



SPRING 2020

NAEMT NEWS

A quarterly publication of the National Association of Emergency Medical Technicians

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What EMS Practitioners Need to Know about Pharmacology

The 3rd edition *Advanced Medical Life Support (AMLS)* textbook was just published, featuring new chapters covering critical illnesses EMS practitioners often encounter in the field. NAEMT News will run a series of articles focusing on the new and enhanced content.

In this issue, we feature “pharmacology for EMS” with Dr. Stein Bronsky, an emergency physician and medical director for the Colorado Springs Fire Department and American Medical Response (AMR) in El Paso County, Colorado. Bronsky is a contributing author of the new AMLS chapter on pharmacology.



you may go off the edge of the cliff. A bus driver saw us swerve. He sped up, swung wide and hit us to plow us up against the canyon wall and keep us from falling off the edge. I don't remember a lot, but I remember having to be extricated.

I had a lot of broken bones. I almost lost my lower leg, and I had a head injury. I didn't have any internal organ damage, but my passenger did. The emergency crews knew how to handle the situation, and it was really impressive. I became an EMT shortly after that, and worked as a ski patroller in Utah while I was in college.

Before we talk about pharmacology, can you tell us what got you interested in EMS?

When I was 17 years old, I got in a car accident – a bad car accident. I was driving and I fell asleep on a really narrow, canyon road, the kind where if you swerve

Did you always plan on becoming a doctor?

No. My dad is a pediatric immunologist, and I wanted to do something different. So I went to Israel to study Middle Eastern studies.

But while I was there, I became a paramedic. During the late 80s and early 90s, there was a lot of trauma there. There were an unbelievable number of car accidents. They didn't have traffic police, so there was nobody stopping anyone from speeding or driving poorly. There were also terrorist attacks – mostly suicide bombers and backpacks left in crowded tourist areas, loaded with explosives. They would just wait for somebody to pick up the backpack, and boom.

Israel got very, very good at MCI triage and treatment. One thing they learned is that people will not stick around and wait to be triaged or wait for an ambulance. If they can get up and physically move away from a scene, they will get as far away as possible. It's human nature. If they are too injured, the people around them will pick them up and extricate them out of that circumstance.

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ELITE



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Laying the Groundwork for Improvements to EMS Pay and Resources

By Matt Zavadsky, MS-HSA, NREMT

Some of the most significant challenges facing our members, such as pay, benefits and work environments, have their roots in the economics of emergency medical services. NAEMT has been actively engaged in initiatives specifically designed to improve the EMS economic environment and working conditions for EMS practitioners.

Legislative initiatives

As you will read in President-Elect Bruce Evan's article in this newsletter on the EMS PAC, many of our legislative initiatives have been focused on EMS finance. Our most recent successful outcome was the passage and funding of the federal SIREN Act, which makes grant funding available for rural EMS agencies for things like equipment and training. Member support for legislative initiatives through meetings and communication with elected officials, and participation in the EMS PAC is crucial in helping NAEMT's legislative efforts.

The same is true for state legislative initiatives – which has been an NAEMT strategic goal for the past two years. NAEMT has expanded our online legislative service to the state level and we have been working with several state associations on EMS economic initiatives in their state.

EMS finance education initiatives

Over the past year, NAEMT partnered with the Academy of International Mobile Healthcare Integration (AIMHI) on a series of educational webinars on the essentials of EMS finance. These webinars covered topics such as revenue cycle management, cost drivers, and the anatomy of an EMS call – walking participants through the various components of a typical EMS call and how each component impacts EMS finance.

The goal of these webinars was to educate the EMS community on the economics of EMS, such as the factors that impact whether an agency gets paid for a given call, how to calculate the full costs of providing EMS, and how this impacts the work of EMTs and paramedics. These webinars were very well attended and the recordings are available on the NAEMT website. Under "Events," choose "EMS Webinars." Or, use your NAEMT member discount to access these webinars from the Recert online education service (Recert.com) for CE credit.

Ambulance cost data collection

NAEMT and other professional associations worked with congressional leaders to support language in the Balanced Budget Act of 2018 extending the Medicare ambulance add-on payments for five years, and requiring the Centers for Medicare and Medicaid Services (CMS) to conduct a comprehensive ambulance cost data collection (ACDC) analysis. The goal of the ACDC project is to determine the adequacy of current Medicare payments for ambulance services, and make adjustments to Medicare payments based on the cost of providing ambulance services. The cost data collection project is exceptionally important to EMS, as it will determine future Medicare payment rates for ambulance service. The accuracy of the cost data submissions by ambulance agencies is crucial to assuring *all* the costs associated with ambulance provision are sufficiently reported.

Knowing the significance of this project, NAEMT is supporting the ACDC project in the following ways:

- Rule development – NAEMT leaders served as subject matter experts for CMS and the Rand Corporation, the CMS contractor engaged to develop the ACDC project. We also hosted several focus groups for CMS and Rand as they worked on the cost collection tool and process.
- Feedback on the proposed rule – NAEMT provided 58 specific comments to CMS and Rand on the proposed rule. NAEMT members from urban, suburban, rural, hospital-based, public utility, private and fire-based EMS agencies participated in the development of the 13-page comment submitted to CMS.
- Assistance with cost reporting for agencies – In November 2019, CMS released the names of the ambulance agencies selected for round one of the cost reporting process. At the request of state associations and numerous ambulance providers, NAEMT's EMS Transformation Committee assembled a workgroup of experts to develop a formal educational program for agencies to help them identify the sources of data for cost collection, and step-by-step guidance on how to accurately complete the online cost data collection instrument.

SEE PAGE 6

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Industry leaders and external stakeholders involved in this project include:

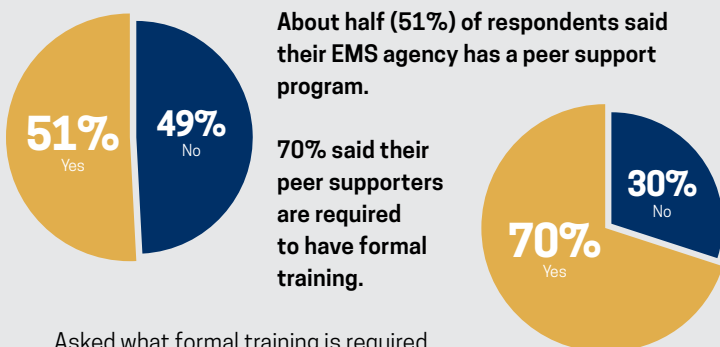
- Steve Kroll, NAEMT advocacy coordinator for New York, executive director and chief of Delmar-Bethlehem EMS and principle for United Concierge Medicine.
- Debbie Von Seggern-Johnson, NAEMT board member and a firefighter-paramedic for North Bend Fire & Rescue in Nebraska.
- Randall (Adam) Parker, NAEMT advocacy coordinator for North Dakota, and operations manager for Sanford AirMed.
- Chris Hanson, NAEMT member and innovation strategist for TMF Health Quality Institute.
- Matthew Sorrentino, manager at Public Consulting Group.
- Matt Zavadsky, NAEMT president and chief strategic integration officer for MedStar Mobile Healthcare.

We are in the midst of a very interesting time for our profession. We truly appreciate all the time, energy and effort by so many of our members to drive our initiatives forward. Input, guidance and engagement from our NAEMT membership is paramount. If you would like to become involved in any of the NAEMT initiatives, please contact us at membership@naemt.org.

Should you have any questions or comments about these programs, feel free to drop me a line at NAEMT_president@naemt.org.

Poll: EMS Agencies Are Split on Peer Support

Peer support programs are one way that EMS agencies help EMS practitioners cope with the stress of the job and support their mental well-being after traumatic calls. NAEMT conducted a brief poll to find out how common peer support programs are in EMS, and whether peer supporters are required to have formal training.*



Asked what formal training is required, responders cited training offered through the International Association of Fire Firefighters (IAFF), the International Association of Chiefs of Police, Mental Health First Aid and the International Critical Incident Stress Foundation. Some said training was developed internally or taught by local health professionals.

*Based on 181 responses.



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How Best to Deal with Unwanted Memories of Tough Calls?

By Dr. Jennifer Wild, BSc(Hons), MSc, DClinPsy



The aftermath of a traumatic experience can be a confusing thing for many of us. How can you identify signifiers of PTSD when it's normal to have some of them early on? Are you even sure that what you have been through has affected you all that much? Is there something small, or something larger lurking underneath the surface?

Dr. Jennifer Wild, associate professor of experimental psychology at the University of Oxford, lays out a few basic approaches to dealing with what may be a traumatic experience in a healthy and balanced way, and how to recognize signifiers that need further help to get you back on track.

On 7 May 2019, dispatch relayed a category 2 call, which John and his crewmate picked up. They were told a man had fallen down, wounding his head. The caller had hung up on the control desk and no more information was available. It didn't sound urgent, but John knew that the information relayed in such calls didn't always match what they found. When he and his crewmate arrived on scene, the man was in cardiac arrest.

The man reminded John of his father. He was about the same age with a similar shock of white hair. John performed CPR with members of the public shouting at him to work faster. The man died.

Sometimes you can walk away from a call, reset, and move onto the next relatively unscathed. Then there are those incidents that really get to you, and always seem to get to you. They remind you of someone or some situation in your personal life. Or you find the crippling circumstances in which some people live tough to bear. These calls may flash to mind as if out of nowhere, pulling you to the past and making you feel like the whole thing you wish had never happened is happening all over again.

Such memories are unwanted and uncontrollable, yet normal in the aftermath of the most difficult call-outs. They usually fade with time and are not something to be too concerned about although they can, of course, interrupt your focus and knock your confidence.

Having helped many paramedics recover from post-traumatic stress disorder (PTSD), the severe stress reaction that can develop after trauma such as witnessing other people die or suffer, I am often asked: "What should I do after the really tough incidents?"

The short answer is...Nothing. Try to let the memories come and go without trying hard to push them away. Research our

team has carried out found that trying to push the memories away causes them to come back more often.

Of course, it's important to follow your service's operational guidelines after critical incidents. Then remember something important: it is normal for our minds to replay tough and traumatic events until they settle. It is normal to question our actions in challenging circumstances. All of this is normal for the first several weeks after a traumatic call-out.

The majority of people after trauma adjust and stay well. People are, for the most part, resilient. It is a minority who will go on to develop longer-lasting PTSD symptoms. Of course, this doesn't mean that paramedics are safe from risk, and research we've conducted shows that paramedics are at greater risk of developing PTSD and other forms of psychological distress compared to the general population. But the good news is that there is natural recovery with PTSD symptoms, especially in the month after trauma.

This is why the U.K.'s National Institute for Health and Care Excellence (NICE) recommends "watchful waiting" after trauma: monitoring symptoms and waiting to see how things settle in the first month. It is also why the NICE guidelines for PTSD recommend no psychologically-focused debriefing to prevent or treat PTSD – it interferes with natural recovery.

What is less clear is the trajectory of PTSD amongst paramedics. Do paramedics benefit from natural recovery from PTSD at a similar rate to that of the general population or are they more susceptible to persistent and enduring PTSD due to the nature of their work?

To answer these questions, longitudinal studies are needed in which we track paramedic health over time and importantly learn much more about paramedics who stay well their entire career and paramedics who do not. We need to identify the psychological, behavioral and organizational factors that support paramedics to sustain good health, including recovery from episodes of PTSD. Similarly, we need to know much more about the factors linked to persistent PTSD and psychological distress among paramedics. Only then can we be clearer about how best to protect paramedics from developing PTSD and other forms of psychological distress, and what intervention or training is best placed to help at different stages of a paramedic's career.

Jennifer Wild is a consultant clinical psychologist and associate professor of experimental psychology at Oxford University, and clinical advisor to the Ambulance Services Charity (TASC). She is passionate about reducing suffering in people who dedicate their lives to improving public health and safety.

This article was reprinted with permission from Ambulance Today, which is based in the United Kingdom.

Celebrating Our Nation's EMS Workforce

National EMS Week 2020

There is no better time than National EMS Week to celebrate the contributions of EMS to the health and safety of our communities. No matter the time of day or night, through storms, floods and blizzards, EMTs and paramedics answer the call of duty to come to the aid of those in need – whether it's saving a life from a heart attack or stroke or showing compassion to an elderly person struggling to care for themselves.

National EMS Week 2020 will be celebrated May 17 to 23. NAEMT urges EMS agencies, hospitals and communities to honor the work of EMS practitioners, the sacrifices they make and the skill and resourcefulness it takes to provide medical care in the field.

NAEMT is proud to partner with the American College of Emergency Physicians (ACEP) on the EMS Strong campaign, which provides opportunities to recognize the EMS community, and enhance and strengthen the profession on a national level. This year's theme is "Ready Today. Preparing for Tomorrow."

"The 2020 theme reflects what individual EMS professionals and organizations do every day as they respond to calls for help at any time and in any place," said NAEMT President Matt Zavadsky. "The EMT and paramedic care of tomorrow will continue to expand into services that include community paramedicine, injury and illness prevention training and CPR and bleeding control education."

We asked NAEMT members to tell us what "Ready Today. Preparing for Tomorrow" means to them. Here's what they had to say.

"We stay ahead of the game and we don't do things just because 'that's the way we have always done it.' We ensure that we receive the latest training and that all of our equipment is ready for whatever calls may come in. We do this because the lives of our fellow citizens may depend on us."

Kevin Turley, Director, Dale EMS and Rescue Squad, Dale County, Alabama

EMS Week dedicates each weekday to a specific theme. EMS agencies and their community partners are encouraged to plan activities and events around these themes in their communities.

- M** **May 18** EMS Education Day
- T** **May 19** EMS Safety Day
- W** **May 20** EMS for Children Day
- Th** **May 21** Save-A-Life Day
(CPR & National Stop the Bleed Day)
- F** **May 22** EMS Recognition Day

"To be 'ready today,' our goal is high quality training no matter what shift you are on. For 2020, our focus is on pit crew CPR and MCI management, among other EMS topics. We are 'preparing for tomorrow' both clinically and administratively. We have developed a continuous quality improvement (CQI) committee that evaluates protocols and evolving medications and equipment that can progress our medicine to ensure we are on the forefront of evidence-based medicine. Along with the CQI Committee,

we have designated a research specialist who seeks out the newest medications, equipment, and practices available to EMS. From there the CQI Committee evaluates the research and votes on whether to adopt it or continue to monitor until more concrete studies are performed. Being 'ready for today and preparing for tomorrow' go hand in hand. When one of our community members or visitors calls 911 for help, it is expected that we are prepared to professionally handle any and all emergencies that we get called to."

Matt Concialdi, EMS Division Chief,
Platteville-Gilcrest Fire Protection District,
Platteville, Colorado

"Being 'ready today' is ensuring we as EMS professionals are ready for whatever challenges we may face during the course of our day. Preparing for tomorrow is to look well beyond the work we are doing today, inspire others to look outside their 'silos' and remain open to new concepts that will ultimately improve best practices and patient outcomes."

Debbie Von Seggern-Johnson, NAEMT
Director, Region III and Firefighter-Paramedic,
North Bend Fire & Rescue, Nebraska

"As the regulatory agency for the state of Louisiana, the Bureau of EMS strives to ensure that EMS practitioners and agencies have the resources they need to serve our citizens. We never know what tomorrow may bring, so we maintain valuable relationships with other state agencies, EMS practitioners and EMS agencies to make certain that we provide a cohesive system of care for whatever tomorrow brings."

Susan Fisher Bailey, NAEMT Director, Region II and Director, Louisiana Department of Health, Bureau of EMS

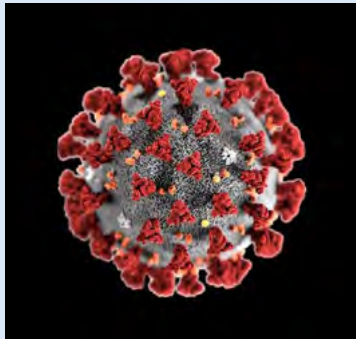


Advocacy Update

NAEMT is continuing to advocate for bills that will help support our nation's EMS agencies in fulfilling their mission to take care of members of the community when they are sick or injured, and to protect the health and safety of the EMS workforce.

2021 SIREN Funding

We succeeded in securing \$5 million in funding for the SIREN Act in 2020. NAEMT is now working with the Health Resources and Services Administration (HRSA) on implementation of the grant program for rural EMS agencies. The grants will support public and nonprofit rural agencies in training and recruiting staff, providing education to satisfy certification requirements, and purchasing critical supplies and equipment, such as naloxone, first aid kits, power stretchers and new ambulances. We are currently



COVID-19 Resources

NAEMT's website has the latest information and resources from federal and EMS agencies to help keep our workforce and patients safe during the novel coronavirus (COVID-19) pandemic. Under the "Initiatives" tab at naemt.org, select "COVID-19". We will continue to update the site as new information becomes available.



working to build congressional support for SIREN appropriations for 2021.

S. 2700/H.R. 4871, Protecting Roadside First Responders Act

In November 2019, the Protecting Roadside First Responders Act was introduced by Sen. Dick Durbin (D-IL) and Rep. Cheri Bustos (D-IL). The legislation requires all vehicles to have crash avoidance technology, and provides funds to states to support enforcement efforts of Move Over laws. Move Over laws require drivers to slow down or move over a lane when passing vehicles displaying emergency or warning lights. All 50 states have Move Over laws.

In related news, Department of Transportation (DOT) Secretary Elaine Chao recently announced a new initiative to help prevent accidents involving first responders. The initiative will provide up to \$38 million to equip emergency response vehicles, transit vehicles, traffic signals and highway-rail-grade crossings with V2X communication technology. (Highway-rail-grade crossings are intersections where train tracks and the road cross at the same level). These systems will use the 5.9 Gigahertz Safety Band of spectrum currently allocated by the FCC for use in transportation systems. V2X stands for "vehicle-to-everything." V2X technology allows cars to "talk" to other cars and to roadway infrastructure, such as traffic lights, to avoid crashes.

S. 851, Workplace Violence Prevention in Health Care and Social Service Workers Act

In November 2019, the House passed H.R. 1309, the Workplace Violence

Prevention in Health Care and Social Service Workers Act. The bill is intended to curb the epidemic of violence against healthcare and social service workers, including EMS practitioners.

The Senate version of the bill was introduced by Rep. Joe Courtney (D-CT) and Sen. Tammy Baldwin (D-WI) as S. 851. The bill directs the U.S. Occupational Safety and Health Administration (OSHA) to create a national standard mandating that employers develop and implement a comprehensive workplace violence prevention plan. In 2020, NAEMT is focusing on securing support for the bill in the Senate.

S. 1479/H.R. 2760, the Next Generation 911 Act of 2019

Introduced by Sen. Amy Klobuchar (D-MN) and Rep. Anna Eshoo (D-IL), the Next Generation 9-1-1 Act accelerates federal efforts to modernize the nation's aging emergency systems. The bill authorizes \$12 billion in federal funding to help state and local governments deploy upgraded 911 systems across the country. The funds will help move the country's legacy 911 call centers into the digital age, enabling them to handle text messages, pictures, videos, and other information sent by smartphones, tablets, and other devices. The legislation also provides technical assistance and training, while ensuring 911 is kept under state and local control.

This bill was included in an \$85 billion package of infrastructure priorities known as the Leading Infrastructure for Tomorrow's America Act. However, this package was not voted on in 2019 and now awaits action in 2020.

The following is an excerpt from NAEMT's *Guide to Building an Effective EMS Wellness and Resilience Program*. NAEMT published the guide in 2019 to assist EMS agencies in helping EMS personnel maintain their physical, mental and emotional health. The guide presents strategies for building resilience, suggestions for specific programs and initiatives, tips from EMS agencies on what works for them, and ideas for engaging community partners and stakeholders.

→ **Download this free guide at:** naemt.org. Go to the "Publications" section and choose the "Health and Safety" link.

Building an Effective EMS Wellness and Resilience Program

Engaging the Community



Employers certainly benefit from employees who have the support and resources they need to maintain their health and well-being, despite challenging, stressful jobs. But a perennial barrier for EMS agencies in establishing programs to support the health and wellness of EMS practitioners is a lack of funds.

For help with developing a wellness and resilience program, EMS agencies should engage their community for assistance. This can include seeing what might be available through their existing relationships, such as with their insurance company that provides employee healthcare benefits. EMS leaders can also work toward creating new partnerships, such as with wellness vendors, local healthcare providers and community groups to provide resources to employees at little to no cost.

When you contact potential community partners for your health and wellness initiative, remind them that EMS practitioners are trained professionals that the community relies on to respond to serious medical emergencies. Certain professionals, such as fitness trainers, nutritionists and counselors, may be more willing to participate if they know they may receive referrals as a result.

Here are some ideas for who to engage when building your program.

Health insurer – See what your health insurance provider has to offer as far as smoking cessation, weight loss or other health and wellness services.

Fitness centers – Reach out to local fitness centers, YMCAs or rec centers for discounted memberships for employees.

Trainers and instructors – Personal trainers and yoga instructors may be willing to offer free or discounted sessions to EMS practitioners.

Healthcare providers – Contact chiropractors and physical therapists to ask if they would offer discounted sessions for your personnel.

Mental health professionals – Identify counselors, therapists, psychologists or psychiatrists you can refer personnel to. Some in EMS believe it's beneficial if mental health professionals have experience in EMS, fire or law enforcement. EMS practitioners may be more willing to open up to those who understand the nature of their job, and may get more out of their sessions if they don't need to explain the unique challenges of working in EMS.

Others feel that EMS or public safety experience as a mental health professional isn't necessary. Experienced,

credentialed counselors and therapists should be able to look at the whole person, taking into account past traumas experienced outside of work, mental health disorders that may have predated the employee's EMS career, relationship dynamics, financial stressors and other factors, and help the individual work through issues and develop tools to cope.

EMS agencies can help by vetting mental health professionals prior to recommending them to their personnel to ensure a sound referral. Word-of-mouth recommendations, online reviews and calling therapists in advance to get a sense of their approach and interest in treating EMS professionals can help in making these determinations. Mental health professionals may be willing to discount fees if you let them know that you're developing a list of select providers to refer your personnel to.

Financial advisors – Financial advisors may also be willing to provide a consultation free of charge, or serve as a resource for people with financial questions and concerns.

Colleges and universities – Ask a local college or university if they want to partner with you to design, collect data and measure the results of a wellness initiative.

NAEMT Urges Congress To Prohibit Bigger, Heavier Trucks

Legislation allowing increases in the size or weight of trucks poses serious safety risks to motorists and EMS practitioners and should not be allowed, according to an NAEMT letter to House and Senate committees.

The NAEMT letter urged the House Transportation and Infrastructure Committee and the Senate Commerce, Science and Transportation Committee to oppose trucking industry efforts to increase the permitted size and weight of trucks on U.S. highways.

Bigger trucks are harder to control and take longer to stop, especially in inclement weather, putting the lives of first responders at risk as they treat crash victims on the roadside. "Increasing the size and weight of trucks only makes this inherently dangerous situation worse," the NAEMT letter states.

Some trucking and shipping industry groups have proposed a 15-year pilot program to lift weight limit restrictions on trucks carrying goods on interstate highways, although support in the trucking industry is mixed, with the Owner-Operator Independent Drivers Association opposing it.



Surprise Billing Bans Should Not Apply to Ground Ambulance Agencies

NAEMT joined with national EMS and fire organizations to ask leaders of a key House committee to exclude ground ambulance services from the Ban Surprise Billing Act.

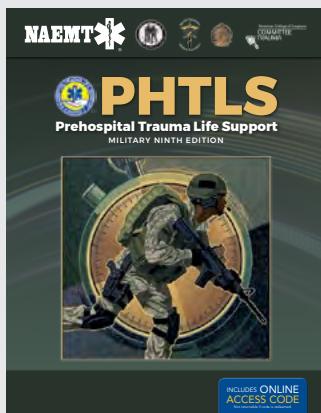
The Ban Surprise Billing Act (H.R. 5800) is intended to prevent doctors, hospitals and air ambulance companies from sending unexpected bills to patients when they are treated in a hospital that accepts their insurance. Surprise bills often occur when a patient goes to a hospital covered by their insurance, but is treated by an out-of-network doctor. The bills can be thousands of dollars.

The Ban Surprise Billing Act includes a provision to create a federal advisory committee to recommend restrictions on balance billing by ground ambulance services.

NAEMT joined with the Academy of International Mobile Healthcare Integration (AIMHI), American Ambulance Association (AAA), International Association of Fire Fighters (IAFF), International Association of Fire Chiefs (IAFC), and National Volunteer Fire Council on the letter to the House Committee on Education and Labor.

The letter expresses concern that the advisory committee could shift oversight of ground ambulance transportation from local governments to the federal government. The letter also notes that cost collection for ground ambulance providers has just started, so it will be several years before an advisory committee will have accurate information about the full costs of providing ambulance services compared to billing revenue.

There are several other similar proposals to limit surprise medical billing pending in Congressional committees. The Ban Surprise Billing Act is the only bill to include a provision for ground ambulances. The Consumer Protections Against Surprise Medical Bills Act (H.R. 5826), for example, does not mention ground ambulance services.



9th Edition PHTLS Military Textbook Now Available

The 9th edition of the PHTLS Military textbook is now available through the Public Safety Group of Jones & Bartlett Learning. The military version of the globally recognized 9th edition PHTLS textbook contains 13 chapters written by members of the Committee on Tactical Combat Casualty Care (CoTCCC) and leading subject matter experts. The textbook presents the latest research, best practices and lessons on treating traumatic injuries in all environments – from the battlefield to the streets. All TCCC faculty are strongly encouraged to use the 9th edition PHTLS Military version to support their TCCC courses.

NAEMT's EMS PAC Turns Two

By Bruce Evans, NAEMT President-Elect



The Good Samaritan Health Professionals Act, the SIREN Act and the Protecting Patient Access to Emergency Medications Act are just a few examples of the EMS-related laws passed in the past few years. Support by Congress for such legislation didn't happen by accident or happenstance. Support was built by the concerted efforts of EMS practitioners who advocated for our profession during events such as EMS On The Hill Day, and by emailing or phoning their members of Congress as part of NAEMT-led advocacy actions.

In addition to grassroots advocacy by EMS practitioners, NAEMT also employs paid professional lobbyists to engage and persuade members of Congress to enact legislation beneficial to EMS and our patients.

As much as we would like to think that the decisions made by elected official are fully altruistic, we know the reality is that campaign contributions are an important part of what makes Washington, D.C., function. Campaign contributions allow members of Congress to pay for staff and advertising when they run for office, which members of the House have to do every two years. While campaign contributions do not guarantee support for a bill, those who donate may find that

their legislation or their issue receives more attention from elected officials. Often, campaign contributions come from organizations known as political action committees (PACs).

PACs in EMS

In 2018, the NAEMT EMS PAC was launched to collect voluntary contributions from members, and use that money to support politicians who support EMS causes. Corporations, trade associations, labor unions and other business and professional groups, such as the American Medical Association, all have PACs.

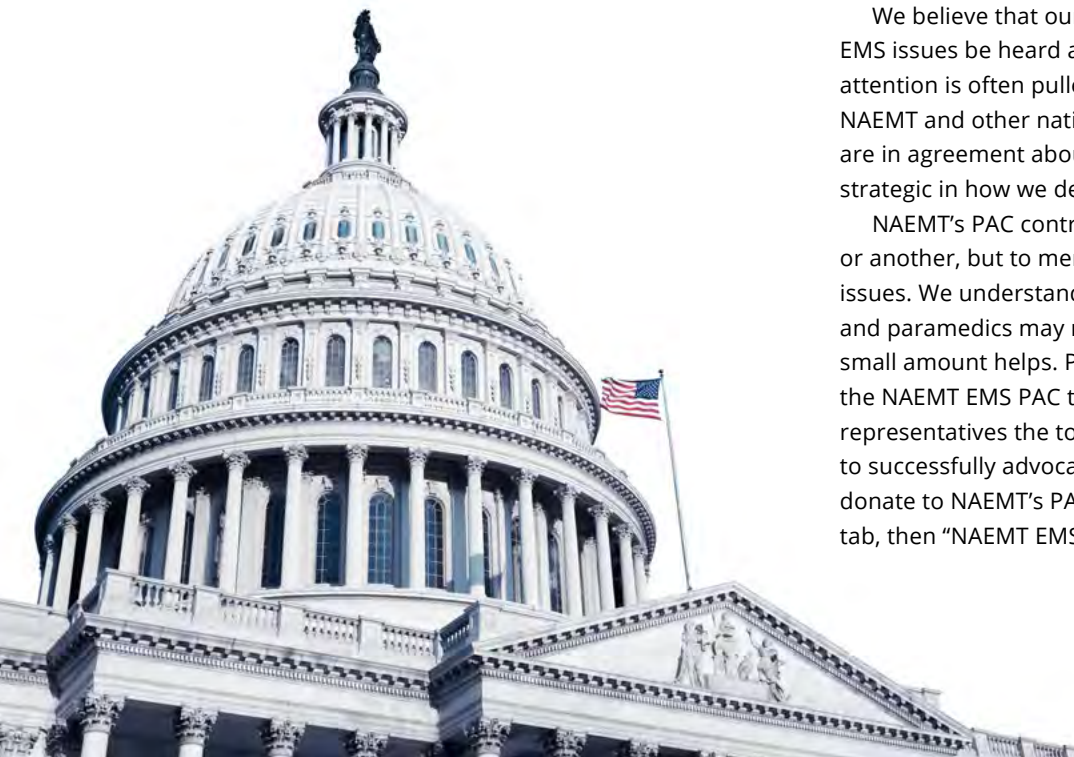
There are rules about how PAC contributions can be collected, and from whom. For corporations, employees typically fund the PAC. For unions or professional associations such as NAEMT, members and their families provide support. The amount a PAC can contribute to a candidate for each election is capped at \$5,000.

Since its launch, the NAEMT EMS PAC has raised over \$35,000. The NAEMT EMS PAC and Advocacy committees are working to determine which members of Congress will receive contributions during this and future election cycles.

Among fire and emergency medicine organizations, NAEMT was actually late to the PAC party. The American Ambulance Association (AAA) and the International Association of Fire Fighters (IAFF) have long-established PACs. Like NAEMT, the National Association of EMS Physicians (NAEMSP) launched their PAC more recently.

We believe that our PAC is an important step in helping EMS issues be heard and considered by busy legislators whose attention is often pulled in many different directions. Often, NAEMT and other national EMS, physician and fire organizations are in agreement about legislation, which will allow us to be strategic in how we deploy our PAC resources.

NAEMT's PAC contributions will not be targeted to one party or another, but to members of Congress who champion EMS issues. We understand the reality that the salaries of EMTs and paramedics may make it difficult to contribute, but any small amount helps. Please consider making a donation to the NAEMT EMS PAC to help give NAEMT's government affairs representatives the tools they need to get our voice heard, and to successfully advocate for our patients and our profession. To donate to NAEMT's PAC, go to naemt.org. Select the "Advocacy" tab, then "NAEMT EMS PAC."



Nominate Your Best for the **National EMS Awards of Excellence**

The National EMS Awards of Excellence nominations are open. The awards recognize EMS professionals who demonstrate the best in EMS and serve as a role model for their colleagues. Award categories include:

- Paramedic of the Year
- EMT of the Year
- EMS Medical Director of the Year
- EMS Educator of the Year
- Military Medic of the Year
- Career EMS Service of the Year
- Volunteer EMS Service of the Year



Winners receive \$1,000 in cash, as well as other prizes.

Nomination deadline: May 31. Submit a nomination at naemt.org. Under "Initiatives," select "National EMS Awards" and then the award category.

Recert Online Courses Can Be Used to Fulfill All NREMT Recertification Requirements

In response to the COVID-19 pandemic, the National Registry of EMTs (NREMT) has

extended the March recertification deadline to June 30, and is also allowing online courses to fulfill all recertification requirements.



Recert (Recert.com) offers over 200 high-quality online EMS, fire and rescue refresher courses on timely topics such as infectious disease, at-risk populations, and EMS provider hygiene, safety and vaccinations.

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Israel learned emergency crews will not get there in time to treat the majority of patients. There may be somebody who freezes up and doesn't move, or who looks dead but is not quite dead and so people left them. But it is single digit percentages of people who are still at the scene when EMS arrives, and who are still alive so you can do anything to try to save them. Nearly all of the action is at the nearest hospital – not a trauma center, and not the place best equipped to help them. Whichever hospital happens to be the closest. After my time in Israel, I knew I wanted to go to medical school and become an ER doctor.

What do EMS practitioners need to learn about pharmacology?

Pharmacology is the study of interactions between a medication and the human body. As an EMT or first responder, you learn practically nothing about pharmacology. When we get to paramedic school, we learn more. But what we don't really learn is the 10,000-foot view – what are the different classes of medications, why do we use them, what are our expectations when using one, and what are the effects, wanted and unwanted.

Opioids are a perfect example. We want to alleviate the person's pain, but there are other effects, including depressing respiration and lowering blood pressure. Those are consequences we have to know about.

Typically, as field providers, we receive a cache of drugs. You are taught about those specific drugs and when to give them. But what happens if you don't have one of those drugs because there is a shortage? How can providers make decisions about what to give when the situation requires critical thinking?

For example, let's say you have a patient who has broken their leg versus one who has a huge, penetrating exsanguinating injury and their blood pressure is low. You have to be able to use critical thinking – what is unique about this patient's physiology and pathology? The drug I'm about to give for pain has some good effects and some bad. Is one of those bad effects something I need to worry about?

Let's say you have morphine, fentanyl and ketamine. Which one would you give to a patient who is elderly, hypotensive, has an unstable pelvis after a fall and is in a lot of pain, vs. somebody who is young, healthy, with a pinned limb who needs to be extricated?



I may give ketamine to somebody who is young, healthy and needs pain management during a prolonged extraction. You may have difficulty getting to them. Fentanyl is short-acting and you may need to multi-dose the patient and monitor their respiratory drive or give supplemental oxygen, which may not be possible. Ketamine would manage their pain and be a hemodynamically stable drug that does not affect the respiratory drive. Ketamine lasts longer and the dissociative affects of ketamine may be a good thing if you have to do an amputation.

But for an elderly patient who is hypotensive with a broken pelvis, we want to use a pain medicine that will not lower blood pressure. Morphine and hydromorphone (Dilaudid) are not the preferred options. Could I use ketamine? I could, but ketamine has unpredictable side effects in elderly patients. Sometimes it works fabulous, but occasionally patients become unresponsive even with a small dose. So we need to be very, very cautious and use critical thinking to assess which drugs are best in a given situation.

What steps can EMS practitioners take to avoid medication errors?

Dosing errors are the most common errors made on patients outside and inside the hospital. To reduce these errors, we need good, systematic communication, and methods of organizing our system. Hospitals have set up extremely elaborate programs to make sure you are giving the right dose, and the right medication, to the right person. In the field, we don't necessarily have those systems in place yet.

In Colorado Springs, we've taken some steps to mitigate that, such as standardized doses. We have also gone to volume-based dosing for pediatrics so you don't have to do the math. Math is not most people's strong point, especially not at 3 a.m. when you're exhausted. We also ask everybody at our agency to tell us when there is a medication error. This is a non-punitive process. We want to understand how we set you up for that failure and change our system so it doesn't happen again.

There's a lot of concern about opioid addiction and the overuse of opioids. In the EMS setting, is there a greater risk of EMS overtreating pain or undertreating pain?

We have gone from potentially overtreating pain, to now potentially undertreating pain because of concerns about opioids. Today we have a greater recognition of the potentially harmful side effects of the acute use of opioids, as well as the addictive properties. One positive change coming out of this is that we have started to think about other possibilities for pain management, such as acetaminophen (oral and intravenous), NSAIDs (nonsteroidal anti-inflammatory drug) and ketamine.

We also need to consider the hazards of opioid medication diversion. Traditionally there isn't a great chain of custody for controlled substances in the EMS system. It behooves everybody to ensure they have systems to track these medications so we can reduce diversion, and if diverted, have a better chance of figuring out how it was diverted. Access to controlled substances is a risk factor for addiction.

How can bias impact pain management decisions?

Bias can be on opposite ends of a spectrum. Some providers may say, 'I believe it's our priority to make sure that every person who is experiencing pain is completely out of pain.' Or you can have the opposite bias where you'd say, 'I understand this person is in a lot of pain, but pain isn't going to kill you. No way am I going to give an opiate medication. They can get opioids at the hospital.'

Cultural biases based on gender, socioeconomics, and race are also well-documented in the prehospital administration of pain medication. Medics may be less likely to offer pain relief to a homeless person, or somebody they believe meets the picture of a drug-seeking person.

I don't claim to have all the answers. But overcoming bias requires taking a really hard look at your personal beliefs and recognizing bias. Although most people don't self-reflect on this topic – they see their beliefs as facts and they don't see another way of looking at it.

Are there pain management medications that you think are underused in the prehospital setting?

I think there are several medications that are underused. As a culture in medicine, we think of opiates as the answer to pain management in emergency situations. Almost all other medications and all other classes of medications are systematically and historically ignored as a possibility for treatment.

We need to do everything we can to broaden that view and determine when it is appropriate to use opiates and when it's appropriate to use other types of medications. Often in the prehospital environment, if a patient is deemed to be in tremendous pain they get an opiate, and if they're not in that much pain, they don't get anything. But we can do better.

Say somebody has severe strep laryngitis (strep throat). We don't think of that as a life-threatening emergency, but it can cause a lot of pain. It's hard to swallow, so they don't want to put anything in their mouth and they can become dehydrated. Does this kid or adult deserve pain management in the prehospital environment? Yes they do. We could use topical medications, such as topical or nebulized lidocaine, which would provide tremendous relief. Tylenol or an NSAID would also help.

Even for bone fractures, not everybody needs an opiate, especially kids who respond very, very well to acetaminophen and NSAIDs. Adults do too, although they are more mentally inclined to think over-the-counter medication isn't going to help, whereas kids haven't formed those beliefs yet.

Studies show that anaphylaxis (a severe allergic reaction) is under-recognized and potentially undertreated in the prehospital setting. What does EMS need to recognize about anaphylaxis and the use of epinephrine to treat it?

The emphasis on recognizing anaphylaxis has traditionally centered around airway issues – if your throat is closing up, you can't swallow and you're having a hard time breathing, you're

having a bad allergic reaction and we want the provider to use epinephrine.

Anaphylaxis is a systemic process that can manifest in different ways – and not always with throat swelling. If you're thinking only about the respiratory system, you may be missing other systemic effects, such as a full body rash or hives. GI issues are common – people who ingest an allergen may have nausea, vomiting or abdominal cramping. Wheezing may make EMS practitioners think more about albuterol than epinephrine, but wheezing may be part of an anaphylactic reaction.

Hives, GI issues, wheezing, hypotension – these kinds of symptoms should trigger using more aggressive treatments, including epinephrine, as well as histamine-blockers such as diphenhydramine (Benadryl) and famotidine (Pepcid).

From an educational standpoint, we need to do a better job explaining what is happening in the body during anaphylaxis, so EMS practitioners are not just focused on the airway.

Some of this also involves changing the culture at EMS agencies. EMS practitioners are often taught to only give epinephrine when you are sure somebody is in anaphylaxis. If the symptoms aren't exactly what they were taught, they are afraid if they give epinephrine they will get into trouble. That environment impedes people from using their brains to work through a situation. In our system in Colorado, we promote the idea that if you think it's the right thing to do, even though it doesn't check all the little boxes, you write down your reasoning and the thought process you went through. Even if you're wrong, you're not in trouble. Guess what? Doctors get it wrong at times too. We want you to think critically. Sometimes you will be wrong, but a lot of times you will be right.



Welcome New NAEMT Agency Members!

- Bryan County EMS, Durant, OK
- Cavalier County Memorial Hospital and Clinics, Langdon, ND
- Moundsville Fire Department, Moundsville, WV
- Plymouth Community Ambulance Association, Plymouth Meeting, PA
- Survival Team EMS, Riyadh, Saudi Arabia

Research among nurses has found that physical and verbal assaults happen often in hospitals, yet those incidents often go unreported. *The NAEMT National Survey on Violence Against EMS Practitioners*, published in October 2019, asked EMS practitioners whether they report verbal or physical assaults, why some incidents aren't reported, and gauged awareness about reporting systems.

→ The following is an excerpt. Download the report at naemt.org. Go to “Publications,” then the “Health and Safety” link.

Reasons Why Violent Incidents Are Not Reported



Research has shown that violence against healthcare workers is “an underreported, ubiquitous and persistent problem that has been tolerated and largely ignored.”¹

In the survey results, the majority of EMS practitioners (84%) said they report any act of violence to their EMS agency. (Only 16% said they don't report all acts of violence.)

- 52% had reported an act of violence against themselves, another EMS practitioner or been included in a colleague's report.
- 43% had not.

Women were somewhat less likely than men to report violence to their agency (46% of women had reported a violent incident compared to 54% of men).

Paramedics were more likely to have reported an act of violence than EMTs (60% compared to 36%). This could be because frequently, paramedics have more years on the job than EMTs and are more likely to have encountered violent patients.

When asked why some acts of violence are not reported, 313 respondents provided a variety of answers that can be grouped into several themes:

Some incidents of violence are relatively minor and are not worth the paperwork and time it takes to report them.

“I'd kill a small forest if I reported every incidence of violence. I just report when an injury occurs.”

“If you reported every patient who was a bit aggressive you'd be doing nothing but filling out reports.”

“System is too busy to take a truck out of service to file a report.”

“Verbal violence happens with almost every [chronic inebriate] or psych patient. And physical violence happens

with about every one in five psych calls. Too much to report.”

“There are too many to report. I've been grabbed and kicked, but not injured. If I reported it every time, I would be reporting it all day.”

Verbal abuse is commonplace and not seen as consequential enough to report.

“Verbal does not bother me and the occasional arm swinging is OK.”

“Because ‘verbal assault’ is not something I will ever report. Who cares? People talked mean to me. Whahhhh!”

“Verbal abuse happens daily. Bosses have enough to worry about without me taking issue with someone verbally abusing me.”

Violence is expected and accepted as part of the job.

“Violence can be expected from sick, disoriented patients.”

“Some of the smaller things like the verbal abuse and people attempting to hit you are just a part of the job. If we were to report every time an elderly patient hit you or a psych patient hit you, the paperwork would be endless.”



"We must accept there is an inherent risk involved with our career."

EMS practitioners are reluctant to report unintentional abuse from patients with dementia or patients who have disorders in which they are not fully aware of what they're doing. They differentiate between patients who are disoriented or confused vs. those who have intent to harm.

"Most acts of verbal assault against me are committed by patients with dementia or psychiatric illnesses and are so routine and minor that reporting them is more bother than just accepting them."

"Not everything classified as violence would I consider an intentional act against my partner and me."

"Most are minor, and hurt people defend themselves sometimes."

"If the violence was unintentional – altered mental status due to hypoglycemia – and no harm or insignificant harm is inflicted, I likely will not report."

EMS practitioners believe that even if they report violence, little will be done.

"Within the past month I had a patient who was in law enforcement custody and altered due to intoxication. He clearly said he was going to kill me, told my partner he was going to kill her, and told the officer who rode in with us to the hospital that he was going to kill him. Did the officer charge him for it? No."

"The first time I was physically assaulted I had a patient's son shove me into a corner by connecting his forearm to my

What Happens Next? After a Violence Report

About 90% of respondents said that when they reported a violent incident, it was reported to agency management. According to the survey results, not all of those incidents were reported to police – about 74% said the incident was reported to law enforcement. Fewer still resulted in charges or other legal action – 45% said charges were filed or legal action was taken.

throat in the presence of an officer. The patient's son was angry I 'wasn't helping' his mother even though I was trying to talk her down from a panic attack. He intervened before assaulting me and attempted to put a spoon in her mouth (I found out after he thought she was going to 'swallow her tongue'). I put my hand on his shoulder and said 'hold on' when he tried to put the spoon in her mouth, so the officer refused to press charges since I touched him first. Go figure."

"There will be no repercussion to the assailant so it's truly a waste of time."

Reporting violence may be perceived as weakness.

"There is to some degree a stigma to reporting it. There is no formal platform to easily report it, no standardized definitions."

"You will be viewed as a wuss."

"An altered mental status patient at times is not aware of their actions and under normal circumstances would not act in such a manner. Oftentimes the stigma associated with allowing yourself to be assaulted can be difficult for some and they do not want that spreading."

"Embarrassment about being on the receiving end of the acts. Possible criticism/ridicule from peers."

Fear of repercussion from the EMS employer.

"The administration of my primary agency may choose to take disciplinary action against a crew who reports an incident."

"Excessive documentation and medical evaluations designed to shift blame onto myself and away from employer or the patient."

"Default assumption is that providers are at fault until proven otherwise."

"In the past violence against EMS personnel has been ignored. When personnel have reported violence against them, the organization has attempted to discredit our employees."

Awareness of Violent Incident Report Systems Lagging

There are various industry efforts to collect data on violence through voluntary reporting. But knowledge of those reporting tools is limited.

- ✓ 18% of respondents have heard of the EMS Voluntary Event Notification Tool (E.V.E.N.T.) which collects anonymous information on near-misses, patient safety events and violent incidents.
- ✓ 21% had heard of the National Fire Fighting Near Miss Reporting System, managed by the International Association of Fire Chiefs (IAFC).
- ✓ 9% were aware of Patient Safety Evaluation Systems, which can be implemented by EMS agencies, hospitals or other providers to track patient safety events, near-misses or reports of unsafe conditions.
- ✓ 65% hadn't heard of any of these reporting systems.

1. "Workplace Violence against Health Care Workers in the United States." *New England Journal of Medicine*, vol. 375, no. 7, 2016, doi:10.1056/nejmc1606816.



NAEMT Establishes New EMS Corporate Engagement Council

goal is to provide companies with the feedback they need to develop medical devices, technology, vehicles and services that best meet EMS needs.

This new EMS Corporate Engagement Council is the first of its kind for the EMS industry. "NAEMT is the nation's largest and most diverse EMS association, with members from all delivery models across the United States and internationally," said NAEMT President Matt Zavadsky. "The EMS Corporate Engagement Council provides a venue for EMS professionals to share information with the companies creating the products and services that EMS agencies and field practitioners rely on. The council will help them better understand what we need and anticipate

where our profession is going in the future."

Topics will include updates on federal and state legislation and regulation, new and developing equipment mandates and standards, trends in product utilization, developments in training and accreditation, and the impact of reimbursement changes on purchasing.

Corporations that participate in the EMS Engagement Council will be invited to two summit events in Washington, D.C., that will feature industry decision-makers, key legislators and representatives of federal agencies. Other engagement opportunities may include private webinars, workshops and focus groups.

To strengthen industry collaboration, NAEMT has established a new EMS Corporate Engagement Council. This new initiative connects companies that provide EMS technology, equipment, supplies and other services with the EMS agencies that provide patient care.

The engagement council will provide a forum for corporations and EMS agency leaders to discuss issues facing the profession, share ideas and receive insights on actual field experiences. The

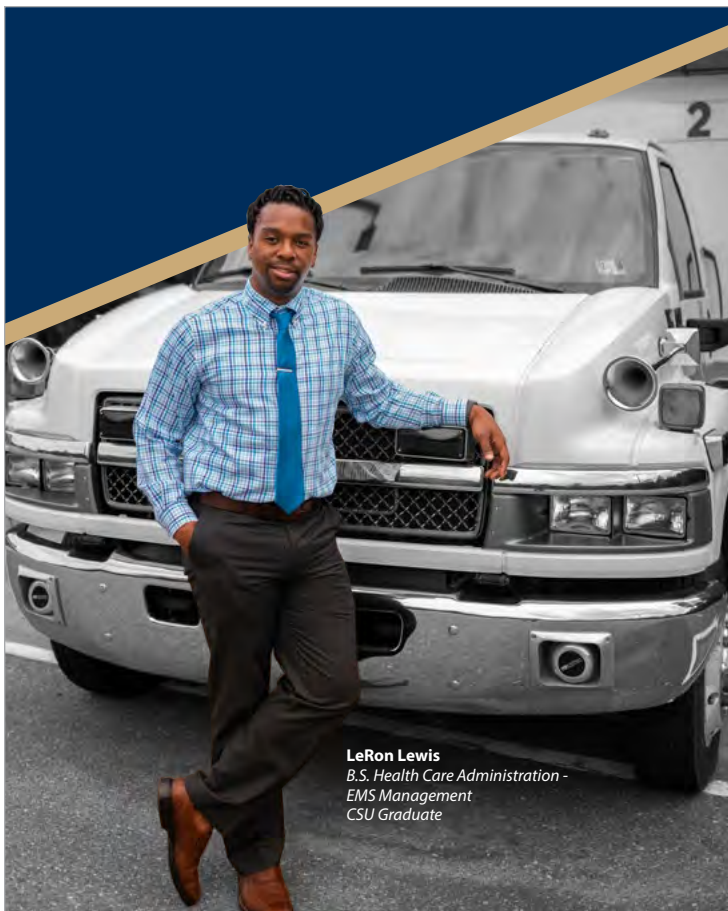
Discounts *for* NAEMT Members

As a proud Learning Partner with the National Association of Emergency Medical Technicians, Columbia Southern University is proud to offer tuition discounts and exclusive scholarships to its members. Through the partnership, NAEMT members save 15% on their tuition and are eligible to apply to CSU's annual NAEMT Scholarship.



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LeRon Lewis
B.S. Health Care Administration -
EMS Management
CSU Graduate

Butler County EMS Receives First Safety in EMS Award

The National EMS Safety Council awarded Butler County EMS in El Dorado, Kansas, with the 2020 National Safety in EMS Award. This new award, sponsored by REV Group, recognizes an organization that is a leader in advancing EMS practitioner and patient safety.

Safety measures implemented by Butler County EMS include:

- ✓ Highly visible, bright green and black uniforms with reflective stripes for crew safety.
- ✓ Enhanced ambulance exterior design and reflective graphics to improve the visibility of emergency vehicles.
- ✓ Reconfigured ambulance patient compartments, to enable crew to stay seated and buckled while reaching for equipment and treating patients in transport. Bench seats were removed and replaced by a forward and a rear-facing single seat with three-point harnesses.
- ✓ Child-sized restraints in ambulances to safely transport younger patients.
- ✓ Strict speed-limit policies and governors (speed restriction devices) on all ambulances that limit top speeds to 82 mph.
- ✓ Training in proper patient lift techniques to avoid crew lift injuries.



- ✓ Incentives for reporting near miss incidents, and a non-punitive approach to correcting hazards that could lead to future incidents.
- ✓ Stretching and other exercises at the beginning of each shift to warm up muscles and prevent injury.
- ✓ Peer support services to provide emotional support after difficult calls.
- ✓ Car seat safety checks and a fall prevention program for seniors to support community health and safety.

The National EMS Safety Council is made up of representatives from 14 national EMS, emergency physician and safety associations, including NAEMT. Butler County EMS received a \$1,000 cash prize, a travel stipend and free registration for one representative to attend EMS Today in Tampa, Florida.



Thank you to NAEMT Membership Committee Members Chris Way and Eric Van Dusen and NAEMT South Dakota Education Coordinator Travis Spier for representing NAEMT at the South Dakota EMS Conference.

And thank you to Utah Membership Coordinator Christian Neilsen for sharing information about NAEMT – and chocolate – at the Summit Conference Provo.



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EMS Education Around the World

NAEMT Education continues to expand to more countries around the world. NAEMT courses are offered in 76 nations, from Afghanistan to Uruguay! In 2019, NAEMT approved training centers in seven countries – Bahrain, Latvia, Bulgaria, Malaysia, Mongolia, Kazakhstan – while El Salvador joined the NAEMT family in 2020.



The first Emergency Vehicle Operator Safety (EVOS) course for women was held in Abu Dhabi, UAE. Female EMTs are a small but rapidly growing part of the EMS workforce in the Persian Gulf nation. NAEMT Affiliate Faculty Ken Dalessandro traveled to UAE to teach the course, offered by National Ambulance.

The first All Hazards Disaster Response (AHDR) course was also held in Abu Dhabi.



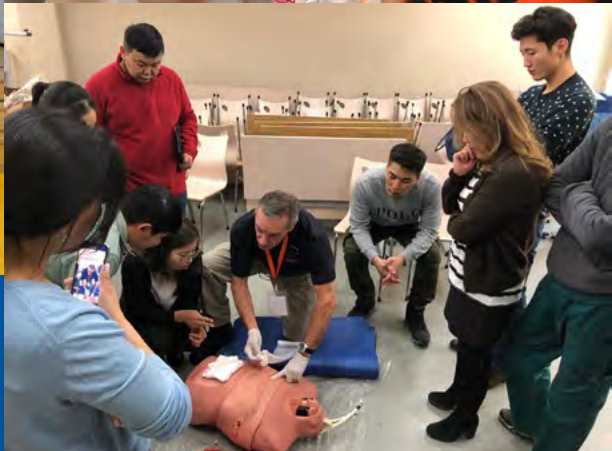
EMS practitioners in Malaysia can now take Advanced Medical Life Support (AMLS). Enoch Chan, NAEMT affiliate faculty, taught the course.



Congratulations to the first graduates of PHTLS at Bahrain's King Hamad University Hospital.



NAEMT Affiliate Faculty Jessie Castillo worked with the Mongolian Society of Emergency Medicine to bring Prehospital Trauma Life Support (PHTLS) to this East Asian country.



Fast Care El Salvador recently launched PHTLS and AMLS with guidance from NAEMT Affiliate Faculty Elkin Fuentes.



PHTLS launched in Kazakhstan! The Kazakhstan Deputy Health Minister issued a mandate for PHTLS training across the country. In Kazakhstan, ambulances are staffed by physician-medic teams. Because Kazakhstan is 1,820 miles wide and ambulance transports can be hundreds of miles, ambulances are equipped with cameras that can reach an EMS coordinating center en route. The coordinating center can quickly arrange for specialists who can advise on care, said NAEMT Affiliate Faculty Michael Kaduce.

MEMBER SPOTLIGHT Mark Kennedy

After working inside hospitals as a lab tech, X-ray tech and cardiovascular diagnostics tech for 30 years, Mark Kennedy decided he wanted to make a career change. "I was always watching EMTs and paramedics come in to the hospital, and I wanted to get out of the building and be a part of that," said Kennedy, who also served four years in the Marines.

Today Kennedy works as a firefighter-paramedic for the Nauvoo Fire Protection District in Nauvoo, Illinois, an EMS instructor at a community college and provides 911 response and critical care transports for Henry County EMS in Mt. Pleasant, Iowa.

Along the way, he brought seven members of his family into the EMS fold. Kennedy's wife, Mavis, is a firefighter-EMT at Nauvoo Fire Protection District, as is his identical twin brother, Matthew Kennedy. Matthew's sons Jacob, John and Aaron, as well as daughter-in-law Eilidh, are also firefighter-EMTs or first responders, while Matthew's wife, Dena, is administrative executive for the Professional Emergency Responders Society of Illinois.

Mark spoke with NAEMT News about what he wished hospital staff knew about EMS, what it's like having an identical twin brother, and how EMS became a family affair.



You worked in hospitals before becoming an EMT. How was the transition?

I had a lot of experience in health care – I've worked at a Level 1 trauma center in Phoenix, taught anatomy and physiology at a community college, and worked in a clinic giving immunizations to babies. So I thought it was going to be easy.

It turned out to be quite difficult. That caught me by surprise. At first, I was nervous and struggling. Prehospital assessment of patients is not the same as in-hospital assessment. In a hospital you have the luxury of an X-ray, blood work and all kinds of diagnostic tests. In the field, you have to rely more on your senses, on listening, observing, and making some leaps of faith. Prehospital assessment was a new language with new medical concepts that I had to learn.

Instead of ordering a test, you look at the home environment, and you listen to the patient. You have to consider things like where did I find them? What position were they sitting in? Is there food in their refrigerator? How are they behaving?

You have to be able to apply treatments in a confined space. There's not a lot of space in the back of an ambulance. Drawing blood and running an IV for someone lying in bed in a hospital is a lot different than doing the same thing to someone while you're bouncing down the road.

What did you learn as a field provider that you didn't know when you worked in a hospital emergency department?

EMTs and paramedics see the patient in their natural state. We have a unique perspective on their crisis. We hear the raw explanation from them at home. We see the good or bad equipment they are using to take care of themselves.

We see how they struggle to keep their medications straight, or to keep their environment clean and free of obstructions. We may come into a house for an asthmatic or someone with COPD and see that they are using tubing for their nebulizer that is years old, yellow, and the nebulizer cup has a crack in it and is

➔ **If you have an EMS colleague who you think would be great to feature in our Member Spotlight, please let us know!** Send suggestions to jenifer.goodwin@naemt.org.

leaking out medicine. Or they have long ago lost the mouthpiece and are breathing in the mist out of the top. The hospital calls them “noncompliant.” But we see their attempts to try to be compliant, even if they are not doing things ideally or correctly.

When we assess a patient’s well-being, it’s important to include their psychological well-being. How emotionally exhausted they are because of the illness? What, if any, support do they have? You cannot assess that as well from a hospital bed as when you walk into their living room.

When you come into their universe, a bond of trust develops quickly. I have learned that we affect our patients through drugs and instruments, and through our relationship with them. That unique relationship is a part of what makes EMS different from the rest of the medical community.

Doctors and nurses don’t see the first 40 minutes of this relationship with the patient. There are many times we go into a home and are collecting medications all over the room. We may realize that someone is malnourished. The trash in the room can tell you what they’re eating. You can tell a lot about a person and how well they are managing.

What brought you to Nauvoo from Phoenix?

My twin brother, Matthew, and I opened a hotel and gift shop in Nauvoo, which is along the Mississippi River and home to a Mormon temple that draws several hundred thousand visitors a year. In the 1840s, the Mormons had a thriving community there, but there were conflicts over religion. A mob killed the Latter-day Saints prophet, Joseph Smith, in 1884. The Missouri governor signed an “extermination order” of the Mormons. Most people fled with a group led by Brigham Young, and eventually settled in Utah. The Nauvoo temple was destroyed after the Mormons left.

In 1999, the president of the Mormon Church announced that the temple would be rebuilt. We built our hotel, the Nauvoo Zion Mercantile, in anticipation of that. We also purchased and refurbished the Woodruff Hotel, a historic building from the 1840s. My brother is the proprietor and the mastermind. In 2013, I told him I was ready to get out of Phoenix and be a part of it so we came.

How did EMS become a family affair?

Shortly after we moved here, we met Vicki Gallaher, the NAEMT state education coordinator for Illinois. She heard I

had a medical background and thought I might want to take an EMT course she was offering to train responders in the rural communities in the area.

I started volunteering for the fire department as soon as I got to town, before I became an EMT. I didn’t tell my brother.

When he saw me riding down the street driving the fire engine, he decided to take the EMT course with me. He’d never been in medicine before. He was a magazine publisher.

My wife had been a certified nursing assistant in the 90s, so she decided to take the EMT course too. Matthew’s sons moved to Nauvoo and they also decided to go to the fire academy and get certified.

My brother and I both became advanced EMTs together, and then I kept going and became a paramedic and then a critical care paramedic.

It’s an unbelievable experience to have your family next to you when you’re putting out a barn fire or helping someone in an ambulance. It’s really nice to have family there with you to share some of those great moments in your career. We are all deeply involved and we love it.

What’s the best thing about having an identical twin?

We read each other’s minds pretty quick, and we both have a good sense of humor. But it comes with its complications too! Having an identical version of yourself sitting next to you, arguing with you about something you think you know more about... You would drive yourself crazy too, right?

You’re the NAEMT Advocacy Coordinator for Illinois and you and your family have attended EMS On The Hill Day several times. Why is it important to advocate for the profession?

I joined NAEMT because it provided an avenue to start addressing some of the legislative problems regarding EMS we saw in Illinois. Our membership led us to EMS On The Hill Day.

It’s so important to share our experiences and our knowledge of EMS with members of Congress, because they have the power to bring important EMS issues to the floor. U.S. Senators and Representatives appreciate our visit each year and take time to listen to the legislative issues we present. It’s such a feeling of accomplishment when a member of Congress says they will support the bill we are proposing. We were thrilled when Sen. Dick Durbin sponsored the SIREN Act, which was signed into law last year and provides grants to rural EMS agencies.





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