
EMS NEWS

No. 09-02

Mountain-Valley EMS Agency

Winter 2009



FROM THE DESK OF THE
Medical Director
Kevin Mackey, MD

London Ambulance Service

I recently had the privilege of visiting England to speak at the British Association for Immediate Care Conference, also known as BASICS. While I was there, I purposely took the time to immerse myself in as much of their prehospital care as I could in order to learn about new approaches or differences in ways of caring for the prehospital patient. What I saw impressed me so much that I could not wait to get home to share what I learned. As an example, I spent an entire day with the London Ambulance Service (LAS), not riding along, but seeing the operations from the inside. The LAS operates like a well oiled machine. Their organization has learned from a variety of events including the London bombings, various plane crashes, and riots, just to name a few. Their daily operational loads are staggering! For example, the dispatch center for greater London handles 1.2 million calls a year; this works out to actual dispatches of 1.9 calls per minute, every minute of the year. They have over 50 ambulances on the road at all times, tracked with GPS for optimal positioning and response.

The LAS also has 20 quick response vehicles staffed with medics and 10 quick response motorcycles that can cut through crowds and traffic to get to a call extraordinarily fast. Very impressive indeed! This idea is similar to what our region has in mind in our "Austere Care" protocols when our EMS resources are heavily burdened and stretched thin.

I think what probably struck me the most was the 12-lead programs run by the LAS. Three years ago, every London paramedic underwent extensive 12-lead training, similar to the training you are going through, or recently went through. Out of that training, every medic learned to approach every 12-lead in the same fashion using a 10 step methodical assessment tool. The medics, to this day, carry a laminated card highlighting this 10 step process of reading a 12-lead. What is amazing is that the LAS then turned off the machine interpretation of the 12-lead and relied solely on the medic interpretation of whether or not to activate a cath lab for a STEMI patient. Win, lose or draw, that medic was on the hook for correctly interpreting the 12-lead. If he or she misread the 12-lead and failed to diagnose a STEMI, there could be a disastrous outcome for the patient. Much to their delight, however, the medics are correctly interpreting a STEMI on a 12-lead 97% of the time (that, by the way, is 3% better than the computer, on average!). Of the 3% of the 12-leads that are misinterpreted, the cardiologists take the time to stop the medic and provide real-time constructive feedback and instruction on what key components were missed so the medic can improve his or her 12-lead skills. Pretty amazing!

When I look to the future of 12-leads in the Mountain Valley region, I am hopeful that our medics will approach this important skill with fervor and determination. Remember that the machine WILL BE wrong about 6 in 100 patients having acute coronary syndrome with ST elevations. BE VIGILANT! Test yourselves. And know that you are a part of something that is HUGE! Consider this: 6 diagnosed STEMIs in the field that are alerted and receive early treatment save 1 additional life!

New Faces at the EMS Agency



Tom Morton, Facilities and Quality Improvement Coordinator

We are pleased to announce that after an exhaustive search, Tom Morton has been selected as the Mountain-Valley EMS Agency Facilities and Quality Improvement Coordinator. Tom came to us from LifeCom where he held the CQI Coordinator position. Tom is currently finishing his Six Sigma Certification in Quality Management. He is a certified EMT within this region and certified by the National Association of Emergency Dispatch as an EMDQ. Tom can be reached at the agency at (209) 529-5085.

CEMSIS/NEMSIS

By Tom Morton, QI Coordinator

CAHAN, OSHA, HIPAA, EMD, CAAS..., you have to love the EMS industry. Here's another one for the list you may have heard, CEMSIS. The California Emergency Medical Services Information System (CEMSIS) was designed by the EMS Authority to house and analyze data collected by the Local EMS agencies (LEMSA's). The CEMSIS will serve as a tool for LEMSAs and EMS providers to compare their services to those provided by other LEMSAs and providers in California for administrative and continual quality improvement efforts.

The objective of the project was to create a statewide database of EMS-based patient information and to then link that data whenever possible to data from other systems such as hospital discharge and emergency department data, to create a picture of the EMS care continuum and, ultimately, a picture of the emergency response system. A pilot program is currently underway to test the collection and reporting of ePCR data using the CEMSIS data dictionary.

MVEMSA is participating in the pilot reporting trauma data only at this time. Once the process is defined and refined, it will be MVEMSA's responsibility to collect the pre-hospital ePCR data from all providers in the region. This data will then be submitted to the state. NEMSIS, (another one for you!) is the National Emergency Medical Services Information System, and will act as CEMSIS but at the national level. Each state will submit its aggregate data to the NEMSIS dataset in order to evaluate and compare EMS delivery in the nation.

While reporting is currently voluntary, be assured that at some point in the future it will become mandatory. MVEMSA will continue to follow this process and update you all with any new developments.

STEMI Pilot Project

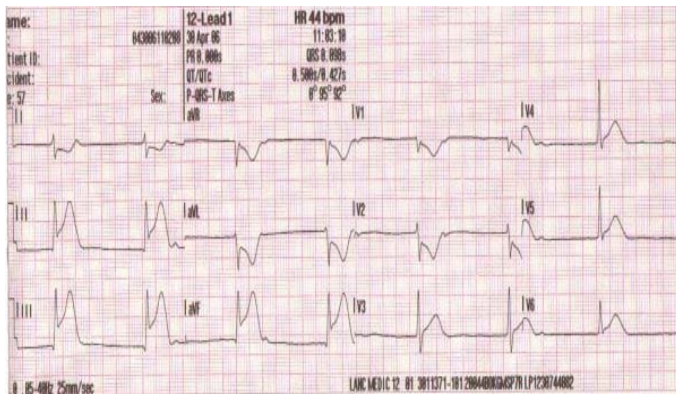
Richard Murdock, Interim Deputy Director

The 12-Lead EKG/STEMI Pilot is off and running to a good start! The “train-the-trainer” classes have been completed and each provider agency has either already provided training to staff or is in the process of scheduling training.

- Amador and Calaveras Counties began 12-Lead application on November 1st, 2009.
- Mariposa County is moving towards the training implementation and will be coming on board in the near future.
- Stanislaus County providers, for the most part, have completed the training and will be implementing the 12-lead EKG’s by early 2010.

Located in the paramedic report writing area of each hospital ED is a file folder that contains the “blank forms” file and the “completed forms” file. The file folder is labeled with “MVEMSA 12-Lead” for easy recognition. Directions are attached to the outside of the folder for clarification.

Please make sure to attach all 12-leads to back of PCR!



Boards and Committees

Tina Casias, Executive Secretary

We have several vacancies on our Regional Advisory Committee (RAC). There are 4 in Alpine County, 2 in Stanislaus County, 1 in Mariposa County, and 1 in Amador County. If you are interested, or know of someone who might be interested in serving on this important committee, please contact the Clerk of the Board in one of the above Counties to request an application.

We also have several vacancies on our Calaveras County Emergency Medical Services Oversight Committee (EMSOC). There is 1 vacancy in District 1 and several alternate vacancies available.

If you are interested in serving on this important committee, and are a Calaveras County resident, please contact the Calaveras County Clerk of the Board for an application.

Diversion, Saturation, or Surge?

By Doug Buchanan, Disaster Preparedness Coordinator

No matter what you call it, when hospital ED's get overwhelmed, it affects the whole community. In Stanislaus County, the EMS Agency has been working with the ED managers for years to try to come up with the right triggers and protocols for effectively responding to the system overload. Additionally, the Stanislaus County Health Services Agency has been developing a Healthcare System Surge Plan as part of the HPP grant objectives. We believe that we now have an EMS and Hospital Saturation Policy that integrates nicely with the recently approved Surge Plan for the county.

The latest draft version of the Stanislaus County System Saturation Policy has been tested for several months as a "pilot project." At their last meeting, the ED Managers approved this latest draft to be moved forward as the final policy. This final version is a result of significant collaboration between the Hospitals, EMS Agency, Health Services Agency, and OES. It was contingent upon all hospitals within the county adopting the same five-tier categories for ED patients, and all hospitals defining their internal surge criteria for the three levels of internal hospital surge, including:

- Sudden increase of medical or trauma patients
- ED waiting times
- Increase in patients over a 4-hour period
- Number of admissions exceeding licensed bed capacity
- Shortage of critical hospital supplies
- Staffing shortages

The new policy requires hospitals to enter their "level" of surge in EMS system, which is monitored by the DCF. The DCF then has protocols for contacting the EMS Agency Duty Officer if two or more hospitals reach Level 2 Internal Hospital Surge, or any one hospital reaching Level 3 Surge. The policy further outlines the process of conducting Conference Calls and implementing Patient Rotation if warranted.

Even though the new criteria require a higher level of system saturation to implement patient rotation, it does authorize the DCF to implement the MCI protocols should any individual hospital receive multiple critical patients at once. This means that the DCF would poll all hospitals within the county and direct patient destinations until the immediate threat has passed.

Although these new triggers and protocols may not be perfect, we believe that we are better prepared to collaborate and respond as a community to the real and growing threat of EMS and Hospital System Saturation.



H1N1 News

Marilyn Smith, Response and Transport Coordinator

H1N1 Influenza Necessitates Change to Paramedic Scope of Practice

The recent increase in the number of cases of H1N1 Influenza resulted in the Mountain-Valley EMS Agency obtaining approval for an expanded scope of practice for paramedics. That expanded scope of practice allows paramedics to administer H1N1 vaccine to pre hospital personnel. Prehospital, as defined in Policy 552.65 - Paramedic Administration of H1N1 Influenza Vaccine are:

- Pre Hospital Employees of an Ambulance Provider Agency or ALS First Response Fire Department
- Fire Department First Response Personnel
- Sworn Law Enforcement and Uniformed Custodial Personnel

Policy 552.65 was developed as a temporary policy. The effective dates of the policy are November 1, 2009 through June 30, 2010. The policy allows ALS ambulance providers and ALS first response agencies that wish to participate in the H1N1 Influenza Vaccination program, the ability to train a select group of paramedic personnel in the administration of the vaccine.

Preventative medicine is a different focus for EMS personnel. In order to facilitate this project, the Mountain-Valley EMS Agency worked in conjunction with the Health Departments in each of its member counties.

In Amador, Calaveras and Stanislaus Counties, most ambulance providers and ALS first response agencies worked to ensure that all prehospital personnel wishing to receive the vaccine were vaccinated. Prehospital personnel in Alpine and Mariposa counties were vaccinated by their Health Departments. Instead of collecting data from pre hospital report forms, the Agency had to develop forms, collect, or report data, on:

- the names of individuals receiving vaccine
- age of recipients of vaccine
- Vaccination Information Statement – which provides information to recipients of vaccine
- a form to report any wasted vaccine

The first priority for administering vaccine went to ambulance and fire department personnel. In Stanislaus County, the ambulance providers also administered the vaccine to law enforcement personnel. The goal was to have the vaccinations completed by mid-December, which was accomplished.

A big thanks to the Health Departments in each county and to the ambulance provider and ALS first response agencies that pitched in and helped ensure that the vaccine was administered in a short amount of time.

LIFECOM Upgraded to Improved Version 12.0 Protocols

Kevin Pagenkop, Training Coordinator
American Medical Response (AMR)
LIFECOM, Modesto

American Medical Response's LIFECOM EMS & Fire Dispatch Center in Modesto upgraded their dispatch protocols to the most recent, and greatly improved, version. The protocols, the Medical Priority Dispatch System (MPDS), are a phone triage system that allows certified Emergency Medical Dispatchers (EMDs) to interrogate callers to determine the most appropriate responders to dispatch and the most appropriate priority level of their response. Through their certification training, EMDs are instructed on the use of the MPDS to obtain both a primary and secondary assessment of the patient without the benefit of being able to see the patient and to triage the symptoms based on scripted protocols. In addition, while responders are enroute to the incident, EMDs are certified in Dispatch Life Support (DLS) and will fulfill the role of *first* First Responders as they can provide care in a variety of situations in the interim between the time the call is received in the Dispatch Center to the time responders arrive at the incident and provide "hands-on" care. The MPDS offers a "zero minute" response time for callers requiring medical instructions or support from a certified healthcare professional.

Since the MPDS released its original set of protocols, EMD Version 1.0, in 1979, it has been continually reviewed, restructured, and improved upon. The National Academy of Emergency Dispatch (NAED) includes a College of Fellows with a Council of Standards that has the responsibility to refine and upgrade the protocols. These Fellows, including Medical Doctors, Registered Nurses, Paramedics, Fire Officers, and Emergency Tele-Communicators, are constantly reviewing data, trending the results, and applying Continuous Quality Improvement (CQI) practices and management to improve responder safety and patient care. The last few upgrades, from Versions 11.1 through 11.3, have addressed minor changes and improvements in a few key areas. This most recent upgrade, Version 12.0, is a complete overhaul of the protocols and one that LIFECOM has been eagerly awaiting and is excited to have implemented.

One of the biggest improvements over earlier versions of the MPDS is the simplification of the interrogation questions. As most of the individuals that utilize the 911 System are non-healthcare providers, laypersons, it is necessary to engage them with simple questions and not utilize medical terminology or industry jargon. Callers often struggle identifying "conscious", "respiratory distress", or "altered mentation". EMD Version 12.0 was structured to identify these situations by asking callers if the patient is "awake", "having difficulty speaking between breaths", or "completely alert" and/or "responding appropriately". Another area that has been improved upon has been identifying patients with a change in skin tone that is of clinical significance. In previous versions, the EMD was only required to ask the caller if the patient was "changing color". Erring on the side of patient care, any deviation in normal skin tone triggered a maximal response. As many callers will describe a change in skin tone as "red", which in itself may not warrant an emergent response, it was necessary to revise the protocol question to further interrogate the caller to separate descriptions of "red" from "ashen", "grey", "blue", "purple", or "mottled", which have a higher percentage of representing a true pre-hospital emergency.



(Continued from page 7)

While the priority complaints of “chest pain”, “difficulty breathing”, and “unconscious” certainly warrant individual Chief Complaint Protocols to address these issues, the majority of the calls received by LIFECOM EMDs are non-priority complaints. To address the variety of these complaints, EMD Version 12.0 completely restructured its “generic” medical protocol, Protocol 26 (Sick Person), with several long awaited improvements. To increase responder safety, several of the more common non-priority complaints have been downgraded to a lower acuity response level. Complaints regarding asymptomatic blood pressure, dizziness, fever, general weakness, nausea, and vomiting will now be addressed on this specific Chief Complaint Protocol, and in the absence of priority symptoms, a responder can be dispatched Code-2 to the incident. Also included in this Protocol is more thorough information regarding ALOC. Identifying any altered level of consciousness can be problematic for a dispatcher as they must rely on the caller’s interpretation of their own lay-assessment of the patient. Version 12.0 provides specific descriptors that, when presented by the caller, can then be applied by the dispatcher to more accurately identify a patient that is not alert and oriented.

In addition to refinements with the non-priority Chief Complaint Protocols, Version 12.0 has also provided enhancements to some of the Trauma Protocols. Protocol 17 (Falls) now has an additional Response Determinant for patients that have fallen from thirty (30) feet or higher. As velocity and distance can affect the severity of injury, it is appropriate to provide more detailed information to the responders regarding the specific details or cause of each fall. The EMD will also be able to link to, or “shunt”, to more appropriate protocols should they need to address the patient’s airway after a fall due to dizziness or a syncopal episode. When callers describe patients with potential fractures, the EMDs can utilize several different Chief Complaint Protocols to triage the incident based on which part of the body is injured instead of the complaint or description of the pain. The Version 12.0 upgrade improves the dispatcher’s assessment by including “deformity” in their clarifications of the described injury. This then allows a lower, and more appropriate, response to be dispatched to the incident when appropriate. One of the most challenging incidents LIFECOM receives calls for are victims trapped in vehicles that are sinking or submerged. EMDs are now provided with Post Dispatch Instructions (PDIs) that can be delivered to callers in these situations instructing them how to equalize the water pressure inside and outside their vehicle before attempting to exit and then “follow the bubbles” to the surface (to give an example of two of the PDIs).

Balancing the dual importance of responder safety and patient care, EMD Version 12.0 is an exceptional tool that allows LIFECOM personnel to triage caller complaints appropriately so that responders can be dispatched accurately with the most appropriate response priority (Code-3 versus Code-2), while at the same time, remaining on the line with the callers to provide DLS until the responders arrive on-scene and take over patient care. We look forward to evaluating the upgraded protocols through our CQI Program and welcome the input of our responders as we continue to trend data, evaluate our processes, and always actively seek out improvements to the system so that we can better serve our responders and the patients we care for.



Certification and Training

Cindy Murdaugh
Certification and Training Coordinator



2010 Training Calendar

We have recently added to our website an annual *Training Calendar*; this calendar will provide you with information on upcoming training opportunities. You can view the 2010 training calendar by visiting our website, www.mvemsas.com and selecting the training option location on our homepage. You will also find additional training opportunities under *Continuing Education & Conferences*. You can email me at cmurdaugh@mvemsas.com with information that you would like to see included on our Training page.

STEMI News...

Kevin Mackey, MD
Medical Director

Conditions that Mimic STEMI's

On November 1, 2009, day one of the STEMI program in Calaveras County, an ALA crew rapidly transports a patient to the hospital after their 12 lead read ** ** * ACUTE MI ** ** * /Abnormal ECG *** Unconfirmed ***. The patient presented with acute chest pain as well as cardiac dysrhythmia. The patient was treated with oxygen, IV, nitrates, aspirin, and lidocaine for the cardiac dysrhythmias. This patient, however, is not the typical cardiac patient. The patient is young and has no prior health problems. But the story is real, convincing, and can present as a STEMI.

What would you do?

As the story unfolds, the patient is discharged home a few hours after arrival at the hospital, only to be taken back to the hospital later that evening for continued chest pain. The cardiac markers measured in the blood are indeed abnormal, but the patient has not suffered a myocardial infarction.

What are the possible diagnoses?

This patient, as it turns out, had myocarditis, an infection in the muscle of the heart. It is a STEMI mimic, meaning that the 12 lead will read ACUTE MI when that is not actually the diagnosis. But there are others! Pericarditis, or inflammation of the sac lining the heart, is another. And left ventricular aneurism, or ballooning of the ventricle usually following a myocardial infarction, is another.

The lesson here is that not all STEMI's are actually STEMI's. But that should not dissuade our continued vigilance for this killer diagnosis! Statistically, 6% of STEMI's identified by machine interpretation will be false negatives (missed altogether), but 1 of 4 will be false positives, as in this case! Remember to look at the 12 lead, use your training and couple that with your assessment. Challenge yourself, as the LAS medics do, and see if you can beat the machine! Keep up the great work that all of you do every day!



Mountain-Valley Launches New Certification ID System

Cindy Murdaugh

Certification/Training Coordinator

On January 1, 2010, the Mountain-Valley EMS Agency we will be implementing a new certification system. This new system provides the ability to produce photo ID certification cards. The Agency’s policy for certification, accreditation or authorization will not change, however, the process in issuing the new cards will change with the New Year.

Effective January 1, 2010 you will be required to submit, in person, an Agency application along with the required items or documentation as identified in the table below to complete the initial or re-certification process:

Certification Requirements:

<p>First Responder Initial Certification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete First Responder application <input type="checkbox"/> Certification Fee (\$30.00) <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current CPR Card – Health Care Provider Level o Course Completion Certificate (within last 6 months) o Pass MVEMSA First Responder Exam (75%) ➤ Digital Photo (taken at the Agency) 	<p>First Responder Re-Certification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete First Responder application <input type="checkbox"/> Certification Fee (\$30.00) <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current CPR Card – Health Care Provider Level o Required CE (16rs) o Skills Verification Form ➤ Digital Photo (taken at the Agency)
<p>EMT Initial Certification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete EMT application <input type="checkbox"/> Certification Fee (\$30.00) <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current CPR Card – Health Care Provider Level o Current National Registry Card <input type="checkbox"/> Complete Fingerprint Background (Live Scan) ➤ Digital Photo (taken at the Agency) 	<p>EMT Re-Certification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete EMT-I application <input type="checkbox"/> Certification Fee (\$45.00 / \$30.00 if 2 weeks prior to expiration) <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current CPR Card – Health Care Provider Level o Required CE (24 hrs) o Skills Verification Form ➤ Digital Photo (taken at the Agency)
<p>Paramedic Initial Accreditation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete Initial Paramedic Accreditation Application <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current State License o Accreditation Fee (\$75.00) <input type="checkbox"/> Digital Photo <input type="checkbox"/> Complete Regional Orientation <input type="checkbox"/> Complete Local Orientation <input type="checkbox"/> Successfully Complete required 5 ALS calls <input type="checkbox"/> Complete OES Region IV MCI Training ➤ Digital Photo (taken at the Agency) 	<p>Paramedic Re-Accreditation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Complete Paramedic Update Sheet <input type="checkbox"/> Provide <ul style="list-style-type: none"> o Photo ID o Current State License o Fee if Lapsed (\$75.00) ➤ Digital Photo (taken at the Agency)



MICN Initial Authorization	MICN Re-Authorization
<ul style="list-style-type: none"> <input type="checkbox"/> Complete MICN application <input type="checkbox"/> Authorization Fee (\$50.00) <input type="checkbox"/> Provide <ul style="list-style-type: none"> <input type="checkbox"/> Photo ID <input type="checkbox"/> Current RN License <input type="checkbox"/> Current ACLS Certification <input type="checkbox"/> MICN Course Completion Certificate <input type="checkbox"/> Complete required 10 ALS Radio Calls <input type="checkbox"/> Complete OES Region IV MCI Training <input checked="" type="checkbox"/> Digital Photo (taken at the Agency) 	<ul style="list-style-type: none"> <input type="checkbox"/> Complete MICN application <input type="checkbox"/> Authorization Fee (\$50.00) <input type="checkbox"/> Provide <ul style="list-style-type: none"> <input type="checkbox"/> Photo ID <input type="checkbox"/> Current RN License <input type="checkbox"/> Required CE (16 hrs) <input checked="" type="checkbox"/> Digital Photo (taken at the Agency)

To ensure that your photo ID card is printed and issued to you at the time you submit your completed application, we have set aside the following hours of operation for this process.

Certification processing will be completed between the following hours:

Monday	10am-4:30pm	Wednesday	8am-4:30pm
Tuesday	8am-4:30pm	Thursday	8am-4:30pm

If you are currently certified with Mountain-Valley, you will be receiving a reminder postcard in the mail 3-6 months prior to your expiration date. You can go to our website, www.mvemsas.com and print the application or obtain an application when you arrive at the Agency to complete your re-certification.

If you should have any questions or concerns, please do not hesitate to contact the Agency at 209-529-5085 or you can email me at: cmurdaugh@mvemsas.com

Sample Postcard-

PARAMEDIC ACCREDITATION

NEW PROCEDURE

On January 1, 2010 we implemented our new accreditation process which includes producing photo ID certification cards.

Accreditation processing completed between the following hours:

Monday	10am-4:30pm	Wednesday	8am-4:30pm
Tuesday	8am-4:30pm	Thursday	8am-4:30pm

To complete your re-accreditation with this Agency you must submit in person the following:

- Paramedic Accreditation Application
You can download from our website: www.mvemsas.com or complete upon arrival at the Agency
- Photo ID
- Current California Paramedic License

Mountain-Valley EMS Agency
Mountain-Valley
Emergency Medical Services

Questions? Contact us at:
Phone: 209-529-5085
E-mail: cmurdaugh@mvemsas.com
Website: www.mvemsas.com



New Triage Guidelines at SR 911

Alicia Hinshaw, Modesto FD QI Coordinator

On Monday December 7, 2009 a new set of triage guidelines was implemented at Stanislaus Regional 911.

At the direction of the Stanislaus County Fire Chiefs Association a committee was formed to look at 3 areas of concern:

- 1) Evaluation of dispatch criteria, (questions asked of the caller and adherence to pre determined questions at SR911)
- 2) Tighten dispatch criteria, (look at modifying the predetermined questions)
- 3) Establish ring back criteria, (identify types of calls that Fire will respond to as well as address medic field requests for Fire)

The concerns voiced by the County Chiefs Association are due to the fact that LifeCom uses the Clausen System (Pro QA) for EMD and SR911 uses a different set of questions resulting in different outcomes for Fire dispatch. There were two separate dispatch centers using completely different criteria with one goal in mind. That goal is to provide pre hospital patient care making the best use of available resources in the least amount of time. As many of you know the process was generating unnecessary fire response and calls for which First Responders are not needed.

The committee is made up of representatives from various participating agencies. Commander Brian Weber from Ceres Fire Department, Cindy Murdaugh from MVEMSA, Lucian Thomas, Judy Griepsma and Carrie Frink from SR911, Jared Bagwell and Teri Griffin from LifeCom, Ray Leverett from Oak Valley Ambulance representing Providers and Alicia Hinshaw from Modesto Fire Department.

The group has met monthly since August and has implemented a new dispatch matrix at SR911. QA indicators have been developed however benchmarks have yet to be established as the data collection has just begun.

Immediate changes recommended and approved by the County Chiefs are:

- 1) Field lift assists will first be met by an available BLS unit. If further assistance is needed then Fire will be dispatched.
- 2) Requests for Fire when Fire has not been dispatched require a medic on scene to make the determination.
- 3) Fire will be dispatched for all Echo, Delta, and Charlie calls. These are the levels of calls in the Clausen System (Pro QA) in which Ambulance is rolling Code 3 and it is determined that there is a level of life threatening illness or injury. This determination hopefully will eliminate the calls in which Ambulance rolls code 2 and Fire rolls code 3.
- 4) Both centers will begin to use common, agreed upon terminology when transferring and dispatching calls. For example, "per EMD" instead of "per AMR" if the call was triaged by LifeCom and "Per Medic on scene" clarifies that the medic did not request Fire while enroute.

As with any change in processes there will still be those calls that will fall out and fire departments will be dispatched to calls that were not necessary. Remember, the information that is relayed to the call takers and dispatchers is only as good as the person giving it. The callers know the "buzz" words to get the response they desire. The committee is dedicated to looking at times and appropriateness of dispatch.

County Chiefs will continue to be involved and will be updated on a monthly basis.



EMS NEWS

**Mountain-Valley EMS Agency
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