Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

# EMS News

Volume 1, Issue 6 Summer 2012

Special points of interest:

- Medication Shortages
- New Chief, Copperopolis Fire District
- CARES
- Disaste4r Preparedness for Hospitals and Healthcare Organizations

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## Running a Little Short?
## Part I:
## Tackling the No-End-In-Sight Medication Shortages

*Kevin Mackey*
*Medical Director*

If you were to attend a meeting of the National Association of State EMS Officials (NASEMSO), the National Association of EMS Physicians (NAEMSP), the National Association of EMTs (NAEMT), the National Association of EMS Educators (NAEMSE), the National EMS Management Association (NEMSMA), the International Association of Fire Chiefs (IAFC), the American Heart Association (AHA), or a multitude of other national and state organizations, medication shortages would be on the top of the discussion list. No doubt, your organization is, or soon will be, facing many of the same medication shortage issues that others are facing in our counties, state and nation. The challenges presented by this unfortunate situation have given rise to some serious out-of-the-box thinking. This month, I will briefly discuss the background behind the medication shortage, resources for tracking the shortage, and suggest a strategy to weather the shortage.

The cause of the medication shortage is, like most things, multifactorial. Perhaps the greatest contributor to the shortage is some drug companies have stopped production of those medications that are off patent, less expensive and bring less profit. Some key ingredients have become difficult to obtain as well. Finally, some key manufacturers, in today's economy, have gone out of business creating a gap in production.

Tracking medication availability is fairly simple. The FDA has a website that provides updates:

(http://www.fda.gov/Drugs/DrugSafety/DrugShortages/ucm050792.htm).

In addition, Boundtree, as well as several other manufacturers, continuously maintain lists of medication shortages, as well as expected backorder fill dates. Contact your manufacturer for resources. So what are the next steps? Below are several ideas to keeping your medication options open and your anxiety level a little lower.

1. STAY INFORMED: Track the medication shortages REGULARLY. Contact your manufacturer(s) for links to their lists or go to the FDA website.
2. INVENTORY: Maintain an ongoing knowledge of what your own supply levels are, both on the street and in your stock, based upon what you now know potential shortages are. This helps in establishing contingency plans.
3. CHANGE SUPPLIERS: If you have the option of purchasing medications from other manufacturers, take advantage of this option. I have found that on occasion, what one manufacturer can not stock, another might have some supply available.

The EMS agency has several options we are considering to address this important problem as well. These options include

1. ALTERNATIVE MEDICATIONS: The nature of EMS limits alternative medications for the same condition. For example, we generally stock ONE medication for nausea, ONE for seizures, ONE for pain control. As an agency, we are considering our options for approving the use of a variety of medications for similar conditions. Of course the challenges to this approach are the costs associated with stocking a variety of medications, patient safety concerns with the increased possibility of medication administration errors, not to mention the training costs and time associated with changing traditional medications stocked in the box. *Continued on page 2*

## *Continued* -Running a Little Short?
## Part I:
## Tackling the No-End-In-Sight Medication Shortages

***Difficult Times, Such As This, Require Serious Out-Of-The-Box Thinking***

2. ALTERING EXISTING PROTOCOLS: The simplest example of this is the use of morphine for pain control.

   Several EMS agencies have disallowed the use of morphine for chest pain if suspected cardiac origin until after the patient has received 3 rounds of nitroglycerine.

   With most having short transport times, the paramedic rarely reaches morphine in the protocol. That is just one example. Other EMS agencies have had to reconsider if their medics will use epinephrine in cardiac arrest at all.

3. EXTENDING EXPIRATION DATES: This is, in my opinion, involves the most risk, medical legally speaking. Several years ago, the FDA conducted research for the military on potency of medications beyond the manufacturer suggested expiration date. It was no surprise to find that the medications maintained their potency well beyond the expiration date. Unfortunately, this is uncharted water and only a handful of medical directors in the country have permitted the extension of expiration dates. The longest most are extended is 6 months. The rest of the country's medical directors (like yours truly) are waiting to watch for fallout and FDA repercussions to this action.

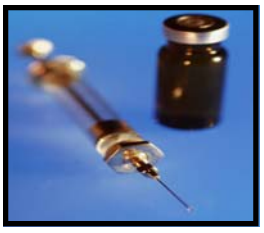
   I am willing to consider it, but it is definitely a LAST resort.

Difficult times, such as this, require serious out-of-the-box thinking. Please, please communicate with the EMS agency and me.

Drop me an e-mail, or give me a call, and let me know what challenges you are facing with medication shortages. Together we can come up with a workable solution.

In the next newsletter, I will focus on the nuts and bolts of maintaining patient safety when changing medication strengths or when changing medications altogether.

Until then, keep up the great work you are doing for our patients and communities! I am proud to work for all of you!




Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

# PROVIDER PROFILE

**by Pat Murphy, Field Liasion**

## Copperopolis Fire District Appoints New Chief

Steve Kovacs first day was July First as the new Fire Chief of Copperopolis Fire Protection District. He is very excited about his new position. I asked Chief Kovacs about his background, having been friends and a work associate of his for 15 years, I am familiar with most of Chief Kovacs background, however I learned a few things. In 1981, Chief Kovacs started his career in the fire service as a volunteer firefighter with Ebbetts Pass Fire District, following in his father's footsteps. He went fulltime in 1985 and worked his way up to Battalion Chief. He went to paramedic school in 1985 attending the San Joaquin County Program.

Chief Steve Kovacs is very dedicated to fire and EMS, as evidence of his extracurricular activities. He worked as a paramedic on ambulances at Stockton Ambulance, as well as Calaveras and San Andreas Ambulances. He was one of the original members of the Motherlode Inter-agency Training Officers. He started his own successful consulting business in 1985 (PMA - Professional Management Associates), in which he helped fire departments with special taxes, strategic planning, and many other projects. He has been involved in teaching many classes at the local and state level.

Chief Kovacs became Fire Chief of Murphys Fire District in 2005 and he plans to keep serving in this part-time position. He is currently the President of the Fire Districts Association of California.

In his spare time, he enjoys his family, his wife Kristin and two children, Ryan and Haley. He has an antique fire engine, 1925 Kenosha, and competes in Musters statewide and recently is providing wine tours on this engine in Murphys.

He is taking over the reins in Copper from Jeff Millar, a retired Cal Fire Battalion Chief. I asked Chief Kovacs his plans with Copperopolis Fire and he answered that he simply needs to assess the organization before he sets plans for any changes. He knows the organization is sound and has no plans to try and fix anything that isn't broken. He is looking forward to working with the crews, which includes an ALS First Responder program, the Board, staff and serving the community.

Good luck Chief!

# MEDICAL HISTORY AND MEDICATION INFORMATION

**by Gregory L. Adams, BS,NREMT-P, Director of Medical Services, Medic Alert Foundation**

Is accessing a patient's past medical history and current medication information really important? If not, why do we spend so much time learning and teaching acronyms like SAMPLE? If so, then what do we do when we cannot get information from our patients?

In the current environment, we focus on using evidence-based treatments for our patients; yet, there are still many things we do that are not based in science or research. Some of these things just make sense to do because they avoid potential harm to the patient. We know that collecting a patients history improves patient care by guiding us to the correct protocol but not all patients can provide us with the appropriate information.

Gathering information from a patient that is non-verbal, altered or doesn't speak a common language with the provider, increases the stress level on scene. Our protocols cover us by going through several steps to rule out things like low O2 stats or blood sugars, but those are not the only signs we see from day to day. There are medical conditions that may challenge our basic EMS knowledge and present contraindications to our basic protocols. If we are not aware of this potentially hidden information then we may do what we are trained to do, but it may not be the right thing to do for this patient or scenario.

Doing the right thing is easier with the information we gather during a patient interview. When patients have hidden medical conditions we need alternative information sources to care for our patients. Some of those patients have prepared for the unexpected by enrolling in the services of MedicAlert Foundation as a way to provide you with their history.

You can access those patients' information with a simple phone call (the number is imprinted on every ID) or by registering with MedicAlert Foundation's online medical information exchange program at www.medicalert.org/emergency

Thank you for your partnership and in working with MedicAlert to further protect our members.

Greg L. Adams—gadams@medicalert.org

# Honoring Patients' End-Of-Life Wishes

**by Marilyn Smith, Response and Transport Coordinator**

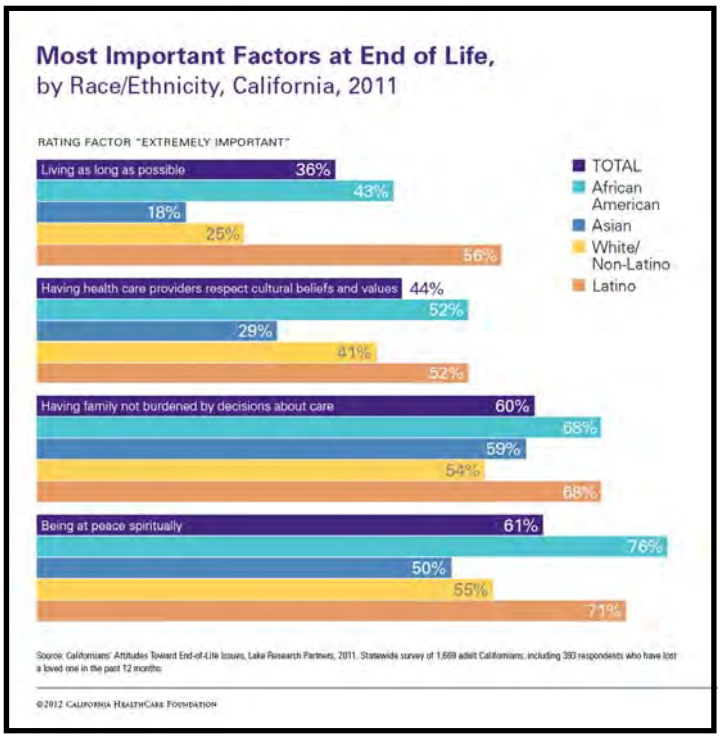
In the last newsletter, you may recall that I discussed the use of the POLST form; the differences between a POLST form and an Advance Directive; where you might find a POLST form in a patient's home; and began the discussion about the aging California population. Not only does the aging California population effect health care decisions, but the cultural diversity in California plays a role in decisions regarding end-of-life care. In this article, I will address important factors at the end-of-life; where patients want to die and where they are dying; and who is having end-of-life discussions with their families.

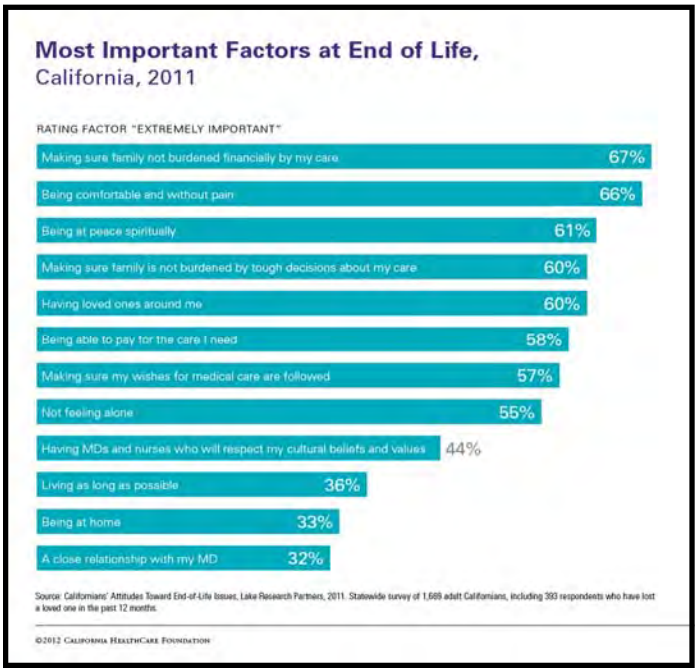
A recent poll conducted by the California Healthcare Foundation found that a large majority of Californians would prefer a natural death if they became severely ill rather than have all possible care provided. Most people prefer to die at home instead of in a hospital or other healthcare facility. Additionally, they want to talk with their physician about their care at the end of their lives. However, a recent poll conducted by the California Healthcare Foundation found that that does not always occur. Some of the highlights of their research which is based upon response from Californians revealed:

- 66% prefer a natural death if they were severely ill
- 7% says they want all possible care to extend their life
- 82% say that having their end-of-life wishes in writing is important
- 23% have their end-of-life wishes in writing

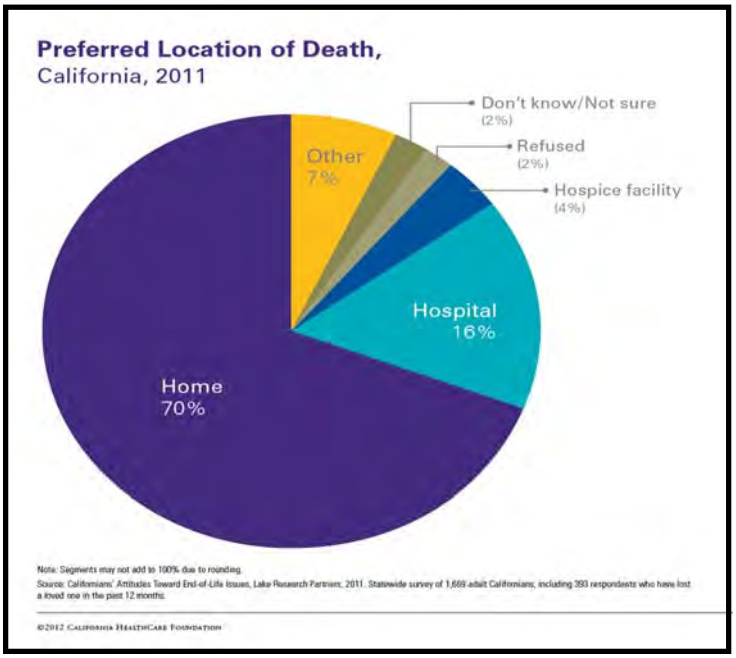
One of the survey questions asked about the most important factors at the end of ones life. The survey results revealed:

The survey grouped ethnicity into the following categories: African American, Asian, White/Non-Latino, and Latino. When you look at the most important end-of-life factors based upon ethnicity the results show:



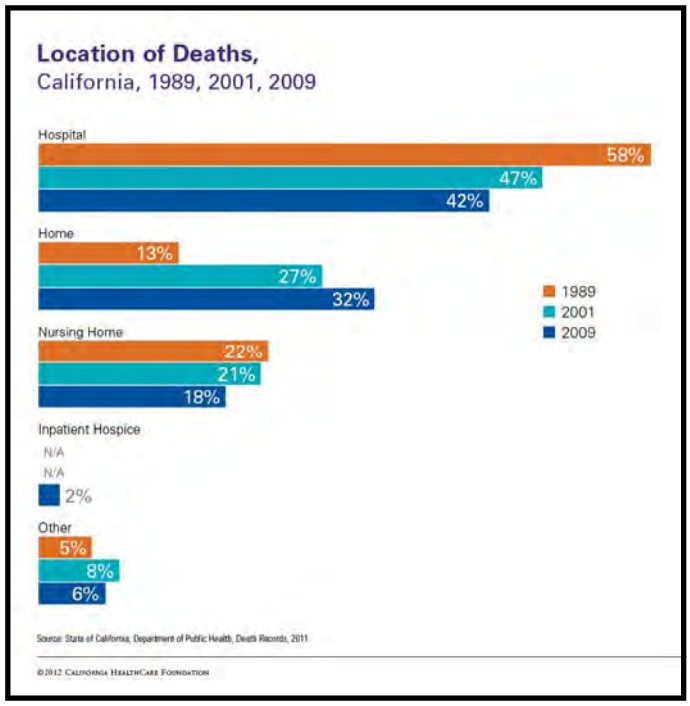




Attitudes toward death and dying are changing, with more individuals wishing to spend their last days at home. This trend



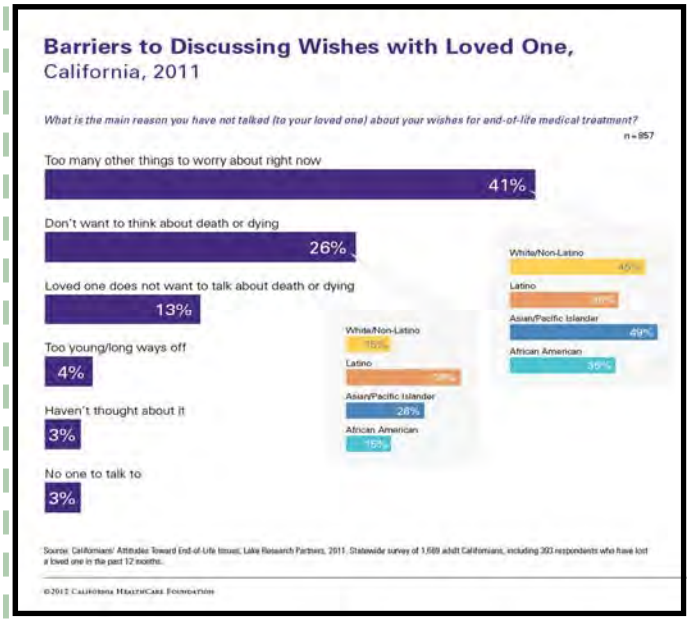
leads to the potential for pre hospital personnel to come into contact with more patients having completed a POLST or DNR form. The survey reflects that trend:

Since 1989, the number of individuals that have died at




home as grown 146%. Conversely, the number deaths that occur in health care settings are decreasing. Research reflects that trend from 1989 through 2009:

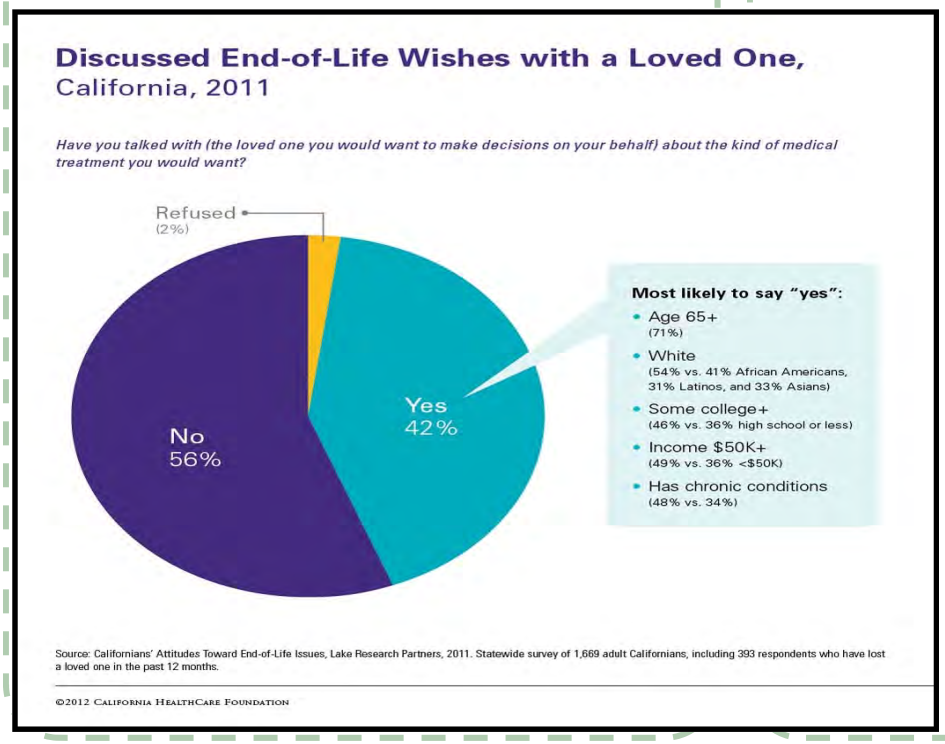
The most important factor in making end-of-life decisions be they established in an Advance Directive or on a POLST or DNR form is discussing your wishes with your family.




However, the survey documented:

What is stopping individuals from talking about their end-of-life thoughts with family?

Have you put your end-of-life wishes in writing? Have you had a conversation with your family regarding your wishes? Make sure your loved ones know your wishes. Do you want to be one of the 82% that believes it is important to make your wishes known but only one of the 23% that has documented your wishes?




POLST CALIFORNIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

# FOCUS ON QUALITY IMPROVEMENT

## CARES

**by Vasti DeFreitas, QI Coordinator**

CARES is up and running. Thank you everyone for participating. When there are a few more months of data entered, MVEMSA will share the cumulative data. For now I would like to give you an overview of CARES: the who, the what, the how and the why of CARES. At the end of this article is a short quiz. Send it back to MVEMSA and we will award you with CEUs.

The Who of CARES – who are the key players in CARES?

If you say the patient - you would be right. But we are talking about QI and data. So where does the data for CARES come from?

Naturally the 911 dispatchers are the first to provide CARES data. Dispatch provides a very important role by getting the correct address and location of the patient, date and time stamps the call and assigns the incident number. The dispatcher also stays on the line with the calling party and provides support, pre-arrival instructions and information until the first responders arrive.

First responders gather information about the time of arrest, document if the arrest was witnessed, if bystanders or family members performed CPR, obtain the patients' medical history and may also initiate the use of an AED. In addition, now that AEDs are becoming more readily available in local businesses and public buildings, an AED may have been used by a Good Samaritan prior to arrival of the first responder, which is important information. First responders will also begin the resuscitation of the patient, ventilations and compressions until the transporting ALS unit arrives on scene. ALS providers provide the bulk of the pre-hospital portion of the data for CARES. The paramedics document the patient's demographic information such as age, DOB, gender and ethnicity. They also provide arrest information such as location, presumed etiology of the arrest, who performes CPR, the presenting cardiac rhythm, and return of spontaneous circulation (ROSC). Other important CARES information includes whether or not hypothermia care was provided (this is a topic for future discussion), was vascular access obtained (IV, IO), and what type airway was used (Advanced or BLS)? Documentation is essential to the success of CARES, so now more than ever all aspects of patient care must be clearly and accurately documented.

The hospital receives the patient from the pre-hospital crew and continues with the resuscitation, and CARES data. The hospital provides essential, never before obtainable, outcome information. What happened in the ED? Did the patient survive long enough to be admitted? Was hypothermia care initiated or continued? What was the patient's final outcome? Did the patient survive to discharge, and what was their neurologic status?

As an ED nurse for the past 20 plus years, I can say that I have participated in the evolution of cardiac arrest care, and what an evolution it has been. Some of you may remember when we gave intra-cardiac Epinephrine. Wow! We have come a long way in the care of cardiac arrest. But our journey is far from complete. CARES will help us gather the data that will give us the pathway for the future of cardiac arrest.

Now for a brief word about hypothermia following ROSC. Most hospitals initiate hypothermia care on cardiac arrest patients in the ED. Studies have shown that lowering brain temperature, even by a few degrees, decreases ischemic damage. In studies of out of hospital cardiac arrest, induced hypothermia protocols have contributed to improved neurological outcomes. Hospitals that have implemented hypothermia care for ROSC have had some fabulous results with patient's surviving cardiac arrests and are discharged home neurologically intact! Incredible!

Finally what is the role of MVEMSA in CARES? As the QI nurse for MVEMSA, it is my job to do the data entry for the pre-hospital information, other than AMR (thank you Michael Corbin). I am given copies of all of the code blue charts from the providers; I review them and input the data. It sounds like a lot of work but really it's not. Most of the charts are well documented; however some are lacking essential information. I have worked with many of you over the years and I know that you all provide very good care to your patient. Unfortunately sometimes the documentation does not reflect that. Remember when you are documenting your care, be as precise as you can about the care you provide for your patient. I know everyone does his or her best for the patient, regardless of outcome. Now reflect that in your documentation!

The What of CARES – what is the purpose of CARES?

CARES is a collaborative effort of the Centers for Disease Control and Prevention (CDC), the American Heart Association (AHA) and Emory University Department of Emergency Medicine. The goal for the CDC and the AHA is to work together to reduce the death rate from heart disease and stroke by 25%. One of the CDC's initiatives is to develop a model national registry to accurately measure the progress in the treatment of out of hospital sudden cardiac death.


The ultimate goal of CARES is to help local EMS administrators and medical directors to identify who is affected, when and where cardiac arrest occurs, which elements of the system are functioning properly and which elements are not, and how changes can be made to improve cardiac arrest outcomes.

The How of CARES –

CARES began in 2004 with the CDC, Emery University and the AHA to develop a registry that could help increase OCHA survival rates. The CDC pilot tested CARES in the Atlanta metropolitan area in 2005. The next year the registry expanded to six additional metropolitan areas. In 2011, CARES has 40 participating communities in 25 states. Currently there are over 40 communities in 18 states representing over 60 million Americans (Emory University 2012).

CARES is a secure web-base with restricted access for authorized users. The database uses simple HIPPA compliant methodology to protect confidentiality. CARES has software that collects and links data to create a single de-identified record for each out of hospital cardiac arrest (OHCA) event. CARES also allows for longitudinal, internal benchmarking of key performance indicators.

The Why of CARES

The goal of the CARES project is to establish a model unifying all essential data elements from three independent sources, which currently record fractured data of a single cardiac arrest event. The CARES system is building this model by establishing a relationship with EMS, hospital and the CAD (computer aided dispatch systems). Through collaboration of these three separate sources of information and data, CARES is able to access specific data elements and participation allows for understanding of data flow. This also provides the ability to develop an efficient and automatic data collection and outcome reporting system.

Sudden cardiac arrest is the leading cause of death among adults in the United States. Its onset is unexpected and death occurs minutes after symptoms develop (AHA 2005). The chances of survival increase with early activation of the 911 system, bystander CPR and rapid defibrillation and access to definitive care. CARES is designed for EMS communities to measure each link in their "chain of survival" quickly and easily and utilize this information to make changes to practice and ultimately save lives.

References:
Emory University Special Programs CARES
CARES, Improving Emergency Cardiac Care Saves Lives, CDC – Division for Heart Disease and Stroke Prevention
Of eCARES and eParos, Dr. Bryan McNally
CARES Reference Manual October 2006
Who CARES, Dr. Kevin Mackey, Mountain Valley EMS News Winter 2012
Massachusetts General Stroke Services, Hypothermia after cardiac arrest Feb. 2011

**The Agency will issue (two) 2 hours of instructor based continuing education (CE), provider # 60-0001, to individuals who complete and submit the following:**

1. **Read the CARES article (located on Page 6 & 7)**
2. **Answer and complete questions 1-12 (located on Page 8)**

**Submit completed *answer sheet to:***

**ncavanaugh@mvemsa.com or to the Agency mailing address.**

Objectives:

- Describe the history of CARES, how it was developed
- Describe the purpose of CARES
- Recognize the key players in CARES

Please Print Clearly!

# CARES Continuing Education Answer Sheet

Name: _____ License/Certification #: _____

Mailing Address:_____ Affiliation/Employer: _____

_____

Note – each question may have more than one answer

1. Who are the Key Player in CARES?

_____

_____

_____

_____

3. What information does the First Responder gather?

_____

_____

_____

_____

5. What information does the ALS provider gather?
   a. Demographic data (age, gender & ethnicity)
   b. Location of arrest
   c. Etiology of arrest
   d. Who initiated CPR
   e. Presenting cardiac rhythm
   f. All of the above

7. What is the benefit of initiating Hypothermia treatment for ROSC?
   a. Decreases Ischemic Damage
   b. Keeps the patient's from getting overheated
   c. Helps the EKG pads to stick better to the chest
   d. Fun new toy for the ED physician

(Circle One)

9. T or F Anyone can log onto CARES website and take a look around

10. T or F CARES is a collaboration between the CAD, EMS and Hospitals

11. T or F Sudden Cardiac death is the leading cause of death among adults in the USA

2. What information does the 911 dispatcher gather?
   a. The correct address
   b. Location of the patient
   c. Date and time
   d. Assigns Incident number

4. First responder resuscitation includes:
   a. Initiate the use of AED
   b. Ventilation
   c. Compressions

6.. What information does the hospital provide to CA-RES?
   a. ED course of treatment
   b. Whether the patient was admitted
   c. What is the patient's final outcome
   d. Whether the patient survived to discharge
   e. What is the patient' neurological status at discharge

8. What is the purpose of CARES?
   a. Reduce the death rate from heart disease and stroke
   b. Accurate measure of out of hospital sud-den cardiac death
   c. Help EMS to identify strengths and weak-ness in their system
   d. There was left over grant money and someone applied for it

12. The diagram below is the symbol for:


   a. The Summer Olympics in London
   b. The mantra for a new Rap star
   c. My gifted child's doodle
   d. The Chain of Survival

To receive CE, submit completed *answer sheet to:*

ncavanaugh@mvemsa.com or to the Agency mailing address.

# Good Shouldn't be Good Enough

**by Kevin Pagenkop, ENP - LifeCom-EMS & Fire Communications**

During a recent internet surf session, a newspaper article from Kansas caught my eye[1]. The featured story involved a Boy Scout that recently received the prestige of successfully completing the requirements to attain the rank of Eagle Scout, the Boy Scouts of America's highest advancement rank. Only 5% of Boy Scouts ever complete the requirements to become Eagle Scouts, but of those that accomplish this achievement, a large percentage of them continue their service into adulthood as astronauts, career military officers, or politicians[2]. What made this specific story so appealing was not just that the young man featured, Curry McWilliams, became an Eagle Scout, but it was the manner in which he completed the difficult requirements.

For those not familiar with the Boy Scouts of America, education is accrued through the receipt of Merit Badges. The subjects are learned through classes, self-study, or apprenticeship instruction. Once the applicable skills are successfully demonstrated or the required tasks completed (some of which take months to complete) the Scout is presented with a small, circular, patch which can then be sewn to a sash which is worn with their uniform. While the number of patches worn is certainly a point of pride, these patches are a physical representation of the knowledge gained and correlate to the number of years an individual has been a Scout. Merit Badges are offered for a variety of subjects and are not necessarily specific to camping or the outdoors (subjects most associated with the Boy Scouts of America). There are Badges for business, architecture, computers, electronics, graphic arts, welding, and chemistry, to name a few.

To rise to the rank of Eagle Scout requires the successful completion of 21 Merit Badges[3]. Curry McWilliams' amazing accomplishment was that after he had earned the required 21 Badges, he continued his self-education and did not stop taking classes and learning new subjects until he had successfully completed the requirements for every Merit Badge available-- 132 in total[3]. That's more than six times what was required.

After reading this article, I was left with a couple thoughts: what level of service could we provide our callers and patients if we applied more than six times the effort required? What if we just marginally exceeded the minimum requirements of our jobs? What if "good" could be replaced by "great"?

Whether EMT or EMD, certification and accrual of continuing education unit hours is often regarded as nothing more than the mandatory application of effort simply to maintain the means to receive a paycheck. This is often more prevalent the farther we advance in our careers and begin to get cynical, frustrated, or burned-out. What once was new and exciting becomes routine or boring. How does that then relate to the quality of service we are providing? Do we find ourselves simply going through the motions and working to the minimum requirements or standards?

Continuing Education should be viewed like Merit Badges and not simply a required amount of training hours that we procrastinate on accruing. There are a variety of topics and venues that range from improving existing skills, gaining new skills, or simply general interest or entertainment. Taking the time and making the effort to self-improve should be celebrated. We may not sew our course certificates to our uniforms but we should work to create a culture where education is valued. Whether or not the completion of additional education is undertaken towards career advancement or simply as an opportunity to improve the quality of care provided, we should encourage one another to continually apply ourselves and work towards mastering our trades. Don't we expect the highest level of professionalism from others? We need to hold ourselves and our peers to that same ideal.

Curry McWilliams does not work in Public Safety and comparing the difficult jobs we do each shift to a Boy Scout may strike some as a tad insulting, but this young man completed the training and earned Merit Badges for Communications, Emergency Preparedness, Fire Safety, First Aid, Lifesaving, Medicine, Public Health, Radio, Safety, and Traffic Safety. In fact, examining the Boys Scouts of America in totality, the most often earned Merit Badge since 1910 has been First Aid, with almost 7 million scouts completing the requirements to wear the badge[2]. So perhaps these similarities are proof that when someone accepts the responsibility to provide service to their community, whether it's through the Boy Scouts or EMS, 'good' shouldn't be 'good enough'.

[1] "Scout grabs elite goal: all 132 merit badges", Kansas City Star, Sunday June 17th, 2012, Dawn Bormann http://www.kansascity.com/2012/06/17/3663154/leavenworth-teen-earns-all-132.html

[2] the Boys Scouts of America on-line, http://scouting.org

[3] The Boy Scout Handbook, 12th Edition, the Boy Scouts of America

# CA Public Health and Medical Emergency Operations Manual (EOM)

**by Tom Morton, Disaster Preparedness Coordinator**

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY

California's rich history also includes a multitude of natural and man-made disaster; from earthquakes to wildfires to riots. These unusual (now considered usual at times!) events often had major effects on the medical and public health systems from local to state levels. As a result of this experience, Public and private organizations understand that effective disaster response is enhanced by pre-planning and operating with standardized operational procedures, terminology, and communications.

The California Public Health and Medical Emergency Operations Manual (EOM) was released in July 2011 as part of a collaborative effort to enhance disaster response and mitigate the long-term effects of these events. The document is the result of efforts to build and improve upon previous guidance delineating roles, procedures and coordination during response to unusual events and emergencies that have public health or medical impact. Using Standardized Emergency Management System structure as the foundation, the EOM provides descriptions of basic roles and responsibilities at all levels of the Public Health and Medical system. Operational checklists by position, functional discipline, and disaster-type, situational reporting formats, and resource ordering templates arte examples of information presented in the EOM.

Education and training are key components to effective disaster response. The familiarization of Emergency Medical Services (EMS) system stakeholders with the contents of the Emergency Operations Manual constitutes a key component. Within an Operational Area, these stakeholders are identified as the Public Health Department; the local EMS Agency; the County Department of Mental Health; the County Office of Emergency Services; Health Care Facilities to include hospitals, specialty centers, and skilled nursing facilities; and local EMS Providers.

Mountain-Valley EMS Agency has identified training materials developed by the Region IV RDMHC/S and scheduled training opportunities for stakeholders. Access to electronic training is posted as a link on the MVEMSA website. Additionally, to assure access to the Emergency Operations Manual, the link to the electronic PDF was sent to stakeholders via email and placed on the MVEMSA website (www.mvemsa.com).


As a participant in the Emergency Medical System, please take the time to review the training and reference materials.

# Disaster Preparedness for Hospitals and Healthcare Organizations

## * Training Announcement *

**Course Date(s):** **August 14-15, 2012** (Tuesday-Wednesday), 8:00 a.m.– 5:00 p.m. (16 Hours)

**Course Location:** **Northern California Regional Public Safety Training Authority** (Building 686), 2409 Dean Street., McClellan, CA

**Course Description:** This course brings together individuals from the hospital and healthcare community who are responsible for ensuring the resiliency of healthcare services during a high-consequence or catastrophic event within a jurisdiction. Through a focus on preparedness processes and activities, this course provides an opportunity to acquire the knowledge, skills and abilities necessary to help them ensure the sustainability of their facilities and organizations during all types of disasters.

Participants will be better qualified to participate in preparing for, responding to and recovering from a natural or man-made incident which impacts their facilities, systems, employees and ability to care for incident victims.

**Recommended Prerequisites:**

- None

**Target Audience / Discipline:** This training class is designed for those who are involved in emergency management and response, specifically those in Law Enforcement, Emergency Medical Services (EMS), Emergency Management Agency (EMA), Fire Service and Public Health, as well as those affiliated with private Health Care

**Cost:** All training and course materials are **FREE**. Course development and delivery is funded by the Federal Emergency Management Agency (FEMA), Sacramento Regional Office of Homeland Security (Sacramento UASI)

**To Register:** Please register by accessing the following web site:
http://srohsdisasterprep.eventbrite.com

**For Information:** Sgt. Marty Picone (916) 874-2211 or mpicone@sacsheriff.com


## Amador and Calaveras County
## Triage Drill Dates for 2012

| Date | Time |
|---|---|
| January 2 - 9 | 0800-0800 |
| April 2 - 9 | 0800-0800 |
| July 2 - 9 | 0800-0800 |
| October 1 - 8 | 0800-0800 |

## Mariposa County
## Triage Drill Dates for 2012

| Date | Time |
|---|---|
| March 5-12 | 0800-0800 |
| June 4-11 | 0800-0800 |
| September 3-10 | 0800-0800 |
| December 3-10 | 0800-0800 |

## Stanislaus County
## Triage Drill Dates for 2012

| Date | Time |
|---|---|
| March 8 - C shift | 1200-2400 |
| June 5 -B shift | 1200-2400 |
| September 6 - A shift | 1200-2400 |
| December 4 - C shift | 1200-2400 |

Mountain-Valley
EMERGENCY MEDICAL SERVICES AGENCY

# PATIENT TRACKING

Tom Morton, Disaster Preparedness Coordinator

For the new Paramedics and EMTs in our region and as a reminder to the veterans in our system; below is the Triage Tag Drill procedure from Mountain-Valley EMS Agency Policy 851.00 “START TRIAGE AND PATIENT TRACKING EXERCISES”. Please refer to our website for the complete policy.

## Policy 851.00 IV. PROCEDURE

During scheduled triage exercises:

The first arriving unit (ambulance or fire) shall conduct triage during the first 30 seconds of patient contact; using standard START triage criteria (see Attachment B).

Triage of patients shall occur where they lie only if the area is safe. If the area is unsafe, the patient shall be moved to a safe area prior to conducting triage.

The transporting paramedic is responsible for ensuring that each patient transported is properly triaged and tagged prior to transport.

Patient treatment shall not be delayed during scheduled triage exercises.

A. Patient Tracking

1. Transporting personnel shall note the triage tag number on the patient care record. PCRs shall be generated on all patients.

2. Receiving hospital personnel shall have a mechanism in place to:

a. Include the triage tag number in the patient registration process

b. Retrieve patient information utilizing the triage tag number

c. Link hospital medical record number with the triage tag number

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## Patient Tracking Workgroup

After each Triage Tag Drill, results from system participation are collected. This information is presented to Emergency Medical Care Committees in our member counties. In Stanislaus County a Patient Tracking Workgroup meets after each drill. This workgroup consists of representatives from Ground Ambulance Providers, Base Hospital Emergency Departments, Public Health, Fire and MVEMSA. They evaluate drill results, assist in Patient Tracking Policy development, plan for upcoming drills, and may also assist in grant opportunities related to patient tracking. The group reports on its activities to the Stanislaus County Healthcare Emergency Preparedness Council.

Patient Tracking Workgroup meeting dates.

The meetings will be from 10:00 to 11:00 on the following dates…

| | |
|---|---|
| Tuesday April 17, 2012 | Tuesday October 16, 2012 |
| Tuesday July 17, 2012 | Tuesday January 15, 2013 |

# Follow-Up to EMS Week 2012

**by Richard Murdock, Executive Director**

On Sunday, May 20, 2012, MVEMSA honored and recognized EMS practitioners within their five member county region. Agency staff worked diligently to prepare and plan the event, which was held at Downey Park in Modesto. The picnic included games for both children and adults, a snow cone and popcorn machine, a vintage fire engine (compliments to Murphy's Fire Department in Calaveras Co.), food and drinks, and great conversations! In addition, the Agency was able to award local "heroes" with an EMS commemorative coin. The recipients of the EMS coin were nominated by their peers several weeks prior to the awards picnic. Congrats to the following award winners:

- First Responder of the Year
- EMT of the Year
- Paramedic of the Year
- MICN of the Year
- Physician of the Year
- Educator of the Year
- Administrator of the Year

**Visit our website to view our EMS Week 2012 video www.mvemsa.com**


Mountain-Valley EMS staff is looking forward to planning the awards picnic for 2013! Many suggestions have already been provided. One suggestion was that we hold a softball game between hospitals. EMS, dispatch, and fire staff could be recruited by the hospital in order to build their teams. Another suggestion was that MVEMSA staff could judge a "Chili-Cook-Off," which would be made up of teams from dispatch agencies, fire agencies, EMS, and hospitals. A nice prize would be awarded to the winner of the cook off. Two great ideas!

Our hope for next year would be to see an increase in attendance and nominations. The staff here at MVEMSA looks forward to serving those who serve our citizens!t

## 2012 EMS AWARDS

First Responder
Tom Hull

Paramedic
Michael Murray

Educator
Kelly Kjelstrom



MICN
Marci Adney

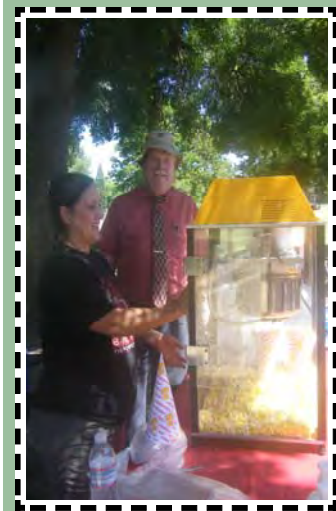
Administrator
Barry Hurd

EMT
Erin Burton

Physician
Alfredo Montelongo, MD

# EMS WEEK 2012

# DOWNEY PARK - BBQ / FAMILY FUN



# 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

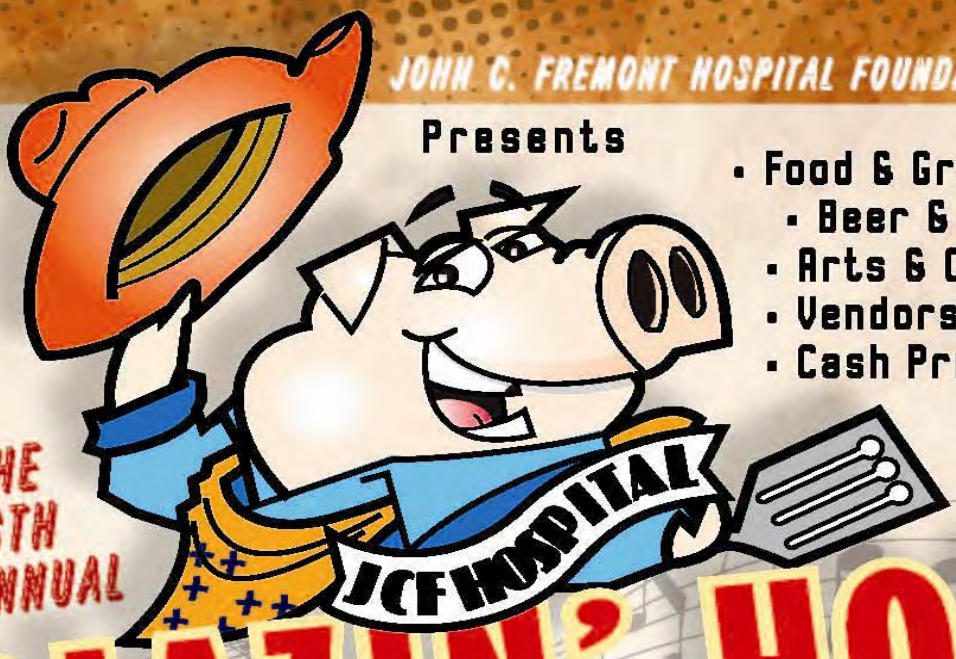
For more information
visit **www.stanemergency.com**
or call the Heat Hotline at 558-8035

HEALTH SERVICES AGENCY
hsahealth.org

STANDING STRONG

JOHN C. FREMONT HOSPITAL FOUNDATION

Presents




- Food & Great BBQ
- Beer & Wine
- Arts & Crafts
- Vendors • BBQ
- Cash Prizes!!!

THE 6TH ANNUAL

# BLAZIN' HOG BBQ COMPETITION!

™ John C Fremont Foundation

## Saturday, September 22nd, 2012

**Mariposa County Fairgrounds - Hwy 49 South at Fairgrounds Road**

Zydeco Music Festival featuring...

## THE BLUESBOX BAYOU BAND

TWO BIG BAYOU SHOWS: 4:30PM & 6:30PM

## MARK ST. MARY & HIS ZYDECO BAND

follow us on Facebook!

"Best West Coast Blues Band" 2:30PM

Budweiser

SPECIAL GUEST OPENER **GOOD MEDICINE** 12:30PM

Dance lesson by Cleo Home! • Gates Open at 12 Noon

**Tickets: General Admission $15 Gate / $10 Advance**

**• Seniors- $10 • Ages 5 thru 17- $5 • Under 5- Free!**

**ADVANCE TICKET PURCHASE ONLINE AND INFORMATION:**

**www.blazinhog.com • Please Drink Responsibly!**

BENEFIT FOR: John C. Fremont Hospital Foundation

BENEFIT FOR: John C. Fremont Hospital Foundation

Design and Promotion by PGrimaldiCreative.com

# 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!

# FACEBOOK FAD?

**Pat Murphy, Field Liaison - Alpine, Amador, Calaveras, Mariposa**

Nearly half of Americans believe that popular social-networking site Facebook is merely a passing fad, a new study suggests. A poll conducted by the Associated Press and CNBC found that 46% of respondents think Facebook will fade away as new platforms come along in the future. However, about 43% believe the site will likely be successful for the long haul.

Regardless of the poll, Mountain-Valley has joined the Facebook generation and now has its own Facebook page. If you have Facebook check it out. I'm trying to put pictures of EMS agencies in action, EMS events, interesting information, updates, catching EMS employees in action and other EMS related activities.

I am the liaison for the mountain counties, so I usually cover more action in those counties; however I try to get around the valley as well. I keep my camera with me and try to catch EMS folks doing what they do best. I let them know why I'm taking their picture and if they chose not to have it posted on facebook I respect their wishes. I'm soliciting ideas for information or pictures you would like to see for this webpage. Please let me know what you would like to see and I will try and make it happen. I encourage your comments on articles and pictures, however remember to keep them proper. Recently I had some rather racy comments on a picture so I immediately deleted those comments. We consider this a professional outreach and we would like your comments to be professional, however that doesn't mean we can't have fun and an occasional funny comment is welcomed, just keep it in good taste.

Facebook is a social tool that seems to be another way of reaching our audience. Our goal is to use this tool to communicate information that is beneficial to our EMS partners. Enjoy!

# Golden Guardian 2012 Disaster Medical Response Exercise

The California Emergency Medical Services Authority (EMSA) organized a training exercise for a medical response to a catastrophic earthquake. The full-scale earthquake medical response exercise was from June 4-6 and is part of the California Emergency Management Agency's annual Golden Guardian readiness exercise. The activities are federally–funded and are an integral part of EMSA's grant-supported preparedness activities.

"The goal of the exercise is to evaluate the integration of state disaster medical resources and practice how the different organizations and resources coordinate to provide medical response to save lives and minimize injuries," Working with our local, state and federal partners, we aim to ensure readiness to help Californians when needed."

Dr, Howard Backer, EMSA Director

Helicopters from the California National Guard, REACH, CALSTAR and Mercy Air Ambulance services transported the mock patients from Mather airport to the exercise site, Sacramento State University.

Ambulance strike teams from American Medical Response met the helicopters at the landing zone and transported the patients to a mobile field hospital operated in cooperation with disaster response teams from Scripps, Tenet, and Stanford Health Systems. Nursing and EMS Students from Sacramento State's College of Continuing Education served as the volunteer Patients.

The Emergency Medical Authority (EMSA) is responsible for coordinating the State's medical response to a major disaster. Photos of the exercise with captions and photo credits are available at http://www.flickr.com/photos/calemaphotos/set/72157630005321767/

**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**

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FAX:

(209) 529-1496

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We're on the Web!

*See us at:*

www.mvemsa.com

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