change existing policies to reflect the provisions of the new law. Some hospital administrators fear legal repercussions and bad public relations should organ donation proceed on the basis of a deceased person's donor card if the family voices opposition. Both research and experience have shown, however, that families abide with the wishes of their loved one despite their own feelings or beliefs about donation. This single fact makes the presence of the donor card or driver license a critical factor in the situation of unexpected death. Yet, again, seldom is either presented as evidence of a patient's rights or wishes when people die in hospitals.

House Bill 271 requires the presentation of the driver license or donor card for trauma patients who are transported by EMS. "The driver license or personal identification card of a person who is involved in an accident or other trauma shall accompany the person to the hospital or other health care facility if the person has executed a statement of gift symbolized on the license or card" says Section 11B.d.

Certainly, emergency medical service personnel need to know the importance of ensuring that the donor card accompanies the patient to the receiving facility so that emergency department staff are aware of a patient's desires to donate. In reality, this can be seen as a logical extension of emergency care: that a patient's wishes, at his own request, are heeded and realized in the event of his death.

Fill this card out and show it to your family. Let them know your wishes, and discover theirs.

UNIFORM DONOR CARD

OF _____
Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) ____ any needed organs or parts

(b) ____ only the following organs or parts

_____
Specify the organ(s) or part(s)

for the purposes of transplantation, therapy, medical research or education:

(c) ____ my body for anatomical study if needed.

Limitations or special wishes, if any: _____

Signed by the donor and the following two witnesses in the presence of each other. Please complete and carry at all times.

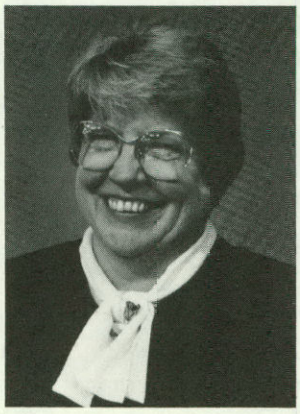
_____ _____
Signature of Donor Date of Birth of Donor

_____ _____
Date Signed City & State

_____ _____
Witness Witness

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

Marsha H. Exley, BSN, RN, CPTC, is with the Southwest Organ Bank, Inc., in Dallas. Contact her at (214) 821-1931. For additional information on organ donation or to obtain Uniform Donor Cards contact Manuel Zapata, Texas Department of Health, Kidney Health Program, (512) 458-7796.



Trauma system rules final after two years' work

By Pam West, Director, EMS Division

After two years of very hard work and compromise amid a smattering of bickering, the framework for trauma systems in the state has been established.

Time is so relative. If we were to ask you to think back to January 1990, most would say, "Oh, my gosh! That was so long ago!" However, for the Trauma Technical Advisory Committee and support staff, the time has quickly flown. But not without important progress!

After two years of very hard work and compromise, amid a smattering of bickering, the framework for trauma systems in the state has been established.

On January 25, 1992, the Texas Board of Health adopted the set of trauma rules that appears on pages 18-26. With these rules it will be possible to move more efficiently and effectively toward regionalized emergency care. In short, it is a move to maximize resources so that patients' lives can be saved.

The rules are a guideline for team building. We hope that each EMS provider will work closely with the hospitals and other EMS providers within each region to strengthen emergency response, and to assure that EMS is a participating member of every regional team.

If you have any questions about the rules or about regional implementation please call Kathy Perkins, Administrator, or Dan Heckler, Trauma Specialist, both with the EMS /Trauma System Development program at (512) 458-7550.

Trauma Technical Advisory Committee

Ray Mason, Chair Lubbock	**Kenneth Mattox, MD** Houston	**Erwin Thal, MD** Dallas
Antonio Falcon, MD Rio Grande City	**Raj Narayan, MD** Houston	**R. Russell Thomas, Jr., DO** Eagle Lake
Jamie Ferrell, RN Amarillo	**Jack Peacock, MD** El Paso	**David Dildy,** exofficio Tyler
Ronald Hellstern, MD Dallas	**M. Tim Philpot** Fort Worth	**Jay Johnson,** exofficio Tulia
Tommy Jacks Austin	**Vayden Stanley, MD** San Angelo	

§157.2 Definitions.

§157.121 Purpose.

§157.122 Trauma Service Areas.

§157.123 Regional Advisory Councils.

§157.124 Regional EMS/ Trauma Systems.

§157.125 Requirements for Trauma Facility Designation.

§157.126 Fees.

§157.127 Complaints.

§157.128 Denial, Suspension, and Revocation of Trauma Facility Designation.

§157.129 State Trauma Registry.

§157.2 Definitions.

§157.2 Definitions.

The following words and terms when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise.

Basic trauma facility - A hospital designated by the department as having met the criteria for a Level IV trauma facility as described in the publication titled "Texas Trauma Facility Criteria" which is adopted by reference in §157.121 of this title (relating to Purpose). Basic trauma facilities provide resuscitation, stabilization, and arrange for appropriate transfer of all major and severe trauma patients to a higher level trauma facility.

Bypass - Direction given to a prehospital emergency medical services unit, by direct/on-line medical control or predetermined triage criteria, to pass the nearest hospital.

Comprehensive trauma facility - A hospital designated by the department as having met the criteria for a Level I trauma facility as described in the publication titled "Texas Trauma Facility Criteria" which is adopted by reference in §157.121. Comprehensive trauma facilities manage major and severe trauma patients, provide educational opportunities in trauma related topics for health care professionals, and conduct trauma research.

Critically injured person - A person suffering major or severe trauma, with severe multisystem injuries or major unisystem injury; the extent of the injury may be difficult to ascertain, but which has the potential of producing mortality or major disability.

Designation - A formal recognition by the department of a hospital's trauma care capabilities and commitment.

Diversion - A procedure put into effect by a trauma facility to insure appropriate patient care when that facility is unable to provide the level of care demanded by a trauma patient's injuries or when the facility has temporarily exhausted its resources.

Emergency medical services and trauma care system - An arrangement of available resources that are coordinated for the effective delivery of emergency health care services in geographical regions consistent with planning and management standards.

Facility triage - The process of assigning patients to an appropriate trauma facility based on injury severity and facility availability.

General trauma facility - A hospital designated by the department as having met the criteria for a Level III trauma facility as described in the publication titled "Texas Trauma Facility Criteria" which is adopted by reference in §157.121. General trauma facilities provide resuscitation, stabilization, and assessment of injury victims and either provide treatment or arrange for appropriate transfer to a higher level trauma facility.

Health care entity - A prehospital provider, physician, nurse, hospital, designated trauma facility or a rehabilitation program.

Health care facility - A licensed hospital.

Lead trauma facility - A trauma facility that has made an additional commitment to its trauma service area. This commitment, which usually is offered by the highest level of trauma facility in a given trauma service area, includes outreach and increased educational activities. The responsibilities may be shared by trauma facilities.

Major trauma facility - A hospital designated by the department as having met the criteria for a Level II trauma facility as described in the "Texas Trauma Facility Criteria" which is adopted by reference in §157.121. Major trauma facilities provide similar services to the Level I trauma facility although research and some medical specialty areas are not required for Level II facilities.

Major trauma injury victim/patient - A person with injuries severe enough to benefit from treatment at a trauma facility, whose revised trauma score (RTS) is less than 11, and/or whose injury severity score (ISS) is 9 or above.

Medical control - The supervision of prehospital emergency medical service providers by a licensed physician through voice communication. Medical control is also referred to as on-line medical supervision.

Medical oversight - The assistance given to the Regional Advisory Council (RAC) and/or regional health care entities in system planning by a physician or group of physicians designated by the RAC to provide technical assistance.

Pediatric trauma facility - A pediatric or other hospital designated by the department as having met the criteria as described in publication titled "Pediatric Trauma Care" which is adopted by reference in §157.121.

Prehospital triage - The process of identifying injury severity so that the appropriate care level can be readily accessed according to patient care guidelines.

Quality management - Quality assurance and quality improvement activities.

Regional EMS/trauma system - An emergency medical services and trauma care system that has been developed by a RAC in a multi-county area and has been recognized by the bureau.

Regional medical control - Direct on-line physician communication for prehospital providers in a given trauma service area. Regional medical control is usually based at the lead trauma facility.

Severe trauma injury victim/patient - A person with injuries severe enough to require care at a comprehensive or major trauma facility, whose RTS is less than 11, and whose ISS is 16 or above.

Site survey - An on-site review of a trauma facility applicant to determine if it meets the criteria for a particular level of designation.

Specialty centers - Entities that care for specific types of trauma patients such as pediatric hospitals and burn units.

Trauma - An injury or wound to a living body caused by the application of an external force or violence. Burn injuries are to be included in this definition, and poisonings, near-drownings and suffocations, other than those due to external forces, are to be excluded from this definition.

Trauma facility - A health care facility that is capable of comprehensive treatment of seriously injured persons and is part of an emergency medical services (EMS)/trauma system.

Trauma nurse - A registered nurse with demonstrated interest and experience in trauma care.

Trauma patient - Any critically injured person who has been evaluated by a physician, a registered nurse, or emergency medical services personnel; and found to require medical care in a trauma facility.

Trauma registry - A statewide database which documents and integrates medical and system information related to the provision of trauma care by health care entities.

§157.121 Purpose.

§157.121 Purpose.

(a) The purpose of these sections is to establish the procedures and standards for the implementation of a comprehensive statewide emergency medical services (EMS)/trauma system (system) as mandated in the Health and Safety Code, Chapter 773, §§81-90, in order to decrease morbidity and mortality which results from trauma.

(b) The Texas Department of Health adopts by reference the following publications developed by the Trauma Technical Advisory Committee (TTAC) titled: "Texas Trauma Facility Criteria," "Pediatric

Trauma Care," "Qualifications of Texas Trauma Care Personnel," "Prehospital Triage Protocol," "Facility Triage Criteria and Decision Guidelines for Transfer," "Facility Diversion," "Facility Bypass," "Medical Control Within EMS/Trauma Systems Development," "Prehospital Standard Data Set" and "Hospital Standard Data Set".

(1) The publications are based on documents titled "Resources for Optimal Care of the Injured Patient" published by the American College of Surgeons in 1990 and "Guidelines for Trauma Care Systems" published by the American College of Emergency Physicians in 1987.

(2) Copies of the publications may be viewed during normal business hours at the Texas Department of Health, Bureau of Emergency Management, Room M-528, 1100 W. 49th Street, Austin, Texas 78756-3199.

(c) The Bureau of Emergency Management and the TTAC shall review these sections every three years.

§157.122 Trauma Service Areas.

(a) Trauma service areas (TSAs) are established for descriptive and planning purposes and not for the purpose of restricting patient referral.

(b) The state has been geographically divided by county into 22 TSAs; however:

(1) counties may be realigned or areas subdivided;

(2) no TSA shall be realigned unless there is a hospital that has at least a lead general trauma facility capacity within the boundaries; and

(3) all TSAs shall be multi-county with no fewer than three counties.

(c) The counties included in the 22 TSAs are grouped as follows:

(1) Area A - Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Wheeler;

(2) Area B - Bailey, Cochran, Crosby, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, Yoakum;

(3) Area C - Archer, Baylor, Clay, Cottle, Foard, Hardeman, Jack, Montague, Wichita, Wilbarger, Young;

(4) Area D - Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Kent, Knox, Mitchell, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton;

(5) Area E - Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise;

(6) Area F - Bowie, Cass, Delta, Franklin, Hopkins, Lamar, Morris, Red River, Titus;

(7) Area G - Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Raines, Rusk, Smith, Upshur, Van Zandt, Wood;

(8) Area H - Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, Tyler;

(9) Area I - Brewster, Culberson, Jeff Davis, El Paso, Hudspeth, Presidio;

(10) Area J - Andrews, Borden, Crane, Dawson, Ector, Gaines, Glasscock, Howard, Loving, Martin, Midland, Pecos, Reeves, Terrell, Upton, Ward, Winkler;

(11) Area K - Coke, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Reagan, Schleicher, Sterling, Sutton, Tom Green;

(12) Area L - Bell, Coryell, Hamilton, Lampasas, Milam, Mills, San Saba;

(13) Area M - Bosque, Falls, Freestone, Hill, Limestone, McLennan;

(14) Area N - Brazos, Burleson, Grimes, Leon, Madison, Robertson, Wash-

ington;

(15) Area O - Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, LLano, Travis, Williamson;

(16) Area P - Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Kinney, La Salle, Maverick, Medina, Real, Uvalde, Val Verde, Wilson, Zavala;

(17) Area Q - Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, Wharton;

(18) Area R - Jefferson, Hardin, Orange;

(19) Area S - Calhoun, Dewitt, Goliad, Gonzales, Jackson, Lavaca, Victoria;

(20) Area T - Jim Hogg, Webb, Zapata;

(21) Area U - Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio; and

(22) Area V - Cameron, Hidalgo, Starr, Willacy.

§157.123 Regional Advisory Councils.

(a) A regional advisory council (RAC) shall be established if a trauma service area (TSA) is to reach regional emergency medical services (EMS)/trauma system (system) status.

(b) All participating health care entities should have representation on the RAC.

(1) Membership status for hospitals for the first six months shall be provisional.

(2) Continuing or renewed membership status for hospitals will be dependent upon a commitment to trauma care, as demonstrated by trauma facility designation or involvement in the designation process as described in §157.125 of this title (relating to Requirements for Trauma Facility Designation).

(c) The bureau shall recognize only one official RAC for a TSA or a group of TSAs.

(d) The RAC shall develop a system plan based on standard guidelines for comprehensive system development. The system plan is subject to approval by the Bureau of Emergency Management (bureau).

(e) The RAC is a voluntary entity which functions without the expectation of state funding.

(f) RACs may request technical assistance from the bureau at any time.

§157.124 Regional EMS/Trauma Systems.

(a) The Bureau of Emergency Management (bureau) shall recognize the establishment of a regional emergency medical services (EMS)/trauma system (system) within a trauma service area (TSA) as described in §157.122 of this title (relating to Trauma Service Areas).

(b) For a TSA to be recognized as a system, a RAC, organized as described in §157.123 of this title (relating to Regional Advisory Councils), shall submit a system plan (plan) to the bureau, which includes the organizational structure of the RAC.

(c) The bureau shall review the plan to assure that:

(1) all counties within the TSA have been included unless a specific county, or portion thereof, has been named within an adjacent system;

(2) all health care entities and interested specialty centers have been given an opportunity to participate in the planning process; and

(3) the following have been addressed:

(A) access to the system;
(B) communications;
(C) medical oversight;
(D) prehospital triage criteria;

§157.124 Regional EMS/Trauma Systems.

§157.123 Regional Advisory Councils.

(E) diversion policies;

(F) bypass protocols;

(G) regional medical control;

(H) facility triage criteria;

(I) inter-hospital transfers;

(J) planning for the designation of trauma facilities, including the identification of the lead facility(ies); and

(K) a quality management program that evaluates outcome from a system perspective.

(d) Bureau approval of the completed plan shall qualify health care entities participating in the system to receive state funding for trauma care when funding is made available.

(e) Annually, on a form provided by the bureau, the RAC shall file a report with the bureau which describes progress toward system development and includes evidence that members of the RAC are currently involved in trauma care.

§157.125 Requirements for Trauma Facility Designation.

§157.125 Requirements for Trauma Facility Designation.

(a) The Bureau of Emergency Management (bureau) shall recommend to the commissioner of health (commissioner) the designation of trauma facilities by levels of care capability as defined by the publications titled "Texas Trauma Facility Criteria" (criteria), "Qualifications of Texas Trauma Care Personnel" and/or "Pediatric Trauma Care" which the Texas Department of Health (department) adopts by reference in §157.121 of this title (relating to Purpose). The levels are as follows:

(1) Level I - comprehensive trauma facility;

(2) Level II - major trauma facility;

(3) Level III - general trauma facility; and

(4) Level IV - basic trauma facility.

(b) The designation process shall consist of three phases.

(1) The first phase is the application phase which begins with completing and submitting to the bureau an application and non-refundable fee as described in §157.126 (relating to Fees) for designation as a trauma facility and ends when the bureau recommends a site survey (survey);

(2) The second phase is the review phase which begins with the survey and ends with a bureau recommendation to the commissioner to designate the hospital;

(3) The third phase is the final phase which begins with the commissioner reviewing the recommendation and ends with his/her final decision. This phase also includes an appeal procedure for the denial of a designation application in accordance with the department formal hearing procedures as described in Chapter 1 of this title (relating to Texas Board of Health).

(c) A secondary review shall be utilized in the event the bureau recommendation (of whether or not) to designate differs from the findings of the survey team. A secondary review shall also be used when a hospital does not agree with a bureau request for specific corrective action prior to recommending designation.

(d) The bureau may provide technical assistance to all hospitals throughout the three phases of the designation process for the purpose of answering questions and clarifying the process.

(e) The bureau's analysis of submitted application materials, which may result in recommendations for corrective action when deficiencies are noted, shall include a review of:

(1) the evidence of participation in system planning;

(2) the completeness of the application materials submitted; and

(3) the hospital's self-study for comparison with the criteria.

(f) When the application phase results in a bureau recommendation for a survey, the bureau shall notify the hospital to

contract for the survey, as follows.

(1) A hospital may choose to request a survey by an American College of Surgeons survey team, may request the bureau to approve an alternate survey team assembled by a bureau-approved organization, or may request the bureau to select individual survey team members.

(2) The hospital shall notify the bureau of the date of the planned survey and the composition of the survey team.

(3) The hospital shall be responsible for any costs associated with the survey.

(4) The bureau may appoint an observer to accompany the survey team. In this event, the cost for the observer shall be borne by the bureau.

(g) The survey team composition shall be as follows.

(1) A survey team for a comprehensive, major, or lead general trauma facility applicant, shall be multidisciplinary and include at a minimum: a general surgeon, an emergency physician, and a trauma nurse all active in the management of trauma patients. The inclusion of a neurosurgeon on the survey team for a potential comprehensive or major trauma facility is recommended.

(2) Other general trauma facility applicants shall be surveyed by a survey team consisting of a nurse and a surgeon both active in the management of trauma patients and a bureau representative.

(3) Basic trauma facility applicants shall be surveyed by a bureau representative or a bureau approved consultant.

(4) It is recommended that a pediatric trauma surgeon and/or pediatric trauma nurse be a member of the survey team for review of a pediatric trauma facility applicant.

(5) Any member of the survey team should come from a public health region outside the hospital's location and at least 100 miles from the applicant hospital.

(h) When an applicant hospital is notified of the survey team composition, it has 15 postmark days to alert the bureau of potential conflict of interest concerns.

(i) From the date the survey team is selected and prior to the survey, the applicant's administration, faculty, medical staff, employees, and representatives are prohibited from having any discussions regarding the upcoming survey with any survey team member except as directed by the bureau. A violation of this provision may be grounds for delaying the survey and reorganizing the composition of the survey team.

(j) The survey team shall evaluate the quality of each hospital's compliance with the requirements set forth in the criteria, by:

(1) reviewing medical records, staff rosters and schedules, quality management committee meeting minutes and other documents relevant to trauma care;

(2) reviewing equipment and the physical plant; and

(3) conducting interviews with hospital personnel.

(k) Findings of the survey team shall be forwarded to the bureau within 90 days.

(l) The bureau shall review the findings for compliance with the criteria. If a hospital does not meet the criteria for the level of designation for which it applied, the bureau may discuss designation at a lower level with the hospital.

(2) A recommendation for designation shall be made to the commissioner based on compliance with the criteria.

(3) In the event there is a problem area in which a hospital does not comply with the criteria, the bureau shall notify the hospital of deficiencies and recommend corrective action.

(A) The hospital shall submit a report to the bureau which outlines the corrective action taken. If the report substantiates action that brings the hospital into compliance with the criteria, the bureau shall recommend designation to the commissioner.

(B) If the hospital dis-

agrees that there is need for corrective action, the bureau shall refer the complete file to the trauma technical advisory committee (TTAC) for review.

(C) If TTAC disagrees with the bureau recommendation for corrective action, the records shall be referred to the deputy commissioner of health for review.

(l) The bureau shall provide a copy of the survey report and results to the applicant hospital.

(m) At the end of the secondary review and final phases of the designation process, if a hospital disagrees with the bureau recommendations, opportunity for an appeal in accordance with the department formal hearing procedures as described in Chapter 1 shall be offered.

(n) The bureau may grant an exception to this section if it finds that compliance with this section would not be in the best interests of the persons served in the affected local system.

(o) The applicant hospital shall have the right to withdraw its application at any time prior to being awarded trauma facility designation by the bureau.

(p) If the commissioner concurs with the bureau recommendation, a letter of notification shall be forwarded to the hospital. If the decision is to designate, the hospital shall receive a certificate of designation for three years.

(q) When a facility has been designated for a period of three years, it shall be necessary to repeat the designation process as described in this section.

(r) A designated trauma facility shall:

(1) notify the bureau and the regional advisory council (RAC) within five days if temporarily unable to comply with designation standards;

(2) notify the bureau and the RAC if it chooses to no longer provide trauma services commensurate with its designation level, as follows.

(A) If the trauma facility chooses to apply for a lower level of designation, it may do so at any time; however, it shall be necessary to repeat the designation process as described in subsections (b) - (e) of this section. There shall be a paper review by the bureau to determine if a full survey shall be required.

(B) If the trauma facility chooses to permanently relinquish its designation, it shall provide at least 30 days notice to the RAC and the bureau.

(3) comply with the provisions within these sections, all current state and system standards as described in this chapter, and all policies, protocols and procedures as set forth in the system plan;

(4) continue its commitment to provide the resources, personnel, equipment, and response as required by its designation level; and

(5) participate in the state trauma registry as described in §157.129 of this title (relating to State Trauma Registry).

(s) After September 1, 1993, a hospital may not use the terms "trauma facility," "trauma hospital," "trauma center" or similar terminology in its signs or advertisements or in the printed materials and information it provides to the public unless the hospital has been designated as a trauma facility according to the process described in this section. This subsection also applies to hospitals whose designation has lapsed.

(t) A trauma facility shall not advertise or publicly assert in any manner that its trauma facility designation affects its care capabilities for non-trauma patients or that its trauma facility designation should influence the referral of non-trauma patients.

(u) The bureau shall have the right to review, inspect, evaluate, and audit all trauma patient records, trauma quality management committee minutes, and other documents relevant to trauma care in any designated trauma facility at any time to verify compliance with criteria. The bureau shall maintain confidentiality of such records to the extent authorized by the Open Records Act, Texas Civil Statutes, Article 6252-17a. Such inspections shall be sched-

uled by the bureau when appropriate.

§157.126 Fees.

The Bureau of Emergency Management shall charge a non-refundable application fee for a hospital to be designated as a trauma facility as follows.

(1) For comprehensive and major trauma facility applicants, the fee will be no more than $3.00 per licensed bed with an upper limit of $3000 and a lower limit of $100.

(2) For general trauma facility applicants, the fee will be no more than $2.00 per licensed bed with an upper limit of $2000 and a lower limit of $100.

(3) For basic trauma facility applicants, the fee will be no more than $1.00 per licensed bed with an upper limit of $1000 and a lower limit of $100.

§157.127 Complaints.

Upon receipt of a complaint describing an alleged violation(s) of these sections, the Bureau of Emergency Management shall:

(1) initiate a review of the complaint;

(2) notify the entity of the complaint and the review procedures, if appropriate;

(3) develop a written report of the review; and

(4) notify the entity of the results of the review.

§157.128 Denial, Suspension, and Revocation of Trauma Facility Designation.

(a) A hospital's application for designation may be denied or a trauma facility's (facility) designation may be suspended or revoked for, but not limited to, the following reasons:

(1) failure to comply with these sections, current state and/or regional emergency medical services (EMS)/trauma system (system) guidelines as described in this chapter, and all policies, protocols and procedures as set forth in the approved system plan;

(2) willful preparation or filing of false reports or records;

(3) fraud or deceit in obtaining or attempting to obtain designation status;

(4) refusal to submit data to the state trauma registry as described in §157.129 of this title (relating to State Trauma Registry);

(5) incompetence, negligence, or misconduct in operating the facility;

(6) failure to have appropriate staff or equipment required for designation as described in §157.125 of this title (relating to Requirements for Trauma Facility Designation);

(7) abuse or abandonment of a patient;

(8) unauthorized disclosure of medical or other confidential information;

(9) alteration or inappropriate destruction of medical records;

(10) refusal to render care because of a patient's race, sex, creed, national origin, sexual preference, age, handicap, medical problem or inability to pay; or

(11) criminal conviction(s) as described in Texas Civil Statutes, Articles 6252-11c and 6252-11d.

(b) Occasional failure of a hospital or facility to meet its obligations shall not be grounds for denial, suspension or revocation by the Bureau of Emergency Management (bureau), if the circumstances under which the failure occurred:

(1) do not reflect an overall deterioration in quality of and commitment to trauma care; and

(2) are corrected within a reasonable timeframe by the hospital or facility.

(c) If the bureau proposes to deny, suspend or revoke a designation, the bureau shall notify the hospital or facility by registered or certified mail at the last

§157.126 Fees.

§157.127 Complaints.

§157.128 Denial, Suspension, and Revocation of Trauma Facility Designation.

address shown in the bureau records. The notice shall state the alleged facts that warrant the action and state that the hospital or facility has an opportunity to request a hearing in accordance with the Department of Health (department) formal hearing procedures as described in Chapter 1 of this title (relating to Texas Board of Health).

(1) The hospital or facility shall request a hearing within 15 postmark days after the date of the denial, suspension, or revocation notice. This request shall be in writing and submitted to the bureau chief. If a hearing is requested, the hearing shall be held in accordance with the department formal hearing procedures as described in Chapter 1.

(2) If the hospital or facility does not request a hearing in writing, after being sent the notice of opportunity for hearing, it is deemed to have waived the opportunity for a hearing and the denial, suspension, or revocation decision shall stand.

(d) Six months after the denial of a hospital's application for designation, the hospital may reapply for trauma facility designation as described in §157.125.

(e) When a designation has been suspended, the suspension shall be in effect a minimum of 10 days. Upon completion of the assigned suspension time, designation shall resume.

(f) One year after the revocation of a facility designation, the hospital may petition the bureau, in writing, for reapplication of designation status. However, the bureau may deny the opportunity to reapply if the bureau determines that the reason for the revocation continues to exist. If the application is allowed, the hospital shall meet the requirements as described in §157.125 of this title (relating to Requirements for Trauma Facility Designation).

§157.129 State Trauma Registry.

§157.129 State Trauma Registry.

(a) The Bureau of Emergency Management (bureau) shall develop and maintain a trauma reporting and analysis system to:

(1) identify major or severe trauma patients within each health care entity in this state;

(2) identify the total amount of uncompensated trauma care expenditures made each fiscal year by each health care entity in this state; and

(3) monitor trauma patient care within each health care entity and regional emergency medical services (EMS)/trauma system (system) in this state.

(b) Each health care entity shall collect a standard data set as defined in the publications titled "Prehospital Standard Data Set" and the "Hospital Standard Data Set" which the Texas Department of Health (department) adopts by reference in §157.121 of this title (relating to Purpose) and provide such data to the bureau, as follows:

(1) prehospital providers shall submit trauma data by:

(A) an annual run response summary; or

(B) bureau approved medium;

(2) hospitals and trauma facilities shall submit trauma data by:

(A) the department's annual hospital survey; or

(B) bureau approved medium; and

(3) rehabilitation programs shall submit trauma data by:

(A) an annual aggregate standard data summary; or

(B) bureau approved medium.

(c) All health care entities shall submit trauma data to the state trauma registry on a quarterly basis by bureau approved medium by August 31, 1996.

(d) The bureau shall provide annual summary data to the systems.

(e) The bureau shall maintain confidentiality of all records to the extent authorized by the Open Records Act, Texas Civil Statutes, Article 6252-17a.

Did you read...

By Alana S. Mallard

Texas Preventable Disease News of January 11, 1992, reports that two counties in Texas, Jim Wells and Nueces, are experiencing an outbeak of measles cases. Thirty cases have been reported in Alice in Jim Wells county between September 20, 1991, and January 8, 1992. Corpus Christi County Health Department is investigating twelve suspected and two confirmed cases.

Cases are occurring primarily in infants less than two years of age and young adults 20 years and older. Health authorities urge health care workers to be suspicious of rash and fever cases in these two communities and to report suspected cases to Texas Department of Health. Call (512) 664-3149 in Alice, (512) 851-7262 in Corpus Christi, or 1-800-252-9152.

(For subscription information contact *Texas Preventable Disease News*, Texas Department of Health, 1100 W. 49th Street, Austin, Texas 78756. Subscription is free.)

The EMS Medical Advisor, a new publication, reports on two studies concerning hepatitis, AIDS and fear among EMS personnel in its Volume 1, Number 2 issue. A survey of 1,228 paid and volunteer EMS personnel in Maryland showed that 38 percent would not treat AIDS patients and that 18 percent considered resigning from EMS because of AIDS.

The second study addressed AIDS and hepatitis and surveyed 420 paid paramedics. Twenty-nine of the respondents wanted their partner to care for the AIDS patient and 11 percent considered resigning from EMS. Both survey groups had received education and training on AIDS and hepatitis prior to the studies.

What researchers found in both studies was that education improved knowledge about AIDS but did not reduce fears. EMS personnel also appeared uninformed about the greater risks associated with contracting hepatitis B. Only 17 percent of those surveyed had received the hepatitis vaccine.

(For subscription information contact *The EMS Medical Advisor*, Scott Bourn Associates, 1546 Euclid Circle, Lafayette, Colorado 80026, or call 1-800-669-9448.)

Emergency covers the movement of EMS into fire service organizations in the January, 1992 issue. "EMS in the Fire Service: Challenge of the '90s" talks about the pros and cons of the EMS function being taken over by a community's fire department. On the positive side, people attracted to fire service are humanitarians; fire stations are everywhere; the fire service has many components needed by EMS, such as communications, dispatch, training, and rapid response; and most fire stations find that assuming EMS duties does not interfere with firefighting duties.

On the other hand, the article points out, EMS is considered an outsider by many fire organizations. Tradition is important in fire service and the system is "traditionally a closed, fraternal" one. Also, not everyone in fire service wants to do EMS, nor does every EMT want to do fire suppression, according to the article. Some characteristics of the fire service environment may not be compatible to EMS care: lack of medical focus in the fire hierarchy, a dirty workplace, and 24-hour shifts.

Economics may be the pull for EMS into fire service because municipalities must work with tighter and tighter budgets, but the move has to be made for the right reasons, according to the article. Ricky Davidson, chair of the EMS section of the Internation Association of Fire Chiefs, said in the article, "If a fire department is going to assume the EMS role, it has to do it for the right reasons. If they are doing it for any reason other than to provide quality patient care, they have assumed it for the wrong reasons."

(Call *Emergency* at 1-800-854-6449 for subscription information.)

Two counties in Texas, Jim Wells and Nueces, are experiencing an outbeak of measles cases. Thirty cases have been reported in Alice in Jim Wells county.

Researchers found in two studies that education improved knowledge about AIDS but did not reduce fears.

If a fire department is going to assume the EMS role, it has to do it for the right reasons. If they are doing it for any reason other than to provide quality patient care, they have assumed it for the wrong reasons.

The information in this section is intended to provide public notice of disciplinary action by the Texas Department of Health and the Bureau of Emergency Management and is not intended to reflect the specific findings of either entity. This information may not reflect any number of factors including, but not limited to, the severity of harm to a patient, any mitigating factors, or a certificant's disciplinary history. This listing is not intended as a guide to the level of sanctions appropriate for a particular act of misconduct.

For information, contact the Bureau's Chief Investigator Vic Dwyer at (512) 458-7550.

* Bird, Tamara C., El Paso, Texas. Revocation of EMT certification. EMS Rule 157.51 conviction of felony while certified.

* Cantor, Dana A., Harker Heights, Texas. Revocation of EMT certification. EMS rule 157.51 (a)(4)(J), conviction of misdemeanor while certified.

Charanza, Paula, Wallis, Texas. Revocation of EMS certification. EMS rule 157.51, conviction of misdemeanor while certified and interference with EMS personnel.

Felps, Sam Bob, Menard, Texas. Denial of EMT certification; hearing held. EMS rule 157.44, felon applying for certification.

* Flores, Jose Alfredo, Laredo, Texas. Revocation of EMT-Paramedic certification. EMS Rule 157.51 (a)(4)(E) and (S), jeopardize health and safety of patient.

Flores, Mario Oscar (Jenkins), Houston, Texas. Denial of certification; no hearing requested. EMS rule 157.44, felon applying for certification.

Freeport Fire Department, Freeport, Texas. Eighteen-month probation of provider license effective through May, 1993. Health and Safety Code, Chapter 773.050, failure to staff emergency medical services vehicle with at least two certified personnel.

* Haynes, Danny H., North Richland Hills, Texas. Emergency suspension of paramedic certification. EMS Rule 157.45, failure to pass and retest for recertification.

Koerth, Melvin Lee, Iowa Park, Texas. Suspension of EMT certification for 12 months through December, 1992. EMS rule 157.51, failure to report conviction on certification application.

Lively, Lois G., El Dorado, Texas. Revocation of EMT-Intermediate certification. EMS rule 157.51, obtaining certification through misrepresentation of ambulance internship.

Malkan, Pradip C., Houston, Texas. Emergency suspension of EMT certification, EMS Rule 157.45, failure to pass exam and retest for recertification.

* Nolte, Randy, Winters, Texas. Revocation of EMT-Paramedic certification. EMS rule 157.51, convicted of felony while certified.

* Reynolds, Donald W., Pittsburg, Texas. Emergency suspension of Paramedic certification. EMS rule 157.51, (a)(4)(A),(D),(I),(K),(N),(Q) and (S).

Salerno, Larry, Houston, Texas. Denial of certification; Bureau action upheld in requested hearing. EMS rule 157.44, felon applying for certification.

Tatum, Charles H., Eastland, Texas. Thirty days jail term, probated for one year, $50 fine. Health and Safety Code, Chapter 773.064, criminal penalties, misrepresentation of EMT certification.

Watkins, Thomas A. Jr., Denton, Texas. Denial of certification; Bureau action upheld in requested hearing. EMS rule 157.44, felon applying for certification.

Young, Michael, San Angelo, Texas. Six-month probation of Course Coordinator certification through May, 1992. EMS rule 157.51, assisting another to gain certification through misrepresentation.

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* These listings are new this issue.
Denials and revocations will be printed in three consecutive issues. Suspensions and probated suspensions will be printed until suspension or probation expires.

The Bureau needs to contact the people listed below. If you know their whereabouts, please have them contact Vic Dwyer at (512) 458-7550.

Atkinson, Johnny W., DOB 4/30/64, last known address - 804 Meadow Gate, Converse, Texas.

Long, Bobby aka Bryant, Leonard, DOB 12/3/68, last known address - 6363 Skyline #53, Houston, Texas.

Perez, Oscar, DOB 01/13/67, last known address - 4951 Woodstone, San Antonio, Texas.

Ailing Patch Collector: I write on behalf of a friend of our fire department. Jeff is a twenty-year-old boy who was diagnosed with cancer in May, 1991. He had an operation to remove the cancer from his arm and is currently taking radiation therapy.

Because of his illness, he missed going to the National Fire Academy at Emmitsburg, Maryland, for the West Virginia weekend to see the famous patch collection. He heard the stories and saw the pictures of the various patches from around the country. He has a small collection himself of around 30 patches.

I'm asking for your help! I'm asking you to help us help Jeff by donating a patch or patches from your department or district and pass this letter on to other fire rescue or EMS departments in your area.

I hope together we can make his life a little brighter. Please help us in any way you can. Your support in this endevor would be greatly appreciated.

George R. Poole
BHVFD
Route 10 Box 162
Morgantown, WV 26505

Houston EMS: I had occasion to read the *Texas EMS* magazine and was quite disturbed to read the article on L.O. "Whitey" Martin.

I had the privilege of being employed by the City of Houston Fire Department back in 1970 when the Houston Fire Department took over the ambulance service. The article is not quite like I remembered it.

The Harris County Medical Society was totally behind the change, including Dr. William Kolter, Dr. Peter Fisher, Dr. Crouch, and Bill Robertson, head of the Medical Society. You should give recognition to people who deserve credit: Fire Chief C. R. Cook, Mayor Louis Welch, Councilman Frank Mancuso, Councilman Curly Miller, and many other people on the Mayor's Committee. It was, in fact, Chief Cook and Mayor Welch who had to overcome the obstacles and barriers from the private ambulance companies.

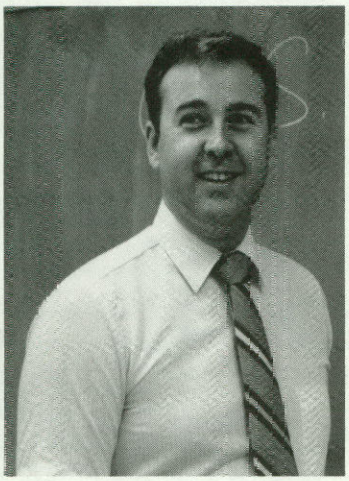
No role model? Baltimore, Maryland; Miami, Florida; and other EMS services were studied by the Mayor's Committee before Chief Martin came into the program. It was in fact, Baltimore, Maryland's Fire Department model that the Houston Fire Department took as the concept to follow and improve upon.

William Edmonds
Houston Fire Department (Retired)

Correction: The correct address and zip code for the Lubbock, Texas Department of Health EMS office is:

Texas Department of Health
Public Health Region 2 - EMS
1109 Kemper
Lubbock TX 79403

Critical Incident Stress Management Can Preserve EMS Careers



Jeffrey Mitchell, PhD

You work so hard to take care of other people. Shouldn't you make sure that you and your people are okay? The distress of working hopelessly to save a tragically mangled child can bring a paramedic to his knees. After your new EMTs work three fatal car crashes in one weekend, how are they coping with the accumulated stress? Are your medics aware that a stressful EMS call may be the cause of their nervousness, inability to sleep, or loss of concentration?

A stress education program can manage critical incident stress and accelerate an EMS worker's recovery from distress. When people understand the signs and symptoms of critical incident stress, traumatic incidents bother them less. People educated about stress seek help earlier if the event is more powerful than they can manage by themselves.

Texas CISD Training

Jeffrey Mitchell, PhD

George Everly, Jr., PhD

June 25, 26, 27, and 28

Austin, Texas

Jeffrey T. Mitchell, PhD, and George S. Everly, Jr., PhD, will come to Austin June 25, 26, 27, and 28 to teach four sessions on Critical Incident Stress Debriefing. The basic CISD program of 16 hours prepares mental health professionals and peer support personnel to provide crisis services and pre-incident education. The advanced CISD program, also 16 hours, exposes clinicians and peer support personnel to specific, proven strategies of intervention. Dr. Mitchell and Dr. Everly will also present a 16-hour course on peer counseling techniques and an 8-hour course on the nature and treatment of Post Traumatic Stress Disorder. Graduates of the basic training qualify for participation with the state Texas CISD Network.

Dr. Mitchell developed the Critical Incident Stress Debriefing process used by emergency medical services across the nation and he founded the International CISD network. He co-authored *Emergency Response to Crisis* and *Emergency Services Stress*.

To register for one of these courses contact Paul Tabor, Texas Department of Health, Bureau of Emergency Management, 1100 W. 49th Street, Austin, Texas 78756, or (512) 458-7550.

Around The State

March 28-29, 1992, **Basic Vertical Rescue.** Fire Commission approved. All equipment provided except leather gloves. $75, Renee Michalski at MCC, Waco. 817/750-3512.

April 9-10, 1992, **Emergency Symposium '92.** 2-day seminar for critical care personnel. Texarkana College. 903/838-4541 ext. 270.

April 25, 1992, **Haz-Mat Recognition and Identification Class.** Texarkana College. 903/838-4541 ext. 270.

April 24-25, 1992, **Trauma-The Twentieth Century Epidemic: Critical Decisions - Are We Thinking?** Colorado Springs, CO. 719/636-8800.

April 25-26, 1992, **Basic Vertical Rescue.** Fire Commission approved. All equipment provided except leather gloves. $75, Renee Michalski at MCC, Waco. 817/750-3512.

April 30, 1992, **Neurological Update '92.** Current issues and advanced techniques in the treatment of head and spinal cord injuries. Texarkana College. 903/838-4541 ext. 270.

May 1, 1992, **Orthopedic Update '92.** Benefits health care professionals responsible for the care of patients with orthopedic problems. Texarkana College. 903/838-4541 ext. 270.

May 10-16, 1992, **EMS Week.** Sponsored by Texas Department of Health and ACEP, contact Alana Mallard. 512/458-7550.

May 15, 1992, **Emergency Medicine Update '92.** Beaumont Plaza, Holiday Inn. Greg Smith 409/899-7888.

May 16-17, 1992. **Preshopital Trauma Life Support (PHTLS).** Texarkana College. 903/838-4541 ext. 270.

May 16-17, 1992, **Basic Vertical Rescue.** Fire Commission approved. All equipment provided except leather gloves. $75, Renee Michalski at MCC, Waco. 817/750-3512.

May 28, 1992, **Difficult Employee Problems.** Seminar to assist managers and supervisors. Texarkana College. 903/838-4541 ext. 270.

May 28-30, 1992, **Advanced Vertical Rescue.** For graduates of the basic class: ascending, haul systems, rough terrain litter handling, midface loading, cliff work at night. $130, Renee Michalski at MCC, Waco. 817/750-3512.

June 10-11, 1992, **Tenth Annual Emergency Care Update.** Sponsored by CareFlite Dallas. Arlington, Tx. Hospital and prehospital personnel. Robin Beardsley 817/882-4010, 1-800-772-5840 or Louann McGrath 214/944-8143.

June 25-28, 1992, **CISD Training,** Austin. Contact Paul Tabor 512/458-7550 for details.

July 24, 1992. **Inviting Success.** Image building. Texarkana College. 903/838-4541 ext. 270.

July 16-18, 1992 **Team Rescue,** Holiday Inn, Virginia Beach, VA. 619/8088.

July 30-August 1, 1992. **Eighth Annual Colorado Trauma Symposium,** Breckenridge, CO. Contact The Colorado Trauma Institute, 777 Bannock Street, 3rd Floor W, Denver, CO 80204. 303/893-6266.

September 12-16, 1992. **Imagine Tomorrow.** International Association of Fire Chiefs', 119th conference, Anaheim CA. Timothy Butters 202/833-3420.

Communications Specialist/Dispatcher: CareFlite of Dallas accepting applications for communications specialist. Texas registered EMT with experience in Dallas area. 214/944-8558 or apply at 1401 Stemmons Ave., Dallas, TX 75265.

Executive Director: Area Metropolitan Ambulance Authority, Fort Worth, TX. Manage business operations. $50,000 to $75,000, depending upon qualifications. E.O.E. Send resume before January 15 to Attn: William Garrison, Area Metropolitan Ambulance Authority, 3113 South University Drive, Suite 500, Fort Worth, TX 76109.

Paramedics: Galveston EMS. 9-1-1 MICU. Advanced protocols. $20,220 after 6 mo. for EMT-P with experience. S. Atwell, PO Box 838, Galveston, TX 77553. 409/766-2144.

Paramedic: Certified as paramedic at least 5 years. Experience in field of ALS or MICU. State certified instructor preferred. Resume: Edinburg EMS, Noe Ramon, 720 N 12th, Edinburg, TX 78539.

State EMS Director: State of Idaho, Department of Health and Welfare, 450 W. State Street, Boise, Idaho 83720. 208/334-5994.

EMS Administrative Director: Operational management of ALS service, Orange County, TX. Interaction with board of directors, healthcare and public organizations. Communication/marketing skills needed. Accomplishments, salary history and professional experience to Jamiel Yamen, Fitch & Assoc., 303 Marshall Rd., Box 170, Platte City, MO 64078-0170. 816/431-2600. (12)

EMT-I/Paramedic: TX Dept. of Corrections. $1654/mo. Texas certification EMT-I/Paramedic. TDC, Box 99, Personnel, Huntsville, TX 77342. 409/291-4029.

Executive Director: Volunteer EMS in Harris County, Texas. Manage operations. $25K(+). Resume (mark confidential) E. Ortega, P.O. Box 2521, 3752, Houston, TX 77252-2521.

EMTs: All levels of EMS certification in all areas of the state. Tech-Star, P.O. Box 7, Stamford, TX 79553, 915/773-5691.

Flight nurses and paramedics: Immediate opening for part-time, on-call, experienced Flight Medics in Houston, Dallas and Austin. ACLS certified; 2 years critical care/ICU/CCU experience; bilingual; previous flight experience. $18-$25/hour. Resume: Mark Monte Mitchell, MD, Air Ambulance America, P.O. Box 4051, Austin, TX 78765.

Paramedics: Hi-Tech Stat Ambulance service. Full-time openings on 24-hour units. ER & fluid pump experience helpful. $20K starting. Jim Becka, 713/790-9002.

Director: Rural south Texas area. Managerial experience preferred. Strong interpersonal skills essential. Send resume to: Administration, 1400 S. St. Marys, Falfurrias, TX 78355.

Instructor/Coordinator: Bachelors degree preferred. National- and state-certified paramedic; ACLS; EMS coordinator and instructor certification. Contact Alfredo C. Zamora, Texas Southmost College, Personnel Director, 80 Fort Brown, Brownsville, TX 78520.

Instructor: Health occupations class for Los Fresnos High School Juniors/Seniors. Must be licensed health care professional. Bachelor degree required. Some teaching experience is preferred. Contact Alfredo C. Zamora, Texas Southmost College, Personnel Director, 80 Fort Brown, Brownsville, TX 78520.

EMS Positions: EMS Employment Newsletter. Lists jobs in CA, TX, OH, partial list in other states. $7 for 3 issues. PO Box 51924, Pacific Grove, CA 93950. (12)

Paramedic: Mature person to work a hospital-based EMS system. Good pay and benefits. Contact Mike Gilbert, Fisher County Hospital, Rotan, TX. 915/735-2256. (12)

EMS Instructors: City of Corpus Christi. ACLS, CPR and Texas EMS advanced Instructors certification required. Resume: Human Resources Dept., PO Box 9277, Corpus Christi, TX 78469. 512/880-3303.

For Sale: Midland LMR radio, 16 CH, programmable; new charger. $375. 903/785-0370. (3)

Bureau Profile by Alana S. Mallard

Heckler goes on the road for the Texas trauma system

When Dan Heckler served in the US Air Force he inspected and evaluated military hospitals in Great Britain. Now, four years after his retirement from the military, Dan will soon go on the road for the Bureau of Emergency Management doing a similar inspection and evaluation of Texas hospitals for trauma system designation.

Dan, a trauma specialist with the Bureau's EMS/Trauma Systems Development Program, wrote the procedures to implement the final adopted rules for Texas' statewide trauma system. He recently began writing chapters of a Texas trauma manual, which will guide hospitals, emergency medical services, health and medical professionals, and citizens as they develop regional trauma systems plans across the state.

"My background in the Air Force helped me clarify some of these triage issues for myself as I wrote these guidelines," Dan said. "The military has a huge trauma system, which includes helicopter evacuation and and every level of facility from MASH units to major trauma centers."

Trauma program administrator Kathy Perkins will travel with Dan to Oregon next month where Dan and Kathy will accompany their counterpart in that state on hospital site inspections to get a little on-the-job training. Soon, both Dan and Kathy will comprise site visit teams to evaluate Texas hospitals that apply to become part of the Texas trauma system.

On his off time, Dan and his wife Lynn enjoy canoeing and bowling, and Dan carries the Bureau's Stars of Life bowling league high average. Dan and Lynn can talk shop, too, because she is Chief Nurse at the Bergstrom Air Force Base hospital. Dan, a Buffalo, New York, native, earned an associate degree in nursing and a degree in business management. But this isn't his first time in our state. His first Air Force assignment in 1968 brought him to Waco. It just took him some time to get back once he left Texas.

"I enjoy working here," Dan said of his eight months of employment in the Bureau of Emergency Management. "I enjoy the creativity and the brand new concept of a trauma system for Texas. It's humbling to think that what I do may have a lasting effect on the state long after I leave."

If you have questions about Texas' trauma system and how EMS fits in, or if you need help organizing your regional advisory council, call Dan at (512) 458-7550.

"I enjoy the creativity and the brand new concept of a trauma system for Texas. It's humbling to think that what I do may have a lasting effect on the state long after I leave."

Bureau of Emergency Management
Texas Department of Health
Austin, Texas 78756-3199

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