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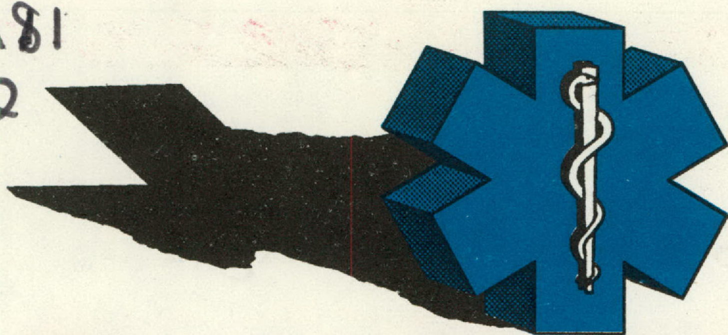

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Texas EMS Messenger

TEXAS DEPARTMENT OF HEALTH • BUREAU OF EMERGENCY MANAGEMENT

Texas Department of Health

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Chairman, Texas Board of Health

Robert Bernstein, M.D., F.A.C.P.
Commissioner of Health

Texas EMS Messenger

February 1990 Volume 11, Issue 2

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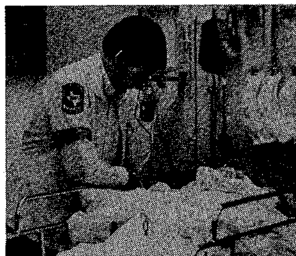

COVER PHOTO:
David Fry of Temple, Texas won third place with this photo in the black-and-white category of the 1989 EMS Week Photo Contest.

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Texas EMS Messenger
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From This Side

by
Gene Weatherall,
Chief
Bureau of
Emergency
Management

When the Trauma Technical Advisory Committee met for the first time last month, it represented the culmination of years of hard work and negotiation by EMS leaders, emergency physicians, surgeons, emergency nurses, hospital officials, legislators, health department officials, and many other groups and individuals who wanted trauma systems legislation for Texas.

House Bill 18 amended the EMS Act and added the development of emergency medical services and trauma care systems to the duties of the Bureau of Emergency Management. One of the most significant things that piece of legislation did for the Bureau and EMS was to set up the Trauma Technical Advisory Committee, because the establishment of that committee is the very first step in developing a trauma system for the State of Texas.

The meeting of the Trauma Technical Advisory Committee was held January 11 at the health department in Austin. Dr. Robert Bonham, a member of the Board of Health and chair of the Board's Emergency and Disaster Committee, gave the members their charge from the Board, then turned the meeting over to the chairperson, Ray Mason, administrator of Levelland Hospital.

The charge from the Board included these goals:

... to develop a trauma registry,

... to recommend rules and regulations on trauma systems to the Board,

... to comment on the operations of hospitals as they function in the trauma system, and ... to focus on the medical and technical aspects of developing a trauma system.

The Bureau has developed a Request for Proposal which Gene Willard presented to the committee members. We are looking for a contractor to analyze data collected from a sample of hospitals so that we can report to the Legislature in January of 1991 on how many severely injured trauma patients Texas hospitals treat and how much uncompensated care is provided to trauma patients.

This study is just the first step in getting funding for trauma systems in Texas. As you may know, our trauma systems legislation has no funding attached to it. We have been able to get some DOT funding to pay for this initial study on uncompensated care.

Pam West gave a report to the committee that outlined some very innovative ways that other states are funding their trauma systems. One state assesses an additional $10 fee on traffic tickets and puts a $25 surcharge on DWI convictions. The money goes into an operating fund and a percentage of it is set aside for catastrophic trauma care. The remaining percentage funds EMS and trauma system development. One state charges its designated trauma centers a membership fee to fund a trauma registry and system evaluation. What we need to do before we get any funding is to first show the data on trauma and its cost in the State of Texas.

There was a great deal of support among the trauma committee members for them to collect patient care and compensation data from their own hospitals in order to speed up the analysis process. One member, Dr. Vayden Stanley from San Angelo, said he had already met with his administrators and gathered a lot of trauma patient data. Dr. Stanley was so enthusiastic that he asked if Gene Willard of our EMIS program could come to San Angelo and help them with their data retrieval. I really liked Dr. Stanley because early in the meeting when everybody was introducing themselves he said that he was an aesthesiologist from San Angelo where they had a lot of "cow wrecks." West Texas. Cattle. Get it?

The Trauma Technical Advisory Committee is interested in working with Texas EMS Advisory Council. Mr. Mason recognized TEMSAC's chair Dr. David Prentice during the meeting and invited him to nominate a member of TEMSAC to serve as an ex officio member of the trauma committee. The members voted to pass on to the Board of Health Dr. Prentice's nomination of Judge Jay Johnson of Swisher county as the TEMSAC liaison to the trauma advisory committee. The Board approved this position on January 27.

Pam West and her staff have done an excellent job of putting together educational materials about trauma systems in other states and trauma registries for this committee. Mr. Mason is eager to begin work on developing a trauma registry for Texas, which is its next job, and asked the members to study the materials we had put together for them. Dr. Bonham said at the meeting that he hoped the trauma registry would be developed quickly enough so that some hospitals could begin collecting active data this Fall and perhaps have some trauma registry data to present to the Legislature along with the uncompensated care study.

The next meeting of the Trauma Technical Advisory Committee will be February 22 at the Texas Department of Health in Austin at 10:00 a.m. in Room T-607.

"The Technical Trauma Advisory Committee will provide the technical and medical leadership to develop trauma systems for Texas."

Local and Regional EMS News

Rod Dennison gets in place to have patient Wayne Matthews "turtled" onto his back during recent cave rescue training at Colorado Bend State Park.

National conference to be held in Texas

The National Cave Rescue Commission's Annual Training Seminar is slated for June 16 through 23, 1990, in San Saba and Colorado Bend State Park. Caves, cliffs, and woods will be the classrooms for this national conference which has been held at Abingdon, Virginia, Wind Cave National Park in South Dakota, and Carlsbad Caverns National Park, New Mexico in past years.

Don Paquette and Noel Sloan, officers in the National Cave Rescue Commission, were featured in a recent segment of the television show **Rescue 911** when they completed a successful underground water mission to bring to safety a stranded sport caver who had been missing for several days.

Sessions will be geared for the inexperienced caver, as well as for those with experience. Garner State Park Wilderness Rescue teams, are you ready for some summer action? Local contacts are Rod Dennison in Public Health Region 1 (817/778-6744) and Alana Mallard with the Bureau of Emergency Management (512/458-7330).

Firefighter cited in fire truck/car wreck

Public Health Region 8 EMS manager Jay Garner clipped a newspaper article for us that may prove that just because you have the right, it may not make it right.

A fire truck in Brownsville collided with a passenger car as it passed through an intersection on its way to a grass fire, and the firefighter driving the truck was ticketed by police for failure to yield right of way.

Brownsville police sergeant Robert Avitia said the driver of the car should have yielded to the fire truck, "but you're supposed to drive the emergency vehicle in a safe and cautious manner."

Denison firefighter/paramedic dies

Talmadge Fulce, a 43 year-old driver and paramedic with the Denison Fire Department was killed December 23 while fighting a fire that destroyed three downtown buildings. Fulce died when the roof of the building on which he was standing collapsed and he fell into the burning building.

Public Health Region 5 EMS manager Jimmy Dunn sent a **Fort Worth Star Telegram** newspaper article from the December 25, 1989 edition which also mentioned the stress felt by the 15-member Denison Fire Department over the loss of their co-worker, and how that loss might be even more keenly felt because of the holiday season.

Two other firefighters - Red Davis and Dennis Manning - were injured during the fire.

Panhandle paramedics travel 10,000 miles for training

Jeanne Gunn and Tom Dinsworth travelled from Darrouzett and Perryton to Amarillo two nights a week for five months for their paramedic training. Gunn estimates that they spent more time in their car than in class from August to December. The two logged in over 10,000 miles driving to class.

EMS moves, transfers, and changes

EMT Ed Zwanziger is back in Texas. Zwanziger, who retired from the Air Force in 1988 and took on hospital administration duties in Oxford, Nebraska, joined Hospitalink in Jefferson in January. Zwanziger is one of two physician's assistants working with Jeff Gusky, M.D., at Hospitalink. The other PA, Tom Yturi, is a graduate of one of Zwanziger's earliest EMT classes.

Paramedic Kerry Craig was recently hired as EMS Supervisor by Graham Memorial Hospital in Cisco. Craig, who has "been in EMS since before the Health Department

started certifying," also works with Randy Nolte and North Runnels EMS in Winters.

The City of Greenville has contracted with Dallas' Darryl Quigley to provide emergency medical services for the city. EMS responsibility had been a function of the Greenville Fire Department where 22 firefighters served as EMTs.

Montgomery County donates ambulance to Cut-n-Shoot

The Montgomery County Medical Center Hospital EMS donated a 1975 modulance Type I emergency vehicle to the Cut-n-Shoot Volunteer Fire Department which Cut-n-Shoot plans to use as a first response unit for medical and rescue emergencies. Paramedic Scott Springfield with Montgomery County Medical Center Hospital EMS said, "Cut-n-Shoot Volunteer Fire Department has been extremely active in the Montgomery County Hospital EMS first responder system."

The ambulance had been modified by Montgomery County Hospital EMS as a mobile disaster and emergency response unit.

Austin public education program wins award

TDH Commissioner Robert Bernstein will recognize the Austin EMS DWI Awareness Program in an award ceremony during the Texas Board of Health meeting on February 25. The Austin program is one of five education programs across the state named as winners of The Secretary's Community Health Promotion Awards for 1990.

Bonnie Liles, who is a paramedic with City of Austin EMS, presented the program at both the Texas Association of EMTs Annual Symposium and the Texas Department of Health EMS Conference during 1989.

The five Texas health promotion winners will compete with other states' winners for the Secretary's Awards for Excellence in Community Health Promotion. In 1988 25 programs received Awards for Excellence.

Austin EMS paramedic Allan Boutwell started the DWI awareness program and was recognized by Texas Association of EMTs and National Association of EMTs for his outstanding work.

San Saba EMT appointed to TDH transfer committee

Trouba Derrick, one of the EMTs who founded San Saba Volunteer EMS, was appointed by the Texas Board of Health to the hospital transfer committee set up as part of H.B. 18, the Omnibus Health Care Rescue Act. Derrick, like many EMTs across the state, has dealt with the problems EMS faces when the local hospital closes. The San Saba hospital closed for the last time in January, 1989.

Killer bees expected to reach Texas soon

Africanized honeybees, the so-called "killer bees," could cross the Mexican border into Texas as early as March of this year, estimate experts attending the 36th annual meeting of the Entomological Society of America which met in San Antonio in December. A story in the Austin **American Statesman** quoted Texas A&M University scientist Fowden Maxwell as saying the Africanized bees could cause twelve to fourteen deaths a year in Texas.

Texas Preventable Disease News said in a recent article that Africanized honeybees present a potential threat to humans via either a direct toxic effect through envenomation resulting from multiple stings or a severe allergic or anaphylactic response to one or more stings in a sensitized individual. Only 40 individuals die each year as a result of honeybee stings, and the majority of those are hypersensitivity reactions.

EMS, police, firefighters, and others who might be involved in activities where they may be exposed to Africanized honeybee stings should be skin or RAST (radioallergosorbent) tested. Sensitive individuals should avoid exposure, even after successful immunotherapy.

No special training of EMS or medical personnel is required to treat Africanized honeybee stings, said the article by Dr. Thomas Betz and Bobby Davis, since management of reactions of the type seen with Africanized honeybee stings is already part of standard medical training. Serious reactions to the stings include large local reactions, systemic reactions, and anaphylaxis with circulatory collapse or respiratory obstruction.

An article in the December, 1989, **jems** magazine quoted a Houston beekeeper as saying that the greatest concern in an attack situation is to secure the area from would-be rescuers. Darrell Lister uses a videotape he made in Venezuela for his four-hour training sessions with the Houston Fire Department. Lister said that insecticides are useless on attacking bees, but that soapy water immobilizes and kills them by clogging their respiratory pores.

The bees were introduced in Brazil in 1957, moved to Central America in 1981, and hit Mexico in 1986. The bees are highly defensive and more easily provoked than honeybees usually found in this country.

by Alana S. Mallard

TEMSAC

Texas EMS Advisory Council plans liaison with trauma committee and hospital transfer committee

At their January 26 meeting in Austin, members of Texas Emergency Medical Services Advisory Council appointed Faye Thomas to represent the council in working with Texas Department of Health's hospital transfer committee on the issue of diversion of ambulances from emergency departments and on the larger issue of transfers. Dr. Bill Gordon told the council that in San Antonio where he is EMS medical director the shortage of acute care beds in hospitals is backing critical patients up in the emergency department. The result for EMS in San Antonio and in other cities in the state is diversion to another hospital.

At the Board of Health meeting on January 27, TEMSAC member Judge Jay Johnson was appointed an ex officio member of the Trauma Technical Advisory Committee. This appointment will help towards parallel goals and actions of the two groups.

Prentice, who was re-elected as chair during the meeting, introduced new TEMSAC members Dr. James Atkins of Dallas, Leslie Madden of Boerne, Fred Falkner of Fort Stockton, and Mayor Fidencio Barrera of Pharr. Johnson was chosen to serve another term as vice-chair, and Dr. Donovan Butter replaces Virginia Scott as parliamentarian. Prentice also reminded the council and audience of approximately thirty that a Legislative Forum was scheduled for May 4 in Austin. William Donahue will moderate the forum.

During the Bureau Chief's Report, Gene Weatherall listed two recommendations made as a result of a National Highway Traffic Safety Administration review of Texas EMS: 1) centralize management and policy/decision making for EMS, and 2) enter into a contractual relationship between central office and regional offices for EMS performance. NHTSA made recommendations in all areas of EMS and the complete list will be published in the March issue of the **Texas EMS Messenger**. NHTSA officials have said that funds may be available to implement recommendations chosen by the Bureau for action.

Weatherall also reported that he and Dr. Prentice would meet in February with the Board of Medical Examiners to propose updates to the BME rules dealing with EMS.

Madden, Falkner, and Atkins join TEMSAC

Texas EMS Advisory Council gained three new members when the Texas Board of Health made appointments on November 5 to fill the expiring terms of six members of the council.

Beginning their six-year terms January 1 were paramedic Leslie Madden of Kendall County EMS in Boerne; Fred Falkner, a volunteer in Fort Stockton; and James Atkins, M.D., with Southwest Medical School in Dallas.

Atkins served on the original Texas EMS Advisory Council in the early 1970's. He is one of three physician representatives on TEMSAC, and serves as Medical Director for Dallas Fire Department EMS. Atkins replaces Kenneth Mattox, M.D., of Houston who was recently appointed to the Trauma Technical Advisory Committee.

Madden represents paramedics on TEMSAC, and replaces Temple Fire Department's Jack Collier as the representative of Texas Association of EMTs. She is secretary of Kendall County EMS. As one of the full-time employees, Madden makes 95% of the city's ambulance calls.

Falkner is the president of Texas Society of EMTs and a long-time EMS volunteer in west Texas. He represents volunteer providers and replaces Frankie Smith of Pearland.

Reappointed for their second six-year terms were David Prentice, M.D., emergency physician from Houston and currently serving as Chair of TEMSAC; William Donahue, San Antonio assistant city manager; and Faye Thomas, administrator of East Texas EMS in Corsicana.

Fidencio Barrera of Pharr had recently been appointed to TEMSAC to replace Robert Hopkins, Killeen city manager, who resigned. Barrera represents municipal government on the council and will serve out the remaining two years of Hopkin's six year appointment.

No other appointments are scheduled until January 1992 when six of the council's positions will expire.

Texas EMS Advisory Council

James M. Atkins, M.D.
Dallas
Fidencio Barrera
Pharr
Gustavo Barrera
Falfurrias
Guinn Burks
Crane
R. Donovan Butter, D.O.
Canyon Lake
William T. Donahue
San Antonio
Fred Falkner
Fort Stockton
Mrs. Barbara Gehring
El Paso
Mr. Joe Huffman
Garland
Jay Johnson
Tulia
Leslie Madden
Boerne
Tommy Nations
Denton
Nancy Polunsky
San Angelo
Kenneth W. Poteete
Georgetown
David Prentice, M.D.
Houston
Virginia L. Scott, R.N.
Sugarland
Faye Thomas
Corsicana
Josiah W. Tyson, III
Houston

"A few months ago in a Messenger article, I advised that each of you had an opportunity to be part of the rulemaking process. Well, here's your chance.

"The following rules were proposed at the Board of Health meeting on January 27, 1990. When these go into effect, present rules that deal with vehicle permits will be repealed. Please review these new rules carefully and make your voice heard either in approval or disapproval. A public hearing will be held in Austin on April 20, 1990 for this very purpose. Written comments are also welcome."

-Pam West
EMS Division Director

Board Proposes New Provider Licensing Rules

Vehicle standards, staffing requirements, spot inspections, insurance minimums, management elements are cornerstone of licensing EMS providers

To recodify and propose new rules regarding definitions and EMS provider licenses the Texas Department of Health proposes the repeal of EMS rules 157.62 concerning definitions, 157.66 - 157.69 and 157.75 concerning requirements for an EMS vehicle permits and fees, 157.70 concerning delegation of vehicle inspection, 157.71 concerning emergency suspension, suspension and revocation of an EMS vehicle permit, 157.72 concerning requests for variances from minimum standards, 157.73 concerning requests for training at the local level and 157.83 concerning time periods for processing applications for EMS vehicle permits and personnel certification.

The Texas Department of Health proposes new 157.2 - 157.4 and 157.11 - 157.20 concerning definitions, processing of EMS provider licenses, requests for training, and EMS providers licenses. These rules cover minimum standards for requests for emergency care attendant training, time frames for processing EMS provider licenses, EMS provider licenses, EMS vehicle requirements, subscription program requirements, suspension, probation, and revocation of the EMS provider license, unannounced inspections, and fees.

Written comments on the two proposals may be submitted to Gene Weatherall, Chief, Bureau of Emergency Management, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756-3199. Comments will be accepted for 90 days after publication of these rules in the **Texas Register**. In addition, a public hearing will be held April 20, at Texas Department of Health.

The repeal and new sections on pages 8 through 25 are proposed under the Health and Safety Code, Chapter 773 as amended by Chapters 372 and 991 Acts of the 71st Legislature, Regular Session, 1989, which provides the Texas Board of Health with the authority to adopt rules to implement the Emergency Medical Services Act.

157.2. Definitions.

157.3. Processing EMS Provider Licenses and Applications for EMS Personnel Certification.

157.4. Request for EMS Training at the Local Level.

157.11. Requirements for An EMS Provider License.

157.12. Basic Life Support Vehicle Requirements.

157.13. Advanced Life Support Vehicle Requirements

157.14. Mobile Intensive Care Unit Requirements

157.15. Requirements for a Specialized Vehicle

157.16. Subscription Program

157.17. Delegation of Vehicle Inspection.

157.18. Unannounced Inspections and Visits

157.19. Emergency Suspension, Suspension, Probation, and Revocation of a License

157.20. Request for Variances from Minimum Standards

157.2. Definitions.

157.2.

*** INDICATES LEGISLATIVE DEFINITIONS**

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

Act - Emergency Medical Services Act - Texas Civil Statutes, Article 4447o.

*Advanced life support (ALS) - Emergency prehospital care that uses invasive medical acts. The provision of advanced life support shall be under the medical supervision and control of a licensed physician.

*Advanced life support (ALS) vehicle - A vehicle that is designed for transporting the sick and injured and that meets the requirements of a basic life support vehicle and has sufficient equipment and supplies for providing intravenous therapy and endotracheal or esophageal intubation or both.

*Basic life support (BLS) - Emergency prehospital care that uses noninvasive medical acts. The provision of basic life support may be under the medical supervision and control of a licensed physician.

*Basic life support (BLS) vehicle - A vehicle that is designed for transporting the sick or injured and that has sufficient equipment and supplies for providing basic life support.

*Board - The Texas Board of Health.

*Bureau - The Bureau of Emergency Management of the Texas Department of Health.

*Bureau chief - The chief of the Bureau of Emergency Management of the Texas Department of Health.

Candidate - An individual who is requesting emergency medical services personnel certification from the Texas Department of Health.

Certificant - Emergency medical services personnel with current certification from the Texas Department of Health.

Course medical director - A licensed physician who shall provide direction over all instruction and clinical practice required in an EMT-I and EMT-P training course.

*Department - The Texas Department of Health.

*Emergency care attendant (ECA) - An individual who is certified by the department as minimally proficient to provide emergency prehospital care by providing initial aid that promotes comfort and avoids aggravation of an injury or illness.

*Emergency medical services (EMS) - Services used to respond to an individual's perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.

*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.

*Emergency medical services personnel -
(A) emergency care attendant (ECA);
(B) emergency medical technician (EMT);
(C) emergency medical technician-intermediate (EMT-I); or
(D) emergency medical technician-paramedic (EMT-P).

*Emergency medical services provider - A person who uses or maintains emergency medical services vehicles and emergency medical services personnel to provide emergency medical services. See 157.11 regarding fee exemption.

*Emergency medical services volunteer provider - An emergency medical services which has at least 75 percent of the total personnel as volunteers and is recognized as a Section 501(c)(3) nonprofit corporation by the Internal Revenue Service.
See 157.11 regarding fee exemption.

*Emergency medical services volunteer - Emergency medical services personnel who provide emergency prehospital care without remuneration, except for reimburse-

ment for expenses.

*Emergency medical technician (EMT) - An individual who is certified by the department as minimally proficient to perform emergency prehospital care that is necessary for basic life support and that includes the control of hemorrhaging and cardiopulmonary resuscitation.

*Emergency medical technician - intermediate (EMT-I) - An individual who is certified by the department as minimally proficient in performing skills required to provide emergency prehospital care by initiating under medical supervision certain procedures, including intravenous therapy and endotracheal or esophageal intubation or both.

*Emergency medical technician - paramedic (EMT-P) - An individual who is certified by the department as minimally proficient to provide emergency prehospital care by providing advanced life support that includes initiation under medical supervision of certain procedures, including intravenous therapy, endotracheal or esophageal intubation or both, electrical cardiac defibrillation or cardioversion, and drug therapy.

*Emergency medical services vehicle -
(A) basic life support vehicle;
(B) advanced life support vehicle;
(C) mobile intensive care unit; or
(D) specialized emergency medical services vehicle.

*Emergency prehospital care - Care provided to the sick and injured before or during transportation to a medical facility, including any necessary stabilization of the sick or injured in connection with that transportation.

Fleet - Twenty or more EMS vehicles operated by an EMS provider in any given service area for the purpose of determining fees.

*Governmental entity - A county, a city or town, a school district, or a special district or authority created in accordance with the Texas Constitution, including a rural fire prevention district, a water district, a municipal utility district, and a hospital district.

*Industrial ambulance - Any vehicle owned and operated by an industrial facility including both ground vehicles at industrial sites used for the initial transport or transfer of the unstable urgently sick or injured and ground vehicles at industrial sites used to transport persons at those sites who become sick, injured, wounded, or otherwise incapacitated in the course of their employment from job site to an appropriate medical facility; provided, however, that the vehicle is not available for hire or use by the general public except when assisting the local community in disaster situations or when existing ambulance service is not available.

*Medical supervision - Direction given to emergency medical services personnel by a licensed physician under the terms of the Medical Practice Act, (Article 4495b, Vernon's Texas Civil Statutes) and rules promulgated by the Texas State Board of Medical Examiners pursuant to the terms of the Medical Practice Act.

*Mobile intensive care unit (MICU) - A vehicle that is designed for transporting the sick or injured and that meets the requirements of the advanced life support vehicle and has sufficient equipment and supplies to provide cardiac monitoring, defibrillation, cardioversion, drug therapy, and two-way radio communication.

Operational policies - Policies and procedures which are the basis for the operation of the service and include but not limited to such areas as vehicle maintenance, complaint investigation, multicasualty incidents, hazardous materials but do not include personnel or financial policies.

*Person - An individual, corporation, organization, government, governmental subdivision or agency, business, trust, partnership, association, or any other legal entity.

Recertification - The procedure for renewal of emergency medical services certification.

Reciprocity - The recognition of certification or privileges granted to an individual from another state.

Service area - A trade, market, patient flow, or other catchment area in which an emer-

gency medical services provider provides emergency prehospital care.

Shall - Mandatory requirements.

Sole provider - The only emergency medical services provider in a service area.

*Specialized emergency medical services vehicle - A vehicle that is designed for transporting the sick or injured by means of air, water, or ground transportation, that is not a basic life support or advanced life support vehicle or a mobile intensive unit, and that has sufficient equipment and supplies to provide for the specialized needs of the patient transported. The term includes fixed wing aircraft, helicopters, boats, and ground transfer vehicles used for transporting the sick or injured.

Staffing Plan - A document which indicates the overall shift patterns of EMS personnel.

*Trauma Patient - Any critically injured person who has been:

(A) evaluated by a physician, a registered nurse, or emergency medical services personnel; and

(B) found to require medical care in a trauma facility.

*Trauma facility - A health care facility that is capable of comprehensive treatment of seriously injured persons and which is a part of an emergency medical services and trauma care system.

157.3. Processing EMS Provider Licenses and Applications for EMS Personnel Certification.

157.3.

(a) Purpose. The purpose of this section is to set out the time periods by which the department processes applications for EMS provider licenses and EMS personnel certification.

(b) First time period. The first period is a time from the date of receipt of an application to the date of issuance of a written notice that the application is complete or that additional specific information is required. An appointment for the inspection of an EMS provider may be in lieu of the notice of acceptance of a complete application. The time periods for each application are as follows.

(1) EMS provider licenses. The time periods are 21 days for the letter of application acceptance for EMS provider license, 21 days for the letter of deficiency, and 45 days after passing vehicle inspection for the issuance of the EMS provider license.

(2) EMS personnel certificates. The time periods are 21 days for the letter of application acceptance for testing for EMS personnel certification, 21 days for the letter of deficiency, and 45 days after testing for the issuance of EMS personnel certificate.

(c) Second time period. The second period is a time from the date of receipt of the last item necessary to complete the application, including inspection or testing, to the date of issuance of written notice approving or denying the application. The denial time periods include notification of the proposed decision and the opportunity for an informal or formal hearing. The time periods for each application are as follows.

(1) EMS provider license.

(A) The time period for the initial letter of approval for a license is 45 days.

(B) The time period for the letter of denial for a license is 120 days. The time period includes the applicant requests for a variance from minimum standards and the review necessary for this request.

(C) The time period for the issuance of a license is 45 days.

(2) EMS personnel certificates.

(A) The time period for the letter of approval for an examination is 45 days.

(B) The time period for the letter of denial for an examination is 180 days. This time limit reflects the applicant being investigated for acceptance for examination based on a criminal conviction or statutory action under the Emergency Medical Services Act, Texas Civil Statutes, Article 4447o.

(C) The time period for the issuance of a certificate is 45 days.

(d) Reimbursement of fees.

(1) In the event the application is not processed in the time periods as stated in subsections (b) and (c) of this section, the applicant has the right to request of the bureau chief full reimbursement of all filing fees paid in that particular application process. If the bureau chief does not agree that the established periods have been violated or finds that good cause existed for exceeding the established periods, the request will be denied.

(2) Good cause for exceeding the period established is considered to exist if:

(A) the number of applications for licenses, registrations, certifications, and permits as appropriate to be processed exceeds by 15% or more the number processed in the same calendar quarter the preceding year;

(B) another public or private entity utilized in the application process caused the delay; or

(C) other conditions existed giving good cause for exceeding the established periods.

(e) Appeal. If the request for full reimbursement authorized by subsection (d) of this section is denied, the applicant may then appeal to the commissioner of health for a resolution of the dispute. The applicant shall give written notice to the commissioner that he requests full reimbursement of all filing fees paid because his application was not processed within the adopted time period. The bureau chief shall submit a written report of the facts related to the processing of the application and good cause for exceeding the established time periods. The commissioner will make the final decision and provide written notification of his decision to the applicant and the bureau chief.

(f) Contested case hearing. If at any time during the processing of the application during the second time period, a contested case hearing becomes involved, the time periods in 1.34 of this title (relating to Time Periods for Conducting Contested Case Hearing) are applicable.

(g) Application for EMS provider license by a corporation. An applicant for an EMS provider license who is a corporation under the Texas Business Corporation Act, Texas Civil Statutes, Article 2.45, shall provide the department with an affidavit issued by the comptroller's office attesting to the applicant's good standing under the Tax Code, Texas Codes Annotated, Chapter 171.

157.4.

(a) Generally. A government entity that sponsors or wishes to sponsor an EMS provider may request the bureau to provide EMS training for emergency care attendants if the training is not available locally or can not be made available locally.

(b) Requests.

(1) Requests from governmental entities shall be signed by the mayor, city manager, county judge, chairman of a hospital district board, or appropriate authority of other governmental entities.

(2) All requests shall be in writing and sent through the appropriate public health region office to the bureau chief and shall contain:

(A) number of residents in service area;

(B) number of square miles in service area;

(C) number and names of trained personnel, their certification level and expiration date;

(D) number of vehicles;

(E) name and distance to closest known training site;

(F) source and amount of monetary support;

(G) local government support and fiscal and other resources;

(H) annual EMS budget;

(I) time and place preferred by provider for training;

(J) number of runs per month; and

(K) other EMS providers in service area.

(c) Evaluation of requests. The bureau will evaluate each request and give priority to those requests indicating the greatest need for training. The bureau may request additional information for clarification.

(1) Evaluation of the request shall be based upon:

(A) the determination of availability of training in service area;

(B) the number of trained personnel in the service area for vehicle numbers and run data;

(C) the level of care being provided by a sponsored EMS provider; and

(D) the cost of training.

(2) The request may be denied if the bureau concludes from data presented that training is unnecessary or the training is available locally or can be made available locally.

(d) Response to requests. The bureau shall respond in writing, to the request within 30 days of receipt of the request.

157.4. Request for EMS Training at the Local Level.

157.11. Requirements for An EMS Provider License.

157.11.

(a) License application process.

(1) Initial application process.

(A) An EMS provider shall request an application form from the bureau.

(B) The EMS provider shall submit the completed, signed and dated application and the nonrefundable fee, if any, as provided in subsection (b) of this section.

(C) The EMS provider shall submit a legal document which records the name of the business and specifies executive officer, chief, director, principal stockholders or board.

(D) The EMS provider shall complete and submit the radio/electronic communication capability form.

(E) The EMS provider shall submit names of all employees indicating paid or non-paid, level of certification, and identification number.

(F) An EMS provider shall provide evidence of:

(i) staffing plan;

(ii) treatment and transport protocols and/or standing orders, signed with date of last review; original signature of medical director required at advanced levels;

(iii) a blank patient run report; and

(iv) a run review process which shall consist of evaluation and action.

(G) The EMS provider shall provide proof of vehicle liability insurance as required by state law.

(H) An EMS provider who is operating at an advanced level either on a full-time or part-time basis shall submit a copy of letter and/or agreement with the medical director.

(I) The EMS provider who operates at an advanced level on a part-time basis, i.e. when advanced level personnel are available, shall be responsible for having the equipment, staff, and medical director necessary for the level of advanced care, either ALS or MICU.

(J) An EMS provider claiming volunteer status shall submit verification and letter of governmental sponsorship or recognition.

(K) The EMS provider shall submit a list of all vehicles with the vehicle identification number (VIN).

(L) Each EMS provider shall have current operational policies in place and shall submit evidence of such by January 1, 1992.

(2) License renewal process.

(A) The bureau shall notify the EMS provider 60 days prior to the expiration date of the provider license. If a provider does not receive notice of expiration from the bureau, it is the duty of the provider to notify the bureau and request a license renewal application. Failure to apply for renewal shall result in expiration of the license.

(B) The EMS provider shall submit the completed application and the nonrefundable fee, if any, as provided in subsection (b) of this section. An application shall be submitted at least 30 days prior to the expiration date.

(C) The EMS provider shall submit a revised/verified radio/electronic communication capability form.

(D) The EMS provider shall provide proof of vehicle liability insurance as required by state law;

(b) License fees.

(1) Fees shall be $100 for each EMS vehicle operated by the provider or a maximum of $2000 during the two-year registration period; except however, an EMS provider who exclusively uses volunteers and has no more than five full-time staff or their equivalent to provide emergency prehospital care is exempt from the fees.

(2) If a license is issued for less than a two-year period under Subsection (f) of this section, the following fees per vehicle shall apply:

(A) $100 if the license is valid for 19-24 months;

(B) $75.00 if the license is valid for 13-18 months;

(C) $50.00 if the license is valid for 7-12 months; or

(D) $25.00 if the license is valid for 6 months or less.

(3) If the EMS provider has met the maximum $2,000 fee during a license period, no fee shall be required for additional vehicles added during the license period.

(c) Vehicle Inspections.

(1) Prior to the issuance of a license, each of the EMS provider's vehicles shall be inspected by the department.

(2) Each vehicle shall have a current motor vehicle certificate of inspection prior to the department's inspection.

(3) The inspection shall include:

(A) Visual and physical inspection of each vehicle for the purpose of determining compliance with the vehicle type specifica-

tions of these rules.

(B) Visual and physical inspection of the equipment on each vehicle for the purpose of determining compliance with the vehicle equipment specifications of these rules.

(C) Visual inspection of safety equipment as follows:

(i) one fire extinguisher securely mounted and readily accessible;

(ii) two "No Smoking" signs, one mounted in patient compartment and one in the cab which are easily visible from each entry way;

(iii) a minimum of two visible warning devices on the vehicle, i.e. flares, reflective triangles, etc. which are safe and effective and visible for at least 500 feet; and

(iv) one functional flashlight (excluding penlight).

(d) Vehicle Inspection failure.

(1) A vehicle shall fail the inspection if the requirements in subsection (c) of this section are not met and an EMS provider license shall not be issued.

(2) The department shall give the EMS provider a written report at the time of the inspection indicating the deficiencies.

(e) Provisional license

(1) The department may issue a 60-day provisional license if it finds that the public interest and the service needs would be served and;

(A) staffing requirements are met;

(B) vehicle specifications are met;

(C) the required fee is received and any part of application process is incomplete; and

(D) the following equipment is present:

(i) one small, one medium, and one large size extrication cervical collar (soft foam rubber cervical collars are not acceptable);

(ii) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing and suction tips;

(iii) three bag valve mask units in adult, pediatric, and infant sizes with appropriate size masks which can be used with an external oxygen supply;

(iv) oropharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(v) two portable medical grade "D" cylinders or equivalent oxygen units in working order with current inspection stamp attached and adequate tubing and semi-open valveless, transparent masks in adult, pediatric and infant sizes;

(vi) padded board, cardboard, or aluminum splints as follows:

(I) two at least 15 inches long by at least three inches wide;

(II) one at least 48 inches long by at least three inches wide; or

(III) may be, but not limited to, any of the following types of splints:

(-a-) inflatable splints;

(-b-) foam-type rapid splints;

(-c-) wire ladder splints;

(-d-) commercial fracture pack;

(vii) long and short spine boards to include:

(I) one long six-foot board or commercial device; and

(II) one short spine board or commercial device; or

(III) commercial device which serves the purpose of both (I)and (II);

(viii) sphygmomanometer with adult, pediatric, and infant size cuffs;

(ix) stethoscope;

(x) one multilevel stretcher with two clean sheets and two clean blankets; and

(xi) dressing and bandaging materials.

(2) A second 60 day provisional license may be issued if:

(A) written documentation is submitted showing that equipment repair and/or part is back ordered; or

(B) written documentation is submitted showing that equipment was ordered but not received.

(f) An EMS provider who meets the requirements of this section shall be issued a license valid for a period of two years, except that the department may issue an initial license for less than two years in order to conform expiration dates to existing inspection schedules for a locality. An initial license shall be valid upon the date of issuance. A renewed license shall be valid on the day after the expiration of the previous license.

(g) Licenses shall be issued for providers with the following types or combination of types of vehicles:

(1) BLS vehicles;

(2) ALS vehicles;

(3) MICU units; and

(4) Specialized emergency medical services vehicles.

(h) A license is not transferable from one EMS provider to another.

(i) Responsibilities of the EMS provider during the license period shall include:

(1) Notification of the bureau if a vehicle is added and submission of the prorated license fee, if applicable, after which the vehicle shall be inspected to determine compliance with these rules.

(2) Completion of the annual run response summary.

(3) Notification of the bureau within 30 days of a change in the provider name. If ownership changes a new application and fee is required for an EMS provider license.

(4) Notification of the bureau within one working day of any change in medical director and written notification within 30 days of the change in medical director and submission of a copy of the new letter or new agreement.

(5) Notification of bureau within 48 hours of any permanent or long term change in level of service provided. The vehicle authorization shall be returned by next day mail. Inspection shall be required if level of service is increased, e.g., BLS to ALS. A replacement vehicle authorization shall be issued.

(6) Notification of the bureau within 30 days of any changes in:

(A) staffing plans;

(B) treatment or transport protocols and/or standing orders;

(C) executive officer, chief, director, principal stockholders, or board; or

(D) communication status, capability, or equipment.

(7) Notification of the bureau if a vehicle is substituted for 15 days or longer. No vehicle shall be substituted longer than 90 days.

(8) The EMS provider shall be responsible that a vehicle when in service is staffed and equipped in accordance with the ACT and these rules for each level of care provided.

(j) The EMS provider shall have the name of the service prominently displayed on the sides of the vehicle.

(k) The vehicle authorization shall be prominently displayed in the patient compartment and the licensure decal shall be displayed on the lower right rear window.

(l) An EMS provider shall not advertise as a volunteer provider unless at least 75% of all personnel are volunteer.

(m) An EMS provider who has a check returned for "insufficient funds" shall be subject to revocation of the EMS provider license and this may be used as grounds for nonrenewal of the EMS provider license.

157.12. Basic Life Support Vehicle Requirements.

157.12.

(a) Staffing requirements. The requirements a basic life support vehicle shall be:

(1) The EMS provider shall be capable of providing this level of care 24 hours per day, seven days per week and the provider shall make available such records or information as requested by the department to confirm the availability of certified EMS personnel to provide this level of care.

(2) When in service, a basic life support vehicle shall be staffed with at least two emergency care attendants.

(b) Vehicle specifications. After June 30, 1990, all vehicles which have not previously been issued a vehicle authorization shall meet the current Federal Specification Ambulance Emergency Medical Care Vehicle as published by the General Service Administration as regard to type (I, II, III).

(c) Required equipment. The following BLS required equipment must be clean and in working order to provide safe transport for patients in the individual service areas:

(1) one small, one medium, and one large size extrication cervical collar (soft foam rubber cervical collars are not acceptable);

(2) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing and suction tips;

(3) three bag valve mask units in adult, pediatric, and infant sizes with appropriate size masks which can be used with an external oxygen supply;

(4) oropharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(5) two portable medical grade "D" cylinders or equivalent oxygen units in working order with current inspection stamp attached and adequate tubing and semi-open valveless, transparent masks in adult, pediatric and infant sizes;

(6) two multi-trauma dressings approxi-

mately 10-inch by 30-inch in size;

(7) a minimum of 5 dozen sterile gauze pads;

(8) twelve soft roller adhering bandages;

(9) six sterile petroleum jelly impregnated gauze or suitable occlusive dressing;

(10) four rolls of adhesive tape;

(11) four sterile burn sheets;

(12) one traction splint with all attachments suitable for an adult and pediatric patient or one adult and one pediatric traction splint;

(13) padded board, cardboard, or aluminum splints as follows:

(A) two at least 15 inches long by at least three inches wide;

(B) one at least 48 inches long by at least three inches wide; or

(C) may be, but not limited to, any of the following types of splints:

(i) inflatable splints;

(ii) foam-type rapid splints;

(iii) wire ladder splints;

(iv) commercial fracture pack;

(14) long and short spine boards to include:

(A) one long six-foot board or commercial device; and

(B) one short spine board or commercial device; or

(C) commercial device which serves the purpose of both (A) and (B);

(15) twelve triangular bandages;

(16) two pairs of bandage scissors; (table shears are not acceptable);

(17) sealed obstetrics kit which has been autoclaved or otherwise suitably sterile with expiration date attached. Commercial kit is acceptable. A non-commercial kit must be labeled and include the following:

(A) sterile gloves;

(B) one disposable sheet;

(C) cleansing cloths;

(D) umbilical clamps;

(E) nylon cord tie-offs;

(F) disposable scalpel;

(G) bulb aspirator;

(H) four inch by four inch sterile gauze pads;

(I) obstetrical pad;

(J) receiving blanket;

(K) disposable towels; and

(L) plastic bag;

(18) nonporous infant insulating device;

(19) sphygmomanometer with adult, pediatric, and infant size cuffs;

(20) stethoscope;

(21) penlight;

(22) one multilevel stretcher with two clean sheets, and two clean blankets; and

(23) two-way radio or cellular phone communication capability between vehicle and dispatch, hospital or law enforcement. (Citizen's band radio is not acceptable).

157.13.

157.13. Advanced Life Support Vehicle Requirements

(a) Staffing requirements. The requirements for staffing an advanced life support (ALS) vehicle shall be:

(1) The EMS provider shall be capable of providing this level of care 24 hours per day, seven days per week and the provider shall make available such records or information as requested by the department to confirm the availability of certified EMS personnel to provide this level of care.

(2) When in service, an ALS vehicle shall be staffed with two EMS personnel, one of whom shall be at least an EMT and the other shall be at least an EMT-I.

(3) A medical director is required.

(b) Vehicle specifications. After June 30, 1990, all vehicles which have not previously been issued a vehicle authorization shall meet the current Federal Specification Ambulance Emergency Medical Care Vehicle as published by the General Service Administration as to type (I, II, III).

(c) Required equipment. ALS required equipment shall include all BLS equipment as provided in 157.12 of this section (relating to Basic Life Support Vehicle Requirements) and the following which shall be in sufficient quantities, clean, and in working order:

(1) intravenous fluids with administration sets for volume replacement or to keep vein open in quantities and types as in EMS provider's Medical Treatment Protocols/Standing Orders;

(2) 50% Dextrose;

(3) esophageal intubation devices and/or endotracheal tubes with laryngoscope and blades in adult, pediatric, and infant sizes;

(4) demand valve oxygen unit or a mechanically operated positive pressure ventilation device which is capable of manual or automatic operation;

(5) intravenous catheters and butterflies;

(6) one copy of the Medical Treatment Protocols/Standing Orders with original

signature of the EMS provider's medical director and date of last review; and

(7) a list signed by the Medical Director which contains the following items as identified in the Medical Treatment Protocols/Standing Orders:

(A) types and quantities of intravenous solutions;

(B) quantities and sizes of intravenous catheters and butterflies;

(C) quantities and sizes of endotracheal tubes and/or esophageal intubation devices, if authorized; and

(D) any specialized equipment required in Medical Treatment Protocols/Standing Orders.

157.14. Mobile Intensive Care Unit Requirements

157.14.

(a) Staffing requirements. The requirements for staffing a mobile intensive care unit (MICU) shall be:

(1) The EMS provider shall be capable of providing this level of care 24 hours per day, seven days per week and the provider shall make available such records or information as requested by the department to confirm the availability of certified EMS personnel to provide this level of care.

(2) When in service, MICUs shall be staffed with at least two EMS personnel, one of whom shall be an EMT-P and the other shall be at least an EMT.

(3) A medical director is required.

(b) Vehicle specifications. After January 1, 1991, all vehicles which have not previously been issued a vehicle authorization shall meet the current Federal Specification Ambulance Emergency Medical Care Vehicle as published by the General Service Administration as regard to type (I, II, III).

(c) Required equipment. MICU required equipment shall include all equipment as provided in 157.12 and 157.13 of this section (relating to Basic Life Support Vehicle Requirements and Advanced Life Support Vehicle Requirements) and the following which shall be in sufficient quantities, clean and in working order:

(1) cardiac monitor with defibrillator and electrodes;

(2) drugs as prescribed by the service's medical director;

(3) one copy of the Medical Treatment Protocols/Standing Orders with original signature of the EMS provider's medical director and date of last review; and

(4) quantities and types of drugs included in the list as required in 157.13 (c)(7) of this section (relating to Advanced Life Support Vehicle Requirements).

157.15.

(a) Helicopter emergency medical services (EMS) vehicle.

(1) General requirements

(A) The aircraft operator shall, in all operations, comply with all Federal Aviation Regulations, Part 135, which is adopted by reference. Copies of the Federal Aviation Regulations are on file in the Bureau of Emergency Management offices, 1100 West 49th Street, Austin, Texas 78756, and may be reviewed during normal working hours.

(B) The helicopter shall have the following specifications:

(i) be configured in such a way that the medical attendants have adequate access for the provision of patient care within the cabin to give cardiopulmonary resuscitation;

(ii) allow supine loading of the patient by two attendants;

(iii) have radio communication with hospitals and public safety vehicles;

(iv) be equipped with radio headsets that insure internal crew communication and transmission to appropriate agencies; and

(v) have hooks and/or other appropriate devices for hanging the intravenous fluid bags.

(2) Requirements for an EMS provider license.

(A) Initial application process. The EMS provider shall meet the requirements of 157.11 (a) (1) (A-F) of this title (relating to Requirements for an EMS Provider License) and in addition shall:

(i) Provide proof of vehicle liability insurance as required by U.S. Department of Transportation Part 298 requirements for liability insurance for aircraft; and

(ii) Submit a list of all helicopters with the registration number or N number if the vehicle is owned by the provider.

(iii) If the helicopter is leased, provide letter of agreement that all helicopters shall meet the specifications of subsection (a) (1) (B) of this section.

(B) License renewal process. The EMS provider shall meet the requirements of 157.11 (a) (2) (A-C) of this title (relating to Requirements for an EMS Provider License) and in addition, shall provide proof of vehicle liability insurance as required by U.S. Department of Transportation Part 298 requirements for liability insurance for aircraft.

(3) Inspections.

(A) Prior to the issuance of a license, each of the EMS provider's helicopter patient care equipment shall be inspected by the department.

(B) The inspection shall include visual and physical inspection of equipment for the purpose of compliance with the equipment specifications of these sections. If the vehicle is rented or leased, all equipment shall be available for inspection prior to the issuance of a license.

(4) Inspection failure.

(A) An EMS provider shall fail the inspection if the requirements in paragraphs 1, 2 and 3 of this subsection are not met and an EMS provider license shall not be issued.

(B) The department shall give the EMS provider a written report at the time of the inspection indicating the deficiencies.

(5) Provisional license

(A) The department may issue a 60-day provisional license if it finds that the public interest and the service needs would be served and;

(i) staffing requirements are met;

(ii) vehicle specifications are met;

(iii) the required fee is received and any part of application process is incomplete; and

(iv) the following equipment is present:

(I) cervical spinal immobilization devices in small, medium, and large sizes;

(II) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing and suction tips;

(III) three bag valve mask units in adult, pediatric and infant sizes with the appropriate masks which can be used with an external oxygen supply;

(IV) oropharyngeal/nasopharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(V) medical grade oxygen; if in cylinders shall be in working order with current inspection stamp attached and capable of being strapped down and adequate tubing;

(VI) semi-open valveless, transparent oxygen masks in adult, pediatric and infant sizes;

(VII) three splints which may be, but not limited to, any of the following types:

(-a-) inflatable splints;

(-b-) foam-type rapid splints;

(-c-) wire ladder splints; or

(-d-) commercial fracture pack;

(VIII) one each long and short spine immobilization device;

(IX) sphygmomanometer with adult, pediatric, and infant cuffs;

(X) stethoscope (a doppler or electronic stethoscope is acceptable);

(XI) one stretcher capable of being secured to the aircraft frame, with restraining belts to safely secure the patient to the stretcher and with clean sheets and blanket; and

(XII) dressing and bandaging materials.

(B) A second 60 day provisional license may be issued if:

(i) written documentation is submitted showing that equipment repair and/or part is back ordered; or

(ii) written documentation is submitted showing that equipment was ordered but not received.

(6) An EMS provider who meets the requirements of this section shall be issued a license valid for a period of two years, except that the department may issue an initial license for less than two years in order to conform expiration dates to existing inspection schedules for a locality. An initial license shall be valid upon the date of issuance. A renewed license shall be valid on the day after the expiration of the previous license.

(7) A license is not transferable from one EMS provider to another.

(8) The EMS provider shall meet the responsibilities required in 157.11 (i) of this title (relating to Requirements for an EMS Provider License).

(9) The vehicle authorization shall be prominently displayed in the patient compart ment.

(10) Staffing and equipment.

(A) An EMS provider who provides helicopter service shall be licensed to provide advanced life support.

157.15. Requirements for a Specialized Vehicle

(B) Staffing shall be:

(i) the medical director shall:

(I) be a physician licensed to practice medicine in Texas; and

(II) be knowledgeable and experienced in emergency trauma, critical care, and the effect of flight on the patient. If the medical director is not experienced in this area, he shall request aeromedical consultation by a physician knowledgeable about the effect of flight.

(ii) the medical flight crew, excluding the pilot, shall:

(I) consist of at least one EMT-P;

(II) show proof of additional training in flight physiology and aircraft and flight safety; and

(III) be familiar with survival techniques appropriate to the terrain as in Federal Aviation Regulations, Part 135 as adopted by reference in paragraph (1)(A) of this subsection.

(iii) the helicopter pilot shall comply with Federal Aviation Regulations, as adopted by reference in paragraph (1)(A) of this subsection, Part 91 or Part 135 whichever is applicable.

(C) The equipment required for each flight, except when transporting a neonate or a patient in a hyperbaric chamber, shall be as follows:

(i) medical grade oxygen; if in cylinders shall be in working order with current inspection stamp attached and capable of being strapped down and adequate tubing;

(ii) semi-open valveless, transparent oxygen masks in adult, pediatric, and infant sizes;

(iii) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing;

(iv) two soft suction catheters;

(v) two tonsil tip suction catheters;

(vi) three bag valve mask units in adult, pediatric and infant sizes with the appropriate masks which can be used with an external oxygen supply;

(vii) one stretcher capable of being secured to the aircraft frame, with restraining belts to safely secure the patient to the stretcher;

(viii) clean sheets and blanket;

(ix) receptacle for emesis;

(x) sphygmomanometer with adult, pediatric, and infant cuffs;

(xi) stethoscope (a doppler or electronic stethoscope is acceptable);

(xii) penlight;

(xiii) three splints which may be, but not limited to, any of the following types:

(I) inflatable splints;

(II) foam-type rapid splints;

(III) wire ladder splints; or

(IV) commercial fracture pack;

(xiv) oropharyngeal/nasopharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(xv) one each long and short spine immobilization device;

(xvi) cervical spinal immobilization devices in small, medium, and large sizes;

(xvii) one copy of the Medical Treatment Protocols/Standing Orders with original signature of the medical director and date of the last review;

(xviii) esophageal intubation devices and/or endotracheal tubes with laryngoscope handle and blades in adult pediatric and infant sizes;

(xix) intravenous fluids in non-breakable containers with administration sets and intravenous catheters and/or needles in quantities and types as prescribed by the medical director;

(xx) cardiac monitor with defibrillator and the following additional equipment:

(I) one spare electrocardiogram electrode for each lead;

(II) spare roll of electrocardiogram recording paper; and

(III) drugs in quantities and types as prescribed by the medical director; and

(xxi) a list signed by the medical director
which contains the following items as identified in the Medical
Treatment Protocols/Standing Orders:

(I) quantities and types of intravenous fluids;

(II) quantities and sizes of intravenous catheters and/or needles;

(III) quantities and sizes of esophageal intubation devices and/or endotracheal tubes;

(IV) quantities and types of drugs; and

(V) any specialized equipment required in Medical Treatment Protocols/Standing Orders.

(D) Additional equipment to be carried to meet the special medical needs of the patient shall be:

(i) dressings and supply kit to include:

(I) two multi-trauma dressings approximately 10 inches by 30 inches in size;

(II) sterile gauze pads in sizes and quantities as determined by the medical director;

(III) soft roller adhering bandages in sizes and quantities as determined by the medical director;

(IV) three sterile petroleum jelly impregnated gauze or suitable occlusive dressings;

(V) adhesive tape; and

(VII) one pair bandage scissors.

(ii) burn kit, to be carried when required, to include:

(I) sterile burn sheets;

(II) sterile gloves; and

(III) twelve four inch by four inch sterile gauze pads.

(iii) sealed obstetric kit which has been autoclaved or otherwise suitably sterile with expiration date attached, to be carried with all pregnant patients. Commercial kit is acceptable. A non-commercial kit must be labeled and include the following:

(I) sterile gloves;

(II) one disposable sheet;

(III) cleansing cloths;

(IV) umbilical clamps;

(V) nylon cord tie-offs;

(VI) disposable scalpel;

(VII) bulb aspirator;

(VIII) four inch by four inch sterile gauze pads;

(IX) obstetrical pad;

(X) receiving blanket;

(XI) disposable towels; and

(XII) plastic bag.

(iv) pediatric kit, to be carried when the patient is under 12 years of age and always with the obstetric kit, to include:

(I) two bulb syringes;

(II) one DeLee suction device;

(III) one pediatric laryngoscope handle with blades;

(IV) one each pediatric endotracheal tubes in sizes 2.5, 3.0, 3.5, and 4.0 French with stylet;

(V) one pediatric Magill forceps; and

(VI) two pediatric drip intravenous tubings.

(b) Fixed-wing aircraft EMS vehicle.

(1) General requirements. The aircraft operator shall in all operations comply with all Federal Aviation Regulations, as adopted by reference in subsection (a)(1)(A) of this section, Part 91 or Part 135, whichever is applicable.

(A) The aircraft operator shall, in all operations, comply with all Federal Aviation Regulations, Part 135, which is adopted by reference. Copies of the Federal Aviation Regulations are on file in the Bureau of Emergency Management offices, 1100 West 49th Street, Austin, Texas 78756, and may be reviewed during normal working hours.

(B) The fixed-wing aircraft shall have the following specifications:

(i) be configured in such a way that the medical attendants have adequate access for the provision of patient care within the cabin to give cardiopulmonary resuscitation;

(ii) allow supine loading of the patient by two attendants;

(iii) have radio communication with hospitals and public safety vehicles.

(iv) be equipped with radio headsets that insure internal crew communication and transmission to appropriate agencies; and

(v) have hooks and/or other appropriate devices for hanging the intravenous fluid bags.

(2) Requirements for an EMS provider license.

(A) Initial application process. The EMS provider shall meet the requirements of 157.11 (a) (1) (A-F) of this title (relating to Requirements for an EMS Provider License) and in addition shall:

(i) Provide proof of vehicle liability insurance as required by U.S. Department of Transportation Part 298 requirements for liability insurance for aircraft; and

(ii) submit a list of all fixed-wing aircraft with the registration number or N number.

(iii) If the fixed-wing aircraft is leased, provide letter of agreement that all fixed-wing aircraft shall meet the specifications of subsection (b) (1) (B) of this section.

(B) License renewal process. The EMS provider shall meet the requirements of 157.11 (a) (2) (A-C) of this title (relating to Requirements for an EMS Provider License) and in addition, shall provide proof of vehicle liability insurance as required by U.S. Department of Transportation Part 298 requirements

for liability insurance for aircraft.

(3) Inspections.

(A) Prior to the issuance of a license, each of the EMS provider's fixed-wing aircraft patient care equipment shall be inspected by the department.

(B) The inspection shall include visual and physical inspection of equipment for the purpose of compliance with the equipment specifications of these sections. If the vehicle is rented or leased, all equipment shall be available for inspection prior to the issuance of a license.

(4) Inspection failure.

(A) An EMS provider who provides fixed-wing aircraft service shall fail the inspection if the requirements in paragraphs 1, 2, and 3 of this subsection are not met and an EMS provider license shall not be issued.

(B) The department shall give the EMS provider a written report at the time of the inspection indicating the deficiencies.

(5) Provisional license

(A) The department may issue a 60-day provisional license if it finds that the public interest and the service needs would be served and;

(i) staffing requirements are met;

(ii) vehicle specifications are met;

(iii) the required fee is received and any part of application process is incomplete; and

(iv) the following equipment is present:

(I) cervical spinal immobilization devices in small, medium, and large sizes;

(II) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing and suction tips;

(III) three bag valve mask units in adult, pediatric and infant sizes with the appropriate size masks which can be used with an external oxygen supply;

(IV) oropharyngeal/nasopharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(V) medical grade oxygen, if in cylinders shall be in working order with current inspection stamp attached and capable of being strapped down and adequate tubing;

(VI) semi-open valveless, transparent oxygen masks in adult, pediatric and infant sizes;

(VII) three splints which may be, but not limited to, any of the following types:

(-a-) inflatable splints;

(-b-) foam-type rapid splints;

(-c-) wire ladder splints; or

(-d-) commercial fracture pack;

(VIII) one each long and short spine immobilization device;

(IX) sphygmomanometer with adult, pediatric, and infant cuffs;

(X) stethoscope (a doppler or electronic stethoscope is acceptable);

(XI) one stretcher capable of being secured to the aircraft frame, with restraining belts to safely secure the patient to the stretcher and with clean sheets and blanket; and

(XII) dressing and bandaging materials.

(B) A second 60 day provisional license may be issued if:

(i) written documentation is submitted showing that equipment repair and/or part is back ordered; or

(ii) written documentation is submitted showing that equipment was ordered but not received.

(6) An EMS provider who meets the requirements of this section shall be issued a license valid for a period of two years, except that the department may issue an initial license for less than two years in order to conform expiration dates to existing inspection schedules for a locality. An initial license shall be valid upon the date of issuance. A renewed license shall be valid on the day after the expiration of the previous license.

(7) A license is not transferable from one EMS provider to another.

(8) The EMS provider shall meet the responsibilities required in 157.11 (i) of this title (relating to Requirements for an EMS Provider License).

(9) The vehicle authorization shall be prominently displayed in the patient compartment.

(10) Staffing and equipment requirements.

(A) An EMS provider who provides fixed-wing aircraft service shall be licensed to provide advanced life support.

(B) Staffing shall be:

(i) the medical director shall:

(I) be a physician licensed to practice medicine in Texas; and

(II) be knowledgeable and experienced in emergency trauma, critical care, and the effect of flight on the patient. If the

medical director is not experienced in this area, he shall request aeromedical consultation by a physician knowledgeable about the effect of flight.

(ii) the medical flight crew, excluding the pilot, shall:

(I) consist of at least one EMT-P;

(II) show proof of additional training in flight physiology and aircraft and flight safety; and

(III) be familiar with survival techniques appropriate to the terrain as in Federal Aviation Regulations, Part 135 as adopted by reference in paragraph (1)(A) of this subsection.

(iii) the fixed-wing aircraft pilot shall comply with Federal Aviation Regulations, as adopted by reference in paragraph (1)(A) of this subsection, Part 91 or Part 135 whichever is applicable.

(C) The equipment required for each flight, except when transporting a neonate or a patient in a hyperbaric chamber, shall be as follows:

(i) medical grade oxygen, if in cylinders shall be in working order with current inspection stamp attached and capable of being strapped down and adequate tubing;

(ii) semi-open valveless, transparent oxygen masks in adult, pediatric, and infant sizes;

(iii) one portable suction unit operated by electric (battery) or gas pressured power source with connecting tubing;

(iv) two soft suction catheters;

(v) two tonsil tip suction catheters;

(vi) three bag valve mask units in adult, pediatric and infant sizes with the appropriate masks which can be used with an external oxygen supply;

(vii) one stretcher capable of being secured to the aircraft frame, with restraining belts to safely secure the patient to the stretcher;

(viii) clean sheets and blanket;

(ix) receptacle for emesis;

(x) sphygmomanometer with adult, pediatric, and infant cuffs;

(xi) stethoscope (a doppler or electronic stethoscope is acceptable);

(xii) penlight;

(xiii) oropharyngeal/nasopharyngeal airways (nonmetallic) in adult, pediatric, and infant sizes;

(xvi) one copy of the Medical Treatment Protocols/Standing Orders with original signature of the medical director and date of last review;

(xvii) esophageal intubation devices and/or endotracheal tubes with laryngoscope handle and blades in adult and pediatric sizes;

(xviii) intravenous fluids in non-breakable containers with administration sets, intravenous catheters, and/or needles in quantities and types as prescribed by the medical director; and

(xix) a list signed by the Medical Director which contains the following items as identified in the Medical Treatment Protocols/Standing Orders:

(I) quantities and types of intravenous fluids;

(II) quantities and sizes of intravenous catheters and/or needles;

(III) quantities and sizes of esophageal intubation devices and/or endotracheal tubes;

(IV) quantities and types of drugs; and

(V) any specialized equipment required in Medical Treatment Protocols/Standing Orders.

(D) Additional equipment to be carried to meet the special medical needs of the patient shall be:

(i) trauma kit to include:

(I) three splints which may be, but not limited to, any of the following types of splints:

(-a-) inflatable splints;

(-b-) foam-type rapid splints;

(-c-) wire ladder splints; or

(-d-) commercial fracture pack;

(II) two multi-trauma dressings approximately 10 inches by 30 inches in size;

(III) sterile gauze pads in sizes and quantities as determined by the medical director;

(IV) soft roller adhering bandages in sizes and quantities as determined by the medical director;

(V) three sterile petroleum jelly impregnated gauze or suitable occlusive dressings;

(VI) adhesive tape in sizes and quantities as determined by the medical director;

(VII) triangular bandages;

(VIII) one pair bandage scissors;

(IX) one each long and short spine immobilization device; and

(X) cervical spinal immobilization

157.16. Subscription Program

devices in small, medium, and large sizes.

(ii) burn kit, to be carried when required, to include:

(I) sterile burn sheets;

(II) sterile gloves; and

(III) twelve four inch by four inch sterile gauze pads.

(iii) sealed obstetric kit which has been autoclaved or otherwise suitably sterile with expiration date attached, to be carried with all pregnant patients. Commercial kit is acceptable. A non-commercial kit must be labeled and include the following:

(I) sterile gloves;

(II) one disposable sheet;

(III) cleansing cloths;

(IV) umbilical clamps;

(V) nylon cord tie-offs;

(VI) disposable scalpel;

(VII) bulb aspirator;

(VIII) four inch by four inch sterile gauze pads;

(IX) obstetrical pad;

(X) receiving blanket;

(XI) disposable towels; and

(XII) plastic bag.

(iv) pediatric kit, to be carried when the patient is under 12 years of age and always with the obstetric kit, to include:

(I) two bulb syringes;

(II) one DeLee suction device;

(III) one pediatric laryngoscope handle with blades;

(IV) one each pediatric endotracheal tubes in sizes 2.5, 3.0, 3.5, and 4.0 French with stylet;

(V) one pediatric Magill forceps; and

(VI) two pediatric drip intravenous tubings.

(v) medical kit to be carried when the patient is suspected of having a cardiac condition to include:

(I) cardiac monitor with defibrillator;

(II) drugs in quantities and types as prescribed by the medical director;

(III) one spare electrocardiogram electrode for each lead; and

(IV) spare roll of electrocardiogram recording paper.

157.16.

(a) An EMS provider who operates or intends to operate a subscription program for the provision of emergency medical services shall meet all the requirements for an EMS provider license as established by the Act and these rules.

(b) The EMS provider shall submit a copy of the contract for subscription service and/or the application used to enroll participants.

(c) The EMS provider shall submit a copy of the advertising used to promote the subscription service, at the time of application for an EMS provider license. The EMS provider shall maintain a current file of all advertising for the service.

(d) The EMS provider shall meet all state and federal regulations regarding billing and reimbursement for participants in the subscription service.

(e) The EMS provider shall secure a surety bond in the amount equal to the amount to be collected or shall purchase and maintain contractual liability insurance and submit to the department evidence of such. The surety bond must be issued by a company licensed by or eligible to do business in the State of Texas.

(f) The requirement for the surety bond or contractual liability insurance may be waived if the provider submits evidence of self insurance or the provider has a contract for service with a governmental entity which insures the contract.

(g) An EMS provider who provides subscription service shall not deny emergency medical services to non-subscribers or subscribers of non-current status.

157.17. Delegation of Vehicle Inspection.

157.17.

(a) Inspections of EMS vehicles may be delegated by the department to the governing body of a municipality or to the commissioners court of a county at its request.

(b) The requirements for delegation of inspections are as follows:

(1) File an application with the bureau on a department prescribed form containing:

(A) name of the municipality or county;

(B) name(s) of individual(s) to perform inspection;

(C) name(s) of firm(s) to be inspected;

and

(D) signature of mayor/city manager or county judge or their agent.

(2) The department may delegate to the municipality or county the authority to inspect EMS vehicles in accordance with Texas Civil Statutes, Article 4447o, Section 3.04 (h), and these rules upon the execution of a contract or binding agreement which includes, but is not limited to, the following provisions:

(A) The municipality or county shall employ an inspector(s) and shall have in place due process hearing procedures for such employees.

(B) The inspector(s) employed by the municipality or county shall meet the following requirements:

(i) The inspector shall be certified as at least an EMT; and

(ii) The inspector shall attend an inspection training program offered by the department. The inspector shall make three inspections with the department's vehicle inspector after which time the inspector will be evaluated, and, if necessary, retrained. The inspector must satisfactorily complete the training program in order to be approved by the department.

(C) The municipality or county shall immediately notify the department when any inspector leaves the employment of the municipality or county.

(D) The municipality or county shall provide the department with reports and information as requested in the format agreed to by the parties. The municipality or county shall agree to periodic evaluations of its inspection program.

(E) The municipality or county may collect the fee for an EMS provider license as required by Texas Civil Statutes, Article 4447o, Section 3.04 (e) and shall keep accurate records of the collection and deposit of such fees. The fee for an EMS provider license is $100 per vehicle or a maximum of $2000 for a fleet. The cost of inspection is $25 per vehicle or a maximum of $500 for a fleet. The municipality or county shall retain 25% of the $100 to $2000 fee collected and send the remaining 75% to the department with the EMS provider license application.

(F) The municipality or county shall comply with all applicable state and federal laws and department rules, policies, and procedures for vehicle inspection.

(G) The inspector may not inspect municipality or county operated vehicles if the inspector is in any way affiliated with the particular division which operates the vehicles.

(H) The contract or binding agreement may be terminated by the municipality or county or by the department for cause upon 30 days written notice.

(c) Nothing in this section shall limit the authority of the department to conduct an EMS vehicle inspection of any vehicle.

157.18. Unannounced Inspections and Visits

157.18.

(a) The department shall conduct routine unannounced inspections on at least 10% of the licensed EMS providers annually. To determine vehicle and staffing compliance, night or weekend inspections may be conducted.

(b) Department personnel may perform unannounced inspection in response to a complaint. If the department substantiates the complaint, disciplinary action as authorized by 157.19 of these rules (relating to Emergency Suspension, Suspension and Revocation of a License) may be taken.

(c) Records or other documents related to patient care or to emergency medical services personnel maintained by the provider may be reviewed by the department during an unannounced inspection.

(d) All reports, records, and working papers used or developed in an investigation authorized under this section are confidential and may only be used for determining violations or deficiencies and for disciplinary action.

(e) Any violations or deficiencies noted during an unannounced inspection shall result in a written warning specifically outlining the violations or deficiencies. If the violations or deficiencies are not corrected, the department may take disciplinary action as authorized by 157.19 of these rules (relating to Emergency Suspension, Suspension, Probation and Revocation of a License).

(f) Unannounced inspections may not be delegated to another agent.

157.19. Emergency Suspension, Suspension, Probation, and Revocation of a License.

157.19.

(a) Emergency suspension.

(1) The bureau chief shall issue an emergency order to suspend any certificate or license issued under this Act if the bureau chief has reasonable cause to believe that the conduct of any certificate holder or license holder creates an imminent danger to the public health or safety.

(2) An emergency suspension is effective immediately without a hearing upon notice to the certificate holder or license holder. In the case of a provider who is exempt from the payment of fees under Section 3.04(l) of the Act, notice must also be given to the sponsoring governmental entity.

(3) On written request of the certificate holder or license holder, the department shall conduct a hearing not earlier than the 10th day nor later than the 30th day after the date on which a hearing request is received to determine if the emergency suspension is to be continued, modified, or rescinded. The hearing and an appeal from a disciplinary action related to the hearing are governed by Section 1.21-1.32 of this title (relating to Formal Hearing Procedures) and the Administrative Procedure and Texas Register Act, Texas Civil Statutes, Article 6252-13a, as amended.

(b) Nonemergency suspension.

(1) Reasons for suspension. An EMS provider license may be suspended for, but not limited to, the following reasons:

(A) the EMS provider fails to:

(i) notify the bureau of a vehicle which is added or operates a vehicle without a vehicle authorization;

(ii) submit annual run response summary;

(iii) notify the bureau of change in the provider name or file a new application if change in ownership;

(iv) notify the bureau of any change in medical director;

(v) notify the bureau of any permanent or long term change in level of service provided;

(vi) operate any vehicle which is staffed and equipped in accordance with the Act and these rules;

(vii)display the vehicle authorization in the patient compartment and/or the licensure decal on the lower right rear window;

(viii)provide care at level authorized;

(ix) allow inspection of the place of business and/or inspection of an EMS vehicle; or

(x) notify the bureau of change in communication status, capability, or equipment.

(B) The EMS provider commits an offense of a different nature within 12 months of a previous suspension.

(C) The EMS provider provides an unauthorized level of service.

(2) Notification. If the bureau proposes to suspend a license, the bureau shall notify the provider by registered or certified mail at his or her last known address as shown in the bureau's records. The notice must state the alleged facts or conduct to warrant the action and state that the provider has an opportunity to request a hearing.

(3) Hearing request.

(A) The provider may request a hearing within 15 days after the date of the notice. This request shall be in writing and submitted to the bureau chief. If a hearing is requested, the hearing shall be conducted pursuant to the Administrative Procedure and Texas Register Act, Texas Civil Statutes, Article 6252-13a, and 1.31 et. seq. of this title (relating to Formal Hearing Procedures).

(B) If the EMS provider does not request a hearing, the provider is deemed to have waived the opportunity for hearing and the license shall be suspended at least 10 days.

(C) If the provider requests a hearing and the findings are upheld, the license shall be suspended for at least 10 days.

(c) Probation. For just and sufficient reasons presented by the provider, the department may probate the suspension. Examples of just and sufficient cause may include:

(A) history of previous exemplary service;

(B) extenuating circumstances which affected the actions of the provider; and

(C) considerations of the local service area and needs.

(d) Revocation.

(1) Reasons for revocation. An EMS provider license may be revoked for, but not limited to, the following:

(A) operating the service while under suspension of a license;

(B) tampering, altering, or changing a

license issued by the department;

(C) failing to correct deficiencies during the period of suspension;

(D) any repeat offense, within 12 months of the initial suspension;

(E) any third offense which may cause suspension which occurs within a 12-month period of a previous suspension;

(F) issuing a check for an EMS provider license which has been returned to the department for insufficient funds;

(G) a history of staff violations which result in disciplinary action as described in 157.21 of this title (relating to Criteria for Decertification, Emergency Suspension, Suspension, and Probation of Certificate); or

(H) continued disregard of violations noted on unannounced inspections and/or not correcting deficiencies noted on unannounced inspections as required in 157.18 of this title (relating to Unannounced Inspections and Visits).

(2) Notification. If the Bureau proposes to revoke a license, the Bureau shall notify the provider by registered or certified mail at his or her last known address as shown in the Bureau's records. The notice must state the alleged facts or conduct to warrant the action and state that the provider has an opportunity to request a hearing in accordance with 1.21-1.32 of this title (relating to Formal Hearing Procedures).

(3) Hearing request. If the provider does not request a hearing, in writing within 10 days, after receiving the notice of opportunity, the provider is deemed to have waived the opportunity for a hearing and the license shall be revoked.

157.20.

(a) An EMS provider may request a variance from a standard or rule adopted under the Act based on a specific hardship by applying to the bureau chief. A request from an EMS provider shall be signed by the county judge for the county or by the mayor/city manager or the designee for a municipality within which the EMS provider intends to operate. The request shall be made on a form provided by the department and accompanied by a nonrefundable fee of $25, except for an EMS provider who is exempt from the payment of fees under 3.04(l) of the Act.

(b) A request for a personnel variance shall be accompanied by a plan to meet the minimum requirements of the Act.

(c) The request for variance and reasons for the request shall be publicized in the local area through the local media.

(d) Evaluation of the request shall be based on the following factors:

(1) the nearest available service;

(2) geography;

(3) demography; and

(4) other relevant factors.

(e) If a variance is granted, an emergency medical services provider license shall be issued subject to annual review by the department. The department shall issue a letter to the EMS provider that states the specific rule or standard waived.

(f) If a variance is denied, the EMS provider shall be notified in writing the reason for the denial. A copy of the denial shall be sent to the governmental entity signing the request for variance.

(g) After the annual review by the department, the variance may be continued for a period not to exceed one year.

157.20. Request for Variances from Minimum Standards

February is American Heart Month

Do something aerobic for yourself - and for your heart

Did You Read...?

...in the November 1989 issue of **jems** about the public education idea of having local movie houses show EMS educational slides prior to the main feature film. These slides are aimed at educating the public on 911 and when to call fire, police, and EMS services.

...in the August 1989 issue of The American Trauma Society's **Traumagram,** that choking is the leading cause of infant death under the age of 1 year? Care for infants is different from that of a teenager or adult. The ATS in cooperation with The American Academy of Pediatrics has produced a pamphlet called "Choking Prevention and First Aid for Infants and Children."The pamphlet gives detailed information. For more information contact The American Trauma Society, 1400 Mercantile Lane, Suite #188, Landover, Maryland, 20785. These brochures with your organization's logo stamped on them would be great for a Health Fair.

...in the October 1989 issue of **The EMS Leader**, that U.S. Surgeon General Koop is recommending a reduction of the legal blood alcohol level from 0.10 to the lower amount of 0.08? He urges that this be effective immediately.

...in the November 1989 issue of **jems** in the article, "Will Air Turbulence Stall Air Medicine?" about Maryland's state police air medical service? The state police provide the air equipment and administer the program by cross-training their personnel as paramedics. The service has been in operation since 1970 and last year flew 3,408 medical missions, an average of 9 per day.

Dave Samuels, past president of the National Flight Paramedics Association is quoted as saying, "Most flight paramedics have at least a bachelor's degree and 9 percent of the more than 400 members of the NFPA have a master's degree." Samuels advises persons wanting to become flight paramedics to "first, get an education."

...in the July 1989 issue of **The EMS Mirror** from British Columbia about the KJ Clips? These clips are designed to clamp stretchers to the backs of seat frames in buses. This allows those vehicles to be used as giant ambulances in the event of a major disaster. Stretchers so placed and secured are "at an ideal level," says the article. Emergency care personnel can move up and down the isles and intravenous bags can be hung from overhead stanchions.

...the article on the new section of COBRA, the Comprehensive Omnibus Budget Reconciliation Act? This section, titled "Examination and Treatment for Emergency Medical Conditions and Women in Active Labor," was the subject of a 5 page article in the December 1989 issue of **Emergency**. The author, Robert E. Dooley, an attorney and former paramedic practicing in Schaumberg, Illinois, says,"Recent court decisions are going to have an impact on interhospital EMS, both present and future." Under COBRA, lawsuits are based not on negligence, but on liability, says the author. One case cited in the article resulted in a fine of $20,000.00 against a physician because of the way that a patient in labor with her sixth child was transferred from one hospital to another. During the transfer, the patient delivered a normal healthy child with no complications. However, the physician was fined because the ambulance did not carry a fetal heart monitor nor the drug pitocin. Have you consulted your legal counsel lately, regarding this relatively new federal law?

...in **Management Focus** for the Fall of 1989, published by the management firm of Fitch and Associates of Kansas City, Missouri, about the fact that the Oklahoma City EMS System had collapsed financially? Amcare, a public trust system had failed to maintain its accounts receivable and was 1.6 million dollars into the red ink. The entire board of trustees resigned.

...and in the same publication, that the Kansas City, Missouri EMS System is 100% employee owned. This is a first in the country, according to Fitch. Seventy percent of the employees opted to convert their retirement funds into company stock. This means that the employees are working for themselves. It isn't a "we"--"they" situation anymore. The employees are now the company owners. If the firm does well, so do the employees. The organization is called, "Emergency Providers, Incorporated."

"Koop recommends a reduction of the legal blood alcohol level from 0.10 to the lower amount of 0.08."

"have local movie houses show EMS educational slides prior to the main feature film."

"choking is the leading cause of infant death under the age of 1 year."

Hazardous Materials Training Required for EMS

An Environmental Protection Agency rule effective March 6, 1990 requires emergency response organizations to be trained to respond to accidents involving hazardous materials. EPA mandates that employers such as fire departments and emergency medical services conduct two hours of monthly training for a total of twenty-four hours annually.

These rules come as a result of SARA, the Superfund Amendment and Reauthorization Act passed by Congress in 1986. SARA states that the public has an inherent right to know what chemicals in their community potentially affect their health and environment and to be protected from chemical accidents.

To meet SARA responsibilities and assist small volunteer or poorly funded emergency response organizations in meeting the EPA mandate, Disaster Response Program personnel have received training in several areas of hazardous materials response operations and plans development for emergency response to hazardous materials incidents.

"For many years the Disaster Response Program has been conducting training in emergency response to radiological materials accidents," said Louis Berry, Training Administrator for the Bureau's Disaster Response Program. "This training activity has now been expanded to include recognition and identification of hazardous materials, and hazardous materials contingency planning. The training is primarily directed to emergency medical services personnel but will be available to other emergency first response organizations."

Berry said that Public Health Region 1 EMS personnel have also been certified to teach the course, "Recognition and Identification of Hazardous Materials," developed by the Federal Emergency Management Agency, National Fire Training Academy.

To assist fire departments and emergency medical services, Berry is developing an audio-visual training materials library. Public Health Region personnel certified to teach the hazardous materials course will also use the library's resources to teach courses for local emergency organizations.

For more information on hazardous materials training contact your Public Health Region EMS office or Louis Berry at (512) 458-7550 or Texas Department of Health, Disaster Response Program, 1100 West 49th Street, Austin Texas 78756.

Communities have right to know about potential for danger

According to a recent Associated Press story, Texas led the nation in the number of toxic spills from railroad cars with 151 incidents in 1988. Those trains released hazardous materials during transportation, loading, unloading or temporary storage.

With 13,000 miles of main railroad track and 28 federally-designated Superfund hazardous waste sites located in Texas, the opportunity for toxic spills increases in our state. Trains carried approximately 400,000 carloads of toxic materials in Texas in 1988.

Although the 151 spills was the highest number in the nation, the Texas rate of 36.54 incidents per 100,000 carloads ranks much better than the national rate of 57.77.

Title III of the Superfund Amendments and Reauthorization Act (SARA) addresses concerns about emergency preparedness for just such incidents as these and lists requirements for government and industry planning and "community right-to-know" reporting on hazardous materials.

SARA Title III legislation helps communities prepare to handle chemical emergencies, and increases public knowledge and access to information about hazardous chemicals present in the communities.

Part II

Is Code II Risky? - You Bet!

Emergency Vehicle Operations

by Jay Garner

The first article on Code II driving dealt with the existence of a Texas law that defines emergency vehicles and the privileges and restrictions under which they operate. This article will address the insurability of EMS providers and the philosophy of insurance companies regarding emergency vehicle operations.

Here are some interesting facts gathered from EMS providers and insurance companies about driving insurance:

-Some companies will not write insurance for an EMS provider who does not require previous driving experience and/or an internal program of driver training.

-Most companies ask detailed questions about drivers and driving habits, including MVR records, criteria for selecting employees based on driving records, internal recordkeeping on employee driver performance, etc.

-Most insurance companies have driver age limits, and limits on the number of tickets/accidents that a driver may incur.

-Some companies want to know if the EMS provider has an internal mechanism for accident review and disciplinary action.

"Prudent insurance carriers within this marketplace do not remain as stable markets for those accounts who frequently demonstrate poor driving habits by way of vehicular accidents. While there are various arguments for lights only driving practices, this practice does substantially increase the liability exposure, especially when driving within city limits and in and around traffic intersections."

-Howard Handler
Executive Vice-President
The American Agency

I have talked to many EMS providers since Jim Moshinskie's article was published (September/October Texas EMS Messenger) in order to determine whether Code II operations were permitted, and why/why not. The ever-increasing response from providers who do not allow Code II driving is that insurability is a component of their rationale.

"Our service allows only two modes of vehicle operation - Code I for non emergency calls and Code III for emergency calls. For a number of reasons, including our insurance carrier's position on the issue, we do not allow Code II (lights-only) operations."

-Doug Key
Clinical Coordinator
Med-Star

In a statewide survey of 55 EMS providers, we discovered that six providers had no driving policies at all. Of those that did, we asked whether Code II was allowed, and why or why not.

Nineteen providers allowed Code II operations. Generally, these providers allowed Code II only on long stretches of road in sparse traffic conditions. Some stated that "unstable conscious cardiac patients" were transported Code II.

Thirty providers specifically prohibited Code II driving. Their reasons were compliance with the emergency vehicle law, safety and risk concerns, and insurability.

"Asked our insurance company's position: we discourage the use of Code II operations. Our rationale for this is that, statistically, it has been proven that under Code II operations operators have a much higher frequency rate of accidents, consequently raising their loss ratio, which causes higher premium costs or cancellation."

-Bill Leonard, Vice President
Loss Control & Safety Services
Az Star Insurance Company

I hope this series of articles evokes new thinking regarding the role of Code II driving in EMS. The next article will address patient, community, and provider safety.

Jay Garner, paramedic and EMS Program Administrator in PHR 8, holds Instructor, Instructor Trainer, and affiliate faculty certifications in several EMS-related disciplines, including Emergency Vehicle Operations, U.S.D.O.T. National Standard Curriculum. Contact him at 601 W. Sesame Drive, Harlingen Texas 78550, (512) 423-0130.

Letters to the Editor

Valsalva Bowl Fan

I recently received the current issue of this month's magazine, (November/December 1989) and was really impressed as always, but felt really sorry for being in the way of whomever was standing behind me in the aisle. The poor soul caught the back side of me in that picture on page 17. Fortunately I do have some fairly decent pictures of the winners of the Valsalva Bowl. I hope that you enjoy them.

I do want to say that I enjoyed the conference, and look forward to the next EMS Conference.

-Jo Anne Gholson EMT/P ACLS, BTLS, Orange, Texas

Thanks to Jo Anne for sending us this photo of Joe Tyson awarding San Jacinto College the coveted Valsalva Bowl trophies

El Paso EMS

I certainly enjoyed Tom Ardrey's article on Margaret in the November/December issue of the **EMS Messenger** (Margarita Brown, "EMS Education in Far West Texas"). As one who has watched and participated in her determined efforts to improve EMS in our remote corner of the state, it was rewarding to see her recognized.

However, as the Chief of the Department of Emergency Medical Services for the City of El Paso it's my duty to point out that EMS in our community is a "third service" system with superb BLS first response provided by El Paso Fire Department and ALS provided through our organization. Paramedic training was not provided to Fire Department personnel prior to the inception of the Community College's program, but rather to our personnel.

El Paso was one of the early "third service" organizations founded in 1979. Since that time it has grown from a six station BLS system to an 11 station organization providing full ALS.

The success of our system has been possible due to the extraordinary relations among all of the agencies involved and a real commitment to EMS in our community. As Margaret said, "El Paso is truly a cooperative community."

Thanks for looking at far West Texas and keep up the good work.

-William H. Brown, Chief of EMS, El Paso, Texas

Are we alone ???

Our EMS group does NOT transport patients for several reasons. First, we cannot afford to do so. Second, we have a fine ambulance service, the Galveston EMS. Because the island is long, and narrow, the road network is often constricted with traffic or other impediments to travel. Our EMS group was formed to supplement the Galveston EMS and Life Flight.

Despite the fact that our vehicle does not transport patients, only first responders and equipment, we are classified as an ambulance - due we are told, to the fact that there is no other niche in which to place us. Our motor vehicle insurance is about $3,800.00 per year. Our vehicle is about 6 years old and has logged just over 4,000 miles. Our police department has two vehicles and logs, I believe, over 50,000 miles per year. Their insurance approximates $800.00 per year per car. Somehow we feel that with no patient transport capability, we are much more akin to police cars, fire chief's cars, fire department rescue trucks and similar vehicles, both in what we do and what we do not do.

Does any other EMS group have a vehicle or vehicles that qualify for some lower insurance category than ambulance? If so, what is the category? How do you qualify? If there are others like us, we would like to know and if there are enough of us, just perhaps we can get the Texas State Board of Insurance to develop a new, cheaper category.

-Cliff Hayes, Director, Jamaica Beach Volunteer EMS, P.O. Box 5438, Galveston, Texas 77554-0438

More on lights and sirens

The article on "Running Code II" in the September/October issue of **EMS Messenger** made me wonder if the people who ran the survey and the people who responded are on the same wave length. I especially like the Henry Barber quote because it so parallels my own thinking. Code II isn't the issue. Driving is.

Our people run lights (at a minimum, flashers) anytime a patient is on board. This serves to notify the public we are about our business and not "deadheading" or training. Hopefully, this will keep them at a distance and protect the patient as well as ourselves. In any event, lights and/or sirens do not "give us the right of way." They only request it. We see no benefit derived from assaulting the eardrums of suffering patients with the scream of a siren nor those of the crew who may, at any moment, have to make a life or death decision. Communications with the hospital (doctor) are sketchy at best with the siren on. It is very frustrating to try to get a report over or instructions back with the siren on. This frustration could lead to "pilot error" (crew mistakes).

We would hate to see "Code" conditions legislated. What is needed is a clear definition of terms and as Henry said, "get a handle on (their) driving and proceed with caution."

-John Mahalitc, Jr., Eagle Lake, Texas

Texas EMS - the good, the bad, the ugly

by
Alana S. Mallard, Editor

I didn't have to look very far for my nominee for The Ugly. It has to be the ad in a national EMS magazine for a firefighters calendar, "the one everyone is waiting for." Not everyone. Not me. What you get is 15 color photos of "beautiful women in high-risk, action, and glamour shots."

I haven't seen this calendar. But don't "ah-ha" me yet, because one of the men in the office has seen it. "It's stupid," he says. I think the ad is stupid; and I think the whole idea of a calendar filled with photos of scantily clad women in dangerous situations demeans women and the people who display the calendar.

Three "pitooeys" is what I give it.

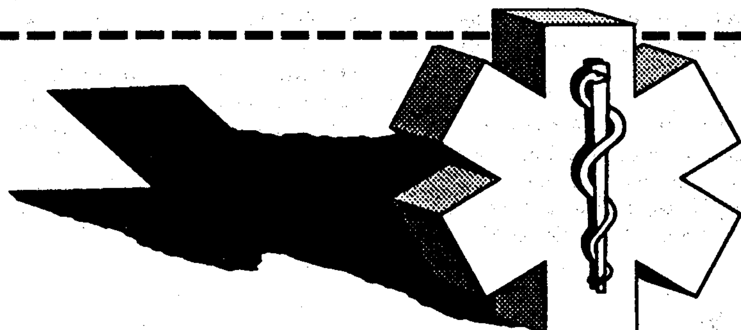
The Bad. No contest. The health care crisis is closing hospitals permanently in rural areas and diverting emergency patients in urban areas. Hospital closures, whether permanent or on an hourly basis because beds are unavailable, cause big problems for EMS. Long transports to out-of-town hospitals leave local communities without EMS coverage.

Day-to-day hospital diversion takes hospital choice out of the hands of those who normally make those decisions -- the presiding EMTs or the conscious patient. Both situations add up to megastress for health care personnel already feeling the pressures of life-and-death work, long hours and low pay.

The Texas trauma legislation gets my vote for The Good in EMS today. This legislation was a long time coming, and I hope you read Gene Weatherall's column on page 3 about the first meeting of the Trauma Technical Advisory Committee. The sense of pride and of history in the making was palpable among the members of the audience as that first meeting of TTAC began.

I have heard others refer to this legislation as a "landmark bill," and it is clear that Dr. Robert Bonham, who chairs the Board of Health's Emergency and Disaster Committee, wants to turn the legislation into very real regional trauma care systems and a statewide trauma system. Dr. Bonham, who served as a triage officer in Da Nang during the Vietnam War, is no stranger to breaking a huge job into manageable pieces and working methodically towards the goal. "We did it in the Army. We did it at Parkland," Bonham said. "I hope this committee comes up with a way to have Trauma I, II, and III hospitals, not some grandiose idea that falls on its face."

Well, there they are. My choices for the Good, the Bad, and the Ugly in EMS. All in all, though, I love it.



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AROUND THE STATE

March 3 & 4, **Beyond the Street**, a two-day management seminar by Fitch and Assoc. Mother Frances Hosp. and Flight For Life, Tyler, Texas. Mitzi Shelton (214)535-7105.

March 9 & 10, **8th Annual Traumatology Conference**, Beaumont Convention Cntr. Lamar Univ., P.O. Box 10008, Beaumont, TX, 77710, (409)880-2233.

March 21, **Street Smart / EMS Stress**, Continuing Ed. Course, $30 or $5 student rate. Kathy Jordan, Texarkana College, 2500 N. Robison, Texarkana, TX 75501 (214)838-4541.

March 22 & 23, **Emergency Symposium '90**, $30 or $5 student rate. Kathy Jordan, Texarkana College, 2500 Robison, Texarkana, TX 75501, (214)838-4541.

March 24 & 25, **Basic Vertical Rescue Course**, $60. Renee Michalski, McLennan Community College, 1400 College Dr., Waco, TX 76708, (817)750-3512.

March 27 - August 29, **Paramedic Completion Course**, Tyler, $300. Apply by Feb. 28, Jim Cress, Mother Frances Hospital, 800 E. Dawson, Tyler, TX 75701, (214)535-7106.

April 11, **Incident Command Seminar**, $25 or $5 student rate, Texarkana College. Kathy Jordan, 2500 North Robison, Texarkana, TX 75501, (214)838-4541; also offered April 12.

April 14, 1990, **EMS in the 90's. Are We Ready?**, Hilton Hotel, College Station, TX, Cynthia Webb, Texas A&M Univ. Emergency Care Team, A.P. Beutel Health Cntr., College Station, TX 77943-1264.

April 21 & 22, **Basic Vertical Rescue Course**, $60. Renee Michalski, McLennan Comm. College, 1400 College Dr., Waco, TX 76708, (817)750-3512.

May 4, **Texas EMS Advisory Council Meeting and Legislative Forum**, Austin, TX. Harold Broadbent, Bureau of Emergency Management, TDH, (512)458-7550.

May 5, **Basic Vertical Rescue Course, $60.** Contact Renee Michalski, McLennan Community College, 1400 College Dr., Waco, Texas 76708, (817)750-3512.

May 18, **Current EMS Legal Problems in Emergency Medicine Seminar**, Texarkana College, $30. Kathy Jordan, 2500 N. Robison, Texarkana, TX 75501, (214)838-4541.

May 24, **Haz - Mat Recognition and Identification Seminar**, Texarkana College, $10 or $5 student rate. Kathy Jordan, 2500 N. Robison, Texarkana, TX 75501, (214)838-4541.

May 24 - 26, **Advanced Vertical Rescue Course**, McLennan Community College. Renee Michalski, MCC, 1400 College Dr., Waco, TX 76708, (817)750-3512.

FOR SALE: Defibrillators and battery support system. Two Liteguard 9 defibrillators by Marquette Electronics $5500 each. Seven batteries, external power pack, battery support system, $700, all accessories.; $9750 for everything. Call Bob Knowles (409)982-4357.

FOR SALE: 1979 Chevrolet Van, good condition, 55,000 miles; BLS equipped, extra equipment included. Call Betty Weaver, Rusk, TX, (214)683-4760.

EQUIPMENT NEEDED: South Anderson County Vol. Emergency Corps is needs a one-man stretcher and portable suction unit. Free or reasonable price. If you can help, please contact Randy McCoy, Elkhart, TX (214)764-5566.

FOR SALE: Two person kickdown stretchers; two person multilevel stretchers; rotating lights; Welen Mod 8 and Twinsonic parts; Federal sirens; CPR boards; 12 volt radio power supply; 1978-1981 Type II & III ambulances. Mike Harmon, Life Line EMS at (817)322-1506.

FOR SALE: New & Used EMS Equipment. T.L. Speed (713)495-9266. P.O. Box 1364, Sugar Land, TX 77487-1364.

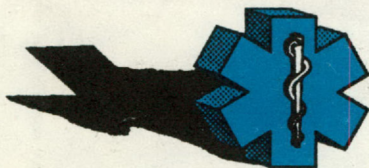
FOR SALE: 1984 Ambulance, Ford Type I, 1980 module, diesel 6.9, 45,000 miles, good condition, currently in service. Mike Legoudes, Kingwood EMS (713)358-2800.

FOR SALE: Two Physio-Control Life Pak 5 Monitor/Defibrillator Units, 3 Lead version. Complete. $4,000 each. Physio-Control Life Pak 5 Monitor/Defibrillator Unit, Single Lead Version. Complete with batteries and charger, $1,500. All 3 units, $8,500. Three Motorola MX-340 Portable Radios, two channels with paging capability and a rapid charger, $700 each unit. Standard HX-300 Portable Radio, $400. Bobby Motes (512)729-2112, P.O. Box 821, Rockport, TX 78382-0821.

Paramedics, EMT-I: LifeLine EMS accepting applications. Prefer ACLS. Send resumes to Charles Grady, Life Line EMS, P.O. Box 2160, Wichita Falls, Texas 76301.

EMTs: Applications accepted for EMT-I, EMT-P for West Texas Ambulance Service with Alpine and Monahans Divisions. Resume to WTAS, P.O. Box 338, Alpine, TX 79831.

EMS Instructor: Requires certification as EMT-P, EMS I/E, ACLS Instructor, PHTLS Instructor, 3 years EMS-related experience. Degree in health-care field, 2 years teaching paramedic preferred. Emergency Medical Programs, Texas Tech Univ. Health Sciences Cntr., 3601 Fourth St., Lubbock, TX 79430.



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