

Texas

Elected Officials' Guide to Emergency Medical Services



Texas

Elected Officials' Guide to Emergency Medical Services

Table of Contents

Introduction	5
History of EMS in Texas	6
Challenges of EMS in Texas	7
Map of Trauma Service Areas/Health Service Regions	8
Chart of EMS Response Times	10
Map of Counties with Designated Trauma Facilities	11
Map of All Texas Hospitals	12
Map of EMS Providers in Texas Counties	13
Map of Air Medical EMS Bases	14
Ground EMS Services	15
Air Medical EMS Services	15
EMS: The Rural/Frontier Dilemma	16
How EMS Agencies are Funded	20
Calculate Per Capita Cost of EMS	21
The Future of EMS... It's Up to Us	21
EMS Related Health and Safety Codes	23

The Texas Elected Officials Guide to Emergency Medical Services was compiled by the Rural Task Force of the Governor’s EMS & Trauma Advisory Council. It is intended to be updated bi-annually to ensure the latest data and revisions.

Task Force members

Pete Wolf, NREMT-P, GETAC Vice Chair and Committee Chair

Anita Aaron, NREMT-P, LP, Project Coordinator

Kelly Daniels, EMT-P

Brett Coghlan, EMT-P

Ron Haussecker, EMT-P, CC

H. T. Fillinghim, LP

The Rural EMS Task Force gratefully acknowledges Al Lewis, LP, formerly of the Office of Rural Community Affairs, for the contributions he offered enabling completion of this guidebook.

Special thanks to Johnny ‘Gene’ Aaron, LP, for his technical support preparing this guidebook.

Introduction

This guide is designed as a living document, to provide a brief but comprehensive overview of what the Emergency Medical System is and why the preservation of emergency medical services provided within every community in Texas is of the greatest importance. This guide is designed to provide information on the different types of emergency medical services (EMS), explain the needs of EMS, and provide general current statistics pertaining to EMS and prehospital medical response. There are many laws that address the needs of emergency medical services as well as the creation of the districts that strengthen the emergency capability of the State. Website addresses have been provided for easy access to additional information.

The Table of Contents breaks this manual into sections which makes the information specific to any issue easy to find and read. These sections highlight many different aspects of EMS and include an overview of the history of EMS as well as an overview of the EMS and Trauma System. Also included are sections describing EMS as it is today in the state of Texas, and where we hope to be in the future of Texas EMS.

Due to the ever-increasing complexity of EMS and the importance of available emergency medical response for homeland security, EMS has become an essential part in everyone's life similar to police and fire services. The public now expects EMS to be just a 9-1-1 call away—available anytime, anywhere. ***Unfortunately, at this time EMS is not defined statutorily as an essential service that must be provided throughout the state of Texas.***

History of EMS in Texas

Over the last 30 years, EMS has transformed from a patient retrieval service operated by funeral homes staffed by a single, inadequately trained crewmember, to state of the art, out-of-hospital healthcare providers resembling, in many areas, an emergency department brought to the patient.

The education and knowledge expected from EMS has increased greatly as the concept of prehospital patient care has evolved. To keep pace with this expectation, emergency medical responders must keep abreast of treatment modalities comparable to modalities for those higher trained medical professionals such as doctors, physician assistants, or nurses.

As late as the early 1960's, EMS was not viewed as a component of the healthcare system, but rather as a transport method comparable to the crude manner injured soldiers were removed from the battlefield during the Civil War 100 years earlier.

With the passage of the Highway Traffic Safety Act and the publication of *Accidental Death and Disability: The Neglected Disease of Modern Society*, written by a commission representing the National Academy of Sciences; National Research Council, and Division of Medical Services in 1966, the Department of Transportation-National Highway Traffic Safety Administration (DOT-NHTSA) was assigned responsibility for and oversight of guideline development related to the provision of EMS.

This included the first attempt at standardizing curriculum development and designing standards for ambulances and communications systems, just to name a few. The prehospital transportation system received an additional boost in 1970 when the Department of Defense combined resources with DOT and Department of Health, Education and Welfare (DHEW) to create the MAST (Military Assistance to Safety and Traffic) program.

Following lessons learned during military actions in Vietnam, it was decided that the use of air resources to extricate seriously injured patients from crash sites to appropriate medical facilities would allow the greatest opportunity for survival because of reduced transport times.

The 1980's were a period of growth and standardization for EMS, especially regarding patient care techniques and training. New advances in the treatment of the cardiac patient hit the scene, and EMS was thrust

into new standards of care for cardiac victims. Cardiopulmonary Resuscitation (CPR) became the focus of a new public education drive, and the American Heart Association (AHA) came out with an Advanced Cardiac Life Support (ACLS) course that increased the impact that prehospital personnel can have on cardiac patients. Through these and many other changes, EMS was identified as an integral part of the healthcare industry. Members of local government and the medical profession were called upon to take steps necessary to lay the groundwork for a standardized, unified prehospital system which would provide care across the nation.

In Texas, EMS is regulated through the Department of State Health Services (DSHS). Texas is also divided into Health Service Regions (HSRs), identified numerically from 1-11. The EMS field offices in these regions are staffed by DSHS employees. Their responsibilities include providing technical assistance to the EMS certificants and EMS providers in the regions, conducting inspections and assisting in the regulatory responsibilities of Texas DSHS.

In addition, EMS is an integral part of the Texas Trauma System. The Texas Trauma System began developing in 1989, after passage of the Omnibus Rural Health Care Rescue Act. Designed to help rural areas gain access to urban resources, that legislation ultimately led to the division of Texas into 22 Trauma Service Areas (TSAs), identified alphabetically from A-V. Regional Advisory Councils (RACs) have been established in each of these TSAs. The function of the RACs is to develop and improve emergency and trauma health care in the state. Website:

www.tdh.state.tx.us/hcqs/ems/Etrarac.htm. (See map on page 8.)

Challenges facing EMS in Texas

The health care system in Texas provides care to one of the largest and most diverse populations in the country, bordering four states and Mexico. Texas has a population total of 22,118,509 people (www.quickfacts.census.gov/qfd/states/48000.html), making up almost 8 percent of the total United States population. Additionally, Texas has a population of approximately 3.2 million people residing within 210,663 square miles in rural and frontier counties. Residents of Texas communities, as well as the growing influx of visitors, depend on local EMS systems to provide prehospital care and transportation, including the

tal to patient care. Language barriers between patient and prehospital health care providers are a significant problem in south Texas, especially in the border communities, where Spanish is commonly spoken, and in urban areas with a high immigrant population. The Texas Workforce Commission has reported that bilingual and Spanish-speaking residents comprise more than 20 percent of the population of rural Texas.

According to the Texas Board of Medical Examiners 2003 data, the number of physicians practicing in urban areas is more than eleven times as high as in rural/frontier areas. Residents living in these rural/frontier areas of Texas have less access to specialized care in cardiovascular diseases, emergency medicine, geriatric and pediatric specialties, and primary care medicine than do residents in the more densely populated urban areas. Most rural residents must travel far from home for medical care and stabilization.

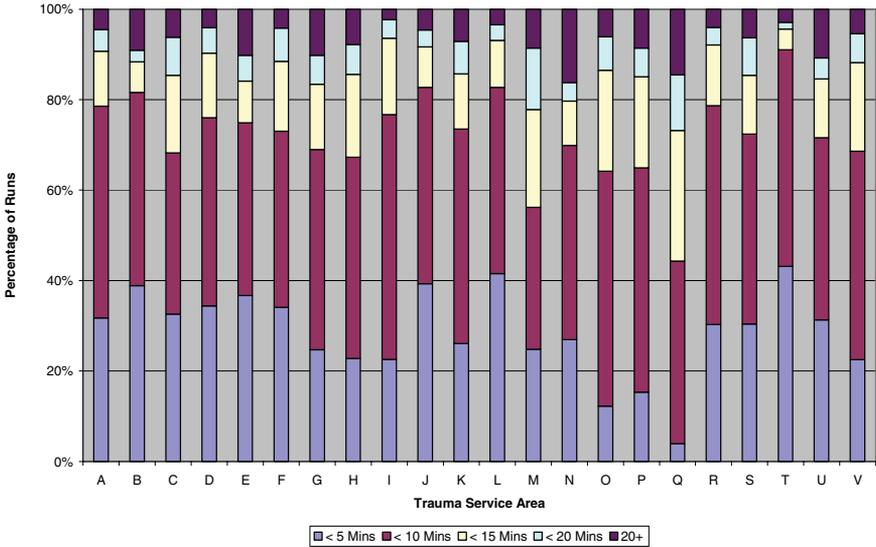
The majority of challenges faced by EMS providers can be placed into one or more of the following four categories:

- Recruiting and retention of employees.
- Providing adequate initial and advanced training, as well as continuing education. *This includes medical personnel as well as administrative and managerial personnel.*
- Acquisition and maintenance of needed equipment.
- Adequate funding.

Salaries for EMS personnel are low, especially in rural and frontier areas, while the cost and time required to meet educational requirements can be high, so an individual interested in attending an EMS course must take into account what it takes to become certified (www.tdh.state.tx.us/hcqs/ems/scertlic.htm). There are many hardships, including the financial costs and time away from their families. Additionally, the travel distance and time involved, especially in rural and frontier areas, can be prohibitive (www.tdh.state.tx.us/hcqs/ems/jobdesc.htm).

Recruitment can be difficult in rural/frontier Texas because of a dependency on volunteer EMS personnel. Only 20 percent (3,000) of the approximate 15,000 paramedics in the state provide services in areas designated as rural or frontier. Approximately one-third of Texas EMS personnel are volunteers and work at least one full-time job in addition to volunteering, with the majority of these jobs being non-health related.

EMS Response Times by Trauma Service Area, 2002



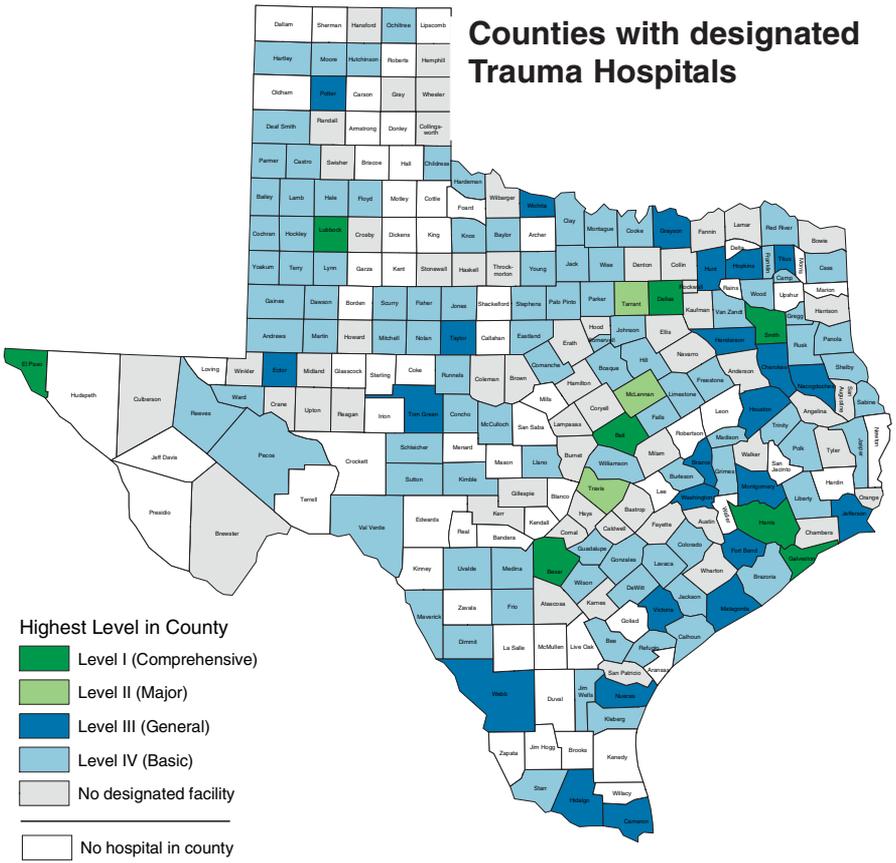
Challenges to employee recruitment and retention in urban areas include high call volumes, rapid job burnout and a high turnover rate of employees. Add in the daily traffic congestion and related transportation problems and it is easy to understand their dilemma.

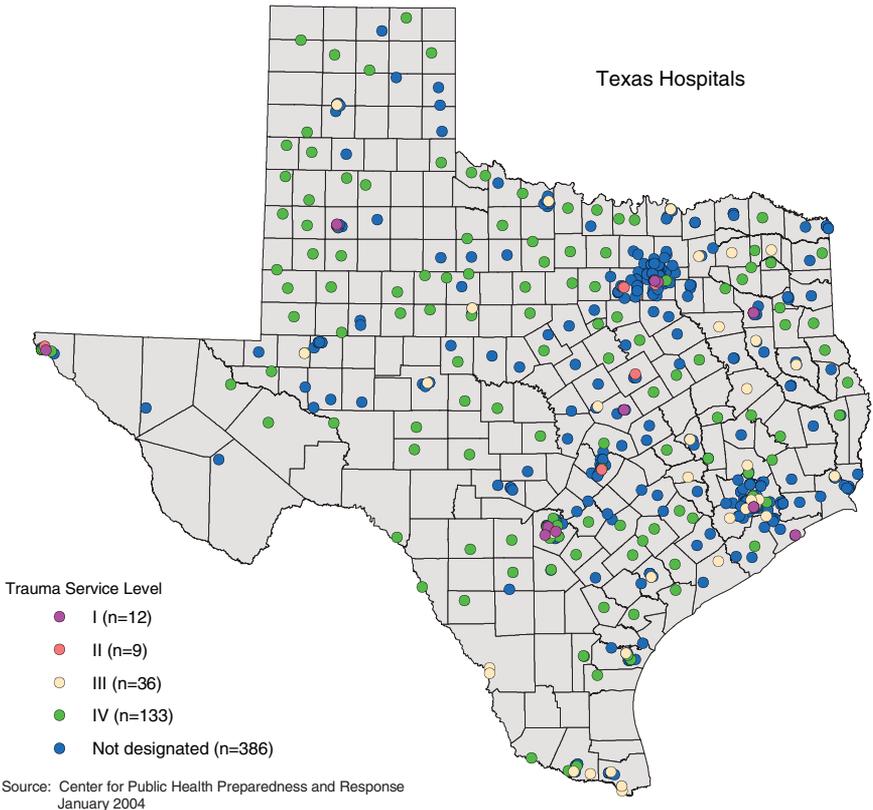
Specific to rural and frontier Texas, problems such as the lack of training, especially advanced training, and the inability to purchase equipment vital for the appropriate provision of emergency medical care, are resulting in the decline of certified and licensed emergency medical service providers in their regions of the state. Many ambulances are old, and costs to repair them are becoming prohibitive for the smaller departments.

Adequate funding affects EMS across the state regardless of location. All EMS providers have seen an increased demand for services, without a corresponding increase in funding, either from taxes or other sources of funding such as grants. Funding affects every aspect of providing adequate EMS, from purchase of equipment to training for street medics.

Many acute injuries or illnesses are time dependent, meaning the prognosis for survival is dependent on how rapidly the patient can get to the appropriate facility. According to data collected by the Texas Department of Health Bureau of Epidemiology (now a division of Texas DSHS,

Texas EMS/Trauma Registry, www.tdh.state.tx.us/injury/), there are areas throughout frontier Texas that have patient response times of up to 136 minutes (2 hours and 16 minutes) and hospital transport times of up to 132 minutes (2 hours and 12 minutes). What makes matters worse is these times represent areas throughout Texas that are not in the same geographic location. In addition, 157 of the 254 Texas counties currently have response times in excess of 10 minutes, while 151 counties have transport times greater than 20 minutes. (See chart on page 10.)





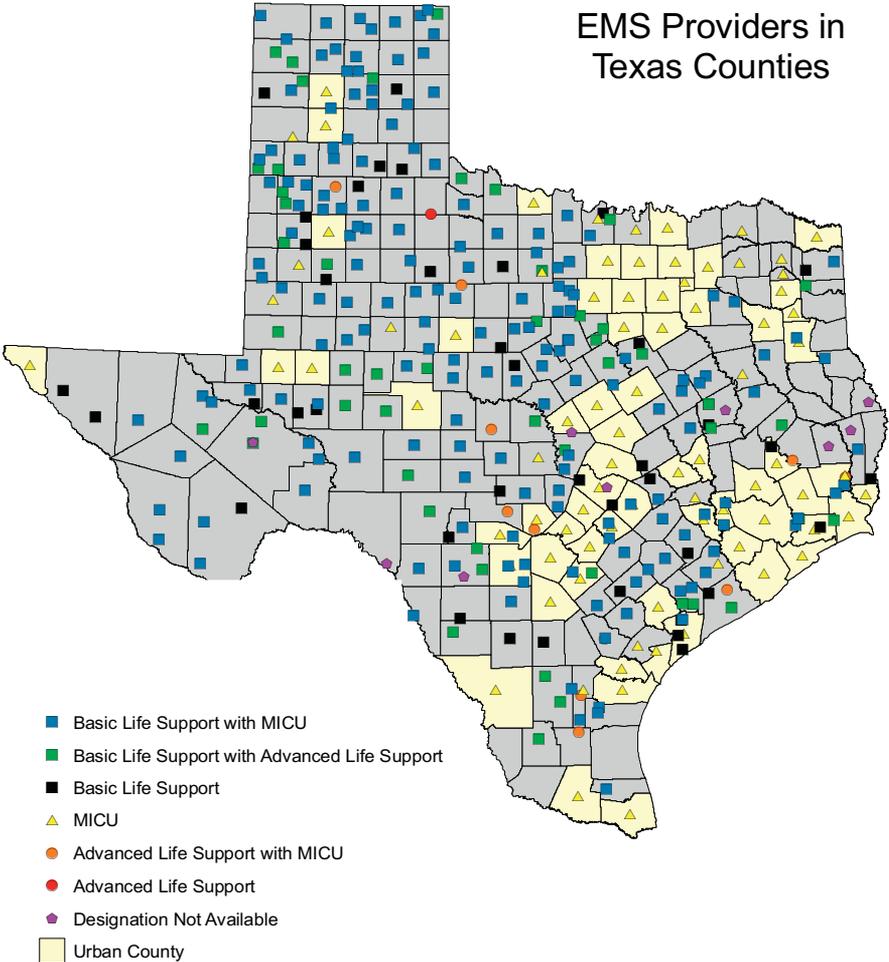
The rural and frontier areas of Texas are also less populated with designated trauma centers. Most hospitals are very small and have difficulty obtaining and maintaining trauma designation due to the associated costs. Those hospitals that are undesignated are often ill-prepared to care for major and severe trauma patients. The hospitals that are designated are usually designated at the lowest level and have very limited resources.

Level IV Trauma Centers are basically “stabilize and transfer” facilities that transfer-out patients requiring a higher level of care. Level III Trauma Centers receive trauma patients from lower level facilities and provide some tertiary care services. The resources of Level III Trauma Centers are varied. Those facilities in rural areas generally have less trauma

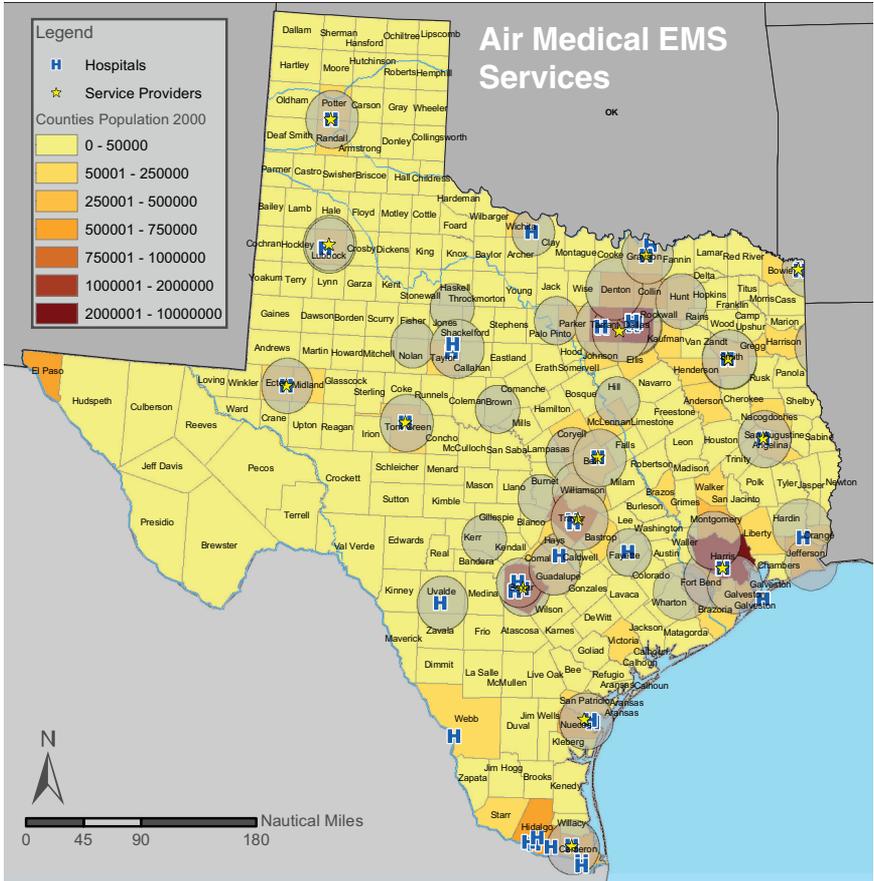
resources than those facilities located in suburban or urban areas. Level II Trauma Centers receive trauma patients from lower level facilities.

Level I and Level II Trauma Centers have virtually the same clinical capabilities. They are the highest Level of trauma care facilities in the state. Level I Trauma Centers have a trauma research component that Level II Trauma Centers are not required to have. (See maps on pages 11 and 12).

EMS Providers in Texas Counties



The individual resources of each area are unique and pose a real challenge to the EMS providers in their area. The decisions the EMS providers make are dependent upon the resources as well as the condition of the patient. Things to be considered are the scene location, distance and time to the nearest appropriate facility, whether to go by ground or air, as well as the level of training of the responding EMS staff.



Ground EMS services

Currently Texas has 6 levels of prehospital emergency medical service provider licensure. The levels are as follows: Basic Life Support (BLS), Advanced Life Support (ALS), Mobile Intensive Care Unit (MICU), BLS with ALS capability, BLS with MICU capability, and ALS with MICU capability.

For clarification, there is a difference between Basic Life Support (BLS) provided by an Emergency Medical Technician (EMT-Basic) and Advanced Life Support provided by an EMT-Intermediate (EMT-I), Paramedic (EMT-P), or Licensed Paramedic (LP). The EMT-Basic is a trained individual who is certified by DSHS as minimally proficient to perform emergency prehospital care that is necessary for basic life support and that includes the control of hemorrhaging (bleeding) and CPR. An EMT-Intermediate is an individual who is certified by the department as minimally proficient in performing skills required to provide emergency prehospital or interfacility care by initiating and maintaining under medical supervision certain procedures, including intravenous (IV) therapy and endotracheal and/or esophageal intubation. An EMT-Paramedic or Licensed Paramedic is an individual certified by DSHS as minimally proficient in providing emergency prehospital or interfacility care by providing advanced life support that includes initiation and maintenance under medical supervision of certain procedures, including IV therapy, endotracheal and/or esophageal intubation, electrical cardiac defibrillation and cardioversion, and drug therapy. Licensed and non-licensed First Responder Organizations are also available in many communities to help stabilize patients and provide BLS care prior to the ambulance arrival (www.tdh.state.tx.us/hcqs/ems/ASystemWeb.PDF). (See map on page 13.)

Air medical EMS service

EMS has progressed in many areas. The utilization of air medical transportation is one facet that saves many lives and can potentially increase the odds for a positive outcome following a life-altering injury and illness.

The concept is simple. When a seriously injured patient (i.e., a car crash with the driver sustaining internal injuries) or a patient with a serious medical illness (i.e., heart attack or stroke) needs transport to a hospital, it is imperative that the patient arrives at the closest medical facility

capable of delivering the care needed, as quickly as possible. In many cases a patient may be located a great distance from the hospital, traffic may prevent rapid ground transport, or some other reason, and air transport is the best transportation solution.

Air medical transport is provided by 2 means, fixed wing (airplanes) and rotor wing (helicopters). Patients being transported longer distances usually go by fixed wing aircraft, which are faster and can fly farther. These patients are typically being transported from one medical facility to another and obviously require the patient be delivered to and from an airport where the airplane is located via ambulance. Rotor wing aircraft can go directly to a scene and land, then transport the patient to the nearest appropriate facility. Typically, rotor wing aircraft don't transport great distances, but are used for shorter inter-facility transports, as well as scene flights.

The medical crew aboard either type of aircraft usually includes a registered nurse and paramedic. In some instances, other or additional medical staff are incorporated, such as respiratory technicians, specialty nurses and possibly even doctors.

Any hospital that is located in a city with an airport, or even a landing strip, has access to fixed wing transport. On the other hand, rotor wing services are typically located only in or near cities with a higher concentration of people. While some of the larger metropolitan areas have had rotor wing service in their cities for 25 years or longer, availability has improved dramatically in just the last 5 to 10 years. Still, there are vast regions, especially in the rural and frontier areas of the Panhandle, Rio Grande Valley, west and southwest Texas that suffer from inadequate rotor wing coverage. (*See map on page 14.*)

EMS—the rural/frontier dilemma

Comparing the population, land area, and prehospital capability in rural/frontier Texas, there are 499 responding emergency medical prehospital agencies, 303 licensed providers, and 193 first responder organizations. The provider capability averages out to one responding agency for every 6,333 people, or one responding agency per 422 square miles. To compound the problem of available immediate health care in rural Texas, data from the Texas State EMS Office documents 21 Texas counties that do not have a licensed EMS organization within their boundaries;

currently, providers in neighboring counties are forced to service these lacking areas. An additional problem in Texas is that only 161 (32 percent) of all Texas hospitals are located in rural/frontier counties.

Advanced training for areas responding only at the basic level, as well as equipment for all providers responding to emergencies throughout rural Texas, equates to the difference between life and death for the population of rural Texas. Personnel shortages have intensified the problem, and many EMS providers classified as Advanced Life Support or Mobile Intensive Care Units are unable to staff ambulances with the appropriate level of personnel around the clock in order to maintain these designations.

Of the 193 first responder organizations, only 23 have advanced life support capability while the remaining 170 respond on a basic life support level. Fifty-four of the 131 Texas frontier counties have first responder organizations. Of the 131 frontier counties, only 5 counties have advanced life support organizations, and 22 counties have basic life support organizations.

There is a serious health care shortage in rural/frontier Texas, leaving some communities without the higher level of medical care that is available in metropolitan areas. Call volumes are low and, therefore, economic incentives for private operators are minimal, leaving only volunteers to respond to medical emergencies. Small volunteer fire-based EMS organizations, volunteer EMS organizations, and volunteers responding in the form of a first responder organizations step forward in rural Texas to fill the service provider void. There is a strong need for assistance in providing critical services in these low-volume, low tax-based communities that provide life-saving services for not only their residents, but visitors and neighboring counties as well.

Another challenge faced by rural EMS organizations in Texas is their inability to purchase the necessary equipment or maintain the aging and commonly breaking down ambulances. These are basic needs not met in order to provide the most basic ongoing life support care. For example, many advanced capable rural EMS organizations that have manual defibrillation capability are operating with manual defibrillators used during the 1980's rather than the more current technology. Quite a number of these manual defibrillators were used by urban areas, and sold to these rural organizations due to their becoming obsolete, however, still functional. Rural EMS providers in the state of Texas respond frequently to cardiac

emergencies, but are often unable to provide advanced information to the receiving hospital, therefore delaying hospital advanced treatment.

All ambulance services are unique, yet each shares common challenges. Each ambulance service operates differently, uses different staffing models, has a different payer mix, and has a differing level of community support. All of these differences affect the financial status, the provider workforce, and the ability to provide the equipment needed to provide care. These factors affect the viability of ambulance service operations. There is, however, a common growing need for a majority of the licensed EMS providers. This is the need for functional, safe ambulances to respond and transport patients, and adequate equipment to meet regulations.

According to the Texas DSHS there are a total of 3,106 licensed ground ambulances in Texas. Of the total amount there are only 696 licensed in rural/frontier Texas. These 696 ambulances make up only 22 percent of the total ambulances in Texas, with an average age of 8 years old. These 696 ambulances average out to one ambulance covering 311 square miles.

Due to the geographic vastness of rural Texas, travel time and expenses for EMS training has become a significant barrier to the recruitment and retention of rural EMS providers as well as the advancement of the state EMS system. As previously stated, many rural EMS personnel serve on a volunteer basis and are unable to travel the long distances required in order to attend classes at the nearest community college or institution of higher learning. They also do not have the funds needed to afford extensive travel.

The resources available to rural EMS organizations are vastly different than the resources available to metro or urban areas. In many rural/frontier areas citizens that call 9-1-1 must wait for longer periods of time to get ambulance response to their emergencies. The common expectation throughout the country is that when 9-1-1 is dialed and an ambulance is requested one will be at their location in a matter of minutes. This isn't the case in a large portion of the state. Currently approximately half of the licensed EMS providers and almost all of the registered first responder organizations in rural/frontier Texas are volunteer and must leave their jobs, or their work in the fields to respond either in their own private

vehicle or in areas where they do have an ambulance to transport the patient, the responder must travel to the ambulance station, pick up the ambulance or other emergency response vehicle and respond to the emergency. *Volunteers can be effective, but only with adequate resources.*

In most of the urban areas there are more choices of teaching institutions as well as more EMS providers hosting continuing education courses for different certifications that are beneficial to the EMS personnel no matter what level they are certified at. The financing of rural and frontier EMS organizations is a particular problem due to the relatively low volume of calls in relationship to the essential overhead costs of full-time preparedness, maintenance of the ambulance, fuel, maintenance of the equipment, use of old and/or outdated equipment. Many rural/frontier EMS agencies lack the funding required for their responders to attend CME/CEU courses that are readily available in distant metropolitan areas. In a lot of the urban areas there are taxes that are used for supporting the EMS services; in rural Texas this generally isn't the case.

A major issue faced by the rural/frontier EMS providers is the difficulties faced with billing and collecting for EMS services.

Payment for EMS by Medicare differs widely across not only the state but also across the country. Rural and frontier areas almost always receive a lower reimbursement. There are many reasons for this; one can be attributed to the staffing as well as the billing capability of the volunteer EMS organizations. There is also the fact that a majority of the services that are volunteer do not have the funds to hire personnel to do the billing and do not have the funds to contract with a billing service. With the changes in the Medicare Ambulance Fee with a reduction in the amount of money they can recover for the services they provide.

The viability and the sustainability of rural and frontier EMS is dependant on having the ability to obtain funds to be used for maintaining a minimum level of service that is statewide. Every community in rural and frontier Texas should have a dependable emergency medical provider they can count on. Currently there is a lack of funding initiative that would ensure EMS is recognized as an essential service, which every citizen in the state should have. Rural areas that provide EMS are vulnerable and may not survive or continue to operate unless it is viewed as an essential service and funding is made a priority.

Even though call volumes are lower in rural and frontier areas, the essential overhead costs of full-time preparedness, maintenance of the ambulance, fuel and the maintenance of the medical equipment remain the same.

As stated previously, payment for EMS by Medicare differs widely across the state, but rural and frontier areas generally receive a lower reimbursement. Reasons for this include staffing and the capability of small and volunteer EMS organizations to provide care and transport for their patients and also bill for their services. This seems to be an issue that really has no bearing on healthcare but has more to do with the cost of providing the services. The bottom line is, when someone calls 9-1-1 and they need an ambulance, they should get one.

In the event of a natural or man-made disaster, every community in rural and frontier Texas should have the availability of a timely emergency medical response. Right now there is a lack of funding and a lack of an initiative to make sure EMS is a living essential service that every citizen in the state should have. Rural areas that try to provide EMS are vulnerable and will not survive or continue to operate unless EMS is viewed as an essential service, and funding is made a priority.

How EMS agencies are funded

EMS agencies are funded many different ways throughout the state. Below are some examples of EMS funding sources.

- County EMS services. Funded by the County with tax money from the general budget and the revenue they generate. Staffing may be paid, volunteer, or a combination.
- City service. EMS is funded by the City within their budget from city taxes and the revenue they generate. Staffing may be paid, volunteer, or a combination. These include fire department-based EMS and third city EMS services.
- Private EMS services. There are private EMS services that operate a County or City EMS and may receive a subsidy from the county or city or both. Staffed by paid personnel.
- Hospital Based EMS services. Funded by hospitals or hospital districts and the revenue they generate, and may receive additional tax funding. Staffing may be paid, volunteer, or a combination.
- Emergency Service District. Districts voted on by the people in the

district to have a tax to pay for emergency services (fire and /or EMS). The ESD maximum tax rate is set by the voters. Staffing may be paid, volunteer, or a combination.

- Other innovative funding possibilities.

To calculate the per capita cost of EMS

Calculating the per capita cost of providing EMS may be accomplished by the following method: Start with a total budget, subtract expected income from billing divide that sum by 8,760 (number of hours in a year).

Budget:	\$1,796,289.00
Less expected revenue:	<u>-700,000.00</u>
	1,096,289.00
Total:	1,096,289.00
Divided by number of hours in a year	÷ 8,760
Cost per hour	\$125.15
Now divide the cost per hour by the number of people in a county per 2000 census	
Cost per hour:	\$125.15
Number of people per census	21,804 people
Cost = less than one cent an hour (0.00573964163)	

This works out to approximately 14 cents per day (0.13775139912) per person.

The future of EMS... it's up to us

We, as EMS personnel, healthcare workers, elected officials and concerned citizens have an obligation not only to our own community but also to all citizens and visitors across the state of Texas. We must ensure that the Future of EMS is to provide the best care possible to all. Only through collective efforts is it possible for all entities involved in the evaluation and treatment of the acutely ill or injured patients to decrease death and disability. Participation at local, state, and national levels is crucial if EMS is to fulfill its potential role in caring for the health of America's communities.

There are many professions involved in a comprehensive EMS & Trauma System including EMS providers, medical directors, public health and safety officials, administrators, local, state, and federal government officials, other community leaders and the general public. The future of EMS is a significant looming challenge for Texas. It will require diligent efforts by those who have the resources and capabilities to influence any aspect of the EMS system

To help with the Future of EMS, first a need for change must be recognized, there must be a vision to help indicate where those changes will lead us. The *EMS Agenda for the Future* (www.nhtsa.dot.gov/people/injury/ems/EdAgenda/final/agenda6-00.htm) identifies the need and offers a vision for the future of EMS that emphasizes its critical role in health care and as the public's emergency medical safety net. The next step toward change is exploration of possible strategies to reach the desired results. The State of Texas' Governor's EMS and Trauma Advisory Council (GETAC) has already started this process with the strategic plan, available for viewing at www.tdh.state.tx.us/hcqs/ems/STRACPlan.pdf.

NHTSA has taken the lead nationally with the development of the National Scope of Practice, (www.emsscopeofpractice.org) with agencies and individuals in the state of Texas by reviewing and offering input. The EMS Education Agenda for the Future may also be viewed at the scope of practice web site.

The path to the future will undoubtedly include barriers. Among them may be a failure to recognize a desirable change, and inadequate exploration of possibilities or a lack of important participation. New and creative partnerships will be required to overcome these barriers. Some partners may seem logical, based upon their current participation in EMS affairs. Others may be found in unlikely places within the health care system, education system, community organizations / agencies and industry. Partnerships must be inclusive. They must seek diversified perspectives and invite enthusiastic participation. Many share the job of making communities healthier. Similarly, the venture to create the future of EMS cannot be done in isolation. It must involve innumerable agencies, organizations, and individuals that interface with EMS. Local, county and state officials, the medical community and many others will have to be included.

Additional information concerning:

Compilation of Laws that impact EMS and Trauma Systems
Adopted EMS and Trauma Rules

Proposed and Pending EMS/Trauma System Rules

May be viewed at: www.tdh.state.tx.us/hcqs/ems/ruldraft.htm

EMS-related Health and Safety Codes

- CHAPTER 771. STATE ADMINISTRATION OF
EMERGENCY COMMUNICATIONS
- CHAPTER 772. LOCAL ADMINISTRATION OF
EMERGENCY COMMUNICATIONS
- CHAPTER 773. EMERGENCY MEDICAL SERVICES
- CHAPTER 774. LOCAL PROVISION OF EMERGENCY
MEDICAL SERVICES
- CHAPTER 775. EMERGENCY SERVICES DISTRICTS
- CHAPTER 776. EMERGENCY SERVICES DISTRICTS IN
COUNTIES OF 125,000 OR LESS
- CHAPTER 778. EMERGENCY MANAGEMENT
ASSISTANCE COMPACT
- CHAPTER 779. AUTOMATED EXTERNAL DEFIBRILLATORS
- CHAPTER 281. HOSPITAL DISTRICTS IN COUNTIES
OF AT LEAST 190,000
- CHAPTER 282. HOSPITAL DISTRICTS IN COUNTIES
OF 75,000 OR LESS
- CHAPTER 283. OPTIONAL HOSPITAL DISTRICT LAW
OF 1957
- CHAPTER 284. SPECIAL PROVISIONS RELATING TO
HOSPITAL DISTRICT BONDS
- CHAPTER 285. SPECIAL PROVISIONS RELATING TO
HOSPITAL DISTRICTS
- CHAPTER 286. HOSPITAL DISTRICTS CREATED BY
VOTER APPROVAL

