2011 Spring Edition
Volume 1, Issue 2

Mountain-Valley EMS Agency

EMS News

Special Interest Articles:

Individual Highlights:

STEMI Report

by Kevin Mackey, M.D.

December 1, 2010 brought the final 12 lead to the EMS agency office for inclusion in the STEMI Pilot project that was launched just one year earlier. It is my pleasure to report to you the results of this important venture and to share with you some interesting findings during the project as well as future directions regarding STEMIs in the Mountain Valley region.

In total, 2222 12-leads were submitted for the pilot. Of those, 104 (4.6%) had a machine read "Acute MI Suspected". 77 of these went to the cath lab from the emergency department, which was the measure I used to label the 12 lead a "true positive". That left 27 patients that had a 12-lead indicating "acute MI Suspected" but did not go to the cath lab (STEMI Alert canceled on arrival in the emergency department). This was my measure of a "false positive" 12 lead. So of all 104, 74% went to the cath lab (72 had a procedure performed) and 26% did not. These numbers are completely consistent with what the manufacturers and independent studies have found in similar evaluations. Interestingly, there were 7 "false negative" 12-leads. This means that 7 patients (or 0.2%) had 12-lead reading something other than "Acute MI Suspected", but on my evaluation of the 12-lead in fact had criteria consistent with a STEMI. These 7 patients went straight to the cath lab on arrival in the ED.

But the truly exciting stuff is found in an evaluation of time intervals. For example, if a patient with chest pain calls 911, how long will it take to acquire a 12 lead on that patient from time of dispatch? **13 minutes!** Knowing that the average time to dispatch from contact to 911 service center takes just 1-2 minutes, this means that time to diagnosis from contacting 911 is just **15 minutes!** That is impressive, to say the least! And once EMS arrives on scene, how long does it take to acquire a diagnostic 12-lead? **7 minutes!** And now that the diagnosis has been made by the EMS provider and the STEMI Receiving Center is alerted, it only takes 57 minutes from arrival at the hospital until the cardiologist has a balloon inflated in that patient's thereby stopping further death of the myocardial tissue.

But the most exciting statistic of all, and the real reason behind why a 12-lead diagnosis of a STEMI by a paramedic is so vital, is the time from DISPATCH to BALLOON. In our region, for our study, that time is **88 minutes!** To put this in perspective, the American Heart Association recommends a 90 minute time frame for a patient to sign in to a hospital until a balloon is deployed in their coronary artery to stop a heart attack. In the Mountain Valley Region, thanks to the team work of our EMS providers, emergency departments and cardiologists, our patients are beating 90 minutes from dispatch of the ambulance until balloon inflated! This is truly exceptional! You all are congratulated for doing such a fine job!

In closing, I would like to extend my sincere thanks and appreciation to several teams and individuals that drove this project and made it such a success. First and foremost, thank you to Tom Morton of the EMS agency for the countless hours he put in to catalogue and number every 12 lead submitted to the agency. And to all the agency staff for picking up those 12 leads for Tom to number. Thank you to the STEMI teams at both Doctors Medical Center and Memorial Medical Center, led by Kate Donovan (DMC), Dr. Merillat (DMC), Mary Velasquez (MMC) and Dr. Hussain (MMC). They are truly experts in the care of STEMI patients. Thanks to Mike Corbin of AMR for his instrumental involvement in training and for being a strong support at monthly STEMI meetings. Thanks Mike! And finally I'd like to also thank each of you. Every provider in the region plays a significant role in caring for these critically ill patients.

So where do we go from here? The EMS agency is in the midst of designating STEMI receiving centers (SRCs) that will be responsible for continuing the excellent care of these patients. The EMS agency has already changed treatment protocols to reflect an approach to getting STEMI patients to lifesaving treatment as rapidly as possible. And the CQI leaders for the region will continue to track these patients as well.

Finally, I'd like to leave you with some closing thoughts. The most common reason a 12 lead was a "false positive" was because the QUALITY of the 12 lead was poor (ie: wavy baseline, missing lead, etc.). Remember that the monitor is simply a computer. If you input poor data, you will achieve poor results.

Congratulations on achieving such great success within your communities! The success of this project is a testimony to the excellent care you provide every day of the year!

The "New Agency" Look by Richard Murdock

The MVEMS Agency is currently going through several changes. The office, located at 1101 Standiford Ave, Suite D-1, has gone through some remodeling changes. The conference room has grown in size in order to provide more opportunities for continuing education, local meetings and ambulance provider use. MVEMSA staff is currently using suite C-2 and will be moving into their remodeled office suite during the week of May 9th, 2011.

National EMS Week – May 15-21, 2011

In recognition of EMS Week 2011, the Mountain-Valley staff invites our EMS personnel to drop by the Agency Parking-Lot for a BBQ lunch on:

Tuesday, May 17, 2011 11:00am - 2:00pm
Thursday, May 19, 2011 11:00am - 2:00pm

Some new implementations for MVEMSA in 2011/12

Some of the following objectives will come into fruition in 2011/2012:

- New Website Design with many features! Just go to www.mvemsa.org and check it out.
- EMS Symposium 2012 – Desiring to have a 2-3 day conference at the Modesto Center Plaza with several well-known "key note" speakers, vendors, and workshops.
- Directors EMT Council – Planning on establishing an **EMT only** Council to assist in revising EMT specific policies/procedures, training, and expanded scope of practice.

New and/or Revised Field Treatment Protocols

The Adult and Pediatric field treatment policies/procedures have been a "work in progress" for the past 1 ½ years. Many of the treatment policies/procedures have been updated to reflect medication changes (route and dosages). A couple of changes you will see on the treatment policies/procedures have to do with the route and administration of Narcan. Intranasal will be added as a route choice for administering Narcan.

Ondansetron Hydrochloride (Zofran) has been approved by the EMS Authority as a paramedic optional scope of practice. Zofran is used as an anti-emetic. The route and dosage was implemented into the train-the-trainer curriculum, which was held in February 2011, and will go into effect starting July 1, 2011.

Draft Field Treatment Policies/Procedures will not go into effect until July 1, 2011. The adult and pediatric draft policies are available on the MVEMSA web page under "2011 Field Treatment Approved Policies/Procedures." The policies can be accessed by clicking on "policies" and following the links.

Last Newsletter – MVEMSA going GREEN!

Mountain-Valley EMS newsletters will be going green! This will be the last edition of the paper newsletter that MVEMSA sends out. All of the future newsletters will be posted on our new website for review. If you do not have internet access please contact the office for a hard copy of the newsletter to be sent to your address.

Congratulations to DMC!

Congratulations to Kate Donovan and her team for successfully working through the tedious process of obtaining accreditation with the Society of Chest Pain Centers.

What does it mean to be accredited?

The Society of Chest Pain Centers will offer Affiliated Chest Pain Center Accreditation for critical access hospitals that have been designated as such by CMS and for freestanding emergency departments. To qualify for this accreditation, the following requirements must be met:

- 24/7 availability with physician coverage
- 24/7 onsite lab capability
- Patients accepted via EMS
- Formal transfer relationship with a PCI-capable facility accredited by the Society of Chest Pain Centers
- Capability to observe low-risk cardiac patients

The Society of Chest Pain Centers' (SCPC) approach to accreditation is radically different from other accreditations that set specifications and measure compliance. In contrast to more traditional certification models, our Accreditation Review Specialists are collaborative and provide feedback, education, and resources to assist facilities in addressing gaps and improving processes. Our team will introduce you to contacts at other facilities that have gone through the accreditation process and are willing to share their experiences and resource materials. Successfully improving the care of the heart failure (HF) and acute coronary syndrome (ACS) patient supports our mission to reduce deaths related to heart disease.

Chest Pain Center Accreditation and Heart Failure Accreditation were developed using the principles of process improvement that are widely known and used successfully in many other disciplines. To improve patient outcomes, the upstream care processes need to be improved. All patient care is a process that can be enhanced. The accreditation process evaluates chest pain centers across the country in order to ensure that these centers meet or exceed quality-of-care measures based on improving the process for the care of the HF and ACS patient.

Today, the accreditation process established and administered by the SCPC formalizes and standardizes this elite mark of excellence. **Accreditation is granted only to those facilities whose heart failure and chest pain center processes meet or exceed the criteria established by the Accreditation Committee.**

Within the next few months – Stanislaus County will possibly have two more Society of Chest Pain Centers Accreditation centers - **Memorial Medical Center and Emanuel Medical Center!**

Memorial Medical Center STEMI Program by Mary Velasquez

Memorial Medical Center's chest pain center (CPC) is working collaboratively to strategize and develop standardize and streamline protocol for patients experiencing an Acute Coronary Syndrome (ACS). This involves reducing the time to treatment during the critical early stages, when treatments are most effective to significantly reduce heart attack deaths. According to the American Heart Association (AHA), coronary heart disease (CAD) is still the leading cause of death in America. Acute coronary syndrome (ACS) is a general term that refers to clinical symptoms of coronary artery disease.

As the Chest pain coordinator, I work closely with Patricia Fallow RN, Cath Lab Manager, Dr. Sweeney, ED Co-Medical director, Chest Pain Center (CPC) physician champion whom are all committed to meeting Memorial's goal of maintaining STEMI Receiving Center (SRC) designation and achieving CPC accreditation. The emergency department and cardiac catheterization laboratory staff prides themselves on quick triage and treatment of chest pain. Memorial Medical Center's CPC and SRC have full administrative support. "We want to demonstrate our dedication to providing quality cardiac care by becoming a Chest Pain Center," states Hassan Hussain, MD, Medical Director of Cardiology and Kathleen L. Van Slyke, MSN, Director of Critical Care / Cardiac Services.

Patients having a heart attack will go directly to the cardiac cath lab for interventional procedures. Those patients requiring more testing for pain, which may be cardiac in origin, will be admitted for observation and testing in our observation unit opening in January 2011. It will be a short stay and these patients will receive focused care if their condition warrants it and they will be admitted for a longer hospital stay. MMC has a cardiothoracic surgery team readily available to perform advanced procedures including coronary artery bypass graft surgery and heart valve repair and replacement for our STEMI patients.

Cardiac Catheterization Procedures

Memorial Medical Center currently has 3 catheterization labs with a 4th hybrid lab opening in 2011.
The labs are state of the art flat plate multi-purpose labs, with one dedicated coronary lab. A wide variety of catheterization procedures are available in our cardiac catheterization laboratories. We are nearing a 4000 procedure count completed annually. These are just some of our more advanced cardiac catheterization services and procedures:

- **Percutaneous Coronary– (balloon) Intervention (PCI):** Once the catheter is in place, using a balloon attached to the tip, the cardiologist inflates the balloon compressing plaque and dilating the diameter of the blood vessel. The balloon is deflated and removed along with the catheter. Many times a coronary stent is placed in the blood vessel to prevent restenosis or blockage recurrence.

- **Atherectomy:** When the removal of plaque is necessary, the catheter is fitted with a special mini high-speed drill at the tip. The plaque or blockage can be shaved off and vacuumed out or vaporized. Atherectomy is performed in conjunction with PCI through one of the large groin vessels.

- **Electrophysiology:** Procedures that require the insertion of an electrode catheter into the heart from veins in the leg and/or neck. Some electrophysiology studies are performed to diagnose abnormalities, while others are done to access the heart for treatment or correction of certain cardiac arrhythmias.

- **Percutaneous Ventricular Assist Device -** A small rotary pump attached to the end of a catheter which is passed through the aortic valve into the left ventricle used to provide partial circulatory support.

- **Cardiac Resynchronization Therapy (CRT)** - A pacemaker or defibrillator that can assist a heart with weakened heart muscle and electrical conduction abnormalities. Used in combination with medical therapy, CRT plays an important role in heart failure management.

Much of our program success is attributed to the Memorial Cardiology STEMI call team which includes:

Joydev Acharya, M.D.	***Reza Narzari, M.D.***
Syed N. Ahmed., M.D.	***Amar L. Pohwani, M.D.***
Oussama I. Dagher, M.D.	***Charles Tsai, M.D.***
Hassan M. Hussain, M.D	***Kent H. Wong, M.D***
Mutahir Khan, M.D.	***Lawrence Waspe, M.D.***
Peter Y. Lai, M.D.	***Rajesh K Dubey, M.D.***

Our new Hybrid Operating Room will be a fully equipped surgical suite designed to handle the most complex adult open heart surgeries, as well as minimally invasive procedures. What sets the Hybrid Operating Room apart from traditional operating rooms is the Artis Zeego, a multi-axis, robotic, high – resolution, 3-D imaging system that utilizes DynaCT software to reconstruct dynamic images of a patient's heart and vascular system.

This precise imaging allows surgeons to open blocked arteries through catheter-based procedures, rather than open procedures. However, because the Hybrid Operating Room is a fully equipped surgical suite, surgeons can immediately convert from minimally invasive to open bypass surgery if needed, without relocating the patient or referring the case to a new surgical team.

The Hybrid Operating Room will result in more minimally invasive procedures, fewer surgical complications, shorter hospital stays, faster recovery times, improved patient outcomes and the capability to treat patients with complex medical conditions.

Patients requiring the following therapies have access to the latest technology offered in the Hybrid Operating Room:

- Minimally invasive heart and vascular procedures, catheter-based heart valve replacement and repair, catheter- based congenital heart defect repair
- Catheter-based vascular procedures, combined open and endovascular procedures, treatment of cardiac arrhythmias, abdominal aortic aneurysm repairs and peripheral angioplasties
- Utilizing the Hybrid Operating Room's advanced technology, heart and vascular surgeons, interventional radiologists and interventional cardiologists work together as highly efficient medical teams.

As a STEMI receiving center applicant for the Mountain Valley EMS Agency's 12 Lead Pilot Project, Memorial Medical Center is working to improve care and outcomes for local residents who experience heart attacks. Patients brought in by EMS are rapidly assessed and triaged. Depending on the patient's diagnosis and condition, he or she may have immediate angiography, angioplasty or even bypass surgery if necessary. The goal of the project is to enhance care for patients by providing rapid cardiac catheterization interventions, consequently reducing mortality and morbidity. STEMI Receiving Center designation assures that Memorial has a highly skilled cardiac response team ready to treat heart attack patients 24 hours a day, seven days a week, and 365 days a year.

Care of the STEMI patient is a collaborative effort by referring hospitals, ambulance providers and Mountain-Valley EMS Agency. We are certainly following the recommendations of the American College of Cardiology and American heart association to meet Door to Balloon (D2B) times of less than 90 minutes 100% of the time. We are working towards meeting an internal goal of D2B in less than 60 minutes; in fact we have D2B times of less than 30 minutes. The joining of hands with such organizations as the AHA Mission Life Line, Door to Balloon Alliance, project upstart and participation in ACTION GWTG national registry has been a tremendous resource for our STEMI program.

STEMI System

MVEMSA is developing a system approach to STEMI care that will provide our community with excellent resources and best practices related to the care of the ACS patient. Joint efforts begin when local chest pain centers look at triage and destination protocols for simultaneous AMIs thus improving transport resources for referring facilities.

The AHA Mission Life Line recommends the following for transfer patients:

- **Inter-hospital Transfer**
    - STEMI patients for reperfusion have the same priority as 911 calls and trauma.
    - Patient stays on EMS stretcher for STEMI evaluation for inter-hospital transfer.
    - Transfer plan including preferred transport modality and backup transport modality is established.
    - Transport directly to catheterization laboratory when laboratory is staffed and available for PCI without reevaluation in the ED.
    - When possible, minimize or avoid continuous IV infusions such as nitroglycerin or heparin.
    - Transfer patients to STEMI-Receiving hospital with similar consideration to patient registration, bed availability, and accepting physician as trauma patients (use of dummy registration numbers, acceptance of all STEMI patients regardless of bed availability, and reliance on a single accepting physician that is on call 24 hours per day / 7 days per week).
    - When transporting a patient treated with fibrinolysis who has continued chest pain and < 50% ST resolution (in the lead showing the worst initial elevation) after initiation of fibrinolysis, notify the receiving hospital about the potential need for rescue angioplasty.

- Hospital records should be faxed to the receiving catheterization laboratory so as not to delay patient pickup.
- EMTALA/COBRA/medical necessity of transfer form should be completed as soon as possible after the decision to transfer.

- **Helicopter Transfer**: In addition to above:

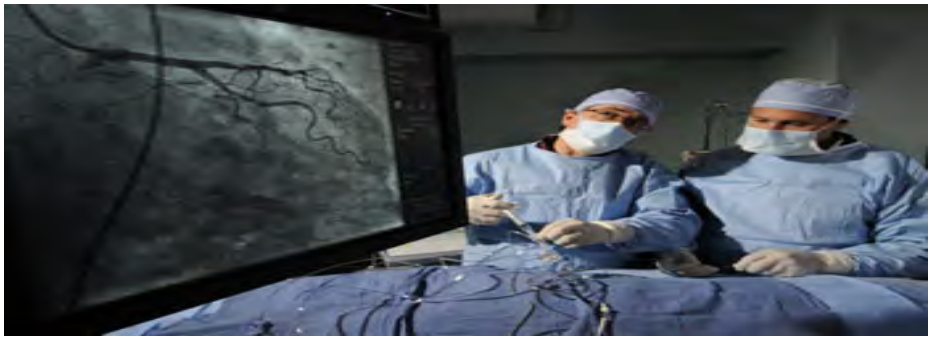
  - Local EMS should generally be used if available and within 30 minutes transportation time to destination hospital.
  - Whenever possible, helipad adjacent to emergency department. Helicopter capable of transporting patients on ten minutes' notice 24/7; when not available, alternate transport options identified
  - Immediately activate helicopter transport during initial communication between referral hospital ED and receiving hospital regarding the need for reperfusion.
  - Establish a system whereby all patient transfers of any type can be specified as time critical within one hour versus diversion possible
  - Another area for our system to focus on is the importance of teaching our patients to call 911 or go to the nearest CPC ED when experiencing CP or any symptoms of a heart attack.

    The American heart association's classic warning signs of a heart attack include:

    - **Chest discomfort.** Discomfort in the center of the chest that lasts more than a few minutes, or goes and comes. It can feel like uncomfortable pressure, squeezing, fullness or pain.
    - **Discomfort in other areas of the upper body.** In one or both arms, the back, neck, jaw or stomach.
    - **Shortness of breath.** May occur with or without chest discomfort
    - **Other signs.** May include breaking out in a cold sweat, nausea, lightheadedness or dizziness. Palpitations or paleness. Unexplained anxiety, weakness or fatigue.
    - **Women** may experience some of the other less-common symptoms, particularly shortness of breath, nausea/vomiting, and back or jaw pain.

Overall the STEMI pilot program developed by Dr. Mackey, MVEMSA Medical Director has been a successful program. Paramedics completing 12 Lead EKGs in the field have decreased time to treatment for patients.

We are excited about our new Physician/Medic mentor program see program details posted in Medic lounges and EMS Newsletter. Our collaborative efforts and metric sharing with EMS has shown a first responder to reperfusion record time of 31 minutes. This translates into better outcomes for our patients such as decreased mortality.



2010 AED Stats by Marilyn Smith

Thirty-six fire departments in the geographic boundaries of the Mountain-Valley EMS Agency are approved to be AED Service Providers.

Of those, thirteen departments supplied statistics on their use of AEDs in 2010. The statistics collected and submitted to the State EMS Authority show:

16 Patients Defibrillated
4 Patients in Witnessed Arrest
14 Patients Non Witnessed Arrest
4 Patients in Arrest with an initial rhythm of Ventricular Tachycardia or Ventricular Fibrillation

Thanks to those fire agencies that submitted their 2010 statistics.

Disaster Preparedness Happenings by Doug Buchanan

Field Treatment Site Plan
As part of this year's HPP Grant objectives, MVEMSA has been working with representatives from its member-counties to develop a Field Treatment Site (FTS) Plan.

What is a Field Treatment Site? An FTS is a temporary facility that allows EMS personnel to provide ongoing triage and treatment of patients, up to 72 hours, while awaiting transport. If the need to provide care for patients is anticipated to exceed 72-hours, the EMS Agency would work with the county's EOC, OES, and Public Health department to request and transition to either a Mobile Field Hospital or Alternate Care Site, which are designed to provide a higher level of care. The current draft FTS Plan can be found on the EMS Agency website, under the Disaster link at: www.mvemsa.com .

When would a Field Treatment Site be activated? A Field Treatment Site is designed to be activated upon request of an Incident Commander when it is anticipated that patients cannot be transported to definitive care within eight hours. Circumstances that might trigger a request for an FTS vary, but may include:

- All hospitals within the region/state are overwhelmed
- Transport resources or transport routes are unavailable
- Large-scale incident requiring additional triage/treatment sites

Where are the Field Treatment Sites? EMS Agency staff has been working with agency and provider representatives to identify targetable sites in each county. These sites are ideally located near a hospital or airport to facilitate transport. An FTS could also be established at the site of an incident if necessary through request and deployment of tents, cots, and other supplies to meet the needs of providing extended care to patients.

Mobile Field Hospitals
The state EMS Authority is currently attempting to identify alternative solutions to sustain the MFH Program, since the Governor's proposed 2011/2012 budget eliminated $1.7 million in funding that was intended to sustain the Mobile Field Hospital maintenance program. EMSA is working with public and private partners at the local and state level to explore alternatives for maintaining this program.

The Mobile Field Hospital program was established in 2006, largely through state general funds. Additional funding from the federal Homeland Security and HPP grants was used for hospital equipment and program development to ensure disaster medical preparedness for California's hospital surge needs during catastrophic emergencies. The three (3) hospitals, of 200-beds each, are strategically located in Sacramento, the Bay Area, and Southern California to allow for rapid deployment and set-up within 72 hours of a request.

Golden Guardian Drill

The Golden Guardian 2011 exercise is coming in May on the 17th, 18th and 19th. This year's scenario is flooding in several regions of California. Planning Conferences are ongoing for this exercise. The state EMS Authority and CDPH will be staffing their Joint Emergency Operations Center to support requests and communications through the RDMHC Programs.

HAvBED Training

The Hospital Available Beds for Emergencies and Disasters (HAvBED) program was developed through HPP grant funding to enable rapid assessment of hospital statuses and bed availability throughout the country. Locally, this procedure is accomplished through creating a query in EMResource (EMSystem). The updated HAvBED training module can be found on the EMS Agency website at www.mvemsa.com under the Disaster link. This module was designed to provide online training for new staff, and walks the user through each step of responding to a HAvBED query.

California's Health and Medical Emergency Operations Manual

The California Department of Public Health and the California EMS Authority are continuing to collaborate on a project to establish an integrated Emergency Operations Manual (EOM). This EOM is being designed to incorporate the elements of the California Disaster Medical Operations Manual (CDMOM) that was previously approved by the state EMS Commission as well as the interim California Disaster Health Operations Manual (CD-HOM) that was release more than a year ago.

The latest version of this manual addresses the Medical and Health Resource Requesting process, and the Health and Medical Status Reporting process. The manual also contains sections on most of the medical and health functions outlined in the MHOAC legislation (e.g. Coordination of Medical Transportation, Coordination with Inpatient facilities, Assurance of Drinking Water Safety, etc.).
The final document is currently scheduled to be released by summer.

Mountain Counties Report by Pat Murphy

Alpine

- Held Red Cross Training Class at Turtle Rock Park on 4/26/11.

Amador

- Sutter Amador Hospital has new MICN Liaison - Connie McKenna
- Maintenance of radio and antennae for Med Net Dispatch Radio
- EMS Awards Dinner May 21 at American Legion Hall
- Renewed Policy #922.20 county specific policy on Dispatch for First Responders
- Changed Triage Tag Training day with Amador County to the first of each month.
- Amador County Health Department completed ChemPack Training on February 8th.

Calaveras

- MCI Exercise completed on 4/12 with a simulated MVA with ROP Students in Vallecito.
- CE Class sponsored coming up July 1 at Mark Twain SJ Hospital.
- System Status Plan approved by the EMSOC in January.
- New clinic opened in downtown Angels Camp by Sonora Regional.
- EMT Class at Murphys Fire District will be finished in June.
- American Legion Ambulance is working on new CCT-P Program.
- Health Department planning an ACS (Alternate Care Site) setup and exercise on May 19th at the High School Gym.

Mariposa

- New Clinic Opened at Yosemite in April.
- New Telemedicine Unit at John C Fremont Hospital for new program called "Specialist on Call"
- Hospital completed ICS 100,200, NIMS 700, NRP 800 programs for all employees.
- EMD Provider started new QI Program.
- County Fire Completed First Responder Class on March 29th in Coulterville.
- EMS Awards at Board of Supervisors planned for their meeting on May 17th.

Ambulance Provider Profile – American Legion Ambulance Post 108

Amador/Calaveras Liaison Pat Murphy conducted an interview on March 16th at American Legion Ambulance main office located on American Legion Drive in Sutter Hill, Amador County. Pat interviewed Al Lennox, President and Alan McNany, Vice President of American Legion Ambulance.

Pat asked Al Lennox "how in the world did a Veteran's organization such as American Legion established in 1919, get into the ambulance business?" Al Lennox answered with pride how the Amador Post 108 was looking for a "public service project" in 1929 and since Amador County didn't have an ambulance they purchased one and staffed it with volunteers. They have remained the sole provider of ambulance services in Amador since then. The ambulance service was staffed with volunteers until after World War II, and then it became "quasi" volunteer/paid staff to full paid staff about 25 years later.

Pat asked "when did American Legion start using paramedics?" Al Lennox responded "in the early 1980's they started with EMT's, EMT II's and a few years later upgraded to Paramedics." Pat asked "what additional areas of geography does American Legion Ambulance cover?" Alan McNany answered, "We cover about 2/3 of Calaveras County." Al Lennox added "American Legion has been covering a portion of Calaveras County, West Point and Wilseyville areas for about 30 years from their Medic 3 station in Pioneer, which covers over 1,200 square miles and over 70,000 in population."

American Legion has over 70 employees, and 20 ALS response vehicles, three being QRV's (Quick Response Vehicles). They have 8 ambulance stations and three 4X4 equipped ambulances for winter operations.

American Legion also has a CCT program with local nurses and provide SAFE exams at their SAFE facility. Alan added that being a non-profit, 501(c) 3, they provide many community service projects through-out the year. Free football standbys for all four high schools, students sponsored to American Legion Boys and Girls State Program, and scholarships for graduating seniors who express a desire to enroll in public safety or health care curriculums for 8 to 10 students a year.

Pat asked Al Lennox how long he had been with American Legion Ambulance. Al replied, "I started in 1990 as a part-time paramedic, after being a volunteer firefighter/EMT for six years, and then became the General Manager in 1992. American Legion felt with his business degree and business experience to bring to the table along with his medical experience that he would make a good GM." Alan McNany stated "In 1993 I started as an EMT before becoming a Paramedic in 1996. I served as a volunteer firefighter and ultimately fire chief for a local area fire department, that later became the Amador Fire Protection District." Alan took over as Operations Manager in 1996.

Alan is currently active in RAC as Chair, on the Board of Directors of the California Ambulance Association, and serving on the EMCC in Amador County. President Lennox acknowledged that this was a natural progression for Alan from when he, Al, used to serve on the same organizations. Al said he is still active in his church, American Legion Nationally and the State of California and the regional association serving the developmentally disabled. Pat asked about Al Lennox's military service. Al served in the United States Navy from 1964 to 1970 as a meteorologist.

President Lennox said "I am very proud of the level of service and oversight our agency provides the community. Our success is based on American Legion's excellent staff, which I feel is the best that the industry has to offer because of their commitment, work ethic, level of training and expertise. The employees have the agency's goal of 'The Relentless Pursuit of Perfection' in mind at all times."

Al stated however, that there are challenges ahead in today's austere environment; all ambulance organizations are challenged to do more with fewer resources. American Legion is well prepared to meet those challenges head on. "There is an expectation from our industry that we will continue to provide our customary high level of service". Al said "we simply have to be more efficient with every dollar that supports our mission. American Legion looks forward to working with the Mountain-Valley agency in the future and we realize that the agency is in transition, but out of transition can come many positive changes. We look forward to that partnership".

Certification and Training by Cindy Murdaugh

EMS Personnel Training Requirements to Incorporate New National Standards

California will be implementing changes in training hours to incorporate the new National Standards.

As California moves closer to implementing changes that will reflect the new "Emergency Medical Services Education Agenda for the Future: A Systems Approach" from the National Highway Transportation Safety Administration, the EMS Authority is revising the EMT and Advanced EMT Regulations to adopt the new education standards and instructional guidelines.

The EMS Authority is also in the process of drafting training standards for Emergency Medical Responders (EMR), currently referred to as First Responders, which is referenced in the First Aid Standards for Public Safety Personnel.

In addition to adopting the education standards and instructional guidelines, the minimum hours of training will also be changed, those proposed changes are:

EMT - Increased from the current minimum of 120 hours to 160 hours.

EMR training will be a minimum of 48 hours.

The revisions to the EMT regulations coincide with the National Registry of EMTs transition of their EMT examination to the new instructional guideline content. This transition occurs on January 1, 2012.

To ensure that students are prepared for the 2012 NREMT exam, EMT Programs should incorporate the new instructional guideline content into courses offered the fall of 2011.

The EMS Authority is planning to release the EMT regulations for public comment in mid-May. Please visit http://www.emsa.ca.gov/ if you wish to comment on these changes.

Continuing Education Opportunities

MVEMSA is pleased to announce a new opportunity for field/hospital/dispatch personnel to acquire continuing education. MVEMSA started providing 6 hour symposiums on a quarterly basis with instruction from various disciplines within the member county region. The last symposium was on Friday, April 15 with the following guest lecturers:

- Richard Murdock (MVEMSA Interim Executive Director) – “Pre hospital Anomalies”
- Dr. Kevin Mackey (MVEMSA Medical Director) – “STEMI Report”
- Kevin Pagenkop (LifeComm Dispatch) – ‘Obvious Death’ & Emergency Phone Triage
- Brenna Garrison, (Doctors Medical Center) – “Acute Stroke”
- Mike Freudenthal (Modesto PD) – “Gang Intelligence”

The next symposium is slated for Friday, July 1, 2011 in Calaeras County and **SPACE IS LIMITED** - so contact MVEMSA to reserve your seat! (209) 529-5085 or email: cmurdaugh@mvemsa.com

Please go to mvemsa.com to see the symposium schedule for future dates and topics.

MVEMSA/Stanislaus County Triage Drill Dates for 2011:

DATE	DAY	SHIFT	TIME
June 28	Tuesday	B	1200-2400
August 25	Thursday	A	1200-2400
October 11	Tuesday	C	1200-2400
December 8	Thursday	B	1200-2400

First Responder/EMT/Paramedic/MICN Application Processing

The Agency will accept applications during the following hours:

Mountain-Valley EMS Agency
1101 Standiford, Suite D-1
Modesto, CA. 95350

Monday **10am-4:30pm**
Tuesday **8am-4:30pm**
Wednesday **8am-4:30pm**
Thursday **8am-4:30pm**
Friday **8am-12:00pm**

Agency staff will be on site to accept applications (Initial & recertification) and take a digital photo of the applicant during the following hours:

AMADOR COUNTY
American Legion Ambulance
12134 Airport Rd.
Sutter Creek, CA. 95685

9:00am-12:00pm
Thursday, July 21, 2011
Thursday, May 19, 2011
Thursday, September 15, 2011
Thursday, November 17, 2011

CALAVERAS COUNTY
American Legion Ambulance
265 W. Saint Charles St.
San Andreas, CA. 95249

1:00pm-4:00pm
Thursday, May 19, 2011
Thursday, July 21, 2011
Thursday, September 15, 2011
Thursday, November 17, 2011

- You can apply for recertification up to 6 months prior to your expiration date.
- Initial EMT applicants must confirm DOJ results prior to submitting application.
- Only COMPLETED Applications with all required documents attached will be accepted.

LifeCom Communications Center by Jared Bagwell

New Communications Manager

I am excited and pleased to announce the promotion of Jeremy Coe to LIFECOM Communications Manager.

Jeremy Coe has been with AMR nearly 5 years. During this time, he has served in many positions such as; Dispatcher, Communications Training Officer, Lead Dispatcher, and Supervisor. Prior to that he had a long history of both paid and volunteer service in Law Enforcement, Fire Service, and Communications where he obtained a vast knowledge that will help him as our new Manager. Jeremy is a dedicated husband to Marcie and father to Maverick, and they all are anxiously awaiting the birth of baby Coe in May.

Jeremy and I will be communicating the new organizational structure as well as goals and visions for LIFECOM over the next couple weeks. His replacement is being recruited for as we speak.

Please join me in congratulating Jeremy and supporting him in this new role.

Fire CQI Supervisor

I am excited and pleased to announce the selection of Kevin Pagenkop as the Fire CQI Supervisor. We had many qualified and competent applicants but Kevin has proven his dedication and competence in his current role over the years.

Kevin Pagenkop has been with AMR for 8 years with prior experience at BAYCOM and the Regional T & QA team. During his time with AMR he has served roles such as Dispatcher, Communications Supervisor and most recently the Lead Instructor with LIFECOM since 2006. Kevin also has experience instructing with the National Academies of Emergency Dispatch (EMD and EFD) in Orlando last year and in Vegas this coming year. He has proven his skills and knowledge in training, education and CQI for many years and has significantly contributed to the success of the ACE accreditation and performance standards maintained by the LIFECOM staff. He has demonstrated excellent communication and organizational skills which will also contribute to improving and maintaining our Fire dispatch and call taking performance.

Please join me in welcoming him in his new role.

Mountain-Valley EMS

1101 Standiford Ave
Suite D-1
Modesto, CA 95350

PHONE:
(209) 529-5085

FAX:
(209) 529-1496

We're on the Web!
See us at:
www.mvemsa.com
www.mvemsa.org **(New Site)**

Mountain-Valley Phone Directory
(209) 529-5085

Richard Murdock *(Interim Executive Director)*	**ext. 212**
Kevin Mackey M.D. *(Medical Director)*	
Linda Diaz *(Trauma System)*	
Tom Morton *(Quality Improvement and Facilities)*	**ext. 213**
Cindy Murdaugh *(Certification, Training, and Communications)*	**ext. 216**
Marilyn Smith *(Response and Transport)*	**ext. 202**
Pat Murphy *(Alpine, Calaveras, Amador and Mariposa)*	
Susan Watson *(Financial Services Assistant)*	**ext. 215**
Joy Thompson *(Receptionist)*	**ext. 201**
Ricardo Martinez *(Information Systems Analyst)*	**ext. 210**
Norma Cavanaugh *(Data Registrar)*	**ext. 204**

MVEMSA
1101 Standiford Ave
Suite D-1
Modesto, CA 95350

Presorted Standard
U.S. Postage Paid
Permit No. 291
Modesto CA

Dated Material
Address Service Requested