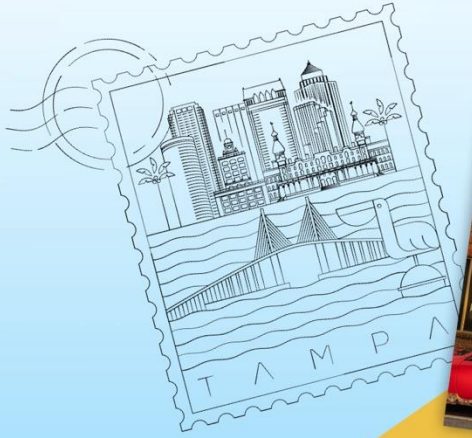
NAEMSP

2026 ANNUAL MEETING

Specialty Workshops, Scientific Assembly & Trade Show



January 26-31, 2026

Tampa, FL

JW Marriott Tampa Water Street

DISCLOSURE SLIDE

2026 ANNUAL MEETING NAEMSP

SPEAKER DISCLOSURE / COI STATEMENT

NAEMSP asks all individuals involved in the development and presentation of Continuing Medical Education (CME) activities to disclose all relationships with ineligible companies within the past 24 months. This information is disclosed to CME activity participants. NAEMSP has procedures in place to resolve any apparent conflicts of interest.

I, (insert name), have no commercial relationships to disclose.
-or-
I, (insert name), have the following commercial relationship(s) to disclose:

Company name (do not use acronyms), relationship type (speaker's bureau, research funding, stockholder, consultant, etc.)

NAEMSP

2026 ANNUAL MEETING

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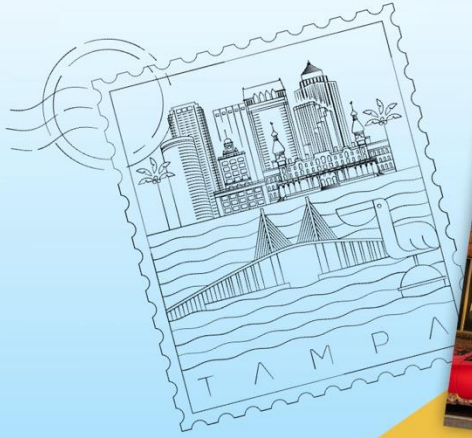

January 26-31, 2026

Tampa, FL

JW Marriott Tampa Water Street

Practical Considerations in Medical Direction

Brent Myers, MD MPH FAEMS

Past President, NAEMSP

Chief Medical Officer, ESO

Disclosure Slide

- **<u>SPEAKER DISCLOSURE / COI STATEMENT</u>**

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- I, Brent Myers, have the following commercial relationship(s) to disclose:
  - ESO, Employee and Stockholder

Learning Objectives

- Describe the situations that require ultra-time critical EMS response vs. an experienced ALS provider (“paramedic paradox”)
- List the evidence-based performance measures for EMS care of patients with stroke, STEMI, and cardiac arrest
- Describe the best practices for providing on-line medical direction
- Describe top-10 leadership attributes of an EMS physician

We succeed only as we identify in life, or
in war, or
in anything else
a single overriding objective
and make all other considerations bend to
that one objective.
- Eisenhower

The Most Impactful Role for the EMS Medical Director/CMO is:

A. Communicating with external stakeholders (receiving hospital personnel, elected officials, media, etc.)

B. Independently evaluating the scientific literature to determine best practices for protocols and treatment guidelines

C. Assuring compliance with response times

D. Monitoring for diversion for controlled substances

Background

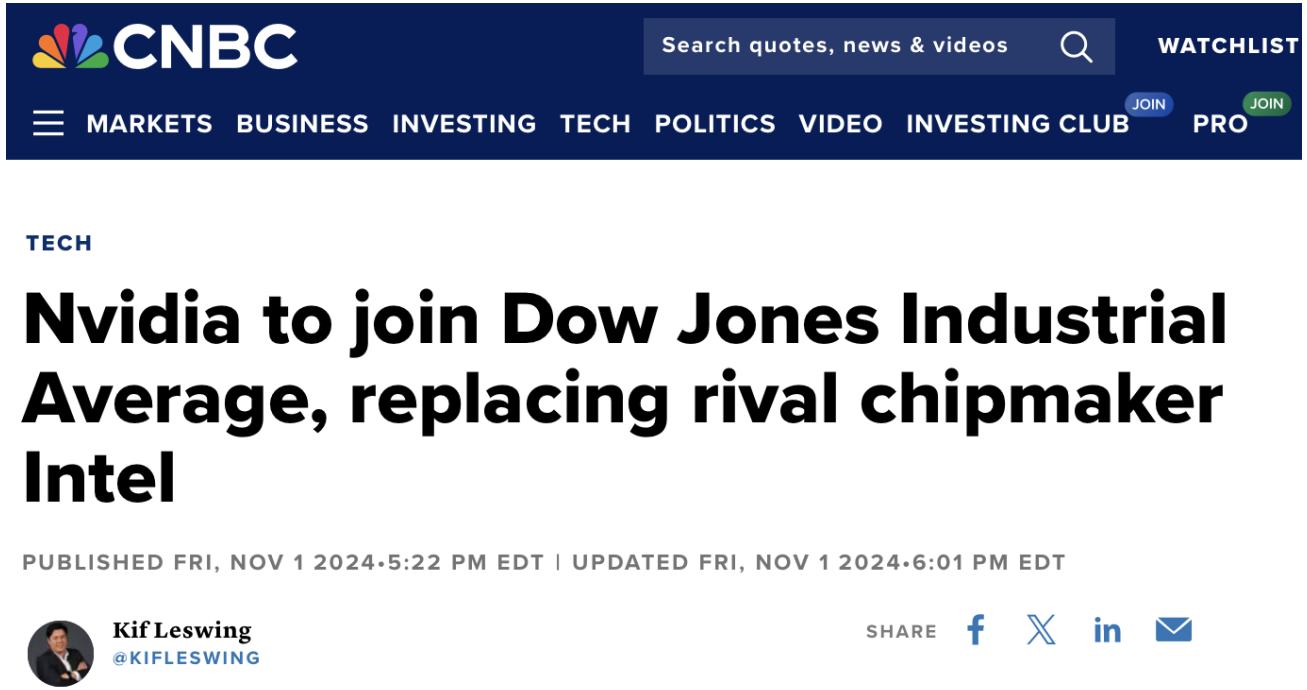
The Medical Director/CMO is the communicator in chief:

- 5% of the job relates to deciding what is the clinically appropriate thing to do
- 48.5% relates to external factors and clarifying the mission for the stakeholders
- 48.5% relates to internal factors and clarifying the mission for your own

Change Management

Watch for the “Status quo police”:

“That’s not the way we do things around here”



#1 Measure What Matters

“You’ve got to be very careful if you don’t know where you are going, because you might end up there.”

-Yogi Bera

Traditional EMS 9-1-1 Pathway

Source of Response Time Measure

Improved neurologic recovery and survival after early defibrillation

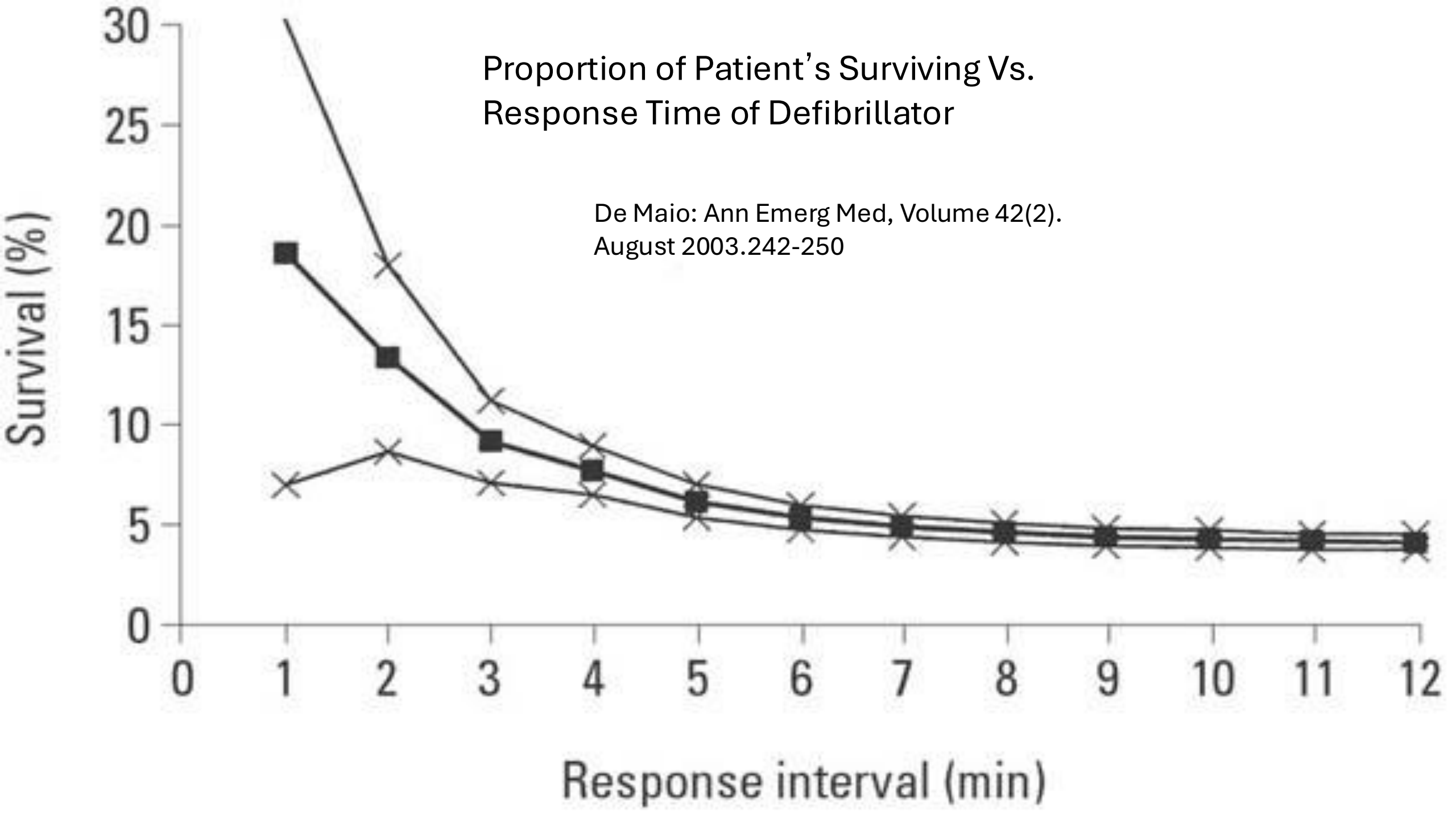
W. Douglas Weaver, M.D., Michael K. Copass, M.D., Debbie Bufi, R.N., Roberta Ray, M.S., Alfred P. Hallstrom, Ph.D., and Leonard A. Cobb, M.D.

ABSTRACT Eighty-seven patients who had out-of-hospital cardiac arrests received defibrillating shocks delivered by minimally trained first responders before the arrival of paramedics in a city with short emergency response times. Their outcomes were compared with those of 370 other victims who received only basic life support by first responders until paramedics arrived. Survival was improved by early defibrillation in cases in which there was a delay in initiating cardiopulmonary resuscitation and in which paramedic response times exceeded 9 min; there was 62% survival after early defibrillation by first responders and 27% if first responders provided only basic life support ($p < .02$). Neurologic recovery was also improved after early defibrillation. Eighteen of 46 resuscitated patients (39%) receiving early defibrillation were awake at 24 hr compared with 49 of 204 patients (24%) who received only basic life support while awaiting paramedics ($p < .02$). Incorporating defibrillation as part of basic life support can reduce both mortality and morbidity from cardiac arrest, even in cities with established, rapidly responding emergency care systems.

Circulation 69, No. 5, 943–948, 1984.

Proportion of Patient's Surviving Vs. Response Time of Defibrillator

De Maio: Ann Emerg Med, Volume 42(2). August 2003.242-250



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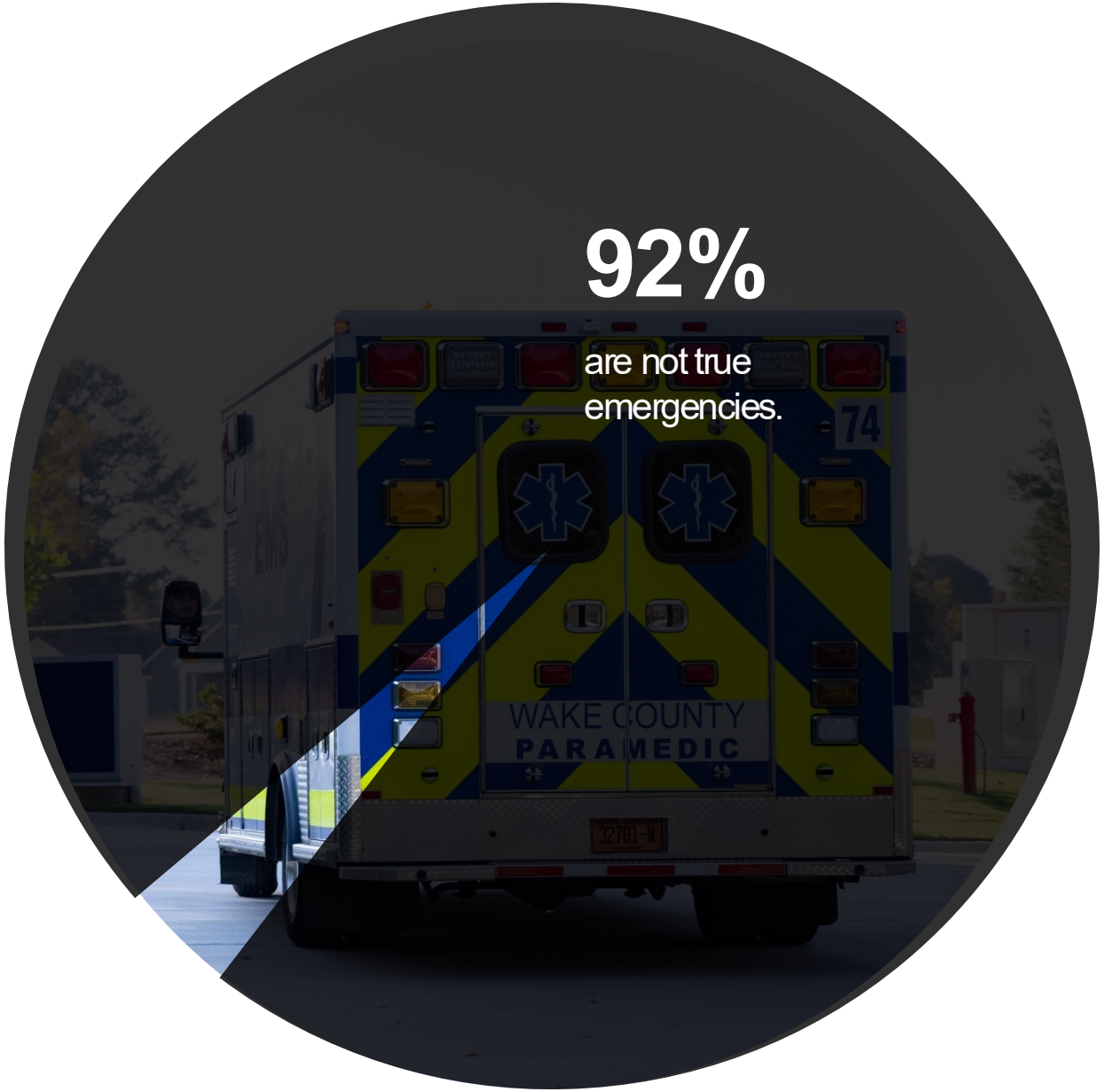


Treatment Bundle Instead of Response Time

Evidence-Based Performance Measures for Emergency Medical Services Systems: A Model for Expanded EMS Benchmarking

A Statement Developed by the 2007 Consortium U.S. Metropolitan Municipalities' EMS Medical Directors (Appendix)

J. Brent Myers, MD, MPH, Corey M. Slovis, MD, Marc Eckstein, MD, MPH,
Jeffrey M. Goodloe, MD, S. Marshal Isaacs, MD, James R. Loflin, MD,
C. Crawford Mechem, MD, Neal J. Richmond, MD, Paul E. Pepe, MD, MPH

PEC 2008;12;141-51

STEMI Treatment Bundle

- ASA Administration or justified
- 12 Lead transmitted
- *Scene time <15*
- *Transport to PCI center*
- *PCI < 90 min*
- NNT=15
  - Avoid re-infarction, stroke, death

Treatment Bundle Instead of Response Time

COUNTY OF ALAMEDA

HEALTH CARE SERVICES AGENCY
REQUEST FOR PROPOSAL No. HCSA-902023

for

911 Emergency Response, 911 Ambulance Services,
and Standby Service with Transport Authorization

Evidence-Based Beyond Response Time

- Clear metrics
- Align with NEMSQA and other national standards
- Can use the number needed to treat (NNT) method to help "prove the negative" to policy makers

TABLE 7: PERCENTAGE CLINICAL PERFORMANCE STANDARDS (Quarterly)

Measure	Description	Standard
CATEGORY 1: CARDIORESPIRATORY MEASURES		
Respiratory Assessment for Pediatric Patients	Percentage of patients age 14 years or younger with Primary Impression of respiratory distress and received a documented respiratory assessment.	Y1 90% Y2 90% Y3+ 92%
EKG for patient with cardiac complaint	Percentage of patients with Primary Impression of Chest Pain, Angina, Palpitations, Arrhythmia or Syncope getting a 12-lead EKG	Y1 90% Y2 90% Y3+ 92%
Aspirin Administration for STEMI	Percentage of patients with STEMI who receive ASA during prehospital treatment	Y1 90% Y2 90% Y3+ 92%
Total On-Scene Time for STEMI Patients	Percentage of STEMI patients with on-scene times of < 15 minutes	Y1 90% Y2 90% Y3+ 92%
Total Call Time for STEMI Patients	Percentage of STEMI patients with < 55 minutes from initial dispatch to a STEMI patient and the patient arriving at a designated STEMI center	Y1 90% Y2 90% Y3+ 92%
ETCO2 Value Documented for Advanced Airway Placements	Percentage of patients with an advanced airway with ETCO2 value documented	Y1 90% Y2 90% Y3+ 92%

National EMS Quality Alliance (NEMSQA)

Safety-01	Percentage of EMS responses originating from a 911 request in which lights and sirens were not used during response.	Process	Patient Safety
Safety-02	Percentage of EMS transports originating from a 911 request during which lights and sirens were not used during patient transport.	Process	Patient Safety

Effective ALS

- Previous AHA guidelines have emphasized “prompt” ALS
- It is now recognized that in most EMS systems there is a balance between paramedic response time and annual paramedic experience
- This has been called the “paramedic paradox”
  - Too few and the patient is not reached in time
  - Too many and the arriving paramedic may lack sufficient on-going experience to be effective

Houston Experience

Table 4
Survival by deployment type

	Uniform response	Targeted response	*P*-value
No. resuscitation attempts	24	181	
Return of spontaneous circulation	8 (33.3%)	101 (55.8%)	0.049
Survival to hospital admission	7 (29.2%)	92 (51.1%)*	0.05
Survival to hospital discharge	1 (4.2%)	43 (23.9%)*	0.03
Alive at 1 year	0	27 (15.0%)*	0.05


74
EMS
WAKE COUNTY
PARAMEDIC
32781-W

- Telemedicine visit with a physician
- Same-day office appointment with primary care
- Link to other resources – social work, transportation, pharmacy, meals on wheels, etc.

POSITION STATEMENT

EMS SPINAL PRECAUTIONS AND THE USE OF THE LONG BACKBOARD

National Association of EMS Physicians and American College of Surgeons Committee on Trauma

PEC 2013;17:392-93

SPECIAL CONTRIBUTION

SPINAL MOTION RESTRICTION IN THE TRAUMA PATIENT – A JOINT POSITION STATEMENT

Peter E. Fischer, MD, MS, Debra G. Perina, MD, Theodore R. Delbridge, MD, MPH, Mary E. Fallat, MD, Jeffrey P. Salomone, MD, Jimm Dodd, MS, MA, Eileen M. Bulger, MD, Mark L. Gestring, MD

ABSTRACT

The American College of Surgeons Committee on Trauma (ACS-COT), American College of Emergency Physicians (ACEP), and the National Association of EMS Physicians (NAEMSP) have previously offered varied guidance on the role of backboards and spinal immobilization in out-of-hospital situations. This updated consensus statement on spinal motion restriction in the trauma patient represents the collective positions of the ACS-COT, ACEP and NAEMSP. It has further been formally endorsed by a number of national stakeholder organizations. This updated uniform guidance is intended for use by emergency medical services (EMS) personnel, EMS medical directors, emergency physicians, trauma surgeons, and nurses as they strive to improve the care of trauma victims within their respective domains.

Received May 23, 2018 from the Department of Surgery, University of Tennessee Health Science Center, Memphis, Tennessee (PEF); Department of Emergency Medicine, University

PREHOSPITAL EMERGENCY CARE
https://doi.org/10.1080/10903127.2025.2541258

Prehospital Trauma Compendium: Prehospital Management of Spinal Cord Injuries – A NAEMSP Comprehensive Review and Analysis of the Literature

Michael G. Millin[a], Johanna C. Innes[b], Gregory D. King[c], Benjamin N. Abo[d], Seth M. Kelly[e], Curtis L. Knoles[f], Robert Vezzetti[g], Chelsea C. White IV[h], Allen Yee[i] and John M. Gallagher[j]

[a]Johns Hopkins University School of Medicine, Baltimore, Maryland; [b]Jacobs School of Medicine and Biomedical Sciences, Buffalo, New York; [c]Virginia Tech School of Medicine/Carilion Clinic, Roanoke, Virginia; [d]Florida State University College of Medicine, Tallahassee, Florida; [e]UMass Chan Medical School-Baystate/Baystate Medical Center, Springfield, Massachusetts; [f]University of Oklahoma College of Medicine, Oklahoma City, Oklahoma; [g]Driscoll Children's Hospital – Rio Grande Valley, Edinburg, Texas; [h]University of New Mexico School of Medicine, Albuquerque, New Mexico; [i]Virginia Commonwealth University, Richmond, Virginia; [j]Hawai'i Emergency Physicians Associated, Kailua-Kona, Hawaii

Conclusion

Despite historical precedent, there is no literature demonstrating a clinical benefit to spinal motion restriction. In fact, efforts to restrict movement cause harms and may have a paradoxical effect. The pathophysiology underlying the development of delayed neurological deficits in the setting of trauma, if this pathology exists, is likely multi-factorial. EMS clinicians should focus on management of shock and hypoperfusion. Efforts aimed to reduce the use of cervical collars should be considered, and the use of backboards and full body vacuum splints should be limited to the point in time of active patient extrication. Given the lack of data supporting clinical benefit, and the extent of data demonstrating the evidence of harm, spinal immobilization, and SMR, should not continue to be upheld as standard of care.

#2 Get Face Time in the Streets

The pessimist complains about the wind;
The optimist expects it to change;
The realist adjusts his sails.
- William Arthur Ward

Evidence to Support This

CRITICAL CARE MEDICINE

Vol. 21, No. 1
Printed in U.S.A.

Clinical Investigations

Effect of full-time, specialized physician supervision on the success of a large, urban emergency medical services system

PAUL E. PEPE, MD, FCCM; KENNETH L. MATTOX, MD, FACS; JAMES H. DUKE, MD, FACS; PETER B. FISHER, MD, FACS; F. DAVID PRENTICE, MD, FACEP

Get Face Time in the Streets

- Part of the communicator in chief is to be the liaison between the EMS providers and the hospital
- Praise in public, reprimand in private
- Remind the providers they work for medical direction but not for every physician in the community

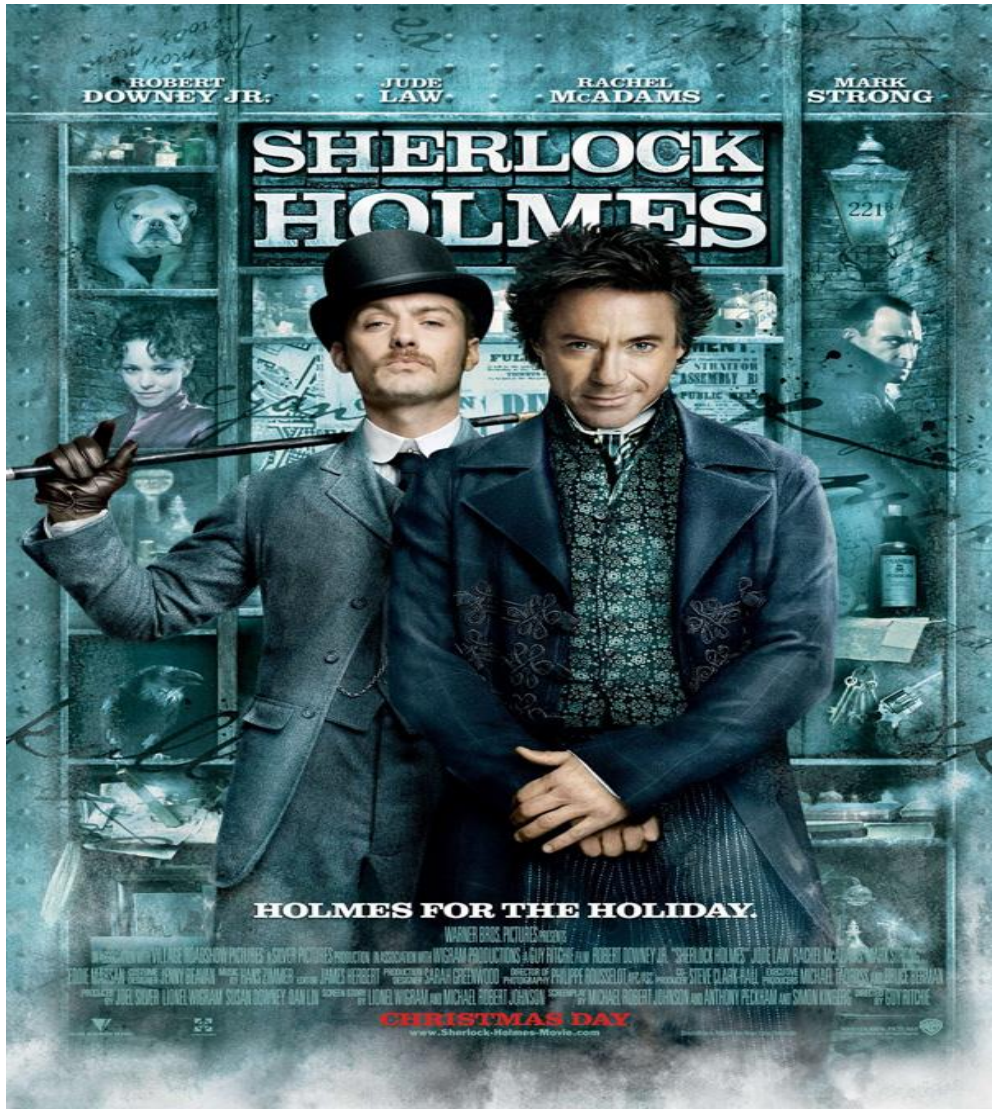
I would rather try to persuade a man to go along, because once I have persuaded him, he will stick. If I scare him, he will stay just as long as he is scared, and then he will be gone.

- Eisenhower

THE CODE GREEN CAMPAIGN

We call code strokes, code STEMIs, and code traumas. It is time we called a code alert on our mental health.

3 Learn from the Streets



AMERICAN AMBULANCE ASSOCIATION
Caring for people—first.

ADVOCACY MEMBERSHIP EDUCATION COST COLLECTION STORE LOG IN

Wall Time Toolkit

WRITTEN BY AAA STAFF ON JANUARY 28, 2022. POSTED IN PATIENT CARE, PROFESSIONAL STANDARDS, REGULATORY.

Extended ambulance patient offload times (APOT), or "wall times," at hospitals are causing long waits for 911 and interfacility patients and exacerbating the EMS workforce shortage. Ambulance services across the country are continually trying to meet demand with fewer resources; when EMS providers are kept out of service for extended periods of time because they are unable to transfer patient care at the hospital, wait times for both 911 and inter-facility patients increase and both emergency and non-emergency calls pile up.

We recognize that the issue of extended wall times is not new, but an existing problem exacerbated by the ongoing battle with COVID-19 across the country. Increased wall times are a symptom of a much larger problem for which there is no easy solution.

This toolkit will provide an overview of EMTALA, highlight the intersection between EMTALA and APOT, and address some frequently asked questions along with links to resources and examples of how services are addressing this issue across the country.

Download Sample Letter

Download EMTALA Memo

Ambulance wait times: Inquiry into deaths after delays

4 January

Some patients are spending hours in ambulances parked outside hospitals because emergency departments are so busy

By Marie-Louise Connolly
BBC News NI Health Correspondent

The Northern Ireland Ambulance Service (NIAS) is investigating whether a delayed response contributed to the deaths of eight people in recent weeks.


Old CPR

Witnessed VF					
All-witnessed VF	n=80	n=71	n=26	n=76	
	11 (13.8)	17 (23.9)	9 (34.6)	31 (40.8)	27.0 (13.6 to 40.4)
Bystander-witnessed VF	n=61	n=56	n=24	n=66	
	5 (8.2)	12 (21.4)	8 (33.3)	23 (34.8)	26.6 (13.2 to 40.0)
EMS-witnessed VF	n=19	n=15	n=2	n=10	
	6 (31.6)	5 (33.3)	1 (50.0)	8 (80.0)	48.4 (16.0 to 80.8)

Hinchey et al. Annals of EM 2010;56:348-57

#4 Control the Message

Accept No Substitute

- National standards have their place – they are necessary but not sufficient
- If there is no local input, then you can’t affect true change
- Example case review follows

Example of Case Review

Assessment Time: **7/29/2011 4:22:00 PM**

Narrative

Dispatched to a traumatic injury: While en route dispatch is updated to a Cardiac Arrest. Upon our arrival we find an estimated 60 y/o m lying supine on the black top pavement. Pt has a pool of blood around head. CPR is in progress by first responders, with BVM use for airway management. Pt is in V-Fib. V-Fib protocol is followed. Pt's pupils are constricted. After first defibrillation pt has a return of circulation. Pt is loaded into ambulance. Pt is having a STEMI per 12-lead ECG.

While en route to hospital: Upon further evaluation it is discovered that the pt has 2nd degree burns to his forearms, back and shoulders. Burns are wrapped. Pt becomes agitated and combative. Pt is moaning and yelling. Versed 5mg IVP is administered. Pt is calm. Pts right pupil is now dilated and responsive, left pupil is non responsive. Rex ED is notified of STEMI. Pt becomes combative once again. A second dose of Versed 5mg IVP is administered. Pt is calm once again.

Care and report are given to Rex ED RN [redacted] in bed 3.

CARDIOLOGY/REVIEW ARTICLE

Systematic Review and Meta-analysis of the Benefits of Out-of-Hospital 12-Lead ECG and Advance Notification in ST-Segment Elevation Myocardial Infarction Patients

Julian Nam, MSc; Kyla Caners, MD; James M. Bowen, BScPhm, MSc; Michelle Welsford, MD, ABEM, FRCP; Daria O'Reilly, PhD, MSc

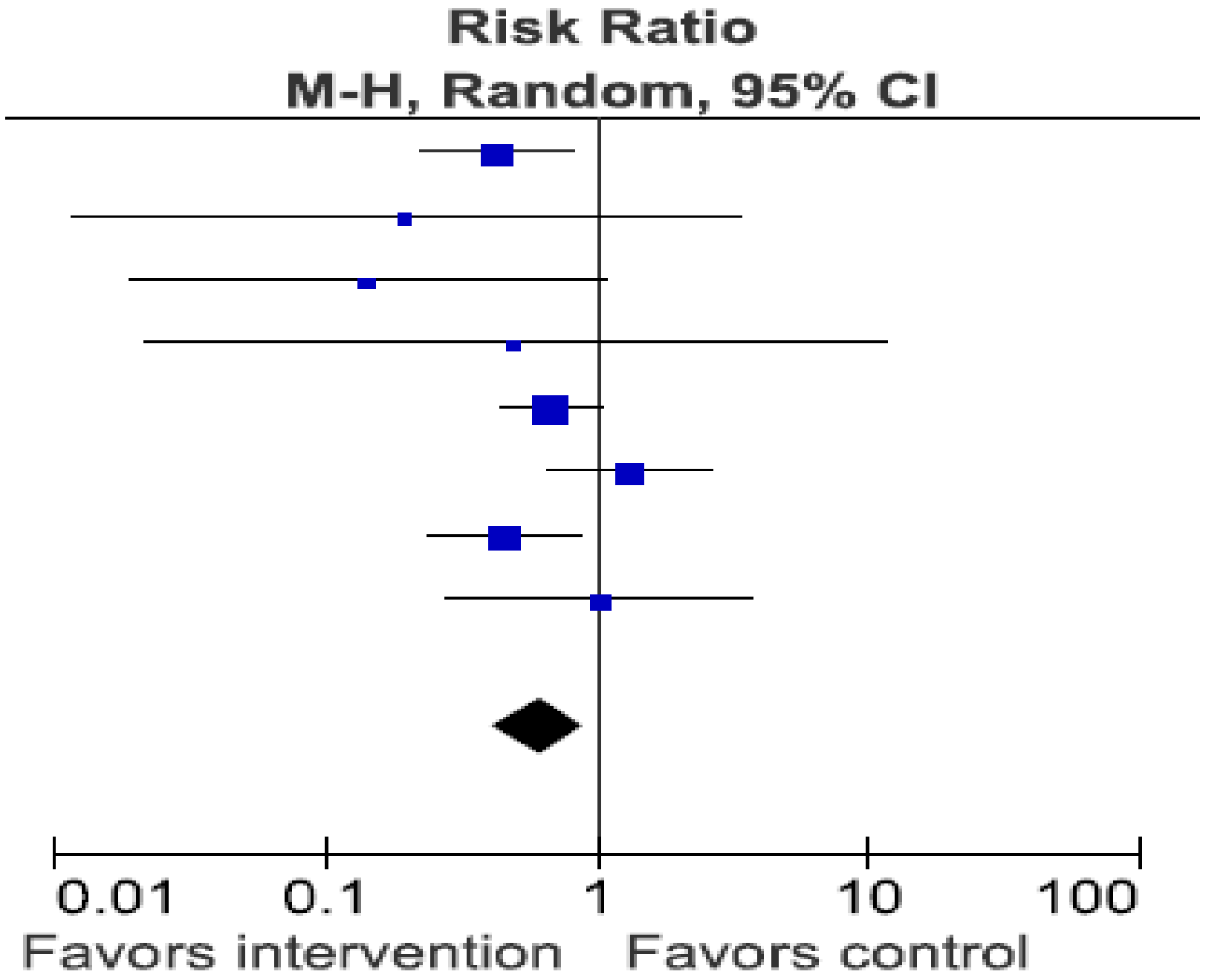
Study objective: To present a review of out-of-hospital identification of ST-segment elevation myocardial infarction patients transported by emergency medical services with 12-lead ECG and advance notification versus standard or no cardiac monitoring.

Methods: EMBASE, PubMed, and the Cochrane Library were searched, using controlled vocabulary and keywords. Randomized controlled trials and observational studies were included. Outcomes included short-term mortality (≤30 days), door-to-balloon/needle time and/or first medical contact–to-balloon/needle time. Pooled estimates were determined, where appropriate. Results were stratified by percutaneous coronary intervention or fibrinolysis.

Results: The search yielded 1,857 citations, of which 68 full-texts were reviewed and 16 studies met the final criteria: 15 included data on percutaneous coronary intervention and 3 on fibrinolysis (2 included both). Where percutaneous coronary intervention was performed, out-of-hospital 12-lead ECG and advance notification was associated with a 39% reduction in short-term mortality (8 studies; n=6,339; risk ratio 0.61; 95% confidence interval 0.42 to 0.89; P=.01; I^2=30%) compared with standard or no cardiac monitoring. Where fibrinolysis was performed, out-of-hospital 12-lead ECG and advance notification was associated with a 29% reduction in short-term mortality (1 study; n=17,026; risk ratio 0.71; 95% confidence interval 0.54 to 0.93; P=.01). First medical contact–to-balloon, door-to-balloon, and door-to-needle times were consistently reduced, though large heterogeneity generally precluded pooling.

Conclusion: The present study adds to previous reviews by identifying and appraising the strength and quality of a larger body of evidence. Out-of-hospital identification with 12-lead ECG and aadvance notification was found to be associated with reductions in short-term mortality and first medical contact–to-balloon, door-to-balloon, and door-to-needle time. [Ann Emerg Med. 2013;■:1-20.]

Please see page XX for the Editor's Capsule Summary of this article.


Risk Ratio
M-H, Random, 95% CI
0.01
0.1
1
10
100
Favors intervention
Favors control

EMERGENCY MEDICAL SERVICES/ORIGINAL RESEARCH

Severity-Adjusted Mortality in Trauma Patients Transported by Police

Roger A. Band, MD; Rama A. Salhi, BS, MHS; Daniel N. Holena, MD; Elizabeth Powell, MD; Charles C. Branas, PhD; Brendan G. Carr, MD, MS

Study objective: Two decades ago, Philadelphia began allowing police transport of patients with penetrating trauma. We conduct a large, multiyear, citywide analysis of this policy. We examine the association between mode of out-of-hospital transport (police department versus emergency medical services [EMS]) and mortality among patients with penetrating trauma in Philadelphia.

Methods: This is a retrospective cohort study of trauma registry data. Patients who sustained any proximal penetrating trauma and presented to any Level I or II trauma center in Philadelphia between January 1, 2003, and December 31, 2007, were included. Analyses were conducted with logistic regression models and were adjusted for injury severity with the Trauma and Injury Severity Score and for case mix with a modified Charlson index.

Results: Four thousand one hundred twenty-two subjects were identified. Overall mortality was 27.4%. In unadjusted analyses, patients transported by police were more likely to die than patients transported by ambulance (29.8% versus 26.5%; OR 1.18; 95% confidence interval [CI] 1.00 to 1.39). In adjusted models, no significant difference was observed in overall mortality between the police department and EMS groups (odds ratio [OR] 0.78; 95% CI 0.61 to 1.01). In subgroup analysis, patients with severe injury (Injury Severity Score >15) (OR 0.73; 95% CI 0.59 to 0.90), patients with gunshot wounds (OR 0.70; 95% CI 0.53 to 0.94), and patients with stab wounds (OR 0.19; 95% CI 0.08 to 0.45) were more likely to survive if transported by police.

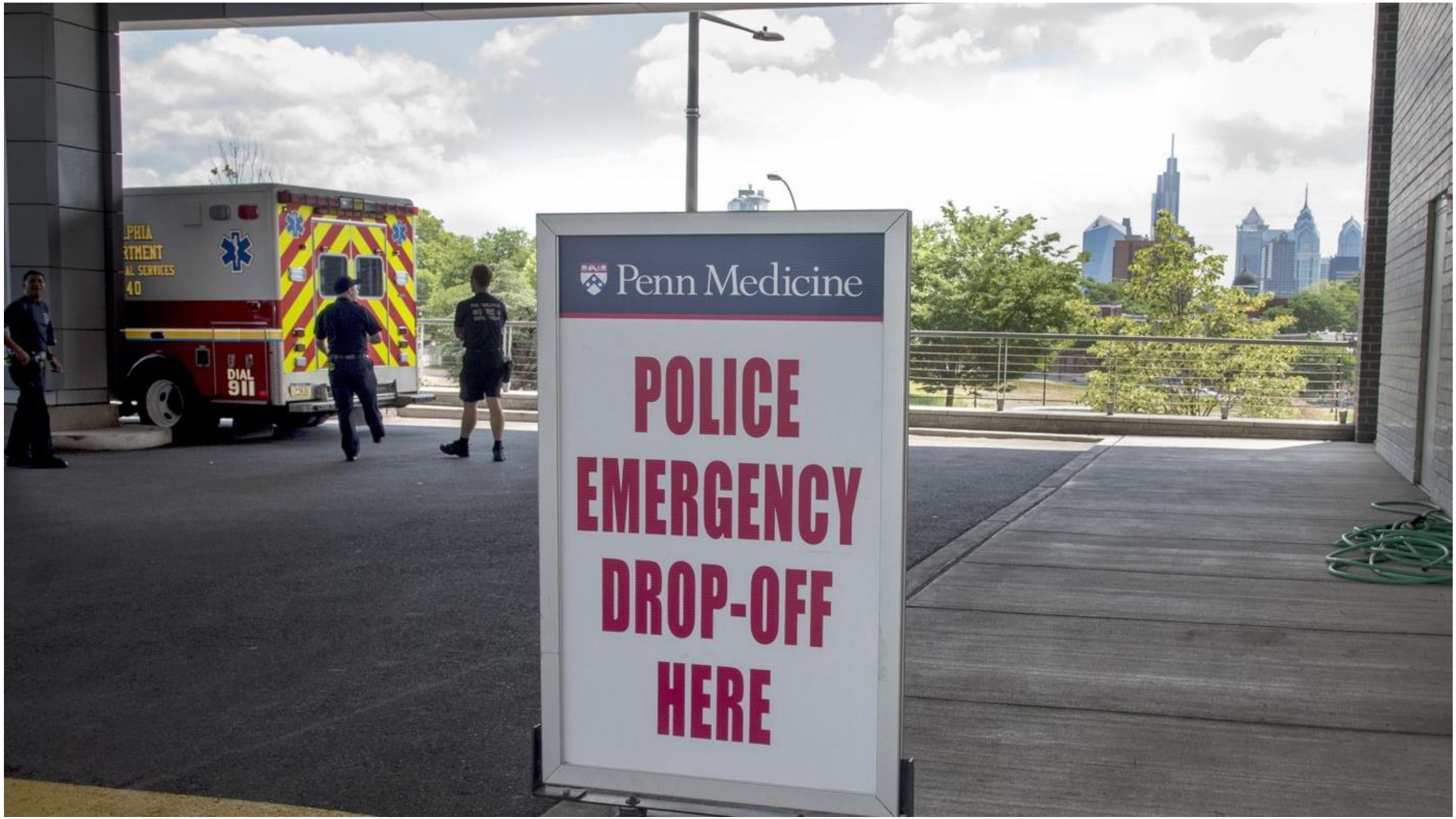
Conclusion: We found no significant overall difference in adjusted mortality between patients transported by the police department compared with EMS but found increased adjusted survival among 3 key subgroups of patients transported by police. This practice may augment traditional care. [Ann Emerg Med. 2014;■:1-10.]

Please see page XX for the Editor's Capsule Summary of this article.

Table 3. Adjusted association between mode of transport and mortality within specified subgroups.*

	OR (95% CI)	
Population Subgroups	**EMS**	**PD**
Overall	Ref	0.78 (0.6–1.01)
ISS >15	Ref	0.73 (0.59–0.90)
ISS ≤15	Ref	0.59 (0.23–1.51)
GSW	Ref	0.70 (0.53–0.94)
ISS >15	Ref	0.67 (0.55–0.83)
SW	Ref	0.19 (0.08–0.45)
ISS >15	Ref	0.39 (0.10–1.48)

*All ORs presented are adjusted for probability of death with TRISS methodology, case mix with a modified Charlson index, age, and sex.


Penn Medicine
POLICE
EMERGENCY
DROP-OFF
HERE
DIAL
911

#5 Do Not Delegate On-Line Medical Direction

Why This Matters?

- To the providers – they get a consistent message
- To your ED co-workers – they get a break and come to respect your decision-making
- To you – you learn more about your providers than by nearly any other mechanism

#6 – Deliver Educational Sessions in Person

- Praise in public
- Remediate in private
- Show positive cases and cases with opportunity for improvement

Be the Face of Patient Care

Apple Chief Executive Tim Cook made a recommendation on the salary adjustment.
PHOTO: CESARE ABBATE/SHUTTERSTOCK

By *Aaron Tilley* Follow
Updated Jan. 12, 2023 at 11:13 pm ET

TECH

Apple CEO Tim Cook requests and receives a 40% pay cut after shareholder vote

PUBLISHED THU, JAN 12 2023•6:42 PM EST | UPDATED FRI, JAN 13 2023•AT 5:48 EST

Kif Leswing
@KIFLESWING

SHARE

JOURNAL REPORTS: LEADERSHIP

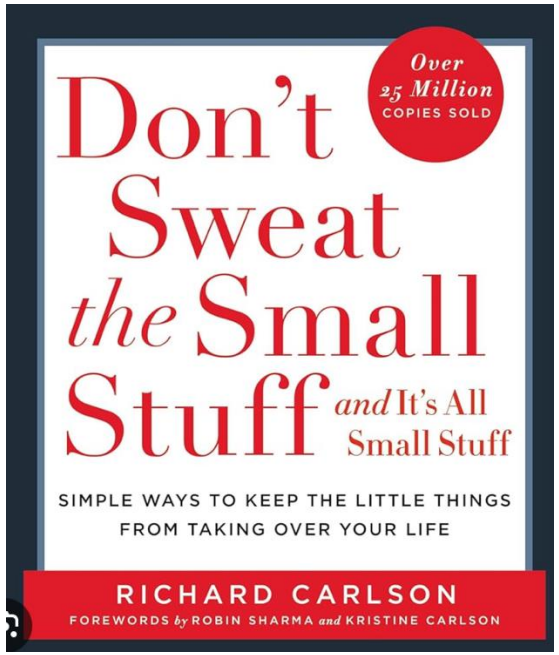
Microsoft Tops the Best-Managed Companies of 2022

The company is No. 1—again—in the Drucker Institute's annual Management Top 250 ranking. But below No. 1, there were a lot of changes, especially among technology companies.

By Meghan Bobrowsky Follow

Dec. 11, 2022 at 9:05 am ET

#7 Don’t Sweat the Small Stuff



Examples

- Medications within categories
- Minor clinical misadventures
- Educational methods
- 8 to 12% of the US population calls for EMS each year
  - We are UMS – unscheduled medical service that occasionally responds to an emergency

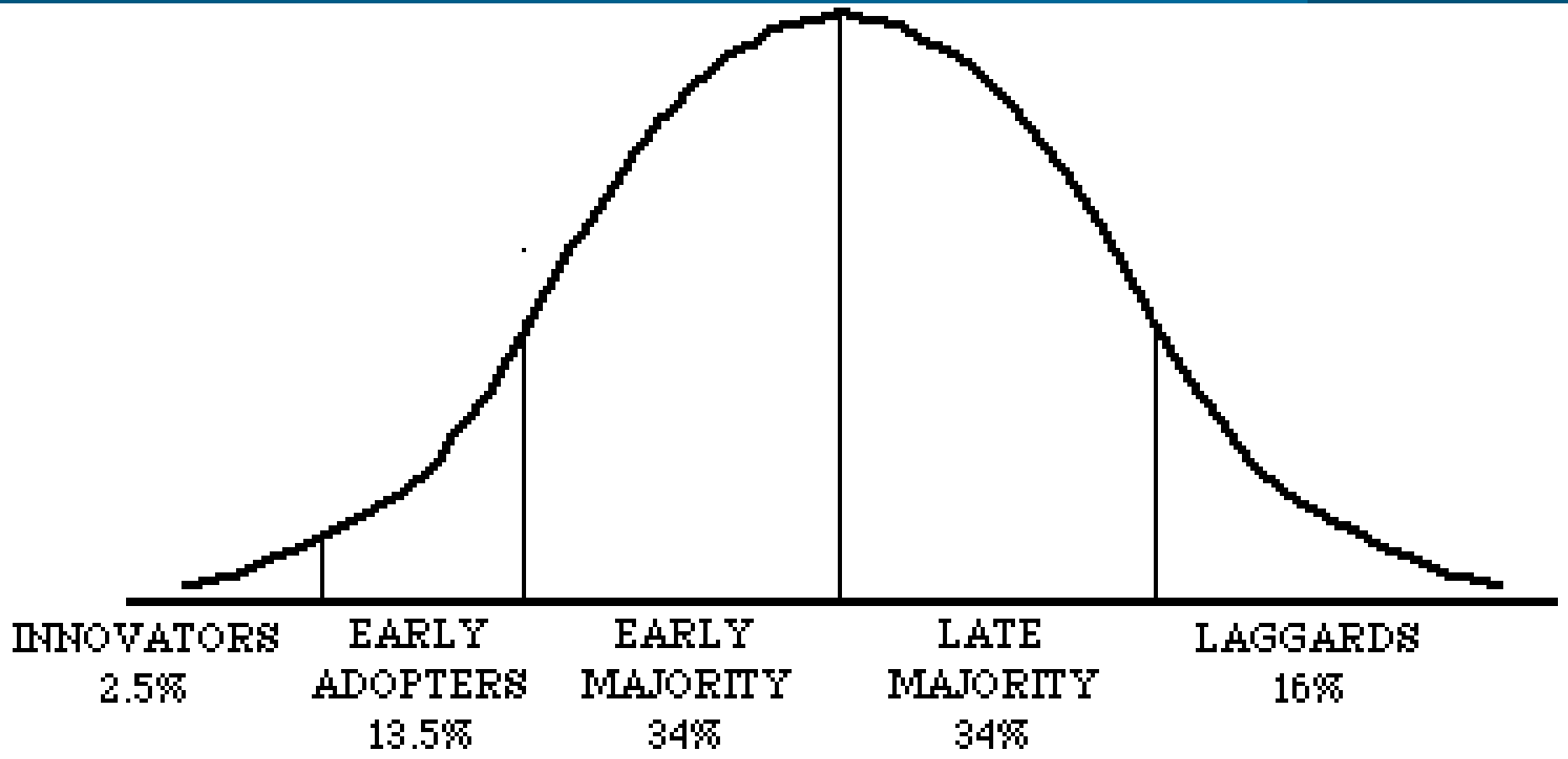


Figure 1. Bell shaped curve showing categories of individual innovativeness and percentages within each category

#8 Stand Up When it Matters

Artificial Intelligence-Facilitated Emergency Medical Services Call Center Software

Market Survey Report

December 2023

Science and Technology

NUSTL®
NATIONAL URBAN SECURITY TECHNOLOGY LABORATORY

Approved for Public Release

SAVER-T-MSR-44

#9 Put Your Money Where Your Mouth Is

- Response Time
- Safety
- Education
- Commitment to the providers

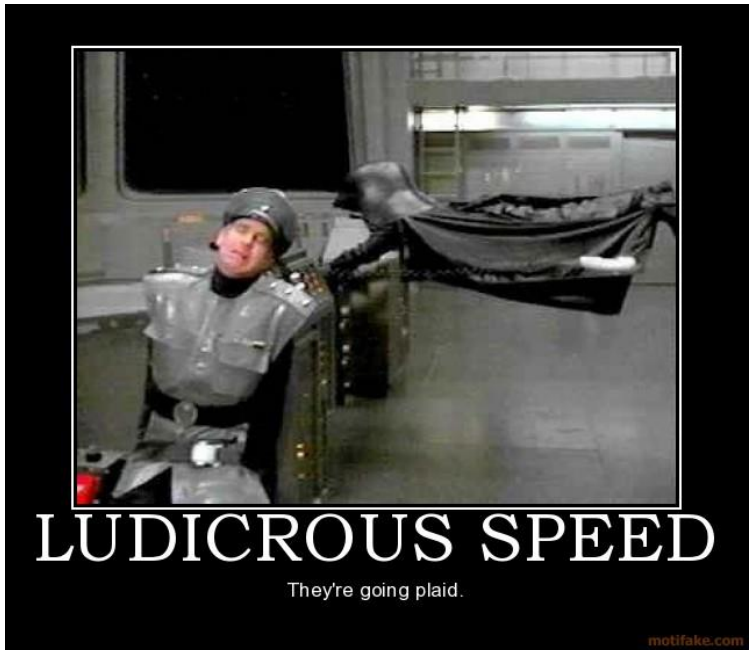
Ultra-Time Critical = BLS

Clinical Condition	Ultra-time critical treatment	BLS or ALS
Cardiac arrest	Compressions and defibrillation	BLS
Severe trauma	Hemorrhage control, reduction of fracture, rapid transport, chest decompression	BLS (save for chest decompression today)
Anaphylaxis	IM Epinephrine	BLS
Asthma	Inhaled beta agonist, IM Epinephrine	BLS

Spaceballs' EMS Measures

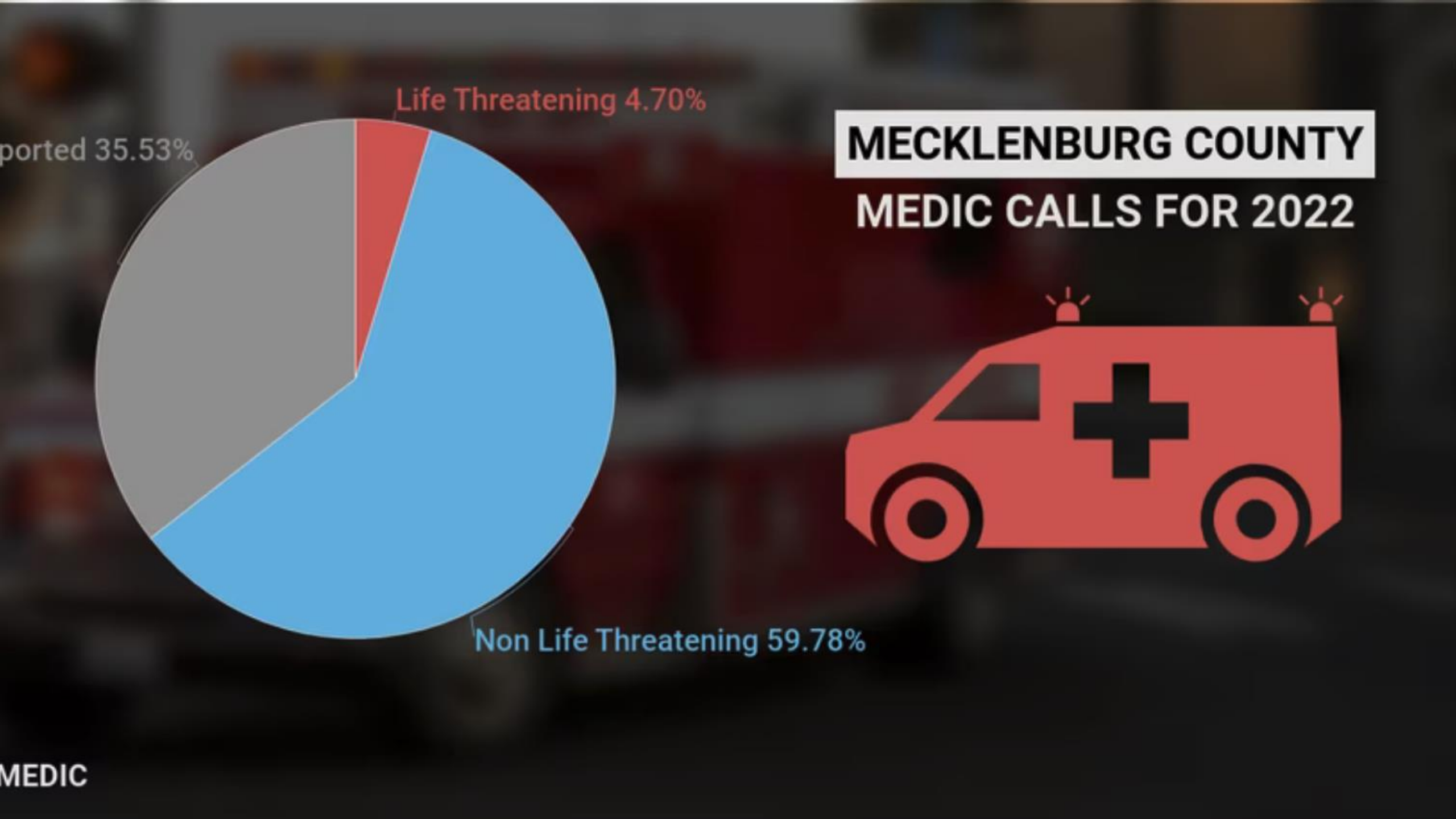

LUDICROUS SPEED

Going to Plaid



Speed Report Rather Than Response Time Report

- All speeds over 80 MPH trigger a review
- Progressive discipline is utilized for those who violate safety/speed regulations
- Save for the laggards, this has been universally well-received


Life Threatening 4.70%
ported 35.53%
Non Life Threatening 59.78%
MECKLENBURG COUNTY
MEDIC CALLS FOR 2022
MEDIC

Medic 911 call volume percentages

With the new Medic response system, operators provide an anticipated arrival time of 15, 30, 60 or 90 minutes. This chart illustrates the response time before and after the change.

Search...

Response Time Standard	10:59	15:00	30:00	60:00	90:00	ON/OP/OC	FR Only
% of call valume pre-change	20%	49%	0%	22%	0%	9%	0%
Actual % of call volume post-change May 2023-September 2023	22%	31%	20%	12%	1%	1%	13%

Patient Safety Protocol

Follow Universal Patient Care Protocol

Utilize Pre-printed Drug Dose Cards For All Weight-Based Drug Administrations for which they are supplied to verify correct drug and dose prior to administration

Document at least once per shift the presence of all equipment, medications, and supplies listed on the Wake County EMS System Ramp Inspection Form

If supplies fall below required levels, restock at the nearest appropriate location. If dispatched to a call that may require depleted supplies, respond and call for next near unit.

If massive depletion of supplies (e.g, post-cardiac arrest) and/or contamination, remain out-of-service until resupplied and clean

If equipment failure, utilize equipment failure procedure and complete the Wake EMS System Clinical Unusual Event Report

If medication error, clinical misadventure, or other adverse patient outcome, contact medical director via policy below.

Appropriate protocol → M Patient doesn't fit a protocol? **Contact Medical Control** M

Transport Patient per Patient Transport Policy

Legend		
	MR	
B	EMT	B
I	EMT- I	I
P	EMT- P	P
M	Medical Control	M

General Protocols

Medical Director Notification Policy:

- If any events as listed in the Automatic Medical Director Notification section of the Foundations of Practice occur, notify the medical director immediately. If no answer with cell phone, call RWCC Rescom for further assistance.
- If any other adverse clinical outcome, notify the medical director as soon as possible via email and/or cell phone. The probability of utilization of the Disciplinary Procedure is greatly diminished if the provider with a misadventure contacts the medical director directly.
- If an error occurs without adverse patient outcome and/or a "near miss" occurs, complete the Wake County EMS System Clinical Unusual Event Report.

Medical Director Notification Policy:

- If any events as listed in the Automatic Medical Director Notification section of the Foundations of Practice occur, notify the medical director immediately. If no answer with cell phone, call RWCC Rescom for further assistance.
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- If an error occurs without adverse patient outcome and/or a "near miss" occurs, complete the Wake County EMS System Clinical Unusual Event Report.

Scene safety

Bring all necessary equipment to patient's side

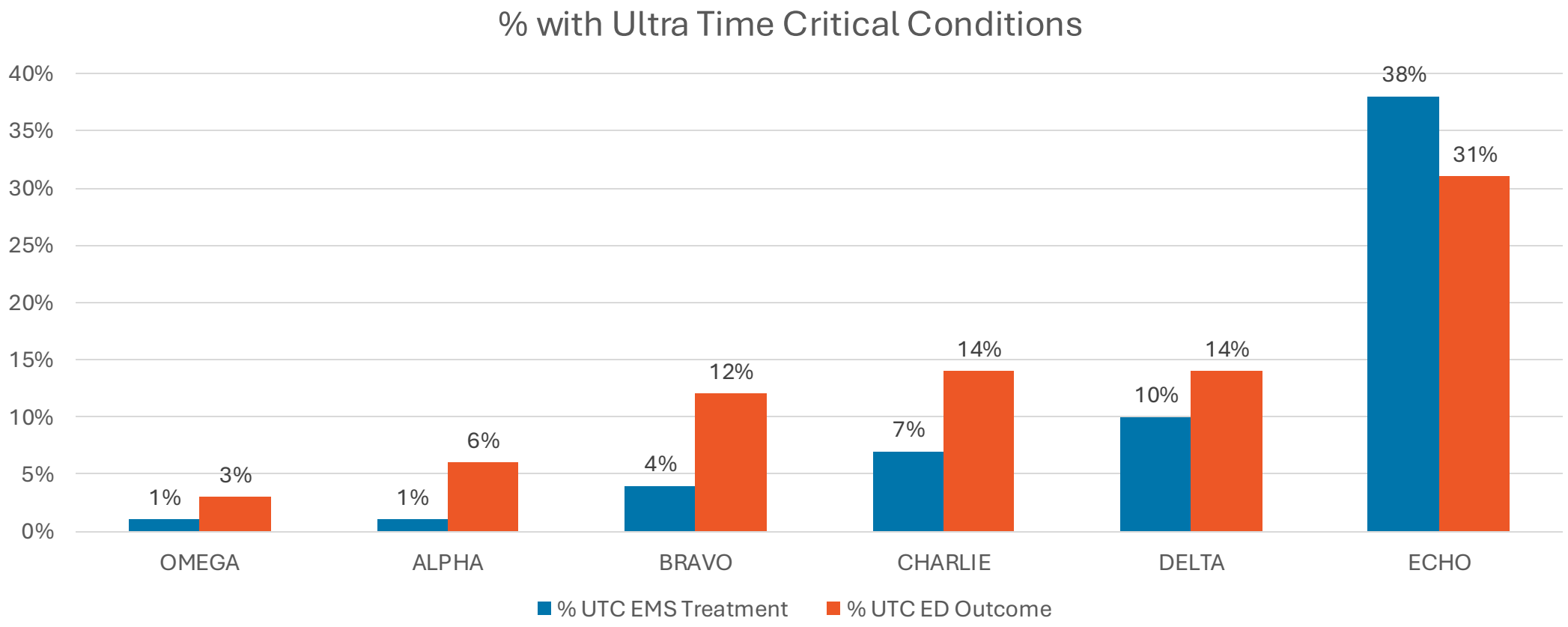
Demonstrate Professionalism and Courtesy

#10 Always Put the Patient First (But Don't Say it Very Often)

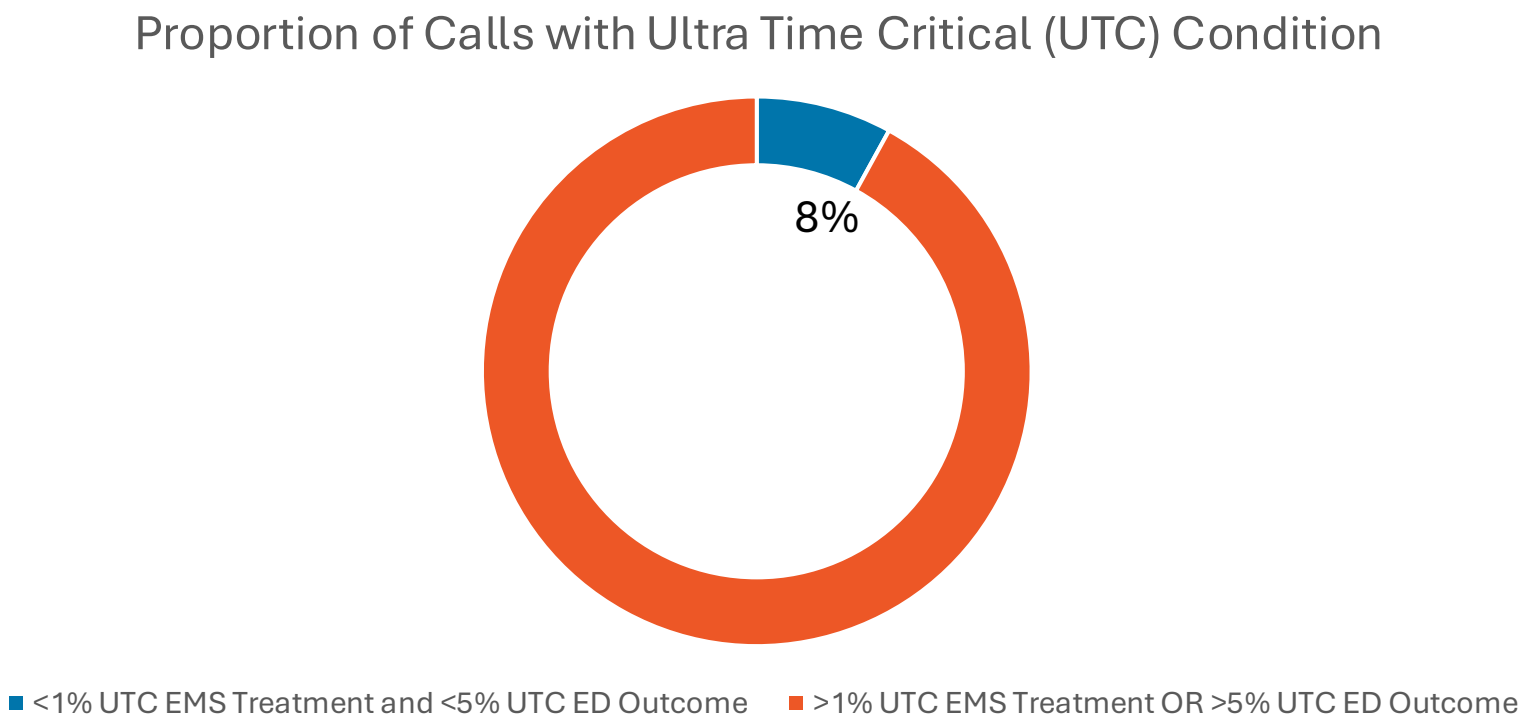
- "I am tired of hiring about the patient – when we can talk about operations!"
    - Anonymous former EMS Chief in the Wake EMS System
- Don't talk about dead babies in the street
- Do bring the medical community along

Dispatch Research

- Goal: determine the probability of an ultra-time critical or urgent situation in ED, based on dispatch chief complaint and acuity
- Method: utilize EHR and HDE outcomes to confirm presence or absence of ultra-time critical or urgent situations in ED
- Question: are the MPDS acuities the best method to stratify response configurations and determine which requests are suitable for alternative disposition (holding calls w/ low resource availablity, telemedicine, nurse line, etc.)?


% with Ultra Time Critical Conditions
40%
35%
30%
25%
20%
15%
10%
5%
0%
1%
3%
1%
6%
4%
12%
7%
14%
10%
14%
38%
31%
OMEGA
ALPHA
BRAVO
CHARLIE
DELTA
ECHO
% UTC EMS Treatment
% UTC ED Outcome

Responses with Time Critical Condition



Higher Acuity Determinants “Safe to Hold”

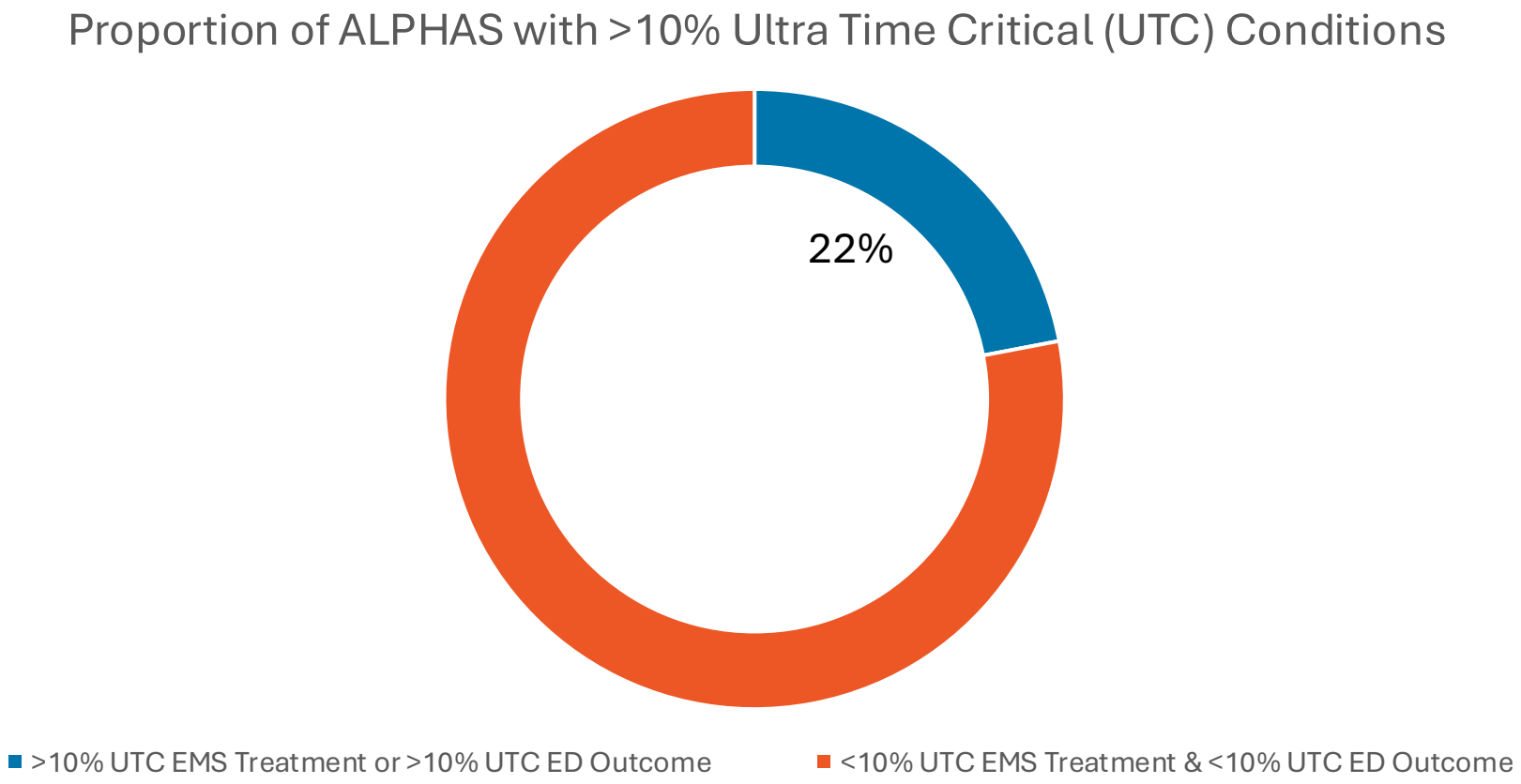
Table 3 of 5

Table 3. Discordant Protocols within higher acuity Determinant levels meeting proposed “safe to hold”* in queue criteria.

Protocol/Determinant level	Chief Complaint	Responses *N* = 142,067	% Transport Row % (n)	% Time-Critical EMS Intervention Row % (n)	% Time-Critical ED Outcome** Row % (n)
01B	Abdominal Pain	1,420	89.1% (1,265)	0.3% (4)	2.5% (36)
01C	Abdominal Pain	19,912	91.0% (18, 114)	0.7% (147)	1.2% (232)
05C	Back Pain (Non-Traumatic)	5,378	89.4% (4,806)	0.7% (38)	1.0% (53)
08B	Carbon Monoxide/ Inhalation/ Haz Mat/ CBRN	339	32.5% (110)	0.9% (3)	0.3% (1)
20B	Heat / Cold Exposure	1,935	61.7% (1,194)	0.9% (17)	0.5% (9)
24B	Pregnancy / Childbirth / Miscarriage	1,603	87.3% (1,399)	0.9% (15)	0.6% (9)
46B	Specialized (Scheduled) Interfacility Transfer	11,339	96.6% (10,954)	0.7% (78)	0.0% (0)
52B	Alarms	225	4.0% (9)	0.4% (1)	0.0% (0)
53B	Citizen Assist/Service Call	547	5.1% (28)	0.2% (1)	0.0% (0)
60D	Gas Leak/Gas Odor (Natural and LP Gases)	162	5.6% (9)	0.0% (0)	0.0% (0)
69E	Structure Fire	3,024	4.8% (146)	0.6% (18)	0.1% (4)

* Safe to hold in queue = <1% time-critical intervention by EMS and <5% time-critical ED outcome. **denominator = EMS transport and ED diagnosis available.

Alphas with >10% Ultra Time Critical Conditions



Lower Acuity Determinants “Unsafe to Hold”

Table 4 of 5

Table 4. Discordant Protocols within lower acuity Determinant levels meeting proposed “unsafe to hold”* in queue criteria.

Protocol/ Determinant level	Chief Complaint	Responses *N* = 883,683	% Transport Row % (n)	% Time-Critical EMS Intervention Row % (n)	% Time-Critical ED Outcome** Row % (n)
02O	Allergies (Reactions) / Envenomations (Stings, Bites)	649	76.6% (497)	1.4% (9)	17.6% (13)
02A	Allergies (Reactions) / Envenomations (Stings, Bites)	3,347	54.8% (1,833)	7.6% (253)	36.6% (333)
09O	Cardiac or Respiratory Arrest / Death	745	3.6% (27)	6.2% (46)	46.7% (7)
19A	Heart Problems / AICD	1,391	56.9% (792)	0.4% (6)	20.8% (94)
21O	Hemorrhage / Lacerations	362	55.8% (202)	2.5% (9)	12.1% (4)
31A	Unconscious / Fainting (Near)	18,725	59.3% (11, 106)	1.5% (283)	10.2% (580)
33A	Transfer / Interfacility / Palliative Care	8,034	93.5% (7,508)	4.7% (378)	16.6% (697)
37A	Interfacility Evaluation/Transfer	1,442	91.3% (1,317)	11.1% (160)	40.8% (269)
46A	Specialized (Scheduled) Interfacility Transfer	36,701	97.1% (35,626)	0.5% (174)	13.1% (20)
53A	Citizen Assist/Service Call	1,897	62.1% (1,178)	2.3% (44)	10.6% (82)

* Unsafe to hold in queue = >10% time-critical intervention by EMS or >10% time-critical ED outcome. **denominator = EMS transport & HDE diagnosis available.

Take Home Points

- #1 Measure What Matters
- #2 Get Face Time in the Streets
- #3 Learn from the Streets
- #4 Control the Message
- #5 Do Not Delegate On-Line Medical Direction (at least not all of it)

Take Home Points

- #6 Deliver educational message in person
- #7 Don’t sweat the small stuff
- #8 Stand up for what matters
- #9 Put your money where your mouth is
- #10 Always put the patient first (but don’t say it too often)

I would rather try to persuade a man to go along, because once I have persuaded him, he will stick. If I scare him, he will stay just as long as he is scared, and then he will be gone.

- Eisenhower

Post Your Thoughts About This Session

Use the hashtag #NAEMSP2026 to share what you learn!