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- ◆ MVEMSA JPA Board Appreciation
- ◆ Provider Profile
- ◆ Focus on QI
- ◆ Performance Recognition
- ◆ EMS Week 2013

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EMS News

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Winter / Spring 2013

From the Desk of the Medical Director "Last Seen Normal?"



Kevin Mackey
Medical Director

If this were asked about me, depending upon whom you ask, a variety of very colorful answers would emerge. My parents would probably admit the last time I was seen normal was the day I entered medical school. My wife might say it was the day we got married. My kids... well they're still looking for me to become normal. But for stroke patients, this question is no joke. Furthermore I would argue that this is the single most important piece of information a paramedic could relate to the hospital staff when presenting a potential stroke or TIA patient. Let me say that again: "Time Last Seen Normal" is the single most important piece of information that a paramedic should communicate to the hospital staff when considering a patient to be suffering from a stroke or TIA. That's not to discount or minimize our beloved Cincinnati Stroke Scale, which is also a very important part of a paramedic's initial evaluation. Additionally, blood glucose measurement is equally vital.

But how does one accurately document when a patient was last seen normal? And what does "normal" mean?

These are valid questions that often have diverging opinions leading to varying answers. For the purposes of stroke/TIA, last seen normal means "when is the last time the patient was seen by a reliable historian (relative, healthcare worker, friend, etc) to be acting normal according to the PATIENT'S OWN BASELINE?" In other words, is his or her observed actions and behavior consistent with his or her normal actions and behaviors? The time that the patient was last seen normal is exactly that: a time. It is NOT an estimate or a range. For example, if the patient is found by family to be confused with slurred speech the first thing in the morning, the time last seen normal would be when the family saw the patient the night before. However, if the patient had breakfast and went in to shower, then fell in the shower and was found confused with slurred speech, then time last seen normal would be whenever the family saw the patient at breakfast. The detail and accuracy of this time being documented cannot be overstated.

But if you are like me, you might be asking "Why?"

What is it about the actual time that makes this so important? To answer this, one would have to go back almost 20 years to the original stroke trial conducted by the National Institute of Neurologic Disorders and Stroke (NINDS) in which over 600 stroke patients were randomized to receive the clot-busting drug called TPA or placebo. What the investigators found was patients suffering from an ischemic stroke caused by a blood clot who received TPA WITHIN 3 HOURS were 30% more likely to recover from their stroke at 3 months versus those that did not receive TPA. That 3 hour time limit can not be estimated, but must be documented clearly from a reliable source. More importantly, giving TPA after that 3 hour window is associated with worse outcomes. Hence the monumental importance of our prehospital providers accessing, documenting and communicating the "time last seen normal".

So consider this a plea from your Medical Director, please be intentional and make every effort to assess, document and communicate when your stroke/TIA patient was "last seen normal". The patient's future ability to recover literally depends on it.

Stay safe and keep up the incredible work that you all do!

**In
Appreciation
Of your
Support and
Service**

Mountain Valley EMS Agency Recognizes Supervisor Jim Allen and Supervisor Gary Toffanelli for their support and service on the MVEMSA Joint Powers Authority Board.

At the December 12, 2012 Joint Powers Authority (JPA) EMS Board of Directors Meeting, Executive Director Richard Murdock presented appreciation plaques to Supervisor Jim Allen (Mariposa County) and Supervisor Gary Toffanelli (Calaveras County) for their much appreciated support and service as EMS Agency JPA Board of Directors.

Supervisor Allen served on the JPA Board from January 2009 to December 2012 bringing quality experience with public safety and EMS. Supervisor Allen served in capacities as the Mariposa County Sheriff and an EMS consultant with a private organization.

Supervisor Toffanelli served on the JPA Board from January 2009 to December 2012, bringing quality experience with contracts and business principles. Supervisor Toffanelli works as a self-employed contractor.



Mariposa County Supervisor
Jim Allen



Calaveras County Supervisor
Gary Toffanelli



Thank-You!



The Best EMT's in the U.S. at CCA

Kristy Kuhn and Henry Benavides tend to a high-definition mannequin during a staged EMT call during the National Clinical and Safety Championships on Sunday at Community College of Aurora. Kuhn and Benavides won the national competition.

Tipsy bar patrons did the limbo as the music blared. Glasses were raised. Shots requested. Chants ensued. It was like your typical rowdy bar on a Saturday night.

Never mind there was a man lying face down in a heap on the floor near an overturned table, or that paramedics and law enforcement arrived and were forced to not only respond to the distress call but to try and tune out the taunts and camera-phone flashes of the drunken revelers. Or that it was a Sunday morning at 10 a.m. Look closely and it became clearer that this is a staged event and not a real bar.

The customers, mainly actors and volunteers affiliated with Community College of Aurora, were just as much a part of the scene hatched at the college's Center for Simulation as the timed clinical skill needed by the paramedics.

The purpose of the setup was fostering intense competition in a realistic setting that mirrors the EMT's work in the field. It was one of two scenes competitors in the National Clinical and Safety Championships held Sunday had to navigate at CCA.

Four two-person teams from American Medical Response vied for top honors: from Olympia, Wash.; Lake Havasu, Az.; New Haven, CT; and Modesto, CA, after local and regional competitions nationwide had pared the field. All of the duos also had to field a distress call at what turned out to be a staged hoarder house at CCA's so-called Katrina Building. That event was set up to replicate a low-rent hotel, and came replete with a full array of disgusting props adding to the realism of the EMT's call.



There was the cat lady next door, with meow accompaniment from her brood. Fly sounds buzzed. A stink-bomb caplet opened in the summer heat in the hoarder room was the desired combustible olfactory mix. An ornery hotel maid argued with the health-care professionals. Painters and custodians did their level best to get in the way of the paramedics every move.

But the theatrics were just white noise if the professionals handled things correctly. They had to drive safely through cone courses, averting obstacles on the way to calls. But it was their clear-headed diagnoses through the staged scenarios, while also saving precious minutes in the process that was most important.

"They prepped us about how amazing it was going to be here, but even still with them prepping us and showing us the mannequins ahead of time, to actually walk in and have it feel like it was a real call, that was amazing," said Kristy Kuhn, who along with partner Henry Benavides, were declared the winners of the national prize.

"The hoarder house was almost to a 'T,'" she added. AMR, whose national headquarters is based in Greenwood Village, returned to CCA for a second straight year and, according to its senior vice president of professional services, Ron Thackery, will come back as long as the college wants to host.

High-tech facilities include a war-room in which judges can watch the teams' every move on multiple cameras around the outdoor driving scenes and inside the two staged simulation areas. The logistical expertise CCA brings to the event, including the establishment of the realism of the scenes, and knowledgeable staff are some of the reasons the relationship has remained strong.

"It's been just an absolutely amazing experience to see all the things we've been able to do here," Thackery said of CCA. "I realize it's a community college, but this could be major university with this asset here. It's way beyond anything that I've been able to use in my job, and everybody who comes here, all the people we bring as judges or as participants, are absolutely amazed at the technology."

Job Well Done!

PROVIDER PROFILE

by Pat Murphy, Field Liaison

Ebbetts Pass Fire Protection District Appoints New Chief

Fire Chief Dave Baugher is very proud of the Ebbetts Pass Fire District and its personnel. The district has to meet significant challenges in a very diverse environment. The district provides a wide range of services along the Highway 4 corridor, over a large area and during the worst weather and conditions at times. The seasons bring different challenges at different times of the year. They handle everything from run-of-the-mill medical aids that all places have, to ice rescues in winter, swift water rescues in summer, high and low angle rope rescues, lost deer hunters in deer season and vehicle extrications just to name a few. The district

covers 204 square miles with a year round population of 14,000; however during certain times of the year they swell to 40 to 50 thousand. The district provides service to the communities of Arnold, Hathaway Pines, Avery, Mineral Mountain, Dorrington, Forest Meadows, Cottage Springs, Tamarack, and Camp Connell. Their response area also covers parts of two other counties, Alpine and Tuolumne. So

in reality they cover about 600 square miles for EMS. EPFPD covers approximately 600 square miles of rugged, beautiful country. Because of it being such a rural area, actually much of it is considered wilderness, and because they have not so ideal road conditions during certain times of the year the ambulance transport times can be extensive. Chief Baugher said that sometimes it can take a four hour ambulance ride to get patients to the closest hospital due to weather and road conditions. This is one of the main reasons they have an Auto Pulse machine.

The Ebbetts Pass Fire District was formed December 7, 1964, (incorporated by 1965) to initially provide

structural fire protection during the winter periods when the local California Division of Forestry station was not staffed. Prior to their formation fire protection was done by just a few men in the 1950's with a surplus Army hose cart. They were called the Hathaway Pines Hose Company. They were absorbed into the Ebbetts Pass Fire District and the last existing member of this company retired at 64 years of age in 1975.

They have been providing ambulance service since 2007, but have provided ALS Fire Engines since 1998. Because they don't have an exceptionally

large call volume, about 1,100 to 1,200 annually, they can't depend on the transport fees to support the ambulance operation. However with the strong support of the community they passed a special tax. This special tax allows them to staff two full time ambulances, one in Arnold and one in Hathaway Pines. They also staff two full time ALS Engines. During the weekends in winter they staff another ambulance in Bear Valley for the ski resort. They have the ability to staff up to five ambulances and have done so on rare occasions. They also have six fire engines, one truck

company, a squad and a 3,000 gallon water tender.

Because of the strong community support, Ebbetts Pass Fire District strongly supports the community. They promote many public programs that help the area. They have a large training room at the fairly new fire station, 2007, and it is open for public use. And they do use it, last year it got used about 100 days by the public. In 2012 they are adding a medical training room to enhance their abilities to prevent skills degradation. Chief Baugher emphasized that they always treat all citizens equally and with the best care they can provide.



Ebbetts Pass Fire Dept. Volunteer Firemen checking over their radio and resuscitation equipment. They meet for drill every Thursday evening. Standing, left to right, G. Claeys, B. Ledbetter, R. Beary, L. Harris, J. Ledbetter, J. Miller, D. Jones, Kneeling, left to right: T. Payne, A. Saplen, V. Claeys, B. Kovacs, missing from picture is vacationing Fire Chief John George.

Ebbetts Pass Fire Protection District

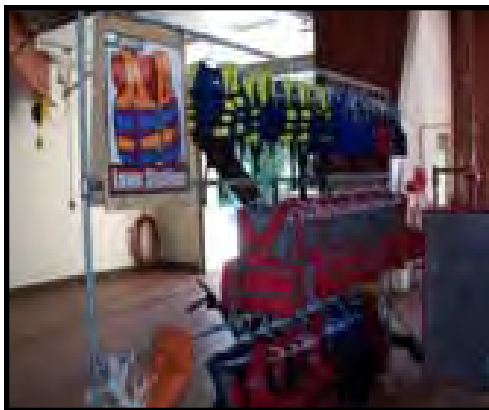
by Pat Murphy, Field Liasion

Chief Baugher joined Ebbetts as a volunteer in 2001 and became its Chief in 2008. Chief Baugher is somewhat private about his background, as he wanted this article to focus on the district and not on him. Suffice it to say that he came from a high tech medical equipment background in the Bay Area, before coming to Ebbetts. He has a five-member board that has four retired fire chiefs from various departments. He cites this as being a treasure trove of resources for running an all-hazards emergency response department.



Ebbetts Pass Fire Chief , Dave Baugher

Matt O'Donnell is their EMS Coordinator and he is very dedicated to providing the best in EMS delivery. Last winter he said that you can tell you're going to have a bad day when you have to get a ladder to get over the snow berm to fight a structure fire. I would tend to agree.



Ebbetts Pass Fire Protection District provides loaner life vests during the summer for all the water activities in the area. No excuse not to be wearing one on the many lakes and rivers there.

Cheryl Howard has worked as the Ebbetts Fire Secretary for many many years.



This picture, which hangs on the wall of the training room, is one of their first fire stations for the district. Pales just slightly to their current headquarters.



Station 1, located in Arnold was built in 2007

FOCUS ON QUALITY IMPROVEMENT

VENTRICULAR ASSIST DEVICE PATIENTS (ADULT) By Vasti DeFreitas, QI Coordinator

DEFINITION:

Ventricular Assist Device is a mechanical pump that is implanted to help the heart's weakened ventricle (right, left or biventricular) pump blood through the circulatory system. The VAD is used as a "bridge-to-transplant." There are pulsatile and non-pulsatile devices. The patients will have a medical I.D. card with type of device. The device is small and portable, typically placed in a "fanny-pack" type of bag that is carried by the patient. There are two batteries connected to the controller, which is typically found in a harness worn by the patient. Additionally, the patient usually has a caregiver present who has been trained in the operation and alarm functions of the device and a VAD Coordinator who is available 24/7 by phone. Most common complications of VAD patients include: stroke, sepsis and cardiac arrhythmias. The caregiver has the most readily available knowledge of the VAD. The caregiver is trained on use and trouble shooting. *Separating the patient from the caregiver should be avoided, if at all possible.*

ASSESSMENT

- a. Assess for non-VAD related injuries, complications or illnesses and treat accordingly.
- b. Pulse:
 - The patient may not generate a peripheral pulse depending on the implanted device.
 - ECG heart rate will differ from the pulse rates since the VAD is not synchronized with the native heart.
 - The pulse rate reflects the rate supporting perfusion.
- c. Pulse oximetry may not be measurable or accurate.
- d. Blood pressure
 - Automated non-invasive blood pressures will not be reliable when used on a VAD patient.
 - VAD patients will typically not have a systolic and diastolic blood pressure in the absence of a pulse.
 - The blood pressure can be palpated or auscultated with a 70-90mmHg as an acceptable range.
 - Manual blood pressures will reveal a single number, the mean, which normally will be between 65-100mmHG.

Note: In the unconscious patient, assess for other signs of life; i.e. breathing, skin signs and cap refill. Do not expose the driveline insertion site. Keep the binder in place. Assess for tether to the external power unit.

TREATMENT GUIDELINES

- a. OXYGEN: adjust flow and delivery mode as needed.
- b. AIRWAY: Standard airway management. Support the Airway per MVEMSA protocol.
- c. IV Initiate (2 large bore if possible)
 - Policy 554.41 - Non-traumatic Shock
 - Give 250 ml bolus, consider contacting base at earliest opportunity.

NEVER STOP THE PUMP

- If stopped, VAD Coordinator will advise treatment.
- Check the pump is functioning by listening with a stethoscope over the left upper quadrant of abdomen.
- Check there are no bends or kinks in driveline and that it is attached to system controller.
- Do not pull on driveline.
- Check for alarms on controller (use alarm guide).
- RED Heart alarm is a Hazard Alarm and could mean low flow or percutaneous lead disconnect.
- Change one battery at a time.

COMMON COMPLICATIONS:

- a. Hemorrhage: Active bleeding/hemorrhage is to be treated with direct pressure following standard protocol. The patient should be transported to the closest appropriate receiving facility. Patients meeting Trauma Criteria are to be taken to the closest Trauma Center.
- b. Stroke: patients should be transported as usual as per protocol.
- c. Arrhythmias
 - These need to be managed according to standard ACLS protocols. Should defibrillation, Cardioversion or external pacing become necessary, follow the appropriate treatment protocol as there are no contraindications. *The pump is insulated and will not be damaged.*
 - Do NOT disconnect the system controller from the percutaneous lead or stop the pump prior to delivering the shock.
 - The patient may potentially be awake while in ventricular fibrillation. **Treat the patient, not the monitor.**
 - The ECG heart rate will differ from the pulse rate since the VAD is not synchronized with the native heart
- d. Altered Level of Consciousness/Unconscious and apneic
 - Assess the patient for non-VAD related causes of altered level of consciousness.
 - ACLS per protocol.
 - Loss of cardiac output from VAD failure and a “Red Heart” alarm may present patient symptoms such as dyspnea, nausea, hypotension, syncope, loss of consciousness or pulmonary edema.
 - If the patient has a first generation (pulsatile) VAD, there may be an external hand pump, which can be used in lieu of performing chest compressions. The caregiver has been educated regarding the use of these devices. You may listen to them in utilizing the equipment. Contact the VAD Coordinator at the implanting center as soon as possible for further directions regarding the device. **Medical direction must always come from the base hospital.**
 - Chest compressions and blunt thoraco-abdominal trauma can disrupt the anastomoses between the left ventricle, VAD and ascending aorta.
 - **Chest compressions ONLY if unresponsive, apneic, pulseless and VAD is presenting with a Red Heart Alarm.**

FOCUS ON QUALITY IMPROVEMENT

VENTRICULAR ASSIST DEVICE PATIENTS (ADULT) CONTINUED FROM PAGE 7

SPECIAL CONSIDERATIONS: LISTEN TO THE VAD PATIENT'S CAREGIVER/COMPANION.

- The caregiver/companion has extensive knowledge of the operation and troubleshooting of the device.
- Every attempt should be made to transport the caregiver/companion with the patient.
- VAD Program coordinator will likely be in contact with the patient/caregiver by phone and can be used as a resource in determining if the presenting chief complaint is a pump related problem or a patient related problem.
- The Coordinator should be in contact with the base hospital MICN and physician as soon as possible to assist in patient management and destination decision.
- If the "Red Heart" alarm is audibly going off, then there is pump failure.
- NO NITRATES
- The pump is preload dependent requiring adequate blood volume and pressure. It's safe to give the patient fluid bolus
- Avoid driveline interruption or dislodgment.
- NO ASPIRIN: The patient will be on an anticoagulation regimen.
- Please note that these patients have a magnet in the device and many times an ICD (Internal Cardioversion Defibrillator) and cannot undergo an MRI study.

TRANSPORT AND DESTINATION:

When identified that the patient as a Ventricular Assist Device (VAD) it is mandatory to contact the receiving hospital. The base contact is critical to help the facility prepare the highly specialized patient.

Base will make every attempt to include the VAD coordinator with the destination determination.

Transport all VAD equipment to the hospital with the patient, including the power base and extra batteries.

Every attempt to transport the caregiver or companion with the patient will be made as they will facilitate device operation and patient care.

Every mode of transport should be considered to transport patient to the most appropriate facility including every attempt to return the patient to their VAD center. Unless the patient is unstable and/or has a non VAD related complaint.

VAD CENTERS:

Sutter Sacramento Medical Center

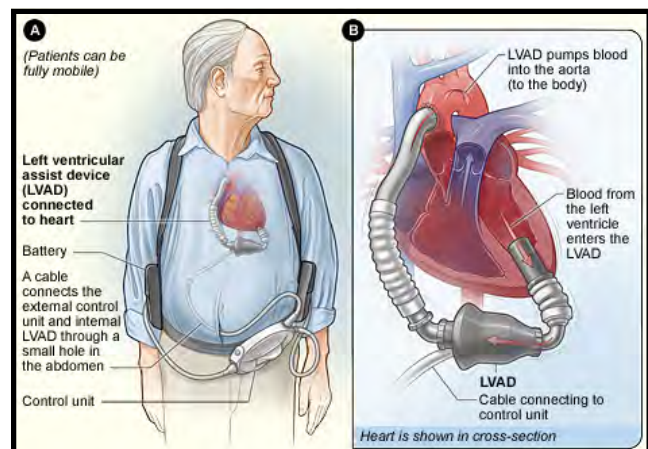
UCDavis

Community Regional Medical Center, Fresno

California Pacific Medical Center, San Francisco

Stanford Medical Center

UCSF



LETTER OF RECOGNITION

By Teri Griffin, CQI Supervisor, LifeCom Fire & EMS Dispatch

American Medical Response

LIFECOM

Letter of Recognition

03/19/2013

Maureen Mckinley

On Thursday February 7th 2013 you received a call from a woman reporting that her husband was unconscious and barely breathing. Without any medical or fire personnel on scene, this caller relied on you, the Emergency Medical Dispatcher (EMD), to provide assistance through the phone before emergency personnel could arrive on scene to render care. You obtained the caller's name and committed to using it throughout the call.

Emergency Tele-Communicators are faced with the difficult, and often thankless, job of controlling a scene that they themselves are not present at. In regards to this particular incident, it was only through your composure and exemplary service that this caller remained calm enough, under the most difficult of circumstances, to be able to answer your questions and comply with your Pre-Arrival Instructions (PAIs). By utilizing a confident, supportive tone and providing multiple reassuring statements, you were able to control the scene and direct those there to provide assistance until help arrived.

It was through your dedication to service and commitment to patient care that you were able to deliver Pre-Arrival Instructions (PAIs) to the caller and through the application of superior calming techniques and reassuring statements, you were also able to ensure that the PAIs were delivered effectively enough to give our responders an opportunity to apply Advanced Life Support (ALS). While patient outcome is often out of our control, it is important to recognize your exemplary efforts as an Emergency Medical Dispatcher (EMD) regardless of what may or may not occur with the patient after they are transported or admitted. It is all the more exciting that your outstanding efforts led to a positive outcome for this patient. It cannot be stated how valuable your involvement on this incident was.

There are not many people that can truly make a difference in the life of another. It is with appreciation and pride that we recognize you for your exceptional performance. Thank you for making a difference.

Teri Griffin-Pagenkop
CQI Supervisor

Quality Improvement Unit -LifeCom



...more than I can say.

Dear Maureen,

You may not remember me, but I will forever remember you! You were that caring person on the other end of the phone line, you were the strong voice encouraging me on, instructing me and counting with me. Together you and I saved my husband's life. You!! Saved Kevin's life that Feb 6 night. Words do not begin to express my thanks but please know that I thank you with all my heart. Thank you and may the Lord Bless You!

Incident Responders Recognition

by Richard Murdock, Executive Director



Seldom does the entire EMS team get recognition for a difficult call that reaps positive returns. It gives Agency Staff great pleasure to recognize the First Responders and ALS crew involved in the incident described below.

Great job to the following people:

Stanislaus Consolidated Fire: Captain Mike Satariano, Engineer Jeremy Smith, and FF Doug Falle, Stanislaus County Sheriff: Deputy Jesus Sigala, Oak Valley Unit 2 Crew: Paramedic Jered Eckle and EMT Robert Shelp.

On 12/22/2012 Oak Valley Unit 2 responded to an incident for a child not breathing. Upon arrival Stanislaus Consolidated Fire Protection District Engine 26 (Captain Mike Satariano, Engineer Jeremy Smith, and Firefighter Doug Falle) presented OV Unit 2 with a 2 year old child in full respiratory arrest with bradycardia, unconscious and cyanotic.

There was also a Stanislaus County Sheriff Deputy (Jesus Sigala) on scene attempting to do artificial ventilations via a BVM, however upon assessment the child had evidence of a tracheostomy, and the deputy was doing what he could to ventilate this little boy.

A tracheostomy Intubation was performed and an Intra Osseous Needle inserted. The patient was transported code 3 to Memorial Medical Center with 1 FF assisting in the back of the ambulance and the Captain driving. Soon after departure the patient's skin began to turn pink, heart rate began to rise quickly to around 134 BPM with agitation to the patient because of the tracheostomy intuba-

tion. The child did display acute decorticate posturing initially during transport. However his condition improved and the posturing was not continuous.

Paramedic Jered Eckle comments, "As the Paramedic on Scene I relied heavily upon my Partner Robert Shelp, EMT, and the Fire Dept. Personnel during this incident, as I had a lot to do and very little time to do it as time was very much so of the essence. The preservation of life for this little boy was merely relying upon our treatment and how fast we could accomplish it.

I followed up with Memorial Medical Center in which informed me that the child had been transferred to Stanford Hospital. I then phoned Stanford Pediatric Intensive Care Unit 2 days later on 12/24/2012 and was informed that the child had been extubated, was awake, eating and happy as can be with a potential discharge date home on Christmas Day. I have left a message with the family at Stanford to call me if they wish, so that I may possibly meet the little boy again when he comes home.

I wanted to share with you how extremely proud I am of all of the responders that were involved with this incident. With the amount of pressure, emotional level, time limitations, and nature of the call, everyone worked together as a team to provide the best level of care possible therefore providing a very successful outcome."



Stanislaus County and Surrounding Areas 40 Year EMS Reunion

In 1973--forty years ago—the first class of paramedics graduated from the Stanislaus County Paramedic Training Program, starting paramedic service in Stanislaus County. Stanislaus was one of the first counties in California to provide paramedics.

Were you part of EMS (Paramedic, EMT, Nurse, Physician, ED Personnel or Dispatcher) in Stanislaus County or the surrounding areas during the past 40 years?

- **When:** Saturday, May 18, 2013, from 5:00 pm to 10:00 pm
- **Where:** Chevy's Restaurant at 1750 Standiford Ave.
(Cross of Carver) Modesto

We're having an informal get together to rekindle old friendships in a private party room at Chevy's in Modesto. No-host food and drinks will be available. Stay for the whole evening or drop in just to say hi. It'll be a great chance to tell the stories that only those of us who were there can believe. We're expecting quite a crowd and a really great time with our old friends.

Please forward this invitation to everyone you know who was a part of the history of EMS in Stanislaus County. Please post this invitation in ambulance stations, emergency rooms, and other appropriate place.

**Please RSVP via the "Stanislaus County EMS Reunion"
Facebook Page**

Too Much Information

by Barry Hurd, Patterson District Ambulance

I can remember how excited we all were when the boss announced that we would be getting the new piece of equipment. It was truly a big deal. You see this equipment was high tech and was going to replace that big orange box we had to lug into calls. Some of you might only know about this orange box from watching old episodes of Emergency on TV Land. It was the two way radio that was used to communicate with the base hospital to get our treatment orders. Yes, I actually have been in the field long enough to have used one of those in real life.

This new equipment the boss put a large sum of money on was going to replace that box and it was cool because it weighed half as much, was more powerful and had duplex communication. The latter allowed the nurse to interrupt you when you started getting a little long winded. And let's not forget that we could send EKG telemetry. That was so the doc could interpret the rhythm to confirm what we were telling them.

This was in a system and in a time when online medical control meant that we had to contact the Base Hospital for all of our ALS patients and get orders for everything. There was a time early on that we actually had to have orders to even load and transport the patient. Because of the direct online medical control the call-in format was necessarily detailed. We had to describe the patient and the scene and events so that the base could "see" what was going on and give us orders and direction accordingly. Thankfully that was a long time ago and things have changed considerably. And they may be changing even more.

I was recently at a forum wherein our Medical Director indicated that he would consider removing all online medical control and have us operate completely under standing orders. No more contacting the base for orders. We'll have to wait and see about that but the reality is that, even now, under the current set of protocols there are really very few occasions that we would actually need to contact a Base Hospital for the purpose of obtaining any kind of order. As professional Paramedics we should

know our protocols inside and out and utilize them and our good judgment to apply the proper treatment modalities available to us for each patient and not wait to be told. So that when we call into the hospital with a report we won't be asking for any orders but merely letting the hospital know to expect a certain type of patient. This brings me to my real soapbox.

I am not at all a scanner hound but my job does require that I listen to the radio and that includes the med-net. I find that there is a lot of air time taken up with some really detailed reports even on some of the most minor patients. And sicker patients can get even more air time and detail. Most of the detail is information that should be reserved for the actual patient hand off when we are face to face with the receiving nurse. MVEMSA actually has a policy that addresses this.

I would like to re-introduce everyone to MVEMSA policy #330.10. It's a short policy that outlines the radio format we should all be using. I think the first three items under section IV makes the case for short, clear and concise radio call-ins:

1. Standard patient reports to a Base Hospital or Receiving Facility should be **no longer than 30-40 seconds**. (emphasis mine)
2. When appropriate, additional information will be offered by prehospital personnel or requested by the Base Hospital or Receiving Facility.
3. Base Hospital contact shall be made for all patients requiring care **beyond standing orders**. (emphasis mine)

I think that it is important to make a clear distinction here regarding Base Hospitals and Receiving Facilities.



In our system all Base Hospitals are also Receiving Facilities. Only for a moment did we have a Receiving Facility that was not also a Base Hospital. However, just because you are contacting a certain hospital that is a Base Hospital does not mean that you are actually making Base Contact for every patient. Base Hospital contact should only be made if Base Physician direction is required. Only those patients that require care beyond standing orders require us to contact a hospital in its capacity as a Base. For 95%+ of our patients we are actually contacting the hospitals in their capacity as a Receiving Facility.

Reviewing 330.10 further we are given distinct formats for each type of contact, Receiving Facility Report and Base Hospital Contact. The format that nearly all of our patients fall under is the Receiving Facility Report and should sound something like this:

“Modesto Hospital, Patterson 91, Code 2 Receiving Facility Report”

“Acme Hospital, MICN Jones, 1325, go ahead 91”

“This is Patterson 91, Paramedic Hurd, enroute Code 2 with a 10 minute ETA with a medical patient, a 53 year old male whose chief complaint is chest pain. Vitals are GCS 15, blood pressure 132/88, Pulse of 92, respirations 16 and I am treating ALS, over.”

That presentation follows the items in the format list precisely but I am sure that there are more natural approaches that include all those items that are perfectly appropriate. For example:

“This is Patterson 91, paramedic Hurd. We are enroute to your facility with a 53 year old medical patient whose chief complaint today is chest pain. We are treating ALS and his vital signs are GCS 15, blood pressure 132/88, Pulse of 92, respirations 16. We currently have an ETA code 2 of 10 minutes, over..”

Either way, it should be noted that there is nothing in there about the patient’s allergies, medications, EKG interpretation, specific treatments, long term medical history or the color of his dog.

All that kind of information should be reserved for the bedside when you have clear communications and the attention of the receiving nurse.

What changes when we are making official Base Contact? Not much. A review of the Base Hospital Contact format reveals that all we add to the previous format is the treatments that we have performed and the patient’s response to them. And there is one more thing, a request for further therapy. I don’t see it as an open ended question for “orders” but rather a request for a specific therapy that you have in mind for this patient at this time that falls within your protocols. Those specific treatments are outlined in our protocols under Base Physician Orders. There should be considerations for those really rare patients that just don’t fit into a specific treatment that would require consult and direction from the Base, of course. Also, whatever contact protocols are in place for STEMI Alerts, Trauma Alerts or Stroke Alerts as well as MCI’s are guided by those specific policies and can affect these formats slightly. At the very least, with a STEMI patient for example, you may want to make it an official base contact and give them your treatment and response as well as the EKG interpretation even if you aren’t actually in need of specific orders.

I can hear some of you saying, “But the nurses would just keep asking for all kinds of information so why not just give it to them up front and save time?” Maybe they would, they’re allowed to if they feel the need. I believe that if we provide them with excellent bedside reports and clear, quick radio call-ins that they would easily become accustomed to the format that, by policy, should already be used and ask fewer and fewer questions of us on the radio as time goes on.

The reality is that long detailed call-ins rarely, if ever, changes the treatment we will be giving in the field and only rarely change the choices that the hospital makes for where they will be placing the patient. So there is no need for them. Review the policy and the formats and give it a try. You won’t spend so much time on the radio, the patient will still be treated appropriately and the hospitals will know that they have a patient on the way.





Amador and Calaveras County Triage Drill Dates for 2013

Date	Time
January 7-14	0800-0800
April 1-8	0800-0800
July 1-8	0800-0800
October 7-14	0800-0800

Mariposa County Triage Drill Dates for 2013

Date	Time
March 4-11	0800-0800
June 3-10	0800-0800
September 2-9	0800-0800
December 2-9	0800-0800

Stanislaus County Triage Drill Dates for 2013

Date	Time
March 7 B shift	1200-2400
June 25 C shift	1200-2400
September 19 A shift	1200-2400
December B shift	1200-2400



National EMS Week 2013 Is May 19-25



National Emergency Medical Services Week brings together local communities and medical personnel to publicize safety and honor the dedication of those who provide the day-to-day lifesaving services of medicine's "front line."

The American College of Emergency Physicians (ACEP) was instrumental in establishing EMS Week when President Gerald Ford declared November 3 – 10, 1974 as the first "National Emergency Medical Services Week." This annual observance continued for four more years and was then reinstituted by ACEP in 1982.

National EMSC Day

Each year, the federal Emergency Medical Services for Children (EMSC) Program partners with the American College of Emergency Physicians (ACEP) to celebrate Emergency Medical Services (EMS) Week. The Wednesday within the week-long celebration is designated as EMSC Day. On Wednesday, May 22, as part of the larger National EMS Week celebration scheduled for May 19-25 2013. Local communities and medical personnel are encouraged to focus their EMS Week activities on raising public awareness about the need for specialized emergency care for children.

"EMS HERO" AWARD PROGRAM

We encourage you to nominate EMS personnel who have made a special contribution to the community or EMS system through such activities as EMS response, systems development, continuing education, quality assurance, medical community liaison, EMS related special projects, etc.

You will find further information regarding eligibility, documentation requirements and timelines on page 16-17 of this Newsletter. You can also find the nomination information/form on the Agency website mvemsa.org.



Drop by the EMS Agency Office

In recognition of EMS Week 2013, the Mountain-Valley EMS Agency will be providing refreshments throughout the week, May 20-24, to all EMS personnel who visit the Agency.



"EMS HERO" AWARD PROGRAM

Nomination forms are available at the Mountain-Valley EMS Agency or on our website at www.mvemsa.gov. EMS providers, supervisors, and managers are encouraged to nominate staff for outstanding performance.

AWARDS REVIEW PROCESS

The Awards Review Committee will review the nominations including all supporting documentation; submit recommendations to the Agency Medical Director, who will make the final selection and presentation of the EMS Awards.

AWARD PRESENTATION

The EMS awards presentation will be held during the following committee meetings each year at a date/time to be determined:

- | | |
|---------------------|--------------------------|
| ➤ Alpine County | MVEMSA JPA Board Meeting |
| ➤ Amador County | Amador EMCC Meeting |
| ➤ Calaveras County | Calaveras EMSOC Meeting |
| ➤ Mariposa County | Mariposa EMCC Meeting |
| ➤ Stanislaus County | Stanislaus EMSC Meeting |

Committee meeting dates will be scheduled and notifications will be made following final selections.

ELIGIBILITY

Eligible nominees for these awards include the following EMS personnel who have made a special contribution to the community or EMS system through such activities as EMS response, systems development, continuing education, quality assurance, medical community liaison, EMS related special projects, etc.:

- ✓ locally certified Emergency Medical Dispatchers, First Responders and EMTs,
- ✓ locally accredited Paramedics,
- ✓ locally authorized MICNs,
- ✓ locally active EMS educators and EMS training officers,
- ✓ local EMS physicians,
- ✓ local EMS administrators, managers, and supervisors

NOMINATIONS

Nominations may be made by anyone. Describe the nominee's qualities and contributions to the local EMS service or system. Letters of support from EMS personnel and local EMS administrators are encouraged.

All nominations and supporting documents must be received by the Mountain-Valley EMS Agency no later than Friday, May 31, 2013.





Nominee: _____ Rank/Position/Title: _____

Agency Affiliation: _____

I hereby nominate the individual named above for the award indicated. **Documentation of the basis for this nomination is attached in accordance with the requirements of this program.** I certify that this information is true and correct to the best of my knowledge, and is provided based upon information personally known to me.

Nominated by: _____ Relationship to Nominee: _____

Address: _____

Phone # _____ Signature: _____

Nominations submitted without supporting documentation will not be considered.

All nominations must be submitted to the Mountain-Valley EMS Agency, by U.S. Mail to 1101 Standiford Ave., Suite D-1, Modesto, CA 95350, fax 209-529-1496 or emailed to cmurdaugh@mvemsa.com.



EMSC: An Historical Perspective Fact Sheet

Emergency Medical Services for Children (EMSC) is a national initiative designed to reduce childhood death and disability due to severe illness or injury. Although EMSC began more than 25 years ago, the larger emergency system of which it is a part dates back to the Korean and Vietnam Wars. Medical experiences in both wars demonstrated that survival rates improved dramatically when patients were stabilized in the field and transported immediately to a well-equipped emergency facility. During the 1960s, civilian medical and surgical communities began to recognize the possibilities in applying these experiences within an organized emergency medical services (EMS) system.

1966: Congress passes the Highway Safety Act of 1966, establishing the National Highway Traffic Safety Administration (NHTSA). The agency's purpose is to help states start their own coordinated EMS programs.

1973: Congress passes the Emergency Medical Services Systems Act of 1973, a program managed by the Health Resources and Services Administration (HRSA), to provide additional resources to state and local governments for implementing comprehensive EMS systems.

1975-79: State EMS systems dramatically improve the outcomes for adults. However, pediatric surgeons, pediatricians, and other concerned groups begin to realize that children's outcomes weren't keeping up the pace.

1979: Calvin Sia, MD, president of the Hawaii Medical Association, urges members of the American Academy of Pediatrics (AAP) to develop multifaceted EMS programs designed to decrease disability and death in children.

1983-84: Senator Daniel Inouye (D-HI) joins Dr. Sias' crusade after learning about the emergency care provided to a senior staff member's daughter. Her treatment demonstrated the average emergency department's shortcomings in treating a child in crisis. Senators Orrin Hatch (R-UT) and Lowell Weicker (R-CT), backed by other staff members with similarly disturbing experiences, join Sen. Inouye in sponsoring legislation to create the EMSC Program.

1984: U.S. Congress enacts legislation (Public Law 98-555), authorizing the use of federal funds for EMSC. Administered by the HRSA's Maternal and Child Health Bureau (MCHB), the EMSC Program provides states grant money to help develop and "institutionalize" emergency medical services for critically ill and injured children. The Program does not promote the development of a separate EMS system for children, but rather enhances the pediatric capability of existing EMS systems.

1985: U.S. Congress appropriates initial funds for EMSC; first program grant announcements published.

1986: EMSC awards first federal grants to Alabama, California, New York, and Oregon, specifically earmarked to improve pediatric emergency medical services.

1987: The first Pediatric Advanced Life Support (PALS) course is made available to all emergency care providers.

1989: The first National Pediatric Emergency Medicine (PEM) course is introduced in collaboration with the American College of Emergency Physicians (ACEP) and the AAP.

1990: HRSA's MCHB establishes the EMSC Resource Network, which includes the EMSC National Resource Center (NRC), located in Washington, DC, and the National EMSC Resource Alliance, located in Los Angeles, CA. Their purpose is to help grantees develop new programs, disseminate their products, promote

public understanding of pediatric issues in the EMS system, and work with professional organizations to further training efforts in pediatric emergency care for all health care providers.

1991: Pediatric emergency medicine is approved as a subspecialty in Emergency Medicine and Pediatrics.

1992: New Jersey becomes the first state to enact EMSC legislation at the state-level. California, New York, and Idaho become the first

states to be awarded an EMSC Targeted Issue (TI) grant. Through the competitive TI grant mechanism, the EMSC Program funds schools of medicine to find new approaches to providing the best possible emergency care for children across the nation. Typically, the projects result in a new product or resource or demonstrate the effectiveness of a model system component or service of value.

1993: The Institute of Medicine (IOM) releases the most comprehensive report on children's emergency medical care, detailing the nature, extent, and outcomes of pediatric illness and traumatic emergencies. The report reveals continued deficiencies in pediatric emergency care for many areas of the country.

1995: To help address "the need for more and better data on the volume, nature, and outcomes of pediatric emergency care," a major shortcoming identified in the IOM report, MCHB funds the National EMSC Data Analysis Resource Center (NEDARC), located in Salt Lake City, UT. NEDARC's primary mission is to assist EMSC grantees in collecting and analyzing data.

1996: MCHB establishes the Partnership for Children Consortium. Members include the Ambulatory Pediatric Association,



the AAP, ACEP, the National Association of EMT's, the American Trauma Society, and several other national and professional organizations that receive federal funding to help implement EMSC Program goals and objectives.

1997: MCHB reports that every state, the District of Columbia, and four U.S. territories have received grant support at some time since the Program's establishment. Many elements of a model EMSC system have been developed since the Program's implementation, including prehospital protocols for triage and treatment of children, curricula for prehospital and emergency department staff, and standards for hospital facilities accepting pediatric patients. In addition, State Partnership grants are first introduced.

1998: MCHB sponsors the first National Congress on Childhood Emergencies. This historic event marks the first nation-wide gathering of all medical and non-medical individuals interested in improving health care for children. During a special luncheon at the Congress HRSA announces the recipients of its first National Heroes Awards. The purpose of the awards program is to identify, honor, and recommend as models the efforts of a select handful of men and women who excel in improving children's emergency health care.

1998: The Interagency Committee on Emergency Medical Research (ICER) is created. Its purpose is to improve the quality and quantity of EMSC research, to foster collaboration between federal agencies in highlighting EMSC research topics during development of research agendas, and to reduce barriers to the production of high quality EMSC research. Participating agencies include: HRSA, the Agency for Health Care Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH), among others.

1999: Recognizing that families are a valuable resource in the planning, development, and evaluation of prehospital healthcare services for children, the NRC creates the Family Advisory Network (FAN).

2000: The Department of Health and Human Services (DHHS) releases Healthy People 2010, a national health promotion and disease prevention initiative that identifies 28 focus areas and 467 objectives to improve the health of all Americans. EMSC succeeds in ensuring that the plan's final version includes two EMSC-related objectives.

2000: ACEP includes information about the first-ever National EMSC Day in its National EMS Week promotional materials. Working in partnership with the NRC, EMSC Day is now celebrated annually on the third Wednesday of May.

2001: The EMSC Program awards four competitive cooperative agreements to academic medical centers through a competitive funding mechanism known as the Network Development Demonstration Project. These cooperative agreements form the Pediatric Emergency Care Applied Research Network (PECARN), the first federally-funded, multi-institutional network for research in pediatric emergency medicine.

2002: HRSA awards the University of Utah a three-year cooperative agreement to serve as the Central Data Management Coordinating Center for PECARN.

2002: DHHS adopts the EMSC theme, The Right Care When It Counts, as the focus of its annual observance of Child Health Month (October 2002). The centerpiece of this year's celebration is the EMSC National Public Information and Education (PIE) campaign, a three-year initiative designed to: (a) help prepare caregivers for addressing the distinctive needs of children in medical emergencies; and (b) raise awareness among parents about the critical need to work closely with their healthcare providers to better prepare for a pediatric medical emergency.

2005: The NRC commences a two-year endeavor to develop the first set of EMSC performance measures to demonstrate the results of Program funding given to states/territories. The final measures included three primary measures and nine sub-measures. These measures become the basis for all State Partnership grants.

2006: The IOM releases the Future of Emergency Care, a series of reports that included "Emergency Medical Services at the Crossroads," "Hospital-Based Emergency Care: At the Breaking Point," and "Emergency Care for Children: Growing Pains." The reports comprehensively describe the "fragmented" system of emergency care with emphasis in the pediatric report on the "uneven" nature of emergency care for children.

2007: PECARN completes its first major trial looking at the use of dexamethasone for the treatment of infant bronchiolitis. The study is published in the July 26, 2007, edition of the *New England Journal of Medicine*.

2008: NIH releases special program announcement (PAR-08-26) inviting applications for EMSC research. This multi-agency program Funding Opportunity Announcement is designed to improve the quality and quantity of research related to EMSC.

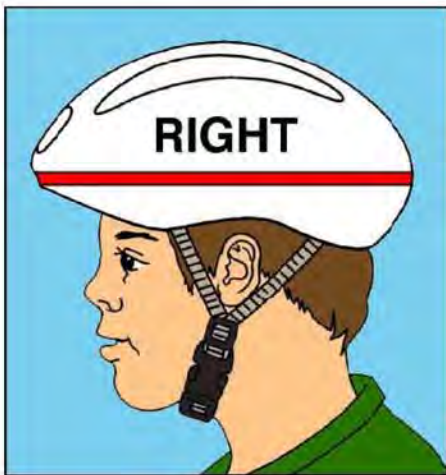
2009-10: EMSC turns 25 and goes social! The EMSC National Resource Center establishes Facebook, Twitter, and YouTube accounts in the hopes of expanding its outreach by educating and informing the online community about EMSC. Want to help spread the word? Join or "friend" each of our sites at /emscnrc. Look for the Facebook and Twitter accounts for the EMSC Data Analysis Resource Center too (/emscnedarc).

2011: HRSA announces the EMSC State Partnership Regionalization of Care (SPROC) Demonstration Grant Program. This new funding opportunity seeks grant proposals for the development of model programs to improve the transfer of pediatric patients to specialty medical centers through the process of a regionalized system of care.



Helmet Safety Fact Sheet

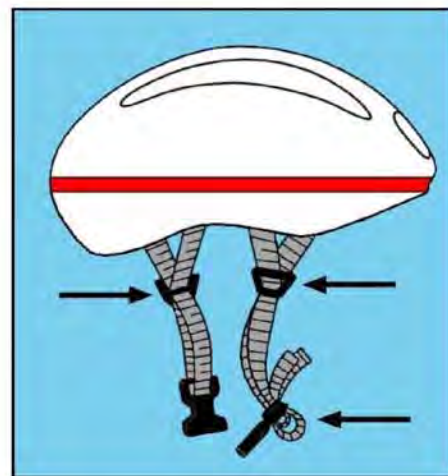
Spring is here and summer is around the corner. You know what that means – time to bring out the bikes, skateboards, and scooters! To help prevent injury, the U.S. Consumer and Product Safety Commission recommends the following: (1) always wear your safety gear, including properly fitted helmets (see below) and elbow and knee pads; (2) always ride your bike, skateboard, and scooter on the sidewalk or on a paved, off-road path away from vehicles; (3) always ride during the daytime; and (4) always ride on smooth surfaces staying away from sand, gravel, dirt, water and other dangers that may cause a child to spin out or fall.



1. Wear the helmet flat atop your head, not tilted back at an angle



2. Make sure the helmet fits snugly and does not obstruct your field of vision.



3. Make sure the chin strap fits securely and that the buckle stays fastened.

Source: U.S. Consumer and Product Safety Commission (<http://www.cpsc.gov>)

EMSAAC MAY 29 & 30

ANNUAL CONFERENCE

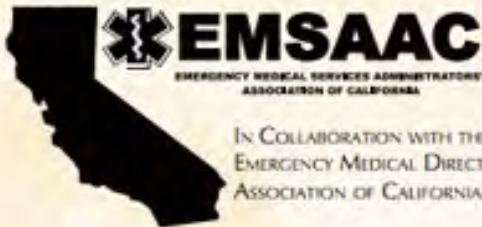
2013

RIDING THE WAVES OF EMS



Hilton
San Diego Resort & Spa

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IN COLLABORATION WITH THE
EMERGENCY MEDICAL DIRECTORS
ASSOCIATION OF CALIFORNIA



The EMS Administrators Association of California continues to lead the way in preparing EMS professionals for the challenges that lie ahead. Join EMS experts from across California and the nation in navigating the currents and developing the ability to ride the waves.

The conference includes lectures, panel discussions, and opportunities to interact with the current leaders and innovators in EMS. The annual EMSAAC conference is designed for emergency physicians, EMS administrators and coordinators, prehospital providers, EMS educators, paramedics, EMTs, emergency nurses, hospital emergency preparedness coordinators, firefighters, and other emergency coordinators.

Attendees at this years EMSAAC Conference May 29-30, in San Diego CA, will have the opportunity to participate in a presentaiton by Anderson Smith, FBI Special Agent in Charge of the Southern California Medicare Fraud Taskforce.

Link to the conference website: <http://www.emsaac.org/conference/conference-2013>



LEARN COMPRESSION-ONLY CPR FOR FREE

**May 22nd, 2013
8:00AM to 8:00PM**

Event will be held at the CrossPoint Community Church
Classes offered each hour

1325 12th Street, Modesto, Ca

Compression-only CPR allows bystanders to keep
life-saving blood flowing through a victim's body
by pressing on the chest in a hard, fast rhythm
Save a Life ~ Learn CPR in less than 30 minutes

**For more information, call the local AMR office
209.567.4023**





Modesto Regional Fire Authority

“Compression Only CPR” Training

May 22, 2013

NO COST Training Provided at 3 MRFA Locations:

Station 12—4820 Salida Blvd., Salida (English & Spanish Versions)

Station 10—148 Imperial Ave., Modesto (English & Spanish Versions)

Station 4—1505 Blue Gum Ave., Modesto (English Only Version)

No Test or Certification

Class Start Times:

12:15 p.m., 3:15 p.m. 5:15 p.m. and 7:15 p.m.

30 Minutes of Your Time to Learn How to Save Someone's Life

***Individuals, Families and Children Welcome ***

For Questions or to Register, call MRFA Headquarters at

(209) 552-3600

STANISLAUS HEART RESCUE PROJECT

“SAVING HEARTS SAVING LIVES”

***IMPROVING CARDIAC ARREST IN OUR
COMMUNITY ONE SURVIVOR AT A TIME***



EMERGENCY MEDICAL TECHNICIAN

WHEN: The course will begin June 8, 2013 and continues through Sept. 21, 2013. Classes are scheduled for every Wednesday 5pm-9pm and 2-3 Saturdays per month, from 9am-5pm, beginning June 8, 2013. Class dates and times are subject to change. Specific course dates available on request.

Saturday, June 8th, is a MANDATORY orientation class. Students MUST attend the Orientation / Registration class No exceptions!

WHERE: Mariposa Public Utility District Fire Department Training Classroom
Highway 49 North (across from DMV & CHP)

WHAT: This EMT Training Course meets the standards for National Registry, The State of California EMS Authority, D.O.T. and American Heart Association

- The fee for the EMT course is \$500. Costs for the textbook, workbook and skillbook are in addition to course fee.
- All course books will be available for purchase (at a discounted price) at the orientation meeting.

Students must have these books by the end of the June 8th class.

INFORMATION & REQUIREMENTS:

- Total course hours 160, includes didactic and field/clinical
- Current CPR/AED certification required prior to start of class
- Must meet American Heart Assoc. or American Red Cross standards for Healthcare Providers
- A CPR/AED course will be offered on Saturday, June 8th – 1pm-5pm. Fee is \$25. Pre-registration required by June 1st.

REGISTRATION INFORMATION:

To Pre-Register contact Mariposa County Fire Dept – 209-966-4330. Pre-registration information must include NAME, E-mail address, Home Phone #, Cell Phone #. **Registration will be on a first-come, first served basis.**

FOR ADDITIONAL INFORMATION: Contact the EMT Instructors
Kathi Whitson or Phil Whitson at 209-966-4880 – leave message

Are You Planning to Become a Paramedic in the Future?

Graduating From an Accredited Education Program will be Required for National EMS Certification in 2013

Planning ahead will help you avoid making costly mistakes when choosing your Paramedic educational program. If you are thinking about becoming a Paramedic anytime in your career, you need to know about an important change in the NREMT policy for National EMS Certification that may affect you and your education!

Beginning January 1, 2013, EMS providers who want to enroll in Paramedic education and obtain NREMT National EMS Certification at the Paramedic level will need to successfully complete their Paramedic education at an accredited program or one that is seeking accreditation sponsored by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

This decision was made by the NREMT Board of Directors in 2007. Requiring a single national accreditation agency for Paramedic educational programs follows the recommendations of the National EMS Education Agenda for the Future: A Systems Approach (2000). Implementation of accreditation has been recommended in the Institute of Medicine Report EMS at the Crossroads (2006).

Most recently, the Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP) implemented a Letter of Review (LoR) for programs that have begun the accreditation process in 2012. The LoR serves as the official designation that a Paramedic program is in the process of "Becoming Accredited." A student who graduates from a program that holds or held a LoR anytime during that student's enrollment will be considered eligible for the NREMT Paramedic Examinations.

NREMT Paramedic Accreditation information can be viewed at: https://www.nremt.org/nremt/about/para_accred_implementation_policy.asp

NREMT Transition to Scope of Practice Deadlines

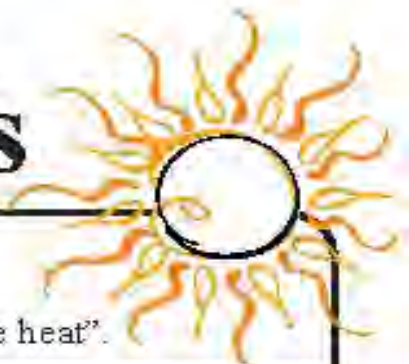
Transitions to the Scope of Practice levels will continue as part of the recertification process through various dates, depending on the provider level. Nationally Certified EMS providers who do not transition by their appointed deadline will be recertified at the next lower provider level; provided all other recertification requirements are met. Please refer to the NREMT FALL 2011 Newsletters for full details– nremt.org.

Transition Deadlines*

<i>Provider Level</i>	<i>Transition Deadline Date</i>
F - First Responder	September 30, 2015/2016
B - EMT-Basic	March 31, 2015/2016
I - EMT-Intermediate-85	March 31, 2016/2017
I - EMT-Intermediate-99	March 31, 2018/2019
P - EMT-Paramedic	March 31, 2016/2017

*The transition deadline date corresponds with recertification dates (odd or even years)

Heat Safety Tips



Summertime is usually hot months, but the heat can turn dangerous when it reaches 100° during the day and stays above 80° at night. When this happens, we have “extreme heat”.

Follow these steps to stay safe and healthy when it's hot:



- Stay indoors and out of the sun during the day.
- Fans alone won't protect you from extreme heat—use your air conditioner and keep it well maintained.
- If your indoor temperature remains above 90 degrees, seek shelter in an air-conditioned building.



- Drink plenty of water, and eat lighter meals.
- Avoid alcoholic or caffeinated drinks.
- Be aware—your prescription medication may affect your heat tolerance. Check with your doctor.



- Wear light colored and loose-fitting clothing, and a hat with a wide brim when outside.
- Take frequent cool showers or baths.

During times of extreme heat, help others stay safe too!

- Check on your neighbors, especially elderly people who live alone.
- Bring pets indoors where the air conditioning is on.
- Get immediate medical help for anyone with these heat-related symptoms:
 - Profuse sweating and muscle cramping
 - Body temperature of 105°, with hot and dry skin
 - Confusion or unconsciousness

For more information
visit www.stanemergency.com
or call the Heat Hotline at 558-8035



WARNING!

Not All CPR Cards Are Equal

Agency policy requires that First Responders and EMT's applying for recertification submit a copy of current CPR certification which is taught to the curriculum standards of the American Heart Association, American Red Cross or the National Safety Council at the Health Care Provider or equivalent level.

On-line CPR classes that **DO NOT** require you to go to a physical testing site to have your skills evaluated, **DO NOT** meet Agency requirements for certification.

Need to Recertify?

The Agency will accept complete applications during the following hours:

Monday	10am-12pm & 1pm-4:30pm
Tuesday	8am-12pm & 1pm-4:30pm
Wednesday	8am-12pm & 1pm-4:30pm
Thursday	8am-12pm & 1pm-4:30pm
Friday	8am-12pm

**All Certifications Processed
in Suite D-4**



MVEMSA going GREEN!

- The Agency no longer mails out reminder cards or applications for recertification. Please go to our website and print the appropriate documents to complete your recertification.

www.mvemsa.com

- The Agency newsletters will be distributed via email and posted on our website for you to read. We request that providers also post for employees. If you do not have internet access please contact the Agency to have a hard copy sent to your mailing address.

PLEASE ensure that we have your most current email address!

NEW OFFICE HOURS: Monday - Friday 8:00am - 4:30pm
Office Closed: 12:00pm - 1:00pm

Mountain-Valley Emergency Medical Services Agency - (209) 529-5085

Richard Murdock	(Executive Director)	(209) 566-7203
Kevin Mackey M.D.	(Medical Director)	(209) 529-5085
Cindy Murdaugh	(Deputy Director, Training/Communications)	(209) 566-7204
Linda Diaz	(Trauma System Coordinator)	(209) 566-7207
Vasti DeFreitas	(QI Coordinator)	(209) 566-7211
Tom Morton	(Data Systems / Disaster Preparedness)	(209) 529-5085
Pat Murphy	(Liasion - Alpine, Amador, Calaveras, Mariposa)	(209) 566-7207
Marilyn Smith	(Response and Transport)	(209) 566-7205
Susan Watson	(Executive Secretary / Financial Services Asst)	(209) 566-7202
Joy Thompson	(Receptionist)	(209) 566-7201
Norma Cavanaugh	(Data Registrar, Certification)	(209) 566-7208

MVEMSA

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

Address Service Requested

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Modesto, CA 95350

Suite D-1

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