

***A GUIDE FOR***  
***EMERGENCY MEDICAL***  
***TECHNICIANS***  
  
***IN ALASKA***

*Prepared by:*

**Section of Community Health and EMS  
Division of Public Health  
Department of Health and Social Services  
Box 110616  
Juneau, AK 99911-0616  
[www.chems.alaska.gov](http://www.chems.alaska.gov)**

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## **MISSION**

*The mission of the Alaska Emergency Medical Service Systems is to reduce premature death and disability due to injuries and sudden illness through prevention activities and comprehensive emergency medical care.*

### **About This Guide**

This guide is designed not only for the individual who is just beginning his or her involvement in Emergency Medical Services in Alaska, but for experienced EMTs and Instructors who need accurate information about state EMS requirements and capabilities. It is intended to provide a basic overview of the EMS system in Alaska, what can be expected of the training and certification processes, what an individual must do to recertify as an EMT, and resources that exist once he or she becomes certified.

It was necessary to simplify descriptions of certification levels and procedures, as well as the complexity and enormity of tasks faced by EMS providers and organizations.

For more detailed information or copies of materials described in this guide, you should contact the State EMS Unit or the nearest Regional EMS Office (a list of EMS agencies can be found on page 65).

This guide, as well as many of the forms, laws, guidelines and other materials described within, can be downloaded from the section's web site at:

<http://www.chems.alaska.gov>

### **Acknowledgments**

The staff of the Section of Community Health & EMS wishes to thank the many individuals who reviewed initial drafts of this manual. A list of those who contributed can be found on page 82.

Additions, corrections, and suggestions for improving this manual should be directed to Kathy McLeron, at the Section of Community Health & EMS. This manual has been adopted by reference in the Alaska EMS Regulations. Suggestions will be reviewed frequently, but changes to the manual must be made in conjunction with regulations changes. A suggestion form follows the index.

### **Reprinting**

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Section of Community Health & EMS  
 Division of Public Health  
 Department of Health and Social Services  
 Box 110616  
 Juneau, AK 99811-0616

**Section of Community Health and EMS Phone Directory**

Main Number.....(907)465-3027  
 Main EMS Program FAX.....(907)465-4101  
 EMS Certification Program FAX.....(907)465-6736  
 Automated Voice Response System.....(907)465-4109  
 Conference Room.....(907)465-4889

Name	Program	Telephone (907)465-xxxx
EMS		
Anderson, Matt	Unit Manager – EMS	3141
Johnson, Mark	Section Chief – CHEMS	8635
Jones, Nadine	EMS Program Support	3027
McLeron, Kathy	EMS Training Coordinator	2262
Owens, Shelley	Emergency Medical Services	3028
Risley, Doreen	Emergency Medical Services	8633
White, Melanie	Emergency Medical Services	3029
Injury Prevention		
Bailey, Maria	Injury Prevention Program Support	4170
Glasier, Gordon	Injury Prevention Program	269-3433
Lawfer, Karen	Health Program Manager	8632
Krom, Mary	Injury Prevention – Smoke Detector Program	269-3489
Maskay, Raj	Poison Control System Implementation	5319
Moore, Martha	Trauma Registry and Injury Prevention Programs	8631
Murphy, Zoann	Injury Prevention Planner	1185
Walters, Alice	Injury Prevention	8623

e-mail addresses are created as: Firstname\_Lastname@health.state.ak.us

# Welcome to EMS!

Emergency Medical Services (EMS) is a complex and exciting field.

Training is one of many components of EMS but it provides the cornerstone for all prehospital emergency care.

To help understand the complexity of an EMS System, imagine the pieces of a system which must be in place to adequately care for a patient.

1. There must be **public education and information** so the patient is recognized as needing immediate care AND people know whom to call AND what to do until help arrives;
2. There must be an emergency number to call (preferably 911) and **trained dispatchers** so that correct information is obtained from the caller, appropriate emergency units are dispatched to the right location, and the advice given to the caller about what to do until help arrives is medically correct.
3. There must be **strategically located services** and **well trained emergency medical service providers** so response is timely and, when possible, trained first responders are on-location providing care while awaiting the arrival of the ambulance or rescue vehicle.
4. Reliable radio **communications** must exist so additional assistance can be requested, the receiving facility can be notified of the patient's condition, and time of arrival, and supplemental medical advice and treatment orders can be given to on-scene personnel.
5. **Physician Medical Direction** should exist for all prehospital emergency medical service workers and is required to be in place for all providers of advanced life support. The physician's responsibilities to the service and EMTs include providing guidance, legal authorization, quality assurance review, and additional training. These are essential to a well functioning EMS system.
6. There must be a reliable means of **transportation** so unnecessary delay does not occur and so the level of care can be maintained, or enhanced, throughout patient transportation.
7. A well equipped **definitive care** treatment facility must be ready to receive the patient with little or no delay between arrival at the facility and initiation of diagnostic and therapeutic procedures. Some emergency medical services systems categorize facilities so the patient is taken to the nearest facility **CAPABLE OF HANDLING THE SPECIFIC INJURY OR LEVEL OF SEVERITY**. As a result, less capable facilities may be bypassed for certain categories of patients.
8. In addition, there must be a system in place to ensure that patients can be safely and appropriately **transferred** from one facility to another.
9. **Recordkeeping** systems must be maintained so system planning and development is based on accurate data. Recordkeeping is also essential in the event you are called into court to explain or defend your actions on a particular response. The rule is: "If it wasn't documented, it wasn't done!"
10. **Continuous Quality Improvement** programs should be in place to ensure that each patient receives the most appropriate care possible and to identify and correct system and individual problems as soon as possible. This system also provides important feedback to the emergency medical technician regarding her, or his, performance in the field. The key is to ensure that all of those involved in meeting the needs of the emergency patient, from dispatch to rehabilitation, have the ability to provide suggestions for improving the system.

Local, regional, and state agencies should be involved in the system evaluation process to ensure that patient needs are anticipated and appropriate services are available and delivered.

11. There must be well equipped and staffed **rehabilitation services** so severely injured patients can return to as productive and normal a life as possible.

As an EMT, the services you provide may fit into more than one of these important categories. Your patients are certainly affected by all of them.

# Early History of EMS in Alaska

## Public Safety Academy

Organized training of prehospital emergency care providers in Alaska has been in progress for about twenty five years, beginning in 1969 with the first EMT training program taught at the Public Safety Academy in Sitka.

In 1973, the Emergency Trauma Technician, or ETT course, was developed by the Department of Public Safety to provide an appropriate level of training for individuals working or living in environments where risk of injury is great, such as logging camps or fishing boats. The 44 hour curriculum has been updated frequently and the text is now accompanied by a comprehensive instructor manual.

In an attempt to ensure maximum coverage of prehospital EMS responders throughout the state, different strategies were developed by the Department of Public Safety and Regional EMS Councils.

One method, used by the Department of Public Safety from 1970 until 1981, was to bring ambulance service personnel to the Public Safety Academy in Sitka for training, with funds provided to individuals to fly from their home communities for either EMT-Basic or EMT-Instructor training. As time passed, increasingly more certified EMT instructors, trained in this manner, were based in communities throughout Alaska.

During this period, the Department of Public Safety trained and certified approximately 2500 basic EMTs and 120 EMT instructors. In the mid-1970's, the newly formed Regional EMS Councils began hiring full time, itinerant instructors, who could provide on-site training in remote communities which did not have locally based instructors. There were several advantages to this method of training. These full time instructors became more experienced in putting on classes, and EMS responders could be trained in the use of their own equipment, learning to function as teams with other members of their ambulance or rescue service. EMTs also were taught the necessity of preplanning emergency care, the need for mutual aid agreements, and identification of local medical resources.

## Regional EMS Councils

Regional EMS Councils are non-profit organizations largely funded by the State EMS Unit which have functioned since the mid-1970's. Subregional Councils are funded by the Regional EMS Councils and local sources.

Regional and Subregional EMS Councils are located throughout Alaska (See the list on page 65). The purpose of the Regional and Subregional EMS Councils is to coordinate and encourage the development of **comprehensive** emergency medical services systems.

In contrast to the Department of Public Safety Academy, which served as a central location for training EMTs and Instructors, Regional EMS Councils have training staffs, and contract instructors, who often travel directly to the communities needing the training.

The Regional and Subregional councils, and some borough governments, serve as a resource to emergency medical technicians, instructors, and organizations within their boundaries. They can provide individuals and agencies with important and timely information related to EMS in Alaska.

Several regions have their own newsletters and sponsor regional EMS symposia. The regional symposia provide outstanding opportunities to get to know others within your region and to learn about more local issues.

## Department of Health and Social Services

In 1977, the Alaska Legislature passed Alaska Statute 18.08.010 which designated the Department of Health and Social Services (DHSS) as having responsibility for Emergency Medical Services (EMS) systems development;

established an eleven member Advisory Council on EMS appointed by the Governor; and gave the department<sup>1</sup> authority to award EMS systems development grants. The following year, the Legislature gave DHSS the authority to adopt regulations for certification of basic and advanced level EMTs, EMT Instructors, and prehospital Emergency Medical Services (i.e. ambulance and air ambulance services).

The Emergency Medical Services Section resides within the Division of Public Health in the Department of Health and Social Services. The goal of the EMS Unit is to promote and guide the development of a comprehensive emergency medical services system in Alaska.

The EMS Unit administers the following regulations:

- Do Not Resuscitate Guidelines (7 AAC 16.010 - 7 AAC 16.090)
- Emergency Medical Technicians, Emergency Medical Technician Instructors, and Paramedic Course Coordinators (7 AAC 26.010 - 7 AAC 26.170)
- Emergency Medical Services Outside Hospitals (7 AAC 26.210 - 7 AAC 26.290)
- Medevac Services, Critical Care Air Ambulance Services, and Specialty Air Medical Transport Teams Outside Hospitals (7 AAC 26.310 - 7 AAC 26.400)
- Emergency Trauma Technician Instructors and approved Emergency Trauma Technician Training Courses (7 AAC 26.410 - 7 AAC 26.490)
- Defibrillator Technicians and Approved Training Courses (7 AAC 26.510 - 7 AAC 26.590)
- Responsibilities of Medical Directors (7 AAC 26.610 - 7 AAC 26.700)
- Trauma Registry (7 AAC 26.710 - 7 AAC 26.745)
- Emergency Medical Dispatchers (7 AAC 26.810 - 7 AAC 26.840)
- General Provisions (7 AAC 26.999)

In September, 1992, the EMS Unit requested an evaluation by a "Technical Assistance Team," composed of six EMS system experts from throughout the country. The process was developed by the United States Department of Transportation and is designed to help states assess their EMS system needs by comparing each state's system against National Highway Traffic Safety Administration (NHTSA) national standards. Most of the states have been assessed by Technical Assistance Teams, some more than once.

The team's review of the Alaska EMS System took three days and culminated in the presentation of an assessment and recommendations by the team<sup>2</sup>. The EMS Unit has already taken action on many of the recommendations. Senator Loren Lehman, assisted by Legislative Aide Annette Krietzer, an EMT-I Instructor, took several of the recommendations and drafted Senate Bill 71, which made widespread changes in the statutes governing EMS in Alaska. These changes, which have been incorporated into AS 18.08:

- Expanded the authority of the department (Health and Social Services) to set standards for Mobile Intensive Care Paramedic (MICP) training programs (but final approval for MICP licensing will remain with the Alaska State Medical Board);
- Expanded the authority of the department to address statewide trauma care system development and to establish standards for the certification of trauma centers;
- Gave the department the option to establish an EMS patient care information system;
- Changed the name of the State Advisory Council on Emergency Medical Services to the Alaska Council on Emergency Medical Services, provided that the Council advise the Governor and the Commissioner of Health

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<sup>1</sup> Unless the context indicates otherwise, "department" means the Department of Health and Social Services.

<sup>2</sup> A copy of this review can be obtained from the EMS Unit for a nominal fee.

and Social Services on EMS issues, and specified the types of EMS system providers to be appointed by the Governor;

- Provided the department with authority to certify emergency medical dispatchers;
- Provided for the disclosure of medical records information to pre-hospital EMS providers for quality of care review and education; and
- Included state certified EMT instructors in the immunity from liability protections listed in AS 18.08.086.

Several of these statutory changes require the development or revision of regulations in order to be implemented. For information regarding the status of any of these projects, contact the EMS Unit.

In 1993, federal funding for the EMS for Children Project ended. During the four years the project was funded, it addressed many of the training and equipment issues associated with the delivery of emergency care to ill and injured children. The project also included components related to injury prevention and rehabilitation. Training funded by the grant included prehospital pediatric care courses, emergency care training for school nurses, a pediatric circuit course, and a variety of other specialty training programs. Importantly, the EMSC project trained instructors for the "Pediatric Prehospital Care" course. In addition, Pediatric "preceptorships" were funded which allowed prehospital emergency care providers to spend time in clinical settings assessing and treating pediatric patients under appropriate supervision.

1993 also saw the development of *The Alaska Medevac Manual*, which was designed for use by air medical services and includes a wealth of information about care during patient transport by both BLS and ALS providers. The *Alaska Billing Manual* was completed in 1993 and seeks to help services develop efficient billing methods.

In 1994, an EMS for Children grant was received to concentrate efforts on injury prevention. It provides regional EMS offices and other providers with an opportunity to provide a specific injury and age group within their region and develop a specific injury prevention strategy to reduce the numbers and severity of the injury. The *Alaska Injury Prevention Plan* was finished in 1994 and provides compelling information on the need for increased injury prevention efforts, as well as strategies for lowering the number of injuries.

Also released in 1994 was the *National Standard Curriculum for EMT-Basic* used throughout the country. This curriculum served as the basis for the EMT-I program in Alaska starting in 1996. The changes include expansion of the EMTs scope of activities, a requirement for increased physician involvement in EMT-I's activities, and an emphasis on assessment based instruction. A significant inclusion in the new curriculum is the skill of automated defibrillation. This skill, which shocks the fibrillating heart of a patient in cardiac arrest, has proven to be lifesaving.

On May 27, 1995, Governor Knowles signed HB 39 into law. This legislation, sponsored by Representative Gene Terriault, amended AS 09.68.120 to allow mobile intensive care paramedics, physician assistants, and emergency medical technicians to pronounce death under certain circumstances. The bill became effective on August 25, 1995. AS 18.08.089 was revised by the same bill to define the circumstances under which death may be pronounced. A curriculum designed to inform prehospital emergency care providers about these regulations can be obtained from the department.

In 1996, in an effort to decrease operating costs and to increase efficiency, the Division of Public Health embarked on a reorganization process to consolidate sections with others having similar missions. The Emergency Medical Services Section was merged with the Community Health Services Section becoming the Community Health and Emergency Medical Services Section. Mark Johnson, EMS Section Chief, became Chief of the new section. Each of the former sections lost one position. The consolidation of the sections was not projected to have an immediate effect on our ability to support EMS activities.

In 1997, legislation was passed which defined the authority of Emergency Medical Technicians. The details of this important law can be found on page 31. In addition, funding from the Alaska Mental Health Trust allowed the section to develop a comprehensive training program regarding the emergency medical response to behavioral emergencies. The program included a two day intensive, a continuing medical education module which can be

delivered at the local level, a self study module, and, lastly, a module which can be presented in initial EMT-I training programs.

In 1998, legislation was passed which had three major effects. First, it stated that a person who uses an automated external defibrillator to treat another person in cardiac arrest is not liable for civil damages as a result of an act or omission in treating the other person if the person using the AED was properly trained to use the device and activates the emergency medical services system by notifying the appropriate emergency medical services agency for that area. Second, it defined “properly trained” as meaning that the individual has completed an automated external defibrillator training course from the American Heart Association, the American Red Cross, or another automated external defibrillator training course approved by the Department of Health and Social Services. Lastly, it inserted the word “manual” before “defibrillation” in the statutory definition of “advanced life support.” We infer from this that the use of an automated external defibrillator is now a basic life support skill, but that manual defibrillation continues to be defined as an advanced life support skill.

In addition to administering the training and certification program, the EMS Unit of the Section of Community Health and EMS:

- manages grants to EMS regions;
- recommends standards and treatment protocols for emergency patient care. (Examples of these protocols include the *Alaska Prehospital Trauma Guidelines*, the *Cold Injuries Guidelines*, the *Trauma Triage and Transfer Guidelines*);
- provides statewide planning, sets priorities, and monitors progress of the EMS system;
- sponsors injury prevention programs in coordination with other agencies;
- maintains a Trauma Register which contains detailed information on trauma patients admitted to participating hospitals in Alaska;
- publishes a quarterly newsletter sent to all EMS agencies and personnel in Alaska;
- provides overall medical direction and works with regional medical directors to establish medical control and supervision of prehospital EMS;
- provides continuing medical education opportunities, such as the State EMS Symposium, to emergency medical services personnel; and
- Coordinates the revision and distribution of the *EMS Goals Document*, the *Alaska EMS Directory*, and several brochures for travelers on Alaskan and Yukon highways and the Alaska Marine Highway System.

Many of the major program responsibilities are contained in AS 18.08.02.

## Table of Regional EMS Offices

<b>Region</b>	<b>Address</b>	<b>Telephone (907)</b>	<b>Fax</b>	<b>e-mail</b>	<b>Web Site</b>
<b>Interior Region</b>	Interior Region EMS Council, Inc. 3522 Industrial Drive Fairbanks, AK 99701	456-3978	456-3970	See web site	<a href="http://www.iremsc.org">http://www.iremsc.org</a>
<b>Southern Region</b>	Southern Region EMS Council, Inc. 6130 Tuttle Place Anchorage, AK 99507	562-6449	562-9893	See web site	<a href="http://www.sremsc.org">http://www.sremsc.org</a>
<b>Southeast Region</b>	Southeast Region EMS Council, Inc. P.O. Box 259 Sitka, AK 99835	747-8005	747-1406	<a href="mailto:seremsc@ptialaska.net">seremsc@ptialaska.net</a> <a href="mailto:trncoord@ptialaska.net">trncoord@ptialaska.net</a>	
<b>Northwest Arctic</b>	Maniilaq Association EMS Program P.O. Box 259 Kotzebue, AK 99752	442-7695	442-7678	<a href="mailto:alie@maniilaq.org">alie@maniilaq.org</a>	
<b>Norton Sound</b>	Norton Sound Health Corporation EMS Program P.O. Box 966 Nome, AK 99762	443-3306	443-3731	Owlkennel@aol.com	
<b>North Slope</b>	Barrow Vol. Fire Department P.O. Box 69 Barrow, AK 99723	852-0234	852-0388	<a href="mailto:gjudd@alaska.com">gjudd@alaska.com</a>	
<b>Yukon-Kuskokwim</b>	Yukon/Kuskokwim Health Corporation EMS Program P.O. Box 528 Bethel, AK 99559	543-6078	543-6079	<a href="mailto:Bill_obrien@ykhc.org">Bill_obrien@ykhc.org</a>	<a href="http://www.ykhc.org">http://www.ykhc.org</a>

# EMT Levels in Alaska

There are several levels of emergency medical service responders in Alaska. This section provides an overview of each. Although the EMT/EMT-Instructor certification regulations mandate a core curriculum, in some cases, the emergency medical service's physician medical director has chosen to add procedures and/or medications to the EMT's arsenal of treatment methods. For example, in the Matanuska-Susitna Borough, EMT-I personnel are trained and authorized to use epinephrine 1:1,000 in the treatment of anaphylaxis. The ability of the physician medical director to tailor emergency care practices to the community's needs (and the EMT's capabilities) results in a higher level of care than would be possible otherwise. The job descriptions of the various levels of responder can be found on page 78.

The use of an automated external defibrillator is no longer considered an "advanced life support" procedure and the devices may be used by those with proper training, including emergency medical technicians.

## ETT

The Emergency Trauma Technician training program is 40 hours, or more, in length and teaches the basics of emergency medical care. The course has evolved considerably since it was first developed in Southeast Alaska for use in logging camps. Courses are taught by certified instructors and occur throughout the state. The ETT course can be modified to meet the particular needs of the students or community. The course exceeds the content found in the 1995 revision of the National Standard First Responder training program. Emergency Trauma Technicians are not technically "certified" by the State of Alaska and therefore do not receive the limited immunity from liability conferred by AS 18.08.086.

## EMT-I

The Emergency Medical Technician-I is equivalent to the National Standard EMT-Basic, as described in the United States Department of Transportation (USDOT) curriculum, revised in 1994, excluding the use of automated external defibrillators and advanced airway devices.<sup>3</sup> The EMT provides basic life support such as splinting, hemorrhage control, oxygen therapy, suction, & CPR. Clearly, most treatment procedures performed **in any EMS System, regardless of level**, are basic life support procedures. Mastery of EMT-I level knowledge and techniques must occur before moving to an EMT-II level of certification. Basic skills should be maintained regardless of certification level. Under the direct or indirect authorization of a physician, an EMT-I may assist with the administration of the patient's own epinephrine autoinjector, nitroglycerin, or hand held bronchodilator inhaler. Properly trained EMT-Is may use automated external defibrillators (AEDs). The use of a manual external defibrillator requires separate certification as a Defibrillator Technician. The EMT-I course is at least 120 hours in length and a valid CPR credential is a prerequisite.

## Defibrillator Technician

It is widely recognized that early defibrillation provides the best chance of survival in out-of-hospital cardiac arrest. Alaska law allows anyone who is "properly trained" to use an automated external defibrillator. EMT-I personnel may also be authorized to use manual defibrillators by taking an additional 16 hours of training and becoming certified as a defibrillator technician. Manual defibrillation remains classified as an advanced life support procedure and defibrillator technicians are required to have physician medical directors. Services which utilize manual defibrillation technicians typically operate in locations with access to advanced cardiac life support, including endotracheal intubation and lidocaine.

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<sup>3</sup> The use of manual defibrillators is restricted to individuals who are certified as Defibrillator Technicians. Advanced airway devices, such as the Combitube and endotracheal tubes may be authorized for use by the service's physician medical director in accordance with applicable regulations.

## **EMT-II**

The Emergency Medical Technician II level exceeds the National Standard Training Program EMT-Intermediate (1985) but does not meet the standards of the 1999 National Standard EMT-Intermediate Training Program. The EMT-II class is at least 50 hours in length and prepares the student to initiate intravenous lines and administer fluids and certain medications. A person must have “at least ten patient contacts” as an EMT-I in order to be enrolled in an approved EMT-II training program. Certification as an EMT-II also requires that the individual be under the sponsorship of a department approved physician medical director.

## **EMT-III**

The EMT-III program is designed to add basic cardiac care skills to those skills previously mastered as an EMT. Also included in the training program is the use of morphine, lidocaine, atropine, and epinephrine. The EMT-III training program is at least 50 hours in length. As with the EMT-II, certification requires that the individual be under the sponsorship of a department approved physician medical director. In order to be enrolled in an approved EMT-III training program, the EMT-III candidate must have “at least ten patient contacts and ten venipunctures” as an EMT-II.

## **MICP**

Mobile Intensive Care Paramedics, the most highly trained of the prehospital emergency care providers, are licensed by the Alaska Department of Commerce and Economic Development through the Alaska State Medical Board. MICP's provide care in excess of the EMT-III level and function under the direct or indirect supervision (standing orders, etc.) of a physician. Generally, paramedics are found in the most populous areas of Alaska, including Anchorage, Fairbanks, Kenai, Soldotna, Nikiski, Juneau, Sitka and Ketchikan. In some of these communities, all pre-hospital emergency medical care is provided by Mobile Intensive Care Paramedics. In others, the MICP may act as a supervisor or EMS director. The EMS Program's web pages contain a link to the Alaska State Medical Board's site within the Division of Occupational Licensing. From there, you can download copies of the relevant statutes, regulations, and the application for licensing as an MICP.

The Department of Health and Social Services is responsible for regulating mobile intensive care paramedic training programs in Alaska.

## **Notes on AED Use in Alaska**

On August, 12, 1998, legislation became effective which substantially increased the number of persons who could be trained and authorized to use an automated external defibrillator. The legislation had three major effects. First, it stated that a person who uses an automated external defibrillator to treat another person in cardiac arrest is not liable for civil damages as a result of an act or omission in treating the other person if the person using the AED was properly trained to use the device and activates the emergency medical services system by notifying the appropriate emergency medical services agency for that area.

Second, it defined “properly trained” as meaning that the individual has completed an automated external defibrillator training course from the American Heart Association, the American Red Cross, or another automated external defibrillator training course approved by the Department of Health and Social Services.

Lastly, it inserted the word “manual” before “defibrillation” in the statutory definition of “advanced life support.” We infer from this that the use of an automated external defibrillator is now a basic life support skill, but that manual defibrillation continues to be defined as an advanced life support skill.

The following persons are allowed to teach AED programs .

- Persons authorized to teach AED programs by the American Heart Association;
- Persons authorized to teach AED programs by the American Red Cross;
- State certified EMT-I Instructors, EMT-III Instructors, and Mobile Intensive Care Paramedic Course Coordinators; and
- Instructors of other AED training programs approved by the Alaska Department of Health and Social Services.

## Paramedic Training Sites in Alaska

Currently, there is one paramedic training program in Alaska. It is taught through North Star Academy . For more information, contact:

Teresa Jorgensen  
North Star Academy  
1200 Airport Heights  
Suite 275  
Anchorage, AK 99508

(907) 222-5279 Phone

(907) 222-5376 FAX

office@NorthStarAcademy.com

<http://www.northstaracademy.com>

### **Advice for Those Contemplating Paramedic School**

It's gratifying to see increasing numbers of Alaska EMTs seeking training as Mobile Intensive Care Paramedics. Unfortunately, many EMTs are in paramedic school before they realize they will need to recertify as EMTs in Alaska in order to continue their MICP training. EMTs planning on attending paramedic school should:

- read the draft or implemented regulations concerning paramedic training programs (available through the EMS Unit);
- understand the qualifications for paramedic licensing set forth in 12 AAC 40.310 - 40.390;
- understand the requirements for maintaining current EMT certification of both the training institution and the state which governs the program;
- make sure that either you become licensed in another state or your paramedic field internship is at least 480 hours in length;
- plan to take the National Registry of EMTs' written and practical examinations for certification following completion of the paramedic training program; and
- develop a plan to maintain a current EMT certification throughout your paramedic training.

Although the actual licensing of Mobile Intensive Care Paramedics is performed by the Division of Occupational Licensing and Alaska State Medical Board, the EMS Unit is always willing to provide technical advice to those who have been accepted to paramedic school.

## The EMT Training Program

The EMT training program is based on an approved curriculum and is taught by an instructor who is certified by the Department of Health and Social Services.

The instructor is responsible for imparting sufficient knowledge and skills for the student to provide acceptable patient care.

Your responsibility as a student is to prepare diligently to take care of sick and injured patients. This means not only learning sufficient theory and skills to pass the examinations for certification, but learning how to relate to, and care for, a wide range of patients.

It is your obligation to make sure that you receive sufficient practice time, under the supervision of a more experienced EMT, to feel relatively comfortable taking care of real patients.

Make sure your instructor explains, and you understand, the requirements for successful course completion, how you will make up classes if you miss them, and how best to prepare for the written and practical examinations for certification.

You should be given copies of the *State of Alaska EMS Skill Sheets*, the *Cold Injuries Guidelines*, and the *Alaska Prehospital Trauma Guidelines* for your level of training.

The practical examinations are based directly on the skill sheets and the written examination for certification includes questions on both sets of protocols. You must successfully complete the course to be eligible to take the examinations for certification.

## The Certification Process

The certification process is governed by the EMT/EMT-Instructor certification regulations.<sup>4</sup> These regulations provide great detail concerning qualifications for certification, training programs, scope of activities, suspension, revocation or refusal to issue certificates, and recertification.

The certification program is administered by the State Emergency Medical Services Section with the assistance of each of the Regional and Subregional EMS Offices.

The certification process is designed to ensure that the patient receives competent care from an Emergency Medical Technician.

The certification system includes training, testing, and assurances that the applicant meets certain other qualifications, such as minimum age.

### Examinations for Certification

In most cases, the examinations will be offered immediately following your EMT training program or will be available soon afterwards. In either case, a "Certifying Officer" provided by the regional or subregional EMS office will coordinate the administration of the examinations for certification. The function of the certifying officer is to make sure that the examinations are fairly administered in accordance with state policies and procedures for testing.

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<sup>4</sup> 7 AAC 26.010 - 7 AAC 26.170 Emergency Medical Technicians and Emergency Medical Technician Instructors.

The written examination is 150 items (questions) long and usually takes between one to two hours to complete. Some examination items may be marked as 'experimental' and are being evaluated for inclusion in future versions of the examination. Experimental items do not count towards your examinations score. Typically, written examinations for certification have a time limit.

The written examination is based on the approved core curriculum and department approved objectives, the *Alaska Cold Injuries Guidelines*, the *Alaska Prehospital Trauma Guidelines*, and information from the Centers for Disease Control regarding the human immunodeficiency virus (HIV) and the hepatitis-B virus (HBV). You should make sure you are familiar with all these materials before taking the examination.

## Testing Fees

There is a \$25.00 fee charged for the first examination for certification or recertification at the EMT-I, EMT-II, or EMT-III level. If a student needs to take the test a second and/or third time, there is a \$10 fee for each additional attempt. The testing fee helps pay for test revision and administration.

## The Practical Examination Process in Alaska

### Overview

The Department of Health and Social Services has adopted the National Registry of Emergency Medical Technicians' practical examination process and will continue to use it for the foreseeable future. Using the NREMT practical examination provides many advantages, including the ability to apply the test results to certification with both the National Registry and the State of Alaska.

We have adapted the practical examination grading sheets to the "Does/Does Not" format familiar to those using the Alaska Skill Sheets. In addition, the Alaska Skill Sheets have been updated to be consistent with the practical examination.

Additional information about EMS testing in Alaska can be found in the *Guide for Instructors and Certifying Officers in Alaska*, available for download from the CHEMS web site.

The EMT-I practical examination consists of the following stations:

- Station 1: Patient Assessment and Management - Trauma
- Station 2: Patient Assessment and Management - Medical
- Station 3: Bag-Valve-Mask Apneic Patient
- Station 4: Spinal Immobilization - Supine Patient **or** Seated Patient
- Station 5: Random Basic Skill Verification (One of the following:)
  - Long Bone Injury
  - Joint Injury
  - Traction Splint
  - CPR
  - Pneumatic Anti-Shock Garment
  - Bleeding Control/Shock Management
  - Upper Airway Adjuncts and Suction
  - Mouth-to-Mask with Supplemental Oxygen
  - Supplemental Oxygen Administration
- Station 6: Cardiac Arrest Management/AED

The “random” skills station, the type of spinal immobilization practical (seated or supine), and the scenarios to be used for testing, will be designated each month by the Section of Community Health and EMS.

The policies below have been reviewed and accepted by the National Registry of Emergency Medical Technicians for NREMT-B certification.

## **Retesting**

The retesting policies for the practical examinations have been modified to conform to those used by the National Registry of Emergency Medical Technicians. The policies offer several advantages. For the purposes of these examination policies, an “attempt,” as found in 7 AAC 26.090 and 7 AAC 26.130, is equivalent to the complete failure of the practical examination, (i.e., failure of a single station three times, or failure of four or more stations at a practical examination site).

An individual failing three or fewer stations is eligible to retest the failed stations on the same day at the same test site. Failing the same day retest will require that the individual retest only those stations failed at a different test site with a different examiner. The person has one attempt to pass the station(s) at the subsequent examination site. Failure of the retest constitutes complete failure of the practical examination.

Failing four or more stations constitutes complete failure of the practical examination and the applicant must retake the entire practical at a later time. The person must have remedial training regarding the EMT skills at the level being tested before reattempting all stations of the practical examination. The remedial training must be provided by a certified EMT Instructor. There is no minimum time required for the remedial training. The remediation should be documented on the Practical Examination Reporting Form given to each examinee needing remediation prior to retesting. See page 17 for more details on remediation.

An applicant for **initial certification** who fails the practical examination in two attempts must complete a refresher course, as required by 7 AAC 26.090 and 7 AAC 26.130, before retaking the entire practical. If, after taking the refresher course, the applicant fails two more attempts at the examination, he or she is ineligible for certification and must retake the entire training program.

An applicant for **recertification** who fails the practical examination in two attempts is not eligible for recertification (7 AAC 26.130) and must apply as for initial certification.

In accordance with 7 AAC 26.030, the individual must complete the practical examination for initial certification within the twelve months following successful completion of the training program.

Since the “random” station changes each month, it is likely that an examinee will be retested on a different random skill than was missed during the initial attempt.

## Examples

Candidate A fails two stations on the initial attempt but passes both retests. The candidate has passed the practical examination for certification.

Candidate B fails two stations and reattempts them a week later at a different test site. The candidate passes both retests. The candidate has passed the practical examination.

Candidate C fails three stations and reattempts them a week later at a different test site. The candidate passes two of the three retests. The candidate has failed the practical examination and must take a refresher or transition course before reattempting all stations. This is considered an “attempt” at the examination for the purposes of the EMT/EMT-Instructor certification regulations.

Candidate D fails four stations at the initial test site. The candidate has failed the practical examination and must take remedial training before reattempting all stations. This is considered an “attempt” at the examination for the purposes of the EMT/EMT-Instructor certification regulations.

Candidate E fails one station out of the six but wants to obtain additional training before retesting the missed station and declines to take the same day retest. The person is eligible to retest the one failed station at a different test site and is eligible to take a same day retest if the initial attempt is failed. If the person fails the initial attempt, and the same day retest, remediation must be completed before all the practicals are attempted again.

Candidate F completely failed an attempt at the practical examination, has taken remedial training, and fails a single station three more times. The person is considered to have failed his second attempt at the practical examination and, if applying for initial certification must document a refresher course before retesting. The person would no longer be eligible for recertification.<sup>5</sup>

## EMT-II and EMT-III Practical Examinations

This section provides an overview of the Alaska EMT-II and EMT-III examinations. These policies do not, however, impact or change the National Registry of Emergency Medical Technicians’ EMT-Intermediate or EMT-Paramedic examinations.

The EMT-II practical examination consists of the following stations:

- Station 1: EMT-II/III Trauma Assessment and Management
- Station 2: Advanced Airway
- Station 3: IV/IV Medication Station
- Station 4: Spinal Immobilization - Supine Patient or Spinal Immobilization - Seated Patient
- Station 5: Random Basic Skill Verification (One of the following:)
  - Long Bone Injury
  - Joint Injury
  - Traction Splint
  - CPR
  - Pneumatic Anti-Shock Garment
  - Bleeding Control/Shock Management
  - Upper Airway Adjuncts and Suction
  - Mouth-to-Mask with Supplemental Oxygen
  - Supplemental Oxygen Administration
- Station 6: Cardiac Arrest Management/AED

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<sup>5</sup> See 7 AAC 26.130

The EMT-III practical examination is identical to the EMT-II practical examination except the AED station becomes a more comprehensive cardiac arrest station.

The entire practical examination must be completed following EMT-II or EMT-III initial training, regardless of the recency of EMT-I or EMT-II testing.

## **Remediation**

The Practical Examination Reporting Form has a section for the Certifying Officer to complete regarding remediation. This section should be completed only if the applicant is required to have remediation. Advice to applicants who do not require remediation may be provided by the instructor or Certifying Officer through other means. There is no minimum or maximum number of hours for remediation. The remediation must be provided by a department approved instructor who is responsible for ensuring the student is capable of competently performing the skills required in the Skill Sheets packet for the level of certification at which the applicant is testing. The burden is on the applicant to obtain the required remediation. There is no requirement that a particular instructor provide the remediation. The applicant has 12 months following successful course completion to obtain the remediation and successfully complete the practical examinations.

## **Student Activities at Examination Sites**

The practical examinations for certification are intended to be used to determine whether an individual can demonstrate, at an acceptable level, the psychomotor skills required for certification. It is expected that students have mastered the required skills before coming to the test site. Therefore, it is not permissible for students to practice at the test site between stations once the examination has started.

Students are expected to be prepared to take the examinations for certification. **Students may not delay or opt out of a practical examination rotation for any reason.**

Students may review the Alaska Skill Sheets between practicals but will not be allowed to practice skills at the test site.

Students may not discuss the contents of the practical examination once it has begun.

Students may not discuss the written examination until all students have completed the written examination(s) administered at the test site.

## **Scoring the Written Examination**

It will take the State EMS Unit approximately 14 working days to process your completed application ONCE IT IS RECEIVED IN OUR OFFICE. The amount of time it takes to process an application varies by time of year (we have many applications to deal with in December through April because of recertifications), and the completeness of the application for certification. The score report for your written examination will allow you to compare your performance against others taking the test. The report will include a list of "key phrases" for the questions missed. This will let you identify areas of weakness and take corrective active.

The passing score is 70% for ETT, EMT-I, EMT-II, and EMT-III examinations for certification.

**Please note that we will return applications for certification and recertification which are not complete and accompanied by evidence of a valid CPR credential.**

The EMS Unit will send notification of deficiencies to you at the address listed on your last application for certification. Typically, notification is contained on the back of the score report.

However, you, the applicant, are responsible for meeting the qualifications for certification. If your application was deficient or if you were less than 18 years old at the time it was submitted, you are responsible for submitting the additional information required or for notifying the EMS Unit that you are now 18.

### **Checking Certification Records**

The EMS Unit has developed an Automated Voice Response System which you can call to learn your test scores and certification status. The system can be reached at (907)465-4109 and is detailed on page 72.

**In addition, CHEMS has developed the capability for EMTs and EMS instructors to check certification records via the internet. The on-line database contains no confidential information but does contain near real-time updates of certification information.**

## How Your Expiration Date is Determined

The State **EMS Unit** uses the date of your class's **FIRST** examination for certification to determine your initial expiration date. If you take the examination before July 1, your certificate will expire on December 31 of the following year. If you take the examination on or after July 1, your certificate will expire on December 31 of the second year.

The expiration date for an EMT-II, EMT-III, EMT-I Instructor, EMT-II Instructor, or EMT-III Instructor will be the March 31 occurring after the December 31 date calculated using the preceding formula.

If you do not pass the examination the first time, we will use the first examination date to determine your certificate's expiration date. This way, all students from one training program will have the same expiration date.

Every time you become recertified as an EMT, your certificate will be extended by two years. If you move from the EMT-I to the EMT-II level, or from the EMT-II level to the EMT-III level, we will use the July 1 cutoff date to determine the expiration date of your new certificate.

The expiration date of your **highest** level of EMT certification determines your expiration date. For example, if you become an EMT-II with a certification expiration date of 03/31/2004 and your EMT-I certificate expires on 12/31/2002, you do not need to recertify as an EMT-I in 2002.

The EMT/EMT-Instructor certification regulations permit you to have your certification period shortened so that your certificate will expire at the same time as other members of your service. Your request must be made to the department in writing.

# Now That You Are Certified

## Your Work Has Just Begun!

When you become certified as an EMT, the State **EMS Unit** will send you a certificate, wallet card, and two sets of patches. You should check to make sure that all of the materials you receive are correct. Approximately four times a year, you will receive a copy of the State EMS newsletter, RESPONSE: EMS Alaska. If you live in a region which has its own newsletter, you will receive that as well.

## Representing Yourself as an EMT

Whether career staff or volunteers, Emergency Medical Technicians are considered professionals and are expected to meet medical, professional, and ethical standards. It takes a great deal of commitment and study to earn the right to call yourself a state certified EMT. In fact, AS 18.08.084 states that "One may not represent oneself, nor may an agency or business represent an agent or employee of that agency or business, as an emergency medical dispatcher, emergency medical technician, or emergency medical technician instructor certified by the state unless the person represented is certified for that occupation under AS 18.08.082." Likewise, 12 AAC 40.380 states that "No person may represent himself or herself as a paramedic, mobile intensive care paramedic, or emergency medical technician paramedic unless he or she is licensed as a mobile intensive care paramedic under this chapter."

So, it is ethically and legally imperative to identify oneself accurately to patients, family or bystanders, and especially to other emergency responders at the scene. Identifying oneself as an "EMT" or "EMT-III" is much more accurate than using the title "medic," which is generic and easily misunderstood.

In any patient care situation, especially those involving multiple patients, personnel may be allocated or other decisions made based on the level of training of the EMS personnel present. If this has been falsely represented, the potential exists for grave consequences.

As documented above, an individual who falsely claims to be certified or licensed at a particular level invites legal and administrative action.

It is recommended that services have policies, reinforced by training, which alert members to the issues surrounding representation as an EMT or MICP and the actions to take when dealing with an individual on-scene who falsely claims to be certified or licensed as an emergency medical technician or paramedic.

## Ordering extra patches

Additional patches can be ordered from the nearest Regional EMS Office. You will need to provide the office with your name, your certification number and expiration date, the type and quantity of patches you wish to order, and the shipping address. There is a small fee for the patches and rockers.

## Recertification Requirements

Your first certification period will be between 1.5 and 2.5 years long. Before your certification expires, you will need to have fulfilled the requirements for recertification. At least one month before your certificate expires, an application for recertification will be sent to you at the address the EMS Unit has on file. If you move, please notify the department of your new address if you wish to continue to receive mailings.

There are two options for recertification. Both require that you complete the application for recertification and have a valid CPR credential from an organization approved by the department, such as the American Heart Association or American Red Cross. The training course must include infant, child, and adult airway, breathing, and CPR skills.

The requirements for recertification are listed on page 71.

You will need to keep a record of the continuing medical education (CME) programs you have attended. These records must include the subject of the program, the number of hours CME obtained, the level of training, and verification of your attendance. Many services have specific methods for keeping track of these hours.

*Meeting the requirements for recertification is your responsibility. The EMS Unit will send you an application for recertification approximately 90 days before the expiration of your certification. In all likelihood, you will need to obtain the required continuing medical education and, if you choose, the refresher training program, well before you receive your application for recertification. Don't wait, begin planning for recertification as soon as your certification is received.*

An individual may apply for recertification up to a year before the scheduled expiration of his or her EMT certification.

It is vital that EMTs understand the importance of recertifying in a timely manner. An individual has up to a year following expiration of his or her certificate to recertify without having to meet additional recertification requirements. Until the twelve months elapses, the requirements for recertification remain the same. However, if a person has not recertified within twelve months following the expiration of his or her certification, additional requirements for recertification are imposed. A person's eligibility to recertify lapses after the certificate has been expired for more than 36 months. After that time, a person must retake the initial training program(s) and apply for initial certification.

## **Change of Address**

If you change addresses, please send a change of address card to the nearest Regional EMS Office, and to the State EMS Unit. In order for you to receive newsletters, such as *Response: EMS Alaska*, and applications for recertification, we need to have your current address.

## **Change of Name**

If you legally change your name, please notify us of the change, in writing, as soon as possible.

## **Requesting Extensions of Certification**

The Department of Health and Social Services is authorized to extend an EMT's certificate up to 60 days. If you wish to request an extension so you have more time to recertify, etc., you must do so **in writing**. The request may be mailed or faxed to the EMS Unit. It's best to make the request as early as the need is known. During the extension, you are actually certified. This means an EMT-II or EMT-III may continue to provide advanced life support during the extension.

The request for an extension should include the requestor's name, certification level, certification number and current mailing address. (A recommended form for this purpose is available for download from the CHEMS web site).

The extension does not affect your ability to recertify. In addition, it does not change the dates used to calculate the 12 and 36 month thresholds used to determine the recertification requirements which apply. For example, if an individual's certificate expires on 12/31/01 and the person requests, and obtains, an extension of certification until March 1, 2002, the person must still recertify before 12/31/2002 in order to do so without having to meet additional recertification requirements. Starting 1/1/2003, the person would be required to meet some additional requirements for recertification. If the person did not recertify on or before 12/31/2004, he or she would have to retake the training program(s) and apply for initial certification.

## **A Note to Military EMTs and Others Who Relocate and Return**

Emergency medical technicians in the military, park service, and other agencies which rotate staff in and out of Alaska often wish to maintain their EMT certification while stationed outside Alaska so it will be current upon their return. In these circumstances, we recommend that the Emergency Medical Technician become registered with the National Registry of EMTs and maintain this credential while outside Alaska. The provisions for Comity, outlined in the EMT/EMT-Instructor certification regulations, make it easy for Nationally Registered EMTs to become certified in Alaska at the EMT-I level. EMT-II and EMT-III personnel should consider NREMT-Intermediate certification. EMTs who will be leaving Alaska and wish to obtain additional information on maintaining EMT status, are encouraged to contact the nearest Regional EMS Office or the State EMS Unit.

### **RESPONSE: EMS Alaska Newsletter**

The Section of Community Health and EMS publishes a newsletter three to four times a year. The newsletter contains information about EMS in Alaska, including symposia schedules, changes in policies and law, and a great deal of other interesting and useful information. The subscription is free. Newsletters are sent via bulk mail to certified EMTs and emergency medical services. The Section has developed the capability of sending the newsletters via the internet.

To receive the *RESPONSE: EMS Alaska* newsletter via e-mail, simply send the message **subscribe ak-response** to [list.manager@list.state.ak.us](mailto:list.manager@list.state.ak.us) or use the subscription system on our web site (<http://www.chems.alaska.gov>). The electronic version of the newsletter is published in Adobe Acrobat Reader format and is sent several weeks before the printed version is available. There is no fee for this service and you can unsubscribe at any time.

Persons interested in authoring articles for the newsletters should go to the CHEMS web site and review the instructions for authors found at [http://chems.alaska.gov/ems\\_response.htm](http://chems.alaska.gov/ems_response.htm).

# CME: What Counts and What Doesn't

## OVERVIEW

To be recertified, an emergency medical technician must participate in 48 hours of continuing medication education, which may include a state approved refresher course, within two years of the date of application.

Policies regarding continuing medical education are developed by the State EMS Training Committee, a subcommittee of the Governor's Alaska Council on Emergency Medical Services. The policies are based on the definition of continuing medical education found on the following page.

The Physician Medical Director for a certified EMS service, Defibrillator Technicians, EMT-IIIs, or EMT-IIIIs, is responsible for a plan of continuing medical education for each of the persons he or she sponsors, and should be consulted early in the CME planning process.

The Department of Health and Social Services tries to be as flexible as possible with the requirements for continuing medical education. The definition of continuing medical education<sup>6</sup> is as follows:

*"continuing medical education" means instruction in topics included in the training course curriculum for EMT-Is, EMT-IIIs, or EMT-IIIIs, that may be presented using critiques, didactic sessions, practical drills, workshops, seminars, or other department-approved means; additional topics for continuing medical education include: air medical emergency care, athletic injuries, battered spouses, child abuse, communications, crime scene response, disabled adults, electrical hazards, explosion injuries, extrication, medical terminology, farm machinery injuries, hazardous materials, incident management industrial injuries, infectious diseases, injury prevention, medico-legal aspects, neonatal care/sudden infant death syndrome (SIDS), protective breathing apparatus, radioactive materials, rape intervention, rappelling, sea survival, hyperbaric medicine, or special rescue (aerial, diving, mountain, search).*

## General Guidelines

In order to be applied toward recertification requirements, continuing medical education must be documented with the:

1. name of the participant;
2. subject of CME;
3. level of CME program;
4. number of contact hours; and
5. signature of course instructor/coordinator or EMS Supervisor.

A special form for recording CME is attached to the application for recertification sent to each EMT prior to expiration of certification. The CME is recorded on this form and copies of CME documentation are attached. Documentation of CME should be sent to the State EMS Unit **with your application for recertification** or when specifically requested.

If you take the same course twice, such as a CPR provider course, it can be applied only once to your CME requirements.

## Notes on Refresher Training Programs and CME

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<sup>6</sup> 7 AAC 26.999 (13)

A refresher training program is required to be at least 24 hours in length. Hours beyond the 24 can be applied toward the CME requirements for recertification. So, for example, a person completing a 40 hour refresher course would need only eight additional hours of CME to meet recertification requirements.

## **CME For Instructor Training Programs**

To obtain CME credit for participation in an EMS instructor training program (e.g. CPR Instructor, ETT Instructor, EMT Instructor, etc.) you must document each separate section of the medical education. Training in course organization and methods of instruction may **NOT** be applied toward CME requirements at the ETT, EMT-I, EMT-II or EMT-III levels. As with all CME offerings, credit will be given on an hour for hour basis.

## **Specific Classes**

There are several courses, such as Basic Trauma Life Support, Advanced Cardiac Life Support, and Alaska Marine Safety and Education Association (AMSEA) Marine Safety which have been approved for a certain number of hours of continuing medical education. A current list of preapproved courses is available from the State or Regional EMS Offices and is available for download from the CHEMS web site.

## **CME for Self Study Programs**

CME credits for self study programs may be applied toward recertification. The number of hours for each class must be verified by the Fire Chief, EMS Service Coordinator, or Training Officer.

The total number of hours of self study CME which may be applied toward recertification is limited to 24. Credits for hours in excess of these limits will be granted, at the discretion of the Alaska Department of Health and Social Services, based on written verification from the applicant's supervisor, the Regional or Subregional EMS Director/Coordinator, or the Regional EMS Training Coordinator that no other training opportunities exist.

## **CME for Internet Programs**

Many high quality programs for continuing medical education are available through the internet. The Section of Community Health and EMS has approved such "self study" activities for up to 24 hours of continuing medical education per certification period. The documentation must conform to the requirements specified above.

## **CME For EMS Related Courses Not Covered In The Definition Of CME**

The maximum number of hours awarded for a single educational offering related to EMS which is NOT included in the definition of CME, such as anatomy and physiology, is 10. Exceptions to this policy are limited to courses relating specifically to EMS and courses for which prior approval for a greater number of hours has been granted.

## **CME For Serving As An Examination Proctor or Certifying Officer**

An individual who has served as an EMT examination proctor and/or certifying officer may receive up to 12 hours of CME per certification period for these activities. Credit is awarded on an hour for hour basis and is determined by adding the number of hours served as a certifying officer to the number of hours served as a proctor and applying the total or 12, whichever is lower, to the CME requirement.

Questions regarding CME can be directed to your nearest Regional EMS Office or the State EMS Unit. The EMS Unit maintains a current list of approved courses on the internet, and distributes the list to subscribers to the "ak-ems" list server. For more information, please refer to page 73.

## **Injury Prevention: An Emerging Role for the EMT**

As an Emergency Medical Technician, you will see many injuries which were easily preventable. There are things you can do to help decrease the number of preventable injuries in your community.

First, recognize that you are a professional (whether or not you are paid) and are seen as such. Your personal knowledge of injury and death makes you very credible. You can use this to great advantage by assisting in prevention efforts in your community.

There are many programs related to injury prevention, including ATV safety, safety belt usage, child safety, water safety, fire safety, and alcohol related crashes that are available through the State and regional EMS Offices.

You can make a big difference in your community and have a great time doing it.

Emergency Medical Technicians are among the most knowledgeable injury prevention specialists. EMTs know immediately upon arriving at the scene of a serious injury that it was not an "accident,"...just a random happening, or the victim's "fate."

As the qualified professional who witnesses the impact of injuries first hand, you can be the most effective person in your community to give guidance to others involved, or to the public...especially when an injury calls attention to the problem.

One of the most important tasks is to report whether or not a safety device was used, or what the circumstances were that lead to the event. Your information, reported and analyzed, will lead to new solutions.

Many of the solutions, however, are known: smoke detectors that work; personal flotation devices on each person; and seatbelts, etc. Sure, most people have heard these messages over and over but haven't changed their behavior.

That is why EMTs who are respected and trusted can make such a difference. Your mentioning how injuries can be prevented can be persuasive.

Alaska leads the nation in almost every type of injury. More than twice as many children die from unintentional injuries in Alaska than in the United States as a whole. For a complete report of the status of injuries in Alaska, contact CHEMS for the Alaska Injury Prevention Plan.

If more information is needed please contact the injury prevention person in your region or within the Section of Community Health and EMS.

## **The EMT and Trauma Systems Development**

### **Trauma in Alaska**

As an EMT, you know from experience that trauma is a major problem in this state. Did you know:

- From 1980 through 1989, motor vehicle injuries were the leading cause of death in Alaska from all causes in persons between 1 and 55 years of age.
- Nationally, the rate of deaths per 100,000 population and per 100 million driving miles is decreasing; in Alaska incidents are increasing.
- The estimated years of productive life lost from vehicle injury fatalities for the years 1980 through 1989 totaled 41,762.
- The fatal and serious injury rate of Alaska Natives was well over twice that of non-Natives.
- In spite of a mandatory seat belt law enacted in 1990, of 880 highway motor vehicle crash victims who required hospital admission, almost one half of them (46%) were known not to be wearing a safety belt at the time of the incident.

Resources like the Trauma Registry, which often use **your** data from the EMS report form, are essential tools to determine the extent of the trauma problem and to develop strategies for injury prevention and better medical response.

**Trauma is a preventable disease.**

### **The Role of the EMT in Trauma**

The role of the EMT on a trauma call is simple. It is to increase the patient's chance of survival, to prevent injuries from worsening, and to transport the patient in a timely manner to an appropriate medical facility. This simplicity understates the training, experience, and teamwork necessary to do this effectively, and the system which must be in place to support the EMT's activities.

### **Good On-Scene Medical Care is Essential, But...**

What you do as EMTs for the patient during the first few moments of a trauma response can be lifesaving. Your mastery of patient assessment, standing orders, and protocols for trauma and triage can significantly increase the patient's chances of survival and may prevent further harm.

However, it's only part of an effective trauma system. Public education on first aid and accessing the EMS System, dispatcher training, an effective 911 enhanced entry system, emergency department resources, trauma center development, and rehabilitation are all critical. This, of course, is in addition to physical resources, such as medical equipment, communications systems, and, in some areas, aircraft.

### **Questions You Need to Ask**

- It's common for EMTs to get together after a run to discuss their actions to try to improve patient care. It's less common for "system" issues to be discussed. Here is a list of questions you should ask yourself after each trauma call:
- Was everything done to prevent these types of injuries from occurring? (Were safety belts, helmets or other safety devices used?)
- Was the EMS system accessed in an appropriate and timely manner?
- Was the time frame from notification to arrival on scene appropriate? (Was the response as quick as it should have been?)

- Were the appropriate resources dispatched?
- Was the level of EMS responder available on scene appropriate for the patient's injuries?
- Were you able to communicate the patient's condition, including neurological status, in an effective and efficient manner?
- Were on-scene roles and responsibilities clearly understood and performed correctly?
- Was the on-scene time as short as possible?
- Was the patient transported to the appropriate facility capable of handling the injuries in accordance with your physician approved transfer and transport protocols?
- Did standing orders and field triage protocols provide you with clear guidance on how to deal with the patient's injuries? If they didn't, was on-line medical control contacted for advice?
- Is your physician medical director involved in all aspects of EMS planning and evaluation for your system?
- Does your agency have a formalized quality improvement program?

If the answers to any of these questions was "no," you may have identified an area of your EMS system which is in need of improvement.

### **What EMTs Can Do About Trauma**

In addition to maintaining your skill levels and obtaining specialized training, such as Basic Trauma Life Support (BTLS), or Prehospital Trauma Life Support (PHTLS), there are many things that you can do to help decrease the deaths and injuries associated with trauma. These include:

- Using your credibility as an EMT to assist in local injury prevention efforts;
- Supporting legislation which assists in trauma system development;
- Becoming involved with local trauma system development activities; and
- Learning more about trauma care planning. The "Alaska Trauma Care System Plan" is an excellent reference concerning plans in Alaska.

The State EMS Unit and Regional EMS Offices have many resources which you can use to become more familiar with trauma systems planning and development; joining, or starting, injury prevention coalitions; triage and transfer protocols; and many other essential facets of an inclusive trauma care system.

## The Future of EMS in Alaska

The field of Emergency Medical Services is one of the most dynamic. It is greatly influenced by changes in medical and business practices, legislation, computer technology, the availability of human and financial resources, and a myriad of other factors. Although change is constant, it can be influenced and, therefore, predicted. All of us in EMS can have a role in shaping the future of our profession.

There are many resources which can assist EMS personnel in learning about issues likely to cause changes in the field of emergency medical services. Many fine magazines and newsletters are documenting and predicting the changes in our field.

At the national level, the National Highway Traffic Safety Administration has developed an excellent document titled *EMS Agenda for the Future*. The document is 87 pages in length and can be downloaded from the NHTSA web site.<sup>7</sup> The “vision statement” in the document expresses the hope that:

***Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public’s emergency medical safety net.***

In Alaska, the Section of Community Health and EMS, within the Department of Health and Social Services, is working to shape the future of EMS through collaboration with its counterparts at the federal level, the Alaska Council on Emergency Medical Services, with Regional EMS Directors, and many other organizations involved in the provision and administration of emergency medical services, such as the Alaska Fire Chief’s Association.

In 1997, the Planning Task Force of the Alaska Council on Emergency Medical Services developed a strategic plan for Emergency Medical Service. The plan is available for download from the section's web site.

Each year, CHEMS and ACEMS develop priorities for the state's EMS system. For more information on this important Council, go to page 55.

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<sup>7</sup> There is a link to this web site from the Alaska State EMS web site.

# The Alaska EMS for Children Project

The Alaska Emergency Medical Services for Children (EMSC) is a federally funded program to improve capabilities within the state to respond to pediatric emergencies. The program is funded by the United States Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Emergency Medical Services for Children (EMSC) Program.

Alaska EMSC program has received funding since 1990 for a variety of projects. Several years ago, the EMSC Program funded the development of a pediatric emergency care course and training programs for EMS instructors. Also, as part of that project, Southern Region EMS Council, Inc., in Anchorage did a marvelous job developing a pediatric "preceptorship" program which enabled emergency medical personnel to see relatively large numbers of pediatric patients under the watchful eyes of experienced clinicians. This program was re-activated in 1998 with new funding from EMSC.

The National EMSC recently developed the Pediatric Education for Prehospital Professionals (PEPP) course through the American Association of Pediatrics. This is a scenario based, skills intensive program designed to train prehospital professionals in handling pediatric emergencies. The course has been presented across the State with enthusiasm. Alaska was also the first state to do a rollout of the course after the national rollout in March, 2000. The EMSC program has sponsored many courses throughout the state. If you are interested in taking a course, contact your regional EMS office for course availability.

Another important project was looking at youth suicide prevention in Alaska. This was a two-year project that developed the ASK survey, **A**sK about **S**uicide in **K**ids who are injured, which was a screening tool to identify children at risk of suicide. This project also included the Gatekeeper training program designed to train people who have contact with youth in identifying children at risk of suicide and referring the children for further treatment.

Some of our goals are to enhance pediatric medical training at all health care provider levels, improve access to pediatric specific equipment, and enhance injury prevention programs. The ultimate goal of the Alaska EMSC program is to expand and institutionalize EMSC activities in Alaska. We are fortunate, indeed, to have many talented and committed professionals (both paid and volunteer), in the fields of medicine and injury prevention, who are willing to help us pursue this goal.

The National EMSC Program has contributed enormously to the well being and emergency medical care of kids and those of you who enjoy "surfing the net" are well advised to stop by the program's web site. It wraps eclectic information, ranging from emergency medical care to planning and legislation, into one aesthetic and intuitive site. The URL for the site is <http://www.ems-c.org> (there is a link to this site from the Alaska State EMS web site). You can also visit the Alaska EMSC web page at: [http://chems.alaska.gov/ems\\_for\\_children.htm](http://chems.alaska.gov/ems_for_children.htm).

This important project is being managed in our office by Doreen Risley, RN. For more information, you can contact her at (907) 465-8633.

# Critical Incident Stress Management (CISD/CISM)

*Contributed by Bruce Bartley, EMT-III*

This Guide and your training program provide a great deal of information about how to become an emergency medical technician. Nothing, however, can truly prepare you for what it is like "in the streets."

While tremendously rewarding and exciting, emergency medical work can be extremely stressful. Unfortunately, and contrary to popular beliefs, emergency medical services workers are NOT usually trained to deal with these stresses. The lack of training manifests itself in a high rate of burnout and attrition, especially among volunteer services.

Growing awareness of this problem has led to the formation of Critical Incident Stress Debriefing (CISD) teams throughout the state. These teams, consisting of mental health professionals and emergency personnel, provide education and debriefing services. The aim is to help emergency service workers return to full effectiveness as quickly as possible and to avoid the cumulative stress that may lead to burnout.

The emotional experiences you will experience at some of the horrible things you will encounter are not unique. They are normal reactions by a normal person to an abnormal situation. CISD training and actual debriefings will help you understand and cope with these reactions.

Debriefings are neither therapy nor counseling. They simply facilitate the very human need and desire to talk about stressful events. They are something many emergency workers have been doing informally for years in the ambulance on the way back from a run, in the fire house after the blaze is extinguished, or in the police station after an event. Volunteer services often are at a disadvantage because they lack the organizational structure and facilities needed to make even these limited efforts work.

The problem with the informal process is that it often overlooks or misses some of the people who need it the most. The more formalized CISD process includes everyone who was involved in a given incident.

New emergency workers often have the misconception that their more experienced coworkers-workers are immune to stress. When the new EMT sees others outwardly unfazed by awful events, it is easy to assume that is the norm and is what is expected of the newcomer. The truth is that you never get "used to" pain and suffering, no matter how often you see it. The tendency to try to block out or ignore those emotions leads to disabling cumulative stress disorders. Burnout and departure from emergency work are common consequences.

CISD is neither a treatment nor a cure. Even after a debriefing, you may be troubled by the incident. But the debriefing process provides a reference and a perspective with which you are better able to work your way through and cope with the stress.

Critical incidents are not always multiple-casualty events. A crib death is a critical incident to most people because of the increased sense of urgency that accompanies the care of infants and children. Incidents that might be considered routine elsewhere become critical in small communities where rescuers are personally acquainted with or related to patients.

Your EMS system should have ready access to a CISD team and should have protocols outlining what types of incidents will be presumed to be critical, such as crib deaths, injury or death of coworkers, multiple casualty incidents, etc.

Editor's Note: A complete list of Critical Incident Stress Management Teams is contained in the Alaska EMS Directory, available for download from the CHEMS web site.

# EMS Statutes and Regulations

This section provides only an overview of SOME of the most important statutes and regulations related to EMS in Alaska. Since statutes and regulations change, and are subject to interpretation, you should always seek the most recent versions and competent legal advice when specific questions arise.

Copies of these statutes and regulations are available for downloading from the Section's web site.

## **AS 18.08.010 - 18.08.090 Emergency Medical Services**

These statutes relate specifically to Emergency Medical Services. They give the Department of Health and Social Services (DH&SS) responsibility for the development, implementation, and maintenance of a statewide comprehensive emergency medical services system through coordination and administration of grants in aid.

These statutes also create and define the Alaska Council on Emergency Medical Services and empower DH&SS to promulgate regulations establishing standards for certification and recertification as well as other regulations necessary to carry out the purposes of this chapter.

The 1993 amendments also permit the department to develop systems for:

- patient information;
- certifying emergency medical dispatchers;
- approving in-state paramedic training programs; and
- hospitals to represent themselves as trauma centers following voluntary compliance with department adopted criteria.

The statutes require certification of individuals and agencies providing (or advertising to provide) advanced life support. In addition, they prohibit individuals from claiming to be state certified as EMTs unless they actually are.

Another significant change in 1993 was the inclusion of a section related to disclosure of medical records. This section allows medical information to be disclosed to EMTs for the purpose of performance evaluation. It also prohibits the information from being further disclosed by the EMT to "a person not entitled to receive that information under this section or another law."

## **AS 18.08.086 Immunity from Liability**

Importantly, AS 18.08.086 specifically provides certified individuals, agencies, training programs, and sponsors some immunity from liability from civil damages as a result of an act or omission in administering emergency medical services or conducting training courses. Immunity from liability is also extended to physicians arranging patient transfers and to Registered Nurses or Licensed Practical Nurses who escort patients in "means of conveyance not equipped as an ambulance."

## **AS 18.08.075 Authority of an Emergency Medical Technician.**

An emergency medical technician who responds to an emergency with an ambulance service or first responder service, who has in the technician's possession a current emergency medical technician identification card, and who provides emergency medical care or other emergency medical service, has the authority to

- (1) control and direct activities at the accident site or emergency until the arrival of law enforcement personnel;
- (2) order a person other than the owner to leave a building or place in the vicinity of the accident or other emergency for the purpose of protecting the person from injury;
- (3) temporarily block a public highway, street, or private right-of-way while at the scene of an accident, illness, or emergency;

(4) trespass upon property at or near the scene of an accident, illness, or emergency at any time of day or night;

(5) enter a building, including a private dwelling, or premises where a report of an injury or illness has taken place or where there is a reasonable cause to believe an individual has been injured or is ill to render emergency medical care; and

(6) direct the removal or destruction of a motor vehicle or other thing that the emergency medical technician determines is necessary to prevent further harm to injured or ill individuals.

(b) A person who knowingly refuses to comply with an order of an emergency medical technician authorized under the first part of this section is, upon conviction, guilty of a class B misdemeanor. In this subsection, "knowingly" has the meaning given in AS 11.81.900(a).

### **AS 09.65.090 Civil Liability for Emergency Aid.**

This is Alaska's "Good Samaritan Law." It provides individuals with immunity from liability, when acting in good faith when providing care to individuals who are sick or injured.

This statute also provides immunity from civil liability to certain members of volunteer organizations which exist for the purpose of providing emergency medical services, even if the members have a preexisting duty to act. For the purposes of this statute, "volunteer" is defined as a person who is paid not more than \$10 a day and a total of not more than \$500 a year, not including ski lift tickets and reimbursement for expenses actually incurred for providing emergency medical services.

This law does not provide an individual with immunity from civil damages resulting from providing or attempting to provide advanced life support services nor does it provide immunity from liability for civil damages arising from gross negligence or intentional misconduct. Anyone providing advanced life support services, e.g. administering medications, using a manual defibrillator, or an advanced airway device, **must** be appropriately certified or licensed.

In August of 1998, this law was amended to provide immunity from civil liability to properly trained persons who used an automated external defibrillator.

### **AS 08.64.366 Liability for Services Rendered by a Physician Trained Mobile Intensive Care Paramedic**

This statute provides Mobile Intensive Care Paramedics (MICP's) with immunity from liability much as 18.08.086 does for Emergency Medical Technicians.

## **AS 47.17.010 Reporting Child Abuse and Neglect**

Emergency Medical Technicians are among the groups of individuals required to report suspicions of child abuse or neglect. The report must be made to the Division of Family and Youth Services of the Department of Health and Social Services or, if the Division cannot be reasonably contacted, the individual may report his or her suspicions to the nearest peace officer. This statute provides immunity from civil damages for those individuals who make reports in good faith and penalties for those who do not make the required reports. The department's Division of Family and Youth Services has advised us that the report must be made as stated above. Notification of your medical director or EMS supervisor is not sufficient to comply with the reporting requirements.

Statewide number: 1-800-478-4444

Anchorage: 269-4000

## **AS 47.24.010 Reports of Harm**

This section is quite similar to AS 47.17.010 except that it relates to abuse of persons 18 years of age or older who, because of physical or mental impairment, are unable to meet their own needs or to seek help without assistance. Under this statute, Emergency Medical Technicians and Mobile Intensive Care Paramedics are required to report suspicions that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self neglect. The report must be made within 24 hours after first having cause for the belief. Due to limited resources, the office is only staffed during normal business hours. If an elderly person is in danger or has suffered harm, the local law enforcement agency should be contacted immediately and the report of harm made to the Division of Senior Services the next business day. The statute provides immunity from civil liability to those making the report in good faith.

Statewide number: 1-800-478-9996

Anchorage: 269-3666

## **AS 08.64.369 Health Care Professionals to Report Certain Injuries**

Emergency Medical Technicians and Mobile Intensive Care Paramedics are required to report certain injuries. These injuries include:

- second and/or third degree burns covering five percent, or more, of the patient's body;
- a burn to the patient's upper respiratory tract or laryngeal edema due to the inhalation of superheated air;
- a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;
- an injury apparently caused by a knife, axe, or other sharp object, unless the injury was clearly accidental; and
- an injury that is likely to cause the death of the patient, unless the injury was clearly accidental.

An oral report must be made promptly to the Department of Public Safety (DPS), local law enforcement, or Village Public Safety Officer for any of the five injuries in the list above.

For second or third degree burns or respiratory injuries due to superheated air, a written report must also be submitted within three days to DPS on a form specifically designed for this purpose. A person making a report in good faith is immune from civil or criminal liability that may be incurred by making the report or participating in legal proceedings.

## **AS 08.66.310 Mandatory Training Regarding Domestic Violence and Sexual Assault**

This law requires that employers provide “continuing education in domestic violence for the public employees who are required by law to report abuse or neglect of children under AS 47.17.020.” These training programs must be provided “in consultation with the Alaska Council on Domestic Violence and Sexual Assault and must address:

- (1) the nature, extent, and causes of domestic violence;
- (2) procedures designed to promote the safety of the victim and other household members;
- (3) resources available to victims and perpetrators of domestic violence; and
- (4) the lethality of domestic violence.

The frequency with which this training must be provided is not specified in statute. The Section of Community Health and EMS recommends that the training be provided at least once per certification period to all EMS personnel in a service. The address of the Alaska Council on Domestic Violence and Sexual Assault is:

Council on Domestic Violence and Sexual Assault  
P.O. Box 111200  
Juneau, AK 99811-1200  
(907)465-4356/FAX: 465-3627

**The Department of Health and Social Services has adapted a resource manual which includes a wealth of information regarding domestic violence in Alaska. The manual is geared specifically for EMS providers and is available for download from the department's web site.**

### **12 AAC 40.310 - 12 AAC 40.390 Mobile Intensive Care Paramedics.**

These regulations define the qualifications for licensure and relicensure as a mobile intensive care paramedic, as well as the scope of activity and prohibited actions. Anyone considering taking a mobile intensive care paramedic training program and returning to Alaska to become licensed as an MICP should read and thoroughly understand these regulations BEFORE entering the program.

### **13 AAC 02.517. Authorized and Other Emergency Vehicles.**

This set of regulations outlines the responsibilities of individuals operating emergency vehicles and those responding to emergencies while displaying a blue light.

The regulations permit an authorized individual with a vehicle displaying a blue light to disobey statutes, regulations, and ordinances governing the operation, stopping, standing, or parking a vehicle.

The provisions of this section do not relieve the driver of an authorized emergency vehicle or a vehicle displaying a flashing blue light from the duty to drive with regard for the safety of all persons, nor do the provisions of this section allow a driver of a vehicle displaying a flashing blue light to proceed past a stop sign or signal without first stopping.

The regulations also state that an individual **responding** to an emergency while displaying a blue light may, if not otherwise prohibited by a municipality, without undue danger to the safety of other persons or property exceed the speed limit so long as the operator slows at each intersection and exercises care under the circumstances. The regulations require that the operator comply with all speed limit requirements when turning.

The Commissioner of the Department of Public Safety, or his/her designee, such as the Fire Chief, must authorize a vehicle to be equipped with a flashing blue light. The designation must be in writing and must be carried at all times in the private vehicle. To be properly designated, the operator must complete a checklist regarding the vehicle to be

used and must read and understand the applicable regulations. The authorization is valid for five years from the date of issue and is void if the person's driver's license is suspended, revoked, or canceled, if the person's vehicle no longer meets the appropriate standards, or if the Commissioner or his/her designee withdraws the authorization.

For many reasons, the EMS Unit recommends that operators of private vehicles responding to emergencies using a blue light DO NOT exceed the posted speed limit and that they DO adhere to all statutes, regulations, and ordinances related to the operation of motor vehicles.

In any case, the operation of an emergency vehicle, or a vehicle equipped with a blue light, is a privilege that is accompanied by the responsibility to operate the vehicle in a safe manner. Driving an emergency vehicle safely is an acquired skill, requiring training, practice, and a professional attitude.

Emergency vehicle operations courses are frequently available and we recommend that you take one if at all possible.

### **AS 13.50.016 Investigations by Law Enforcement and Medical Personnel.**

This statute requires that law enforcement and medical personnel, responding to an incident in which someone has died make a "reasonable search for a document of gift or other information identifying the bearer as a [an organ] donor or as an individual who has refused to make an anatomical gift." Failure to do so is not the basis of criminal or civil liability but "may be the basis for appropriate disciplinary sanctions."

### **AS 11.81.430 Justification: Use of force, special relationships.**

This statute describes the circumstances under which the use of force upon another person that would otherwise constitute an offense is justified. Included in the statute is wording which states the conditions which must be met for an emergency medical rescuer to administer a medical treatment without the patient's consent.

## **Clinical Laboratory Improvement Amendments of 1988 (CLIA)**

CLIA was intended to increase the quality of laboratory tests and the scope of these standards extends to all sites testing human specimens, including prehospital services performing blood glucose measurements. The collection of samples (even via venipuncture) is not regulated by CLIA.

Some testing, like blood glucose determination with an approved machine, can be performed once an agency has obtained the CLIA Waiver. More comprehensive blood testing systems, like the i-STAT, require certification by CLIA as a laboratory. Certification as a lab requires the following: proficiency testing, site survey by CLIA, documentation of training, and a quality assurance program.

In order to avoid stringent fines, a waiver or certification must be obtained by those services performing the activities described above.

Information regarding CLIA may be obtained from the:

Health Facilities Licensing and Certification  
Attn: CLIA Lab Inquiries  
4730 Business Park Blvd. Suite 18  
Anchorage, AK 99503  
(907) 334-2491

The person who handles CLIA certification in Alaska is Diana Parks, her e-mail is [diana\\_parks@health.state.ak.us](mailto:diana_parks@health.state.ak.us) and she has indicated that she is willing to work with agencies to assist them in complying with the regulations.

Specific information is available on the internet at <http://www.hcfa.gov/medicaid/clia/cliahome.htm>

## **Americans With Disabilities Act (ADA)**

The Americans With Disabilities Act was passed by Congress on July 26, 1990 and provides comprehensive civil rights protection to individuals with disabilities. The five titles in the Act cover all state and local governmental services, telecommunications, employment, and public accommodation.

The substance of ADA is **equal access** to all public funded programs, services, and activities (Titles I & II). Private entities are not exempt from ADA and must comply under Title III of the Act.

EMS managers must review emergency access capabilities, employment decision making procedures, and provisions for public access, to make sure they are in compliance with ADA.

If you have special skills useful for caring for the disabled (e.g. sign language), make this known to your EMS supervisor. These skills can make you an even more important member of your EMS team.

## Regulations and Guidelines Related to Infectious Diseases

### Disclaimer:

This section provides an overview of the regulations, guidelines, and rules related to infectious diseases. Some of the materials have been simplified and summarized in an effort to make the material concise and readable. There is no substitute for reading the relevant laws when you have specific questions.

### Overview:

There are several regulations and guidelines related to infectious disease with which the EMT should be familiar. Each EMS Service is required to have an "Exposure Control Plan" which defines many of the service's activities regarding infectious disease training, as well as reporting, notification, and follow-up to exposures. **It is imperative that the EMS provider read and understand the contents of the exposure control plan.**

### *8 AAC 61.1010 Bloodborne Pathogens.*

In response to federal mandates, the Alaska Department of Labor adopted by reference Federal Regulations, including 29 CFR 1910.1030, related to bloodborne pathogens. The regulations impose training, immunization<sup>8</sup>, and recordkeeping requirements on agencies with an employer-employee relationship with "at-risk" workers, including emergency medical, fire, and rescue personnel. Most volunteers are considered "employees" in the context of these regulations. Penalties for non-compliance could be severe.

### Services are required to:

- have an exposure control plan which covers training, equipment, and exposure evaluation and follow-up, as well as operational issues, such as handwashing;
- provide HBV vaccination at no cost and at a reasonable time and place. The vaccinations must be started within 10 days of putting the individual in an at-risk occupation;
- make available Personal Protective Equipment (PPE) equipment, such as eye shields, gowns, gloves, bag-valve-masks, pocket masks, etc.;
- institute methods of controlling exposures, such as using "sharps" containers, "red bags," disposable ventilation devices, etc.;
- have an acceptable and separate system for handling and decontaminating contaminated materials, such as clothes, backboards, etc.; and
- provide adequate training in recognition of potentially infectious materials, exposure reduction practices, documentation, and the details of the exposure control plan.

### The training must include:

- An accessible copy of the regulatory text of the standard and an explanation of its contents;
- A general explanation of the epidemiology and symptoms of bloodborne diseases;
- An explanation of the modes of transmission of bloodborne diseases;
- An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;
- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

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<sup>8</sup> Emergency medical and rescue workers who provide care primarily within an unincorporated community, or within a municipality which does not fund the emergency service may be eligible for the Department of Health and Social Service's HBV immunization program outlined on page 41.

- An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;
- Information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment;
- An explanation of the basis for selection of personal protective equipment;
- Information on the HBV vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
- Information on the appropriate actions to take and persons to contact in the event of a possible exposure to blood and other potentially infectious materials;
- An explanation of the procedures to follow if an exposure occurs, including reporting methods and medical follow up which will be made available;
- Information on the post exposure evaluation and follow-up that the employer is required to provide following an exposure;
- An explanation of signs, labels, and color coding used to identify any potentially infectious materials stored or transported; and
- An opportunity for interactive questions and answers with the person conducting the training session.

**The training must be refreshed annually or when the exposure plan or risks change.**

**Copies of the regulations can be obtained by writing:**

Department of Labor  
 Division of Labor Standards & Safety  
 P.O. Box 21149  
 Juneau, AK 99802-1149

*AS 18.60.880. Needle stick and sharps injury protections for health care workers.*

This regulation became effective January 1, 2001; it states “An employer shall conduct product evaluations of needleless systems and sharps with engineered sharps injury protections. The product evaluations shall include the categories of devices that are used in the employer's facilities. For each category of device, the product evaluations shall be performed by front-line health care workers representing all wards and medical specialties where the devices are used. The evaluation committee described in this section shall determine the amount of time necessary for the front-line health care workers to perform product evaluations under this subsection. The categories of devices to be evaluated under this subsection include:

- IV catheters;
- IV access devices and IV connectors;
- vacuum-tube blood collection devices;
- blood-drawing devices including phlebotomy needle and tube holders, butterfly-type devices, and syringes and other similar devices;
- syringes used for purposes other than blood drawing;
- suture needles;
- scalpel devices; and
- any other category of device used at the employer's facilities where there is a sharps injury risk.

The department shall, by regulation, adopt a standard concerning the use of needleless systems and sharps with engineered sharps injury protections for devices listed above.

### *Hepatitis B Vaccination Act*

On July 1, 1991, "An Act relating to hepatitis B vaccinations for law enforcement officers and emergency medical and rescue personnel; and providing for an effective date." became effective. The Act, now AS 18.15.250, requires the Department of Health and Social Services to establish a program for making hepatitis B (HBV) vaccinations "reasonably accessible at no charge to all volunteer emergency medical and rescue personnel in the state" who provide care primarily in an unincorporated community or within a municipality that does not provide funding for the emergency service. The act requires municipalities that fund emergency services to make HBV vaccinations reasonably accessible at no charge to all law enforcement officers and volunteer or employed emergency medical and rescue personnel who provide service to the public within the municipality.

If funding continues, so will the services provided by this Act. If you are an active emergency medical provider or rescuer and you believe you are eligible for this program, contact the Emergency Medical Services Section at 465-3027 for more information.

The process for obtaining the vaccine is straightforward. Your agency completes a form we provide which lists the individuals who are eligible for the vaccine, as well as the medical provider (RN, Mid-Level Practitioner, or physician) who will be administering the vaccinations. We send letters of confirmation to the EMS contact for the organization and request that the department's Section of Epidemiology send the vaccine to the medical provider designated. It is the individual's responsibility to ensure the series is completed and appropriately documented.

### *The Ryan White Act*

The Ryan White Act establishes a system by which emergency responders are informed that they may have been exposed to an infectious disease. Components include:

- A. Development and publication of a list of potentially life threatening infectious diseases to which an emergency medical responder may be exposed.
- B. Guidelines describing circumstances in which emergency responders may be exposed to such diseases.
- C. Guidelines for medical facilities to determine whether exposure to the listed diseases occurred.
- D. Guidelines for notifying emergency responders of exposures to infectious diseases on the list described in (A).

The Ryan White Act was implemented in Alaska on April 20, 1994 and affects emergency responders, including law enforcement personnel and firefighters. Each emergency service "employer" is required to have a "Designated Officer" who is central to the notification and reporting process. The Ryan White Act does **not** require patients to be tested for communicable diseases. Questions about how your emergency service and the local medical facilities comply with the Ryan White Act should be directed to your service's Designated Officer. A list of Designated Officers is maintained by the Section of Community Health and EMS and is contained in its EMS Directory, which is available on-line at the section's web site.

### *Tuberculosis Guidelines*

The Centers for Disease Control and Prevention and the Federal Occupational Safety and Health Administration have published guidelines for preventing the transmission of tuberculosis. The guidelines state that emergency medical response personnel who are transporting patients with confirmed or suspected active TB should place a surgical mask on the patient, if possible. The guidelines also recommend that in emergency transport situations that health care workers wear respiratory protection. In July 1995, the National Institutes for Occupational Safety and Health (NIOSH) indicated that N95 respirators meet the CDC performance criteria for tuberculosis respirators, although there are other, more expensive, devices which also meet the requirements of OSHA Standard CFR 1910.134. Before using any respirator in the field, an EMT must have medical determination that he or she can wear a mask, and be fit tested

to ensure the mask seals adequately. Fit testing must be repeated annually and when facial features change dramatically (i.e. after facial surgery, gain or loss of 10 or more pounds, or after significant facial injury).

The guidelines also require the development of programs for medical surveillance, training, compliance monitoring, recordkeeping and engineering control, as well as protocols for post exposure management and work restrictions for those who have TB or who are immunosuppressed.

As an EMT, you should:

- be periodically tested for tuberculosis in accordance with CDC and OSHA guidelines (OSHA currently requires testing every 6 months for all employees who meet certain criteria, one of which is those who “transport individuals with suspected or confirmed tuberculosis in an enclosed vehicle;”
- understand the section related to airborne pathogens in the Ryan White Act;
- know the signs and symptoms of TB, e.g. lethargy, weight loss, fever, loss of appetite, weakness, night sweats, recurrent cough or bloody sputum;
- receive appropriate training related to the risks of airborne pathogens and the use of filtration devices and other controls;
- use a N95 Respirator and take other precautions to minimize droplet exposure when caring for a patient with known or suspected TB.

The Department of Labor, Division of Labor Standards and Safety, may enforce these guidelines under the "General Duty" clause. You should make sure you understand the TB section of your service's exposure control plan before providing patient care.

Information from the Centers for Disease Control and Injury Prevention can be found at <http://www.cdc.gov>.

The Federal OSHA proposed guidelines can be found at [http://www.osha-slc.gov/OCIS/toc\\_fed\\_reg.html](http://www.osha-slc.gov/OCIS/toc_fed_reg.html) in Federal Register 62:54159-54309.

# Pronouncement of Death by EMTs and Paramedics

## History and Overview:

AS 09.68.120 allows mobile intensive care paramedics, physician assistants, and emergency medical technicians to pronounce death under certain circumstances. The law became effective on August 25, 1995. AS 18.08.089 was revised by the same bill to define the circumstances under which death may be pronounced. Mobile Intensive Care Paramedics and EMTs must be active members of **a state certified Emergency Medical Service**.

Each EMT-Instructor should have a copy of this law to refer to when teaching EMS classes regarding this subject.

## Planning Considerations:

Emergency medical service agencies should incorporate the tenets of AS 18.08.089 and AS 09.68.120 into their policies, procedures, and standing orders. Particular attention should be paid to the issues of: attempting to contact medical control; and deaths en route. Many of these decisions will require the assistance of local law enforcement, medical, and court personnel. EMS agencies should anticipate special circumstances in which pronouncement of death might occur, such as in a wilderness setting, and ensure they are adequately covered in standing orders and understood by responding personnel.

Also, the EMS service should have guidelines, for dealing with deceased patients who are organ donors, which define the information required by the receiving facility.

Since these situations are among the most stressful encountered by prehospital emergency medical personnel, EMS agencies should ensure that the decision making process involved in pronouncing death is well defined and that supervisory personnel are attentive to manifestations of critical incident stress.

## Authority to Pronounce Death

AS 09.68.120 provides EMTs, MICPs, and physician assistants the authority to pronounce death under certain circumstances.

To pronounce death, EMTs and MICPs must:

- be active members of an EMS service certified by the state;
- be unable to immediately communicate with a physician by radio or telephone.

In most circumstances, EMTs know where the communications "dead spots" are and it is recommended that, if the EMTs anticipate regaining radio contact shortly, resuscitation efforts continue until the decision can be made by the on-line physician.

## Important Definitions

"Post Mortem Lividity" - A red or purple skin discoloration resulting from pooling of blood to dependent parts of the body after death. It is generally discernible clearly 1 hour after death and increases in color for 6 - 10 hours after death. It may be mimicked by hypothermia. Heat hastens the speed with which it develops, cold slows it.

"Rigor Mortis" - Stiffening of body and limbs which usually is discernible approximately 1 hour after death, with stiffening increasing for 6 - 10 hours after death. It may be mimicked by profound hypothermia. Heat hastens the speed with which it develops, cold slows it. Rigor mortis is initially detectable in the jaw and large joints, and progresses to include smaller joints over time.

"Hypothermia" means a cold core temperature which caused, or complicates the cardiac arrest. At room temperature, a dead body will lose about 2 degrees per hour. Consequently, EMS personnel must be able to distinguish hypothermia from normal cooling of the deceased.

"Detruncation" and "decapitation" are essentially synonymous.

## Acceptable Medical Standards for Pronouncing Death

These criteria are set forth in AS 18.08.089.

The EMT or MICP may withhold resuscitation efforts when the patient has:

1. injuries incompatible with life, including cardiac arrest accompanied by:
  - a. incineration;
  - b. decapitation;
  - c. open head injury with loss of brain matter;
  - d. or detruncation;
2. cardiac arrest accompanied by rigor mortis or cardiac arrest accompanied by the presence of post mortem lividity;
3. Advanced life support<sup>9</sup> is not available, the patient is not hypothermic, proper CPR has been performed for at least 30 minutes and the patient has not developed spontaneous respiration or pulse.

The EMT or MICP may terminate resuscitation efforts when:

1. Advanced life support is not available, the patient is not hypothermic, proper CPR has been performed for at least 30 minutes and the patient has not developed spontaneous respiration or pulse;
2. Advanced life support has been properly provided for at least 30<sup>10</sup> minutes to a patient without restoring spontaneous respiration or pulse; or
3. The patient is hypothermic and the patient has received at least 60 minutes of properly performed cardiopulmonary resuscitation in conjunction with rewarming techniques as described in the current *Cold Injuries Guidelines* without the patient developing spontaneous respiration or pulse.

### When in doubt, resuscitate.

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<sup>9</sup> For the purposes of this document, "advanced life support" means the presence of one or more individuals capable of providing first line advanced cardiac life support medications and procedures, such as defibrillation, epinephrine, lidocaine, atropine, and intubation.

<sup>10</sup> The EMS Unit recommends that each advanced life support emergency medical service consult its physician medical director when developing this part of its standing orders.

## **After pronouncing a patient dead**

### **If the death was pronounced en route**

- Reattempt radio communications with on-line physician, if appropriate.
- Transport the deceased in accordance with standing orders. If standing orders do not cover such an occurrence, contact the law enforcement agency which has jurisdiction for that area for additional guidance.

### **If the death was pronounced at the scene**

- Notify law enforcement personnel.
- Notify survivors, if appropriate, as outlined in section below.
- Treat the scene as if it were a crime scene.
- Protect scene until medical examiner or law enforcement personnel arrive<sup>11</sup>.
- Minimize the number of personnel at scene.
- If in a residence or building:
  - ⇒ Remember what you've touched and your entrance route;
  - ⇒ Avoid touching objects; and
  - ⇒ Avoid using the residence telephone.
- Personnel exiting the scene should retrace the same route they took to enter, if possible.
- Be prepared to describe the condition of scene, e.g. placement of objects, who was at the scene, what were their functions, etc., when you arrived.
- Leave tubes and IV lines in place.
- Don't leave the scene without first talking with law enforcement personnel.
- Don't disturb clothing, jewelry, the contents of pockets, and other personal effects, particularly if this case is likely to be reviewed by the Medical Examiner.

## **Documentation**

- The pronouncement of death must be certified by a physician within 24 hours after the pronouncement is made by the EMT or MICP.
- The EMT or MICP should complete the EMS run report in accordance with local protocol.
- The EMT or MICP must provide, to the person signing the death certificate, the following information:
  - name of the deceased;
    - ⇒ the presence of a contagious disease, if known;
    - ⇒ date and time of death.
- Providing the EMS run report to the person signing the death certificate may be helpful.

## **Summary**

- Pronouncing death is an important responsibility. EMTs and MICPs must understand and apply the law correctly.
- EMS personnel should reattempt to contact on-line physician medical control before pronouncing death when the possibility of communications exists.
- When in doubt whether the circumstances meet the criteria for pronouncement of death, resuscitation efforts should be initiated and/or continued.
- Anticipate and be responsive to the psychological needs of rescuers, patients, and survivors, as well as your own.
- Work cooperatively with law enforcement and the medical examiner's office so they can complete their investigative responsibilities.
- Ensure that your findings and actions are documented appropriately and that the pronouncement of death is confirmed by a physician within 24 hours.

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<sup>11</sup> In the event that there will be a substantial delay in the arrival of law enforcement personnel or the coroner, EMS personnel should contact the nearest appropriate law enforcement agency for guidance.

# The Alaska Comfort One Program



## Overview

Some individuals who are terminally ill do not wish to have life saving measures, such as cardiopulmonary resuscitation, performed when they go into respiratory or cardiac arrest.

In October, 1996, Alaska laws and regulations established the “Comfort One Program” to help health care providers identify terminally ill persons who have expressed these wishes. In addition, the program establishes a protocol for health care providers to respect these wishes once the person has been identified as being enrolled in the program.

In the Comfort One statute, *health care provider* means a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession. For the purposes of this statute, an individual who is certified to administer cardiopulmonary resuscitation appears to fall within the definition of a “health care provider” as defined in AS 18.12.100(7) with respect to activities related to CPR. Consequently even those certified to administer only limited health care must, by statute, respect the Comfort One form, wallet card, or bracelet.

At the time the physician enrolls the patient in the Comfort One program, the patient is given a copy of the enrollment form and a wallet card. Patients and families are encouraged to keep them in a visible or easily accessible location.

The person may choose to purchase a Comfort One bracelet. Bracelets are only available to those enrolled in the Comfort One program and are particularly useful for persons who travel outside the home.

The Comfort One form, wallet card, and optional bracelet serve as proof to the health care provider that the person is enrolled in the program.

**The two steps to identifying the “Do Not Resuscitate” patient are set out in the regulations**, they are confirming the identity of the patient and determining whether the patient has a valid DNR order.

It is important to ensure that both criteria are met prior to treating the patient as if he or she has a valid DNR order.

### **Establishing the Patient’s DNR Status**

The caregiver should establish the patient’s DNR status through at least one of the following means:

- a Comfort One form or Comfort One card for the patient;
- a Comfort One bracelet worn, or carried by the patient;
- a DNR identification for the patient that is from another state, a territory, or a possession of the United States;
- an attending physician's DNR order, when the order is in writing and a copy has been provided or seen by the physician or other health care provider; or
- a verbal order has been issued directly to the physician or health care provider by the attending physician.

### **Comfort One Identification Form**

The Comfort One Identification form is printed on 8.5 x 11 carbonless paper with the Comfort One logo printed at the top. The form contains the patient’s name, address, date of birth, and gender. To be valid, the form must be signed by both the patient, if the patient is able, and the patient’s physician.

### **Comfort One Wallet Card**

The wallet card is detached from a larger form and measures approximately 2.5 inches x 3.5 inches. The Comfort One logo is printed at the top. The front of the wallet card contains the patient’s name, date of birth, and gender. A serial number for the card is printed vertically on the front side of the card. The reverse side lists the name of the patient’s physician and the physician’s contact number.

### **Comfort One Bracelet**

The bracelet has a gold chain, gold border, and a green background. The Comfort One logo prominently displayed on the bracelet in white and gold lettering.



## Confirming the Patient's Identity

Under the Alaska DNR Protocol, the following are acceptable methods of confirming the patient's identity:

- the patient communicating the patient's name;
- the patient's hospital or other institutional identification arm band;
- the patient being personally known to the physician or other health care provider;
- the patient's driver's license or credit card; or
- another person having identified the patient.

## Do Not Resuscitate Protocols

Once the DNR status and patient's identity have been confirmed, and the patient is pulseless or apneic, the protocols are easy to follow:

- **If the patient does not have a valid DNR order**, the standard treatment and transport protocols, including CPR, should be employed.
- If the patient **DOES have** a valid DNR order, resuscitation efforts should not be initiated or, if already in progress, terminated immediately.

**If the patient is unconscious or otherwise unresponsive to questions regarding the patient's identity, the physician or other health care provider may rely solely on the department approved DNR necklace or bracelet worn by the patient without using further methods to identify the patient.**

## Revocation of DNR Orders

A Do Not Resuscitate order may be revoked by:

- the qualified DNR patient;
- the patient's attending physician;
- a third party to whom the patient conveyed an intent to revoke; or
- the parent or guardian of the person for whom the order has been written if the person enrolled in the Comfort One program is less than 18 years of age.

The health care provider should carefully document the revocation. In some cases, the patient may simply destroy copies of the Comfort One form and wallet card.

## Patients with Out of State DNR Orders

A Do Not Resuscitate order issued in another state or a territory or possession of the United States should be considered valid by the caregiver and the patient should be treated in accordance with the Alaska Comfort One Protocols (AS 18.12.090).

## Palliative Care

Health care personnel should provide comfort care as appropriate for the patient and within the scope of lawful activities for the individual health care provider. Appropriately trained and equipped health care workers **may** provide comfort to the do not resuscitate patient by:

- suctioning the airway.

- administering oxygen.
- assisting the patient to a comfortable position.
- providing emotional support.
- contacting hospice, home health agency, or attending physician.
- providing pain medication (advanced life support personnel with standing orders).

Health care workers **should not:**

- Use advanced airway devices, such as an ET tube or multilumen airway.
- Initiate cardiac monitoring
- Administer cardiac resuscitation drugs
- Defibrillate
- Provide ventilatory assistance

EMTs should consult their local, physician signed standing orders for more specific information on this subject.

# Standing Orders

Standing orders are written guidelines which state how the EMT should take care of specific types of emergencies and what the EMT may, and may not do, before contacting the base station physician. Alaska regulations<sup>12</sup> require that the physician medical director for a certified EMT or certified emergency medical service:

- establish and annually review treatment protocols; and
- approve medical standing orders that delineate the advanced life-support techniques that may be performed by each state certified EMT-II or EMT-III and the circumstances under which the techniques may be performed.

Most standing orders are designed to be used by all EMTs within an EMS organization. Standing orders for Defibrillator Technicians, EMT-IIs, EMT-IIIs, and Mobile Intensive Care Paramedics must be signed by their physician medical director. The standing orders are, in essence, a contract between you and the physician. Since the orders entrust you to perform certain functions, it is **your** responsibility to ensure that you are competent at the skills.

Many basic life support services do not yet have comprehensive EMT-I standing orders. Standing orders are NOT required for EMTs to perform the basic life support skills contained in the EMT-I curriculum. However, on-line (voice) or off-line (standing orders) medical control is required to perform the advanced life support skills contained in the EMT-I scope of certified activities, such as assisting a patient with the patient's hand held bronchodilator, epinephrine autoinjector, or nitroglycerin.

Usually, standing orders are quite detailed, providing information on the sequence of care, drug dosages, etc. If your service has standing orders which will govern your care as an EMT (at any level), it is your responsibility to make sure you understand and comply with them.

Standing orders are designed to allow the physician to provide medical direction while allowing you to provide care correctly and with few interruptions to contact the medical facility. The authorizations granted by the standing orders are limited to your EMS service area unless otherwise specified in the orders themselves.

This means that if you are an EMT-II or EMT-III and need to use your advanced life support skills outside your normal service area (you come upon a motor vehicle crash while out of your service area), you cannot do so legally unless you obtain verbal authorization from a physician.

It is critical that you understand that standing orders usually exist as an extension of the physician's license. Consequently, it is your responsibility to ensure you know the standing orders thoroughly.

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<sup>12</sup> 7 AAC 26.330

# The Incident Command System

Contributed by Lt. David Hull, Ketchikan Fire Department

The Incident Command System (ICS) brings into play a process of organizing an emergency scene to use the available resources, including response personnel, in the most efficient way feasible under the circumstances. ICS improves communication on scene and helps to reduce scene stress. Most importantly perhaps, ICS produces a safer scene environment. The end result is a higher quality response and ultimately better care being administered to the patient.

The function of the ICS system is simple. Situation specific information and needs are conveyed to a centralized command location. At this command location, the information is received, is analyzed and compared with the information received from other segments of the overall incident. Using that compiled information, decisions are made regarding the next best step in the stabilization process. Sound complicated? It isn't. A system of organization and use of skills and equipment is a primary component of any emergency response training. Yours will be no exception. Your training requires that you evaluate information gathered from many sources and make the right decisions. The Incident Command System builds on this training by providing you with a system to deal with large or escalating events. ICS training will show you how to integrate the additional personnel and equipment which will be responding to the request for help.

ICS is not new. It was developed in the early 1970's as a tool to locate and bring together a vast array of equipment and personnel to fight large wildland fires. The beauty of the system lies in its versatility. ICS allows the scene to be coordinated in a such a way that individuals are responsible for a portion of an event, so they do not have to consider necessarily the entire scene. This leaves the remaining personnel free to concentrate on other tasks. No scene is too small or too big to use the concepts of the Incident Command System. If put into place during the early stages of the incident, ICS will be up and running if the situation suddenly turns ugly. Trust me, it always happens suddenly.

ICS is tailor made for use in EMS. From spinal immobilization to triage, all skills require that someone take charge. This is reinforced in every EMS class taught.

The secret to successfully using the Incident Command System is to implement it on every scene, expanding and contracting it as needs dictate.

The Incident Command System has proved its worth on large and small events. It provides the EMT with a solid foundation for identifying and integrating resources. All EMS providers are encouraged to learn more about ICS and its role in their particular system.

Editor's Note: The Alaska EMS Unit strongly recommends that EMTs take additional training in the Incident Command System. Understanding how you will fit into a coordinated response is a prerequisite to success in an MCI or disaster situation. Importantly, Governor Knowles' Administrative Order compels the adoption of the National Interagency Incident Management System-Incident Command System (NIIMS/ICS) as the state command and control system for emergency response and recovery operations, and that NIMS/ICS be incorporated into all emergency plans for state agencies prepared under state law.

# The Community Health Aide Program

Sharon M. Peabody, RN, MS, FNP

The Community Health Aide Program (CHAP) was developed in the 1960's to deliver primary health care services to Alaska Natives, and emergency services for all people living in rural Alaska. Today approximately 425 Community Health Aide/Practitioners (CHA/Ps) serve 200 villages located great distances from the nearest traditional health facilities. Most villages are accessible only by air. CHA/Ps are selected from and by the communities in which they live and work. The program is funded through the Indian Health Service and administered by tribal contractors who contract with the federal government to provide health and social services for Alaska Natives. The tribal contractors employ the CHA/Ps, CHA supervisors, and program administrators. In some cases, the tribal contractors also operate training centers for the provision of basic training for CHA/Ps. The tribal contractors coordinate interaction of the CHA/P with the many agencies and departments offering services to rural Alaska Natives. In the United States, this system of health care is found only in rural Alaska.

The CHA/Ps have one of the most important and difficult jobs of any health care provider in Alaska. They are formally trained for 16 weeks (in four four-week sessions) and receive medical supervision from a physician by telephone. When a CHA completes the training center's certification process (two to three years), he/she becomes a Community Health Practitioner.

The duties of the CHA/P are to provide primary health care in the villages. CHA/Ps maintain regular clinic hours Monday through Friday and provide emergency care 24 hours a day, every day of the year. Their major responsibilities are to assess and treat or refer patients seeking care for illness or injury. Depending on the area in which they live, the CHA/Ps may also be expected to provide preventive services such as health surveillance, dental prevention activities, well child and prenatal care. Other duties include monitoring the care of the chronically ill, assisting itinerant health professionals when they are in the village, health education, and some patient counseling.

CHA/Ps use a problem-oriented approach to patient care, directed by the *Community Health Aide/Practitioner Manual (CHAP Manual)*. The patient encounter is oriented toward gathering subjective and objective data from the patient and then using this information and the CHA/P Manual to formulate an assessment and plan. In the development of an appropriate assessment and patient care plan, the CHA/P relies on his/her referral physician or that person's designee (often a mid level practitioner). The physician calls the CHA/P on a daily scheduled basis, and the CHA/P calls for assistance as needed. The CHA/P reports any patient whom he/she is unable to care for using the *CHA/P Manual* and receives advice on patient care from the consultant. Selected CHA/Ps may have standing orders for routine, common health problems.

Perhaps the most significant source of stress and resultant burnout for CHA/Ps is the occurrence of emergencies. The victim is often a family member or person well-known to the health aide. That, combined with a critical health problem, bad weather, no road access to a hospital, and the belief by the village that the CHA/P should be able to prevent death, results in almost unbearable pressure. Although the CHA/P maintains ETT/EMT certification, he/she is very dependent on other emergency medical services providers who may reside in the village for support and assistance. Unfortunately, in many of the very small communities, the CHA/P is the only person with any emergency training. It is critical to the well being of all people who live in the Bush that CHA/Ps and any other EMS personnel have a close working relationship, and mutual respect for each other's skill and experience. The CHA/P must have the support of all EMS personnel to provide safe, quality emergency care. Establishment of mutual reliance and trust, and the opportunity to discuss the emergency afterward with someone who understands, will have a positive impact on the ability of all EMS personnel and CHA/Ps to provide care.

If you wish to learn more about the Community Health Aide Program, contact your Regional EMS Office to obtain a copy of the short video titled *Alaska's Vital Link* and a program description booklet.

## Common Medical Abbreviations

One of the most challenging tasks facing an EMT student is learning the language of medicine. If this wasn't difficult enough, medicine also uses a large number of medical abbreviations.

If EMTs want to communicate more effectively they must understand medical abbreviations. Many EMTs find report writing is easier when they can use abbreviations, but it is vital to make sure the abbreviations used are used correctly and commonly understood. Poor documentation can make the smartest EMT look foolish.

This is not a comprehensive list of abbreviations, but rather a guide to help get the EMT started on their journey into the language of medicine.

<b>Abbreviation</b>	<b>Meaning</b>
a	Before
AED	Automated External Defibrillator
a.c.	Before meals
ASA	Aspirin
AMA	Against medical advice
AMI	Acute myocardial infarction
ASHD	Arteriosclerotic heart disease
b.i.d.	Twice a day
BP	Blood pressure
BS	Breath sounds, bowel sounds, or blood sugar
BVM	Bag-valve-mask
c/o	Complaining of
Ca	Cancer/carcinoma
cc	Cubic centimeter
CC	Chief Complaint
CHF	Congestive heart failure
CO	Carbon monoxide
COPD	Chronic obstructive pulmonary disease (emphysema, chronic bronchitis)
CPR	Cardiopulmonary resuscitation
CSF	Cerebrospinal fluid
CVA	Cerebrovascular accident
CXR	Chest X-ray
d/c	Discontinue
DM	Diabetes mellitus
DOA	Dead on arrival
DOB	Date of birth
Dx	Diagnosis
ECG, EKG	Electrocardiogram
e.g.	For example
ETA	Estimated time of arrival
ETOH	Alcohol (ethanol)
Fx	Fracture
GI	Gastrointestinal
GSW	Gun shot wound
gtt.	Drop
GU	Genitourinary

GYN	Gynecologic
h, hr.	Hour
H/A	Headache
HEENT	Head, ears, eyes, nose, throat
Hg	Mercury
h/o	History of
hs	At bedtime
HTN	Hypertension
Hx	History
ICP	Intracranial pressure
ICU	Intensive Care Unit
IM	Intramuscular
IO	Intraosseous
JVD	Jugular venous distension
KVO	Keep vein open
L	Left or Liter
LAC	Laceration
LOC	Level of consciousness
LR	Lactated Ringers solution
mcg	Micrograms
MS	Morphine sulphate, multiple sclerosis
NAD	No apparent distress
NC	Nasal cannula
NKA	No known allergies
npo	Nothing by mouth
NRB	Non-rebreather mask
NS	Normal saline
NSR	Normal sinus rhythm
NTG	Nitroglycerin
N/V	Nausea / vomiting
O <sub>2</sub>	Oxygen
OB	Obstetrics
OD	Overdose
OR	Operating room
PCN	Penicillin
PEA	Pulseless electrical activity
PERL	Pupils equal and reactive to light
PID	Pelvic inflammatory disease
PND	Paroxysmal nocturnal dyspnea
po	By mouth
PRN	As needed
PSVT	Paroxysmal supraventricular tachycardia
Pt	Patient
PTA	Prior to arrival
PVC	Premature ventricular contraction
q.h.	Every hour
q.i.d.	Four times a day
R	Right
r/o	Rule out
Rx or Tx	Treatment
SIDS	Sudden Infant Death Syndrome
SOB	Shortness of breath

stat.	immediately
SVT	Supraventricular tachycardia
TIA	Transient ischemic attack
t.i.d.	Three times a day
TKO	To keep open
V.S.	Vital signs
x	Times
w/o or s	without
WNL	Within normal limits
y/o or y.o.	Years old
Δ	change
+	Positive
—	Negative

For fun, you may want to translate this report from “medicine” into English

67 y/o male c/o chest pain and SOB x 2 h. Pain is severe (8 out of 10), centered under sternum, and radiates to the L arm and jaw. Pain woke patient from sleep, and is w/o Δ with movement or breathing. Pt. has a h/o ASHD, MI 1/15/01, HTN, and DM. Meds include ASA, insulin, lasix, and lisinopril. Allergic to PCN.

On exam pt is A+O x 4, diaphoretic, and anxious.

HEENT: PERL

Neck: – JVD, positive use of accessory muscles

Chest: BS crackles at bases, + retractions

Abdomen: soft, non-tender

Extremities: — edema/clubbing/cyanosis

Assessment: r/o chest pain of cardiac origin

# Essential Elements and Proper Sequence of Radio Medical Report

**1. Identify unit (level of provider)**

*XYZ Hospital, this is ABC Fire Dept. BLS ambulance enroute to your location...*

**2. Estimated Tim of Arrival (ETA)**

Allows the facility to prepare for your arrival, as well as helps to influence patient care instructions.

*With a ten minute ETA.*

**3. Age and gender of patient**

In pediatrics it may be helpful to give an approximate weight of the child here as well.

*We are transporting a 23 year old male patient...*

**4. Chief Complaint**

*Complaining of neck, and right ankle pain.*

**5. Brief pertinent history of present illness**

This may include mechanism of injury information in the trauma call.

*Patient was the restrained driver in a single car front end impact motor vehicle crash. Patient's mid-size car was traveling at a high rate of speed and there is extensive front end damage to the car with approximately 6 inches of passenger compartment intrusion. Driver side airbag did deploy during the crash.*

**6. Major past illnesses**

This is especially important if it is a factor in the current illness/injury.

*No significant medical illnesses.*

**7. Mental status**

*Patient is alert and oriented; there was no loss of consciousness.*

**8. Baseline vital signs**

*Pulse is 110 and regular, respirations 20, unlabored,*

*Blood pressure 118/74, skin is warm and dry.*

**9. Pertinent findings of physical exam**

*Patient has tenderness to palpation over the cervical spine, and swelling, tenderness and deformity of the right ankle.*

**10. Emergency medical care given**

*We have applied a c-collar and KED for extrication from the vehicle, patient on a long spineboard, he is receiving oxygen, 10 L/min via non-rebreather, and we have applied a long leg splint to the right leg.*

**11. Response to medical treatment**

*Pain level, vital signs, and mental status have not changed.-*

Ambulance responders should avoid saying the patient's name or other identifying information over unsecured channels. Many community members have scanners capable of monitoring radio communications. Care must be taken to protect patient confidentiality.

# EMS Organizations

## **Governor's Alaska Council on EMS**

The mission of the Emergency Medical Services program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to injuries and sudden illness. The Governor's Alaska Council on Emergency Medical Services, also known as "ACEMS," provides the Commissioner of the Department of Health and Social Services and the Governor with recommendations related to all aspects of EMS, including distribution of funding, and policy development. The council:

- brings together technical resources, experience, and knowledge to assist and advise on the continued development of the EMS and trauma system in Alaska;
- advises the state EMS staff and EMS regional directors regarding public education and generation of broad community support for the goals of the EMS program;
- provides recommendations regarding EMS program policy and priorities;
- reviews EMS or EMS-related program proposals on request of the Commissioner of the Department of Health and Social Services, the Director of the Division of Public Health, and Section of Community Health and EMS staff; and
- reviews EMS budgetary allocations and program priorities, and advises the Commissioner on these matters.

ACEMS was established by Alaska Statute 18.08 and meets two times a year to take action on issues affecting EMS in Alaska. More information on the council's activities and priorities can be found on the EMS Program's web site.

The meeting dates are publicized in major newspapers and all meetings are open to the public.

An important role of ACEMS is setting statewide EMS goals for inclusion in requests for proposals, as well as in state and regional plans. ACEMS goals have included:

### **Fiscal Years (FY) 2000/2001**

- Revitalize current EMS services through the retention, recruitment and training of volunteers;
- Support training in pediatric trauma care and prevention; and
- Support public education/marketing of EMS.

### **FY 99**

- Revitalization of current services and creation of services;
- Support of pediatric injury prevention and trauma care education;
- Support of volunteer retention and recruitment and training; and
- Support of public education and marketing.

### **FY 98**

- Maintenance of current programs and services;
- Training EMT Instructors and EMTs in the new curriculum;
- Volunteer retention and recruitment and support of volunteers; and
- Training for trauma and injury prevention.

### **FY 96-97**

- Maintenance of current programs and services;
- Training of EMT Instructors and EMTs in the new curriculum;
- Training for trauma and injury prevention; and
- Mass casualty and disaster response training.

## State EMS Training Committee

The State EMS Training Committee is a subcommittee of ACEMS and provides the Department of Health and Social Services with recommendations related to EMS training and certification. Training Committee Members are appointed by ACEMS.

The EMS Training Committee meets three to four times a year, usually rotating between Anchorage, Fairbanks, Juneau, and Sitka. Typically, the committee travels to a rural community, such as Nome, Kotzebue, Bethel or Barrow once a year.

The meetings are open to the public. Contact the State EMS Unit or your nearest EMS Office to learn the dates of the next meeting.

The Training Committee is responsible for proposing amendments to EMS regulations, recommending testing and certification policies, revising examinations for certification and recertification, approving educational offerings for continuing medical education and many other issues related to EMS training.

If you have suggestions for improving the EMS Training system, send them, in writing, to your Training Committee representative. It's often useful to follow up with a phone call to ensure the person understands your concerns and suggestions.

## **State Medical Board**

The Alaska State Medical Board, through the Division of Occupational Licensing, Department of Commerce and Economic Development, licenses Mobile Intensive Care Paramedics and is responsible for administering and revising the regulations which govern licensure and relicensure of MICPs, with input from the Emergency Medical Services Section, DHSS, through a Memorandum of Agreement.

Members of the Board are appointed by the Governor.

The Board has an Executive Secretary in Anchorage and a Licensing Examiner in Juneau and meets 4 times per year at rotating meeting sites. Meeting dates are publicized in major newspapers and all meetings are open to the public.

The address for the Medical Board's Licensing Examiner is:

Medical Board Licensing Examiner  
Department of Commerce and Economic Development  
Division of Occupational Licensing  
P.O. Box 110806  
Juneau, AK 99811-0806

Executive Secretary: Leslie Abel (561-2878)  
Licensing Examiner: Joanie Studie (465-2541)  
Web site: <http://www.dced.state.ak.us/occ/pmed.htm>

## National Registry of EMTs

The National Registry of Emergency Medical Technicians, based in Columbus, Ohio, is a non-profit organization which serves as a standard setting agency through the administration of its examinations. The National Registry also provides national leadership through their involvement in standard and policy setting organizations, its support of the National EMS Blueprint project, and other activities.

The National Registry provides three levels of certification: EMT-Basic, EMT-Intermediate, and EMT-Paramedic. In 1996, the National Registry began certifying First Responders.

NREMT-Basic examinations are frequently administered at the end of an EMT-I training program in Alaska. This examination is optional and is not necessary for initial certification in Alaska at the EMT-I or EMT-II levels.

The practical examinations used for state certification at the EMT-I level can be applied towards the NREMT-Basic practical examination requirements for a period of up to 1 year.

Your practical examination results are valid for twelve months. As a result, you need only take the NREMT written examination to become certified by the National Registry, if you take it within the 12 months following successful completion of the Alaska practical examinations for certification. (**NOTE:** Having your instructor evaluate your skills during a refresher training course does NOT count as a 'practical examination').

NREMT-Intermediate and Paramedic examinations are given less frequently and require significant coordination of testing resources.

Recertification with the National Registry of EMTs is separate from recertification with the department. As a result, you need to ensure that you have obtained and appropriately documented the applicable requirements for recertification for all agencies with which you intend to recertify.

The National Registry Representatives for testing at the EMT-Intermediate and EMT-Paramedic levels are David Rockney, of Interior Region EMS Council, Inc. (456-3978); Rob Janik, of Southeast Region EMS Council, Inc. (747-8005); and Kathy Griffin at Southern Region EMS Council, Inc. (562-6449).

National Registry of Emergency Medical Technicians  
P.O. Box 29233  
Columbus, OH 43229  
(614)888-4484  
<http://www.nremt.org/>

# Alaska EMS Symposium

Each year, the EMS Unit and Southern Region EMS Council, Inc. co- sponsor a statewide symposium hosted in Anchorage. The symposium is usually held in November and provides an opportunity for Emergency Medical Technicians to obtain more than half of the number of CME hours needed for recertification. The symposium features nationally acclaimed faculty and registration fees are kept as low as possible.

The symposium agenda is published in a special issue of *RESPONSE: EMS Alaska* in September.

The Annual EMS Symposium features a set of day long pre-symposia workshops devoted to key EMS topics, a day and a half more of high quality continuing medical education, and the annual EMS Skills competition which pits teams from different services against each other in a good natured competition to see who can provide the best care that day.

The EMS symposium has tracks for basic and advanced EMTs and MICPs, nurses, mid-level practitioners, physicians, instructors, and administrators.

Other sponsors of the symposium include the regional EMS offices, the Alaska Chapter of the Emergency Nurses Association (ENA), the Alaska Chapter of the American College of Emergency Physicians (ACEP) and others.

## How topics are selected:

Topics and speakers are identified and recommended by a Symposium Planning Committee. Each of the EMS regions in the state, and other sponsors, nominate an individual from within their region to be a representative on the committee. Evaluations from the previous year are read and topics suggested by attendees are placed on a list. The Symposium Planning Committee adds topics to the list based on unmet training needs. Once completed, the list is prioritized by the committee and speakers are identified for the topics with the highest priority.

Individuals who wish to suggest topics for the symposium should write the Alaska EMS Unit and provide as much information as possible concerning the topic, the recommended target audience, and, if possible, a suggested speaker for the topic.

Year  
2002

Dates  
November 13 – 16, 2002

# Annual State EMS Awards

Each year, the Governor's Alaska Council on Emergency Medical Services recognizes accomplishments in the field of Emergency Medical Services. The award recipients are announced during the opening session of the State EMS Symposium. Awards are presented at the banquet that follows the Symposium. The categories and criteria for the awards are as follows:

## **Consumer/Citizen Award:**

Person who, not in the regular line of duty, performs life-saving, limb-saving, or medical techniques in a medical emergency. Shows quick-thinking, common sense, and initiative to save a life or reduce injury.

## **EMS Provider Award:**

Medically trained person who performs meritorious service above and beyond expectations of the job.

## **EMS Researcher/Administrator Award:**

Any person who successfully develops a new approach, technique, device, etc., to improve EMS in Alaska and/or for an outstanding administrator in an EMS agency or service

## **Longenbaugh Memorial Award:**

Dr. George Longenbaugh was a pioneer in Alaska EMS. This award honors a physician who exemplifies leadership and dedication to EMS systems and, through his or her efforts, has significantly promoted the Alaska EMS system.

## **EMS Instructor of the Year Award**

This award is given to a State certified ETT or EMT Instructor, who is dedicated to quality instruction and promoting the best in prehospital care or has made an outstanding contribution to EMS education.

## **Melissa Ann Peters Memorial Award**

The Melissa Ann Peters Memorial Award is given in memory of a young nurse whose untimely death prompted her family and friends to remember her by honoring other nurses who have contributed in a special way to the encouragement of EMS skills, efforts and education.

Additional information about this award, including the name of the person to whom to send nominations, is found in the annual "Symposium Edition" of *RESPONSE: EMS Alaska*.

## **Outstanding Ambulance Service Award:**

Since 1982, Safety, Inc., of Anchorage has awarded \$500 in gift certificates to an "outstanding" ambulance service at the Annual EMS Awards Banquet. The criteria for selection are the following: 1) heroic performance on a special occasion, such as a mass casualty response or 2) outstanding success in providing year-round community service and in gaining support and involvement of the entire community in its service and educational activities. In short, an ambulance service will be chosen that exemplifies in some way the outstanding service that all our ambulance organizations and rescue squads provide to Alaska. The Council has developed a standard nomination form to be used for nominations. This form can be obtained from the EMS Unit.

### **Letter of Nomination:**

To nominate a person for the Consumer, Provider, or Administrator Awards, or a physician for the Longenbaugh Memorial award, a letter of nomination of 500 words or less should be submitted, with newspaper clippings and additional information, if available.

To nominate a service for the "Outstanding Ambulance Award," the Council's standard nomination form, attached, should be used for nominations.

### **Submission Date:**

The submission date is published in the special symposium issue of *RESPONSE: EMS Alaska*. Generally, the date is 60 days prior to the first day of the State EMS Symposium.

You should contact the EMS Unit if you have any questions about the awards.

### **Award Winners:**

A complete listing of award winners can be found on the CHEMS website.

<http://www.chems.alaska.gov>

## **Southeast Symposium**

The Southeast Symposium is held annually in Sitka. Check with Southeast Region EMS Council at 907-747-8005 or the CHEMS web site for more information.

## **Interior Region EMS Symposium**

The Interior Region EMS Symposium is held annually in Fairbanks. Check with Interior Region EMS Council at 907-456-3978 or the CHEMS web site for more information.

# EMS Goals Document

To assist local communities and regions in planning for EMS system improvements, the EMS Unit in the Department of Health and Social Services has developed *Alaska EMS Goals: A Guide for Planning Alaska's Emergency Medical Services System*. This planning guide uses the "levels of care" concept adapted from Alaska's original State Health Plan. The EMS Goals Document now identifies six levels of communities in Alaska, including: Level I - Villages; Level II - Subregional Centers; Level III<sup>13</sup> Large Town or Regional Centers; Level IV - Small Cities, Level V Urban Centers, and Level VI Metropolis.

COMMUNITY TYPE	POPULATION	EMS
Level I <ul style="list-style-type: none"> <li>• Isolated village</li> <li>• Highway village</li> </ul>	Usually 50-1,000 in immediate community	Community clinic with a CHA or EMT
Level II <ul style="list-style-type: none"> <li>• Isolated Sub-Regional Center or Town</li> <li>• Highway Sub-Regional Center or Town</li> </ul>	Usually 500-3,000+ in immediate community	Community clinic with PA, NP, MD or DO
Level III Large Town or Regional Center	Usually 2,000-10,000+ in immediate community, provides services to a regional population	Community hospital and physicians; health care service agencies include both public and private
Level IV Small City	Usually 10,000-100,000 in immediate community, provides services to a larger regional population	Hospitals with a 24 hour staffed ED and full continuum of care; multiple providers of health care and other services including both public and private programs
Level V Urban Center	Usually 100,000+ in immediate community, provides services to a statewide population	Some specialized medical and rehabilitation services for low incidence problems

Although Alaska does not currently have a Level VI - Metropolis, the planning guide recognizes Seattle, Washington as the nearest Level VI community. For each level community, the EMS Goals document outlines specific goals and objectives appropriate for that size community, including personnel, training, communications, patient transfer/transport, facilities, public safety agencies, access to care, recordkeeping, public education and information, evaluation, disaster response, mutual aid, medical direction, and injury prevention. These recommendations are much more basic for Level I and II communities than for level III, IV, V, and VI communities.

In addition, the EMS Goals document includes recommendations for emergency medical services on highways, the marine highways, in schools, in high risk occupation sites, and in communities with 25 people or less. This planning guide provides a tool for communities to evaluate their local EMS services and thereby pinpoint areas needing attention; and helps State and Regional EMS programs to prioritize use of staff time and funding of resources.

A completely revised EMS Goals Document was released in February, 1996.

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<sup>13</sup> The primary difference between a level III and a level IV community is that the latter has 24 hour in house physician coverage of the emergency department.

## ***Alaska Trauma Triage, Transport and Transfer Guidelines***

This document, produced by the Alaska EMS Unit, supported by a State Trauma Systems Grant, provide guidelines for decisions related to the triage, transport, and transfer of trauma patients. The guidelines categorize communities by available medical resources and provide recommendations on the information which should be collected at, and distributed from, the trauma scene, as well as optimizing decisions regarding transport of the patient to more definitive medical care.

## State, Regional and Subregional Training Contacts

Matt Anderson, EMS Unit Manager  
Section of Community Health & EMS  
Box 110616  
Juneau, AK 99811-0616  
Voice: 465-3141  
FAX: 465-4101

Dan Johnson, Executive Director  
Interior Reg. EMS Council, Inc.  
3522 Industrial Avenue  
Fairbanks, AK 99701  
(907)456-3978  
<http://www.iremasc.org>

Tim Biggane, Emergency Manager  
Fairbanks North Star Borough  
P.O. Box 71267  
Fairbanks, AK 99701  
(907) 459-1219

Chuck Surface  
EMS Coordinator/Instructor  
Tanana Chiefs Conference, Inc.  
1302 21<sup>st</sup> Avenue  
Fairbanks, AK 99701  
(907)459-3930

Jodi Zufelt, NREMT-P  
Training Coordinator  
Southern Region EMS Council, Inc.  
6130 Tuttle Place  
Anchorage, AK 99507  
Voice: 562-6449  
FAX: 562-9893  
<http://www.sremasc.org>

Skip Richards, EMS Coordinator  
Health & Social Services  
Chugachmiut  
4252 Hohe Street  
Suite B  
Homer, AK 99603  
(907)235-0557

Teresa Seybert  
EMS Coordinator  
Bristol Bay Area Health Corp.  
P.O. Box 130  
Dillingham, AK 99576  
(907)842-5201

Mel Vostry/Bill Mackreth

Emergency Medical Services  
680 North Seward Meridian Parkway  
Palmer, AK 99687  
(907)373-8000

Aleutian/Pribilof Island Subarea – East  
Donald Johnstone  
Executive Director  
Eastern Aleutian Tribes, Inc.  
721 Sesame Street  
Anchorage, AK 99503  
(907)563-1414

Aleutian/Pribilof Island Subarea – West  
Harriet Cutshall, EMS Liaison  
Aleutian/Pribilof Islands Association  
401 East Fireweed Lane  
Suite 201  
Anchorage, AK 99503  
(907)276-2700

Chuck Wengenroth, EMS Coordinator  
AK Voc-Tech Center  
P.O. Box 889  
Seward, AK 99664  
(907)224-3322

David LeBaron, Administrator  
Copper River EMS Council  
P.O. Box 529  
Glennallen, AK 99588  
(907)822-3671

Sue Hecks  
Kenai Peninsula EMS Coordinator  
P.O. Box 215  
Seldovia, AK 99663  
(907)234-7861  
FAX: 234-8003

Rob Janik  
EMS Training Coordinator  
Southeast Reg. EMS Council, Inc.  
P.O. Box 259  
Sitka, AK 99835  
(907)747-8005  
trncoord@ptialaska.net

ETT Training Coordinator  
Public Safety Academy  
877 Sawmill Creek Road  
Sitka, AK 99835  
(907)224-3322

Mike Motti, EMS Coordinator  
Southeast Regional Health Corp.  
222 Tongass Drive  
Sitka, AK 99835  
(907)966-2406

Gary Judd, MICP  
EMS Coordinator  
North Slope Borough  
P.O. Box 69  
Barrow, AK 99723  
(907)852-0235

Tom Frazzini, Director of Education  
Yukon-Kuskokwim Health Corp.  
P.O. Box 528  
Bethel, AK 99559  
(907)543-6081  
thomas\_frazzini@ykhc.org  
<http://www.ykhc.org>

Mike Owens, EMS Coordinator  
Norton Sound Health Corp.  
P.O. Box 966  
Nome, AK 99762  
(907)443-3311

Aggie Lie, EMS Coordinator  
Maniilaq Association  
P.O. Box 256  
Kotzebue, AK 99752  
(907)442-7695

# **Training Committee Members**

David Rockney, MICP  
EMS Training Coordinator  
IREMSC, Inc.  
3522 Industrial Avenue  
Fairbanks, AK 99701  
456-3978          drockney@iremsc.org

Jodi Zufelt, NREMT-P  
EMS Training Coordinator  
Southern Region EMS Council, Inc.  
6130 Tuttle Place  
Anchorage, AK 99507  
562-6449          jzufelt@sremsc.org

Steve O'Connor, MICP, **Chair**  
Central Peninsula Emerg. Services.  
231 South Binkley Street  
Soldotna, AK 99669  
262-4792          soconnor@borough.kenai.ak.us

Rob Janik, NREMT-P  
Southeast Region EMS Council, Inc.  
P.O. Box 259  
Sitka, AK 99835  
747-8005          trncoord@ptialaska.net

Ken Zafren, MD  
State EMS Medical Director  
C/O CHEMS  
Box 110616  
Juneau, AK 99811-0616  
465-3027

Jean Rounds-Riley, PA-C  
CHAP Training Center Coordinator  
Alaska Native Medical Center  
4315 Diplomacy Drive  
Anchorage, AK 99508  
(907) 729-2427      jroundsr@anmc.org

Robert Painter  
Alaska State Fire Chief's Association  
Homer Volunteer Fire Department  
604 East Pioneer Avenue  
Homer, AK 99603  
(907) 235-3155                      RPainter@ci.homer.ak.us

Aggie Lie, EMS Program Manager  
Maniilaq Association  
P.O. Box 256  
Kotzebue, Alaska  
442-7695                      alie@maniilaq.org

Kathy McLeron, EMS Training Coordinator  
Section of Community Health & EMS  
Dept. of H&SS  
P.O. Box 110616  
Juneau, Alaska 99811-0616  
465-2262 kathy\_mcleron@health.state.ak.us

Mike Owens, MICP  
Emergency Medical Services  
Norton Sound Health Corp.  
P.O. Box 966  
Nome, AK 99762  
443-3311                      owensm@nshcorp.org

Bill O'Brien  
Emergency Medical Services  
YKHC  
Box 528  
Bethel, AK 99559  
543-6078 (FAX: 543-6143)  
bill\_obrien@ykhc.org

Gary Judd, MICP  
North Slope Borough Fire Department  
P.O. Box 69  
Barrow, AK 99723  
852-0234 (FAX: 852-0388)  
gjudd@alaska.com

Mark Barker, Supervisor  
Fire Service Training  
Department of Public Safety  
5700 East Tudor Road  
Anchorage, AK 99507  
(907) 269-5789  
[mark\\_barker@dps.state.ak.us](mailto:mark_barker@dps.state.ak.us)

# Options for Recertification

If your certification has not expired or has been expired for 12 months, or less:

- Completed application for recertification;
- \$25 testing fee;
- A valid CPR credential;
- Documentation of 48 hours, or more, of approved continuing medical education obtained within the two years preceding the date of application for recertification. This may include a state approved refresher training program.
- Documentation of successful completion of the recertification written examination. (The written examination will be scored at the State EMS Unit.)

## Option 1

- Documentation of successful completion of the recertification practical examination.

## Option 2

- Verification from an Alaska-Certified EMT-I instructor attesting to the fact that you have successfully demonstrated competence in the skill areas outlined by the department.

### **If your certification has been expired for between 12 and 36 months:**

- Completed application for recertification.
- \$25 testing fee.
- Valid CPR credential.
- Documentation of 48 hours, or more, of approved continuing medical education obtained within the two years preceding the date of application for recertification.
- Documentation of successful completion of the recertification written and practical examinations. (The written examination will be scored at the State EMS Unit).
- Documentation of successful completion of a refresher training program. (The program must have been completed no more than 12 months preceding the date of expiration).
- Verification from the instructor of the refresher training program attesting to the fact that you have successfully demonstrated competence in the skill areas outlined by the department within the twelve months preceding the date of application.
- Letter of recommendation from your EMS Supervisor.

### **All EMT-II and EMT-III Applicants (in addition to requirements above)**

- Evidence that you are under the sponsorship of a physician medical director who agrees to fulfill the responsibilities of a physician medical director outlined in the EMS regulations.

The written examination for recertification is identical to the one that currently in use for initial certification at the EMT-I, EMT-II or EMT-III level.

# Automated Voice Response System

## **Purpose:**

This system is designed to allow EMTs, Instructors, and Defibrillator Technicians to obtain information regarding their certification records via a touch tone phone. In addition, the system can be used by EMS administrators to check records, by EMS Instructors to check test scores for their students, and by Certifying Officers to verify credentials of practical examination proctors.

## **Information Provided:**

- Record Level and Status, Expiration Date
- Last Test Date and Scores
- Whether Mailing Address is Bad
- Date Record was Last Revised
- Unmet Qualifications for Certification

## **Telephone Number:**

(907)465-4109

## **Availability:**

The system is available during evenings, weekends, and holidays. It is not available during normal business hours.

## **Instructions:**

Have your social security number or EMS record number (certification number) available. Dial the number and wait for the prompt to enter the number. Enter your number followed by the "#" sign. The system will provide you with the information about the record. It's helpful to have a pad and pencil ready to write down some of the information.

If you have more than one EMS record, for example, you are an EMT-I and a Defibrillator Technician, you must use the record number corresponding to the appropriate file. If you enter your Social Security Number instead, the system will provide you with information from the first one of your records it finds.

## **Questions:**

If you have questions regarding the use of this system, or have questions about your certification record which were not answered by the Automated Voice Response System, please call the EMS Unit at (907)465-3027.

# Alaska EMS and the Internet

The Section of Community Health and EMS maintains a web site at <http://www.chems.alaska.gov> which contains a great deal of information about EMS in Alaska.

## Downloadable Files

The site has over a hundred files for download, including:

- Newsletters
- Training and Testing Related Documents
- Training Curricula
- Treatment Guidelines (*Cold Injuries Guidelines, Alaska Prehospital Trauma Guidelines*, etc.)
- **Model Standing Orders**
- Model Recommended Operating Procedures
- Photographs
- Application Forms
- Statutes and Regulations
- EMS for Children related files
- Files for Public Notice/Review
- Powerpoint Presentations

## Training Schedules

The site contains dates and information on state and regional EMS symposia, as well as a list of all courses approved by CHEMS.

## Links

The CHEMS web site has links to dozens of high quality state, national and local sites concerned with EMS and injury prevention, including:

- Southern Region EMS Council, Inc.
- Interior Region EMS Council, Inc.
- Alaska State Medical Board
- North Star EMS Academy
- House of DeFrance
- National Registry of EMTs
- American Heart Association
- National Highway Transportation Safety Administration (NHTSA)
- State of Alaska Fire Service Training
- Mat-Su Borough Department of Public Safety
- And many more.

## Discussion Board

The discussion board offers case studies in EMS, posting of job announcements and more.

## Internet Mail List Servers

Another service provided through the internet involves "list servers." An individual can subscribe to a particular list and, from then on, new mail in that list is automatically echoed to the user's internet mail account. To subscribe to the list sponsored by the Section of Community Health and EMS, send an internet e-mail message to:

[list.manager@list.state.ak.us](mailto:list.manager@list.state.ak.us)

The body of the message should be:

subscribe ak-ems	(for the general EMS list)
subscribe ak-prev	(for the injury prevention mailing list)
subscribe ak-emsc	(for EMS for Children List)
subscribe ak-data	(for EMS data collection project)
subscribe ak-response	(to receive electronic version of newsletter)
subscribe ak-emd	(for the emergency medical dispatcher list)
subscribe ak-cism	(for the critical incident stress management list)

To send mail to this list (remember, every subscriber to the list will see it!), address your message to

[ak-\\_\\_\\_\\_@list.state.ak.us](mailto:ak-____@list.state.ak.us)

where ak-\_\_\_\_ is the name of the list above. For example, to send a message to the injury prevention mailing list you would address it to [ak-prev@list.state.ak.us](mailto:ak-prev@list.state.ak.us) and it would be sent to all of the list's subscribers.

## On-Line Certification Database

CHEMS has developed an on-line certification database, accessible through the web site, which provides information on the certification status of EMTs in Alaska. No confidential information is displayed or accessible through the EMS database system.

The direct address of the certification database is:

<http://www.chems.alaska.gov/emsdata>

Records are only considered as valid or current when the record status is "CERTIFIED" or "RECERTIFIED" and the expiration date is in the future. Records marked as "PENDING" are incomplete and are not considered valid or current.

## Technical Assistance Team Reassessment

The Emergency Medical Services (EMS) Program has many responsibilities related to injuries occurring on Alaska's highways, interstates, and arterials. Injury prevention, emergency medical responder training and certification, injury epidemiology, trauma system development and evaluation, and many other activities are undertaken by the Section of Community Health and EMS to reduce the numbers and consequences of injuries. To assist in ensuring a comprehensive approach to Emergency Medical Services, the National Highway Traffic Safety Administration (NHTSA) has developed standards for statewide EMS programs. To determine compliance with, and progress towards, these standards, Technical Assistance Teams are sent upon the state's request to evaluate its EMS system.

During the week of September 6, 1999, a Technical Assistance Team (TAT), funded by the Alaska Highway Safety Planning Agency, and coordinated by the National Highway Traffic Safety Administration's EMS Division, visited Anchorage to perform a reassessment of the state's Emergency Medical Services program. The Alaska EMS program was initially assessed by a TAT in 1992.

The purpose of the Technical Assistance Team program is to bring a small group of experts to a state to evaluate its EMS program based on accepted national standards (.pdf) related to the following components:

- Regulation and Policy;
- Resource Management;
- Human Resources and Training;
- Transportation;
- Facilities;
- Communications;
- Public Information, Education and Prevention;
- Medical Direction;
- Trauma Systems; and
- Evaluation.

The team read extensive briefing materials and listened intently to approximately one and a half days of testimony from Alaska EMS experts providing information on the system's characteristics, strengths and weaknesses. The process was comprehensive and intense.

After listening to testimony on each of the components, the team completed a final report which provided its recommendations for improving the state's emergency medical services system. The completed report was delivered verbally prior to the team's departure and was provided in written and electronic forms approximately two weeks after the team's visit.

The 1999 reassessment team was composed of an eclectic group of EMS experts, several of whom had been members of the initial 1992 assessment. The team's efforts were coordinated by Susan McHenry, an EMS Specialist with the NHTSA EMS Division (Susan participated in the 1992 Alaska assessment while working as EMS Director for the State of Virginia). Administrative support to the team was provided by Janice Simmons, of the NHTSA EMS staff, in Washington.

Team members included:

- Bob Bailey, former North Carolina EMS Director and Past President of the National Association of State EMS Directors.
- Gail Cooper, Public Health Administrator (specializing in EMS), San Diego County, California.
- Dan Manz, Vermont EMS Director and Past President of the National Association of State EMS Directors.
- Stuart Reynolds, MD, Trauma Surgeon, Havre, Montana.
- John Sacra, MD, FACEP, Medical Director, Medical Control Board, Tulsa Oklahoma.

Acknowledgements: The Alaska EMS Unit expresses its appreciation to Karen Peterson, of Southern Region EMS Council, Inc., for her meeting coordination efforts, to Romayne Kareen and the Alaska Highway Safety Planning Agency for funding and oversight of the TAT reassessment process, and to the many presenters who provided candid, credible and comprehensive information to the team during its visit.

The Alaska EMS System is stronger for the efforts. A copy of the entire Technical Assistance Team report can be downloaded from the CHEMS web site at <http://www.chems.alaska.gov>.

# The Code Blue Project

**Brief History:** During the past decade, a crisis has quietly developed in rural Alaskan EMS programs resulting in some services closing their doors and others downgrading the level of emergency medical care they are capable of providing. These EMS agencies are essential components of the rural emergency health care and transportation systems. The Code Blue Project was initiated by the Department of Health and Social Services in 1999 as an attempt to quantify the unmet needs of rural emergency medical services agencies. The development and continuing evolution of the Code Blue project involves a partnership between the department, the Regional and subarea EMS offices, local communities, and others, such as the Alaska Council on Emergency Medical Services. The Code Blue Database includes EMS needs supported by Regional EMS agencies and represents a “snapshot” of documented needs in rural Alaska.

**Funding Sources:** The need to reinvigorate emergency medical services agencies in Alaska is urgent and worsens with time. Agencies such as the Denali Commission, the United States Department of Agriculture (USDA) and the Rasmuson Foundation have been contacted as potential sources of funds. Governor Knowles is including \$533,000 in his proposed capital budget for improving EMS and matching other funding sources. We continue to look diligently for other sources of funding.

**Items Included:** Equipment for patient transportation (ambulances and transport vehicles), patient care, training, and communications are contained within the Code Blue list. The Code Blue database does not include the costs of essential EMS related training that also has been identified.

**Local Match:** We support the concept of local matching funds and we believe that many communities within the Code Blue Project are capable of generating reasonable amounts of matching funds if given adequate time. Other communities, however, such as those which are significantly economically distressed, based on USDA or Denali Commission Criteria, are not likely to be able to find matching funds, since their available funding is used for mission critical EMS operations (e.g. gasoline, vehicle maintenance, insurance, etc.). The maximum amount of funding from the USDA for a project is 75%.

Consequently, the community’s share of a \$150,000 ambulance would be \$37,500. Many small communities simply don’t have the financial resources to amass these funds.

**Applications for Funding under the Code Blue Project:** There are well over a hundred emergency medical services agencies in Alaska ranging from small first responder squads to extremely sophisticated, paramedic staffed, urban EMS systems. The Alaska EMS System is divided into seven regions. The Regional EMS Offices are either 501(c)(3) non-profit organizations, or are within Native Health Corporations or are incorporated into a borough government. The regional EMS offices have been in place for years (some over 20) and are uniquely qualified to apply for and manage funds received under the Code Blue Project.

**Importance of Funding:** It is likely that the problems in rural emergency medical services will increase in frequency and severity if there is not a substantial influx of resources to provide the equipment, training and support necessary for volunteer EMS personnel to do their jobs in a safe and effective manner. Agencies can play an important role in helping improve rural emergency medical care by providing funding to purchase essential equipment and which also can be used as match for other funding sources.

Since many rural EMS squads in Alaska respond to more calls from people from other parts of Alaska or visitors from out-of-state than from local residents, it is in our collective best interests to ensure that we have effective emergency medical services available 24 hours a day, seven days a week, throughout the state.

For more information on this important project, contact your regional EMS Office.

# Responsibilities of the Emergency Medical Technician

and  
Defibrillator Technician

## An Emergency Medical Technician:

1. Understands local EMS medical protocols.
2. Responds to emergency calls to provide efficient and immediate care to ill or injured patients, and either;
  - a. documents that the patient declined or refused care;
  - b. transports the patient to a medical facility;
  - c. transports the patient to other rescuers; or
  - d. waits on scene with the patient for additional rescuers.
3. After being dispatched, responds to the scene in a safe and expeditious manner with appropriate considerations of weather and traffic, reads maps, identifies street names, and distinguishes house numbers. Understands and observes state and local statutes, regulations, and ordinances regarding emergency vehicle operations.
4. Assumes EMS and other emergency service team role as defined by standard operating procedures.
5. Upon arrival at the scene, parks the vehicle in a safe location. Before initiating patient care, using the senses of sight, smell, and hearing, determines that the scene is safe, identifies the mechanism of injury or nature of illness, determines the total number of patients, and requests additional help, if necessary. In the absence of law enforcement personnel, creates a safe traffic environment.
6. Protects patient's modesty and personal possessions.
7. Maintains alertness for hazards throughout the call, warns other personnel, and takes other appropriate action.
8. Dons protective gear, e.g. gloves, mask, eye protection, etc., required at the scene.
9. Avoids unprotected exposures to blood and/or other body fluids.
10. Recognizes patients who may have infectious tuberculosis and takes appropriate protective steps.
11. Determines the nature and extent of illness or injury and establishes priority for required emergency care. Based on assessment findings, renders appropriate emergency medical care to adult, infant, and child medical and trauma patients. Duties include:
  - a. assessing the patient;
  - b. obtaining a medical history;
  - c. opening and maintaining an airway, using appropriate adjuncts, if necessary;
  - d. ventilating the patient;
  - e. performing CPR;
  - f. controlling hemorrhage;
  - g. bandaging and dressing wounds;
  - h. immobilizing suspected orthopedic injuries;
  - i. assisting in childbirth;
  - j. managing respiratory, cardiac, diabetic, allergic, behavioral and environmental medical emergencies;
  - k. treating suspected poisonings;
  - l. searching for medical information identification;

- m. administering oxygen;
  - n. assisting patients, under on-line or off-line medical directions, with the patient's hand held bronchodilator inhaler, epinephrine autoinjector, or nitroglycerin;
  - o. using the pneumatic anti-shock garment; and
  - p. using additional medications and procedures authorized by physician medical director.
12. Verbally communicates with the patient, obtains a medical history, and comforts the patient.
  13. Reassures patients and bystanders by working in a professional and efficient manner while avoiding haste and mishandling.
  14. Where the patient must be extricated from entrapment, assesses the extent of injuries, protects the patient during extrication, and removes the patient efficiently and safely using appropriate devices. Requests additional resources for extrication, if necessary.
  15. Complies with regulations on the handling of the deceased, notifies authorities, and arranges for protection of property and evidence at the scene.
  16. Lifts patients, backboards, and stretchers in a safe manner using proper body mechanics.
  17. Reports to incoming medical personnel, or personnel at the receiving medical facility, the nature and extent of injuries or illness, the number of patients, vital signs, and treatment rendered.
  18. Constantly assesses the patient while en route or while awaiting incoming medical personnel.
  19. Communicates with patient, family, and bystanders in a calm, professional, and nonthreatening manner.
  20. Communicates with partner(s) and driver during transport regarding hazards, medical needs, and other issues regarding patient care and safety.
  21. After each response, restocks all supplies, cleans equipment, and makes sure that he or she is ready for the next response.
  22. Attends and documents continuing medical education sessions in order to maintain proficiency as required by the service and the State.
  23. Maintains knowledge of regulatory requirements related to mandatory training and reporting.
  24. If the EMT cares for the patient in an ambulance, ensures that the ambulance is cleaned, washed, and that the patient compartment is decontaminated prior to returning the ambulance to service.
  25. Performs triage in multiple patient incidents in accordance with local multiagency response guidelines.
  26. Reports hazardous materials incidents, search and rescue cases, and disasters to the appropriate agencies.
  27. Reports suspicion of child abuse or neglect, elder abuse, and other reportable suspicions, injuries, and events to the appropriate agencies.
  28. Completes and distributes all paperwork regarding the response in a timely, accurate, and legible manner.
  29. Stores medications and supplies in accordance with manufacturer's recommendations, as well as applicable federal and state laws.
  30. Recognizes signs of stress in self and coworkers and takes appropriate action.

31. Properly uses an automated external defibrillator if properly trained and authorized.
  - a. Assesses the patient and determines that the application of an AED is appropriate.
  - b. Turns on the device, attaches electrodes to the patient, and records verbal report.
  - c. Ensures that other rescuers and bystanders are not in physical contact with the patient when the defibrillator is in use.
  - d. Ensures that appropriate shocks are delivered.
  - e. Efficiently transports the patient in a timely manner.

#### Additional Duties of the EMT-II (All of EMT-I Duties Plus This Section)

1. Estimates patient's weight and calculates medication dosages.
2. Initiates IVs and uses balanced salt solutions to replace lost blood volume.
3. Safely and appropriately uses medications authorized by the EMT's physician medical director in standing orders or by on-line medical direction.
4. Identifies patients needing advanced airway devices and uses devices in a safe and efficient manner.
5. Under proper medical direction, uses medications and procedures listed in 7 AAC 26.040 and other medications authorized by the physician medical director in accordance with 7 AAC 26.670.

#### Additional Duties of the EMT-III (All of EMT-I and EMT-II Duties Plus This Section)

1. Safely, appropriately, and expeditiously defibrillates patients in cardiac arrest according to standing orders or by on-line medical direction.
2. Identifies and treats patients with dysrhythmias in accordance with standing orders or on-line medical direction.
3. Under proper medical direction, uses medications and procedures listed in 7 AAC 26.040 and other medications authorized by the physician medical director in accordance with 7 AAC 26.670.

#### Responsibilities of Defibrillator Technicians using manual defibrillators (in addition to EMT duties)

1. Assesses the patient and determines that the use of a defibrillator is appropriate.
2. Turns on the device, attaches electrodes to the patient, and records verbal report.
3. Determines whether the rhythm is one which should be shocked.
4. Ensures that other rescuers and bystanders are not in physical contact with the patient when the defibrillator is in use.
5. Ensures that appropriate shocks are delivered.
6. Monitors patients for life threatening dysrhythmias.
7. Efficiently transports patient in a timely manner.



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Wendy Natkong, MICP

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01/96	<ul style="list-style-type: none"> <li>• Updated contact list</li> <li>• Updated graphs</li> <li>• Updated section related to EMS history in Alaska</li> <li>• Updated Name of Section</li> <li>• Added CME Reporting Form</li> </ul>
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07/97	<ul style="list-style-type: none"> <li>• Added section on representing oneself as an EMT</li> <li>• Updated history section</li> <li>• Deleted graphs to decrease overall size of document</li> <li>• Added section on military EMTs</li> <li>• Updated section on the practical examination system</li> <li>• Updated section on statutes and regulations</li> <li>• Added section on Alaska Comfort One program</li> </ul>
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Suggestions for Improving the *Guide for EMTs in Alaska*

From:

Suggestion:

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Department of Health and Social Services  
Division of Public Health  
Section of Community Health and  
Emergency Medical Services  
Box 110616  
Juneau, AK 99811-0616

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