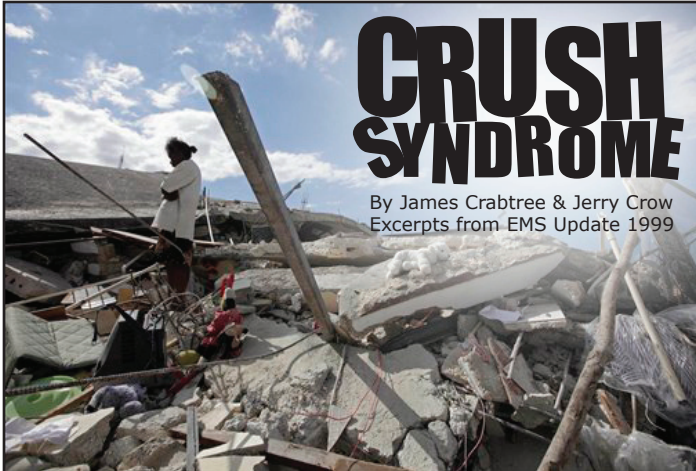




EMERGI PRESS

SPRING/SUMMER 2010 VOLUME 15, ISSUE 1



Images of collapsed buildings from the recent earthquakes in Chile and Haiti should be viewed as likely scenarios for Los Angeles should we experience an earthquake of a life altering magnitude. In 1971, when fire department members worked at the collapse site of Veteran’s Hospital in Sylmar, they used techniques derived from mine rescues. The dynamics of extricating victims from collapsed buildings were not understood and ultimately just one person was rescued alive. The frustration of wanting to achieve greater success in performing confined space rescues drove research that resulted in tools and techniques that proved successful in Haiti. This applied science is essential so that the affected rescue means the victim will not only survive, but do so with as little morbidity as possible.

Crush Syndrome is the name given to the series of physiological processes that ensue when the human body is squeezed and/or remains immobile for a lengthy period of time. Every emergency provider is familiar with how cardiovascular shock alters physiological processes that support life in the short term but can hasten death if not recognized and reversed. The same applies to crush syndrome; it must be recognized and treated before patient removal or the effort may ultimately become a body recovery.

In this article we will explore low pressure/high duration situations; partial burials such as trench collapses, entrapments such as when extremities are pinned under rubble and forced immobility as when severe intoxications or neurological damage causes a person to lie completely motionless for many hours. With these scenarios the

(continued on pg.6)



ST-ELEVATION MYOCARDIAL INFARCTION RECEIVING CENTER PROGRAM

By Paula Rashi

The ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) program in Los Angeles County has been in existence for over three years and currently has 33 approved SRCs, including three hospitals from the surrounding counties. Los Angeles County maintains one of the largest SRC programs and is regarded as a national model due to our geographical size and number of paramedics. The goal of the program is for patients to receive percutaneous coronary intervention (PCI) within 90 minutes of the prehospital 12 Lead electrocardiogram (ECG) identifying a STEMI. Our “Prehospital 12 Lead ECG” to “PCI” times exceed that goal with 2009’s 3rd quarter data reflecting a median time of 79 minutes based on 447 STEMI patients.

As we continue to develop into a more mature system, changes in policy and procedure occur. This is evident in a change to the 12 Lead ECG Guideline, updated November 2009. The guideline now requires performing a 12 Lead ECG on patients with a return of spontaneous circulation (ROSC) after a cardiac arrest, if the pre-arrest 12 Lead ECG was negative for an acute MI, or was not performed prior to the arrest. Since not all cardiac arrests are the result of an

(continued on pg.5)

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EMT CERTIFICATION



The Certification Section is one of the busiest units at the EMS Agency. This is demonstrated by over 3,000 “hits” on the EMS Agency web page for the Certification Section in a single month. The section is responsible for the certification and accreditation of EMS personnel, namely Emergency Medical Technicians (EMTs), Paramedics and Mobile Intensive Care Nurses (MICNs) in accordance with State regulations and EMS Agency policies. Currently, seven employees, four RNs, two support staff and one administrator, carry out the varied functions of this section. The RNs are also responsible for the review and approval of EMS Training and Education Programs including skills and curriculum development.

EMT Certification

Currently, 80 to 100 EMT certification applications are processed each week and over 5,800 EMTs hold current Los Angeles County (LAC) certification. EMT certification is valid for a two year period and must be renewed prior to expiration. To be certified as an EMT in California, an individual must successfully complete an EMT basic course and then comply with the following requirements:

- Clear criminal background check using the Department of Justice Criminal History Information Report via Live Scan prior to first time certification. Effective July 1, 2010, FBI level background reports will also be required for first-time applicants and those with a lapse in EMT certification greater than 1 year.
- Proof of passing the National Registry EMT Basic written and skills examination for first-time applicants.
- Completion of Los Angeles County Expanded Scope of Practice.
- Current BLS Healthcare Provider or Professional Rescuer card.
- Appropriate continuing education and proof of passing the State Skills Competency verification for recertification.
- Payment of applicable fees.

Application processing was recently changed to incorporate the State of California EMS Authority regulatory changes that are effective July 1, 2010. Applications for EMT certification may be submitted in person during regular business hours or by mail. For recertification, in order to avoid a lapse in certification, complete applications should be submitted 30 days prior to expiration. Applications are processed and certification cards are issued and mailed within 15 days of receipt of a complete application.

Additional EMT information can be obtained by visiting our web site at <http://ems.dhs.lacounty.gov> or by contacting us at emtinfo@dhs.lacounty.gov or (562) 347-1500. A staff member will respond to inquiries within 3 business days. ■



Dr. Eckstein receives the Michael Keys Copass Award

Marc Eckstein MD, MPH, Medical Director for Los Angeles City Fire Department (LAFD) was honored at the 2010 “EAGLES” conference with the *Michael Keys Copass Award*. This award is given to that Emergency Medical Services Medical Director who has demonstrated longstanding service, contributions and leadership in the unique realm of out-of-hospital emergency care and who, in addition, has served as a role model, not only for emergency medical services personnel, but also for fellow 9-1-1 system medical directors across the nation.

Winners of the *Michael Keys Copass Award* are selected by the members of the *U.S. Metropolitan Municipalities Emergency Medical Services Medical Directors Consortium*, the *de facto* coalition of jurisdictional 9-1-1 system medical directors for the nation’s most populous cities, as well as the medical directors/lead medical officers for key related federal agencies and units such as the FBI, *U.S. Secret Service*, *White House Medical Unit*, *Immigration and Customs Enforcement*, and the *U.S. Department of Homeland Security*. Collectively, this small, but cohesive, cadre of about two dozen emergency care physicians is responsible for the day-to-day out-of-hospital 9-1-1 emergency and resuscitative care for about 50,000,000 Americans as well as for guiding the medical aspects of homeland security and disaster mitigation in the nation’s highest-risk venues.

Dr. Eckstein was also promoted to full Professor at USC Keck School of Medicine in December. Please join the EMS Agency in congratulating him on these accomplishments. ■

Medical Alert Center at 2010 LA Marathon Incident Command Post

by John Quiroz, Program Director,
Medical Alert Center



The inaugural *Stadium to the Sea*, 2010 LA Marathon, with 25,000 registered runners and thousands more spectators scattered along the 26-mile stretch starting at Dodger Stadium and ending at Santa Monica, was held on March 21, 2010. Los Angeles City Fire Department (LAFD) was the lead emergency medical services (EMS) provider of the event. Other EMS providers that participated in the Unified Command Post included Los Angeles County, Santa Monica and Beverly Hills Fire Departments.

It's no surprise to hear that each year hundreds of racers succumb to heat exhaustion, muscle cramps, fatigue, falls, dehydration, scraped knees and other sports related injuries that you might expect with an endurance race. Warm weather seems to be the most reliable predictor to the number of medical incidents and racers that require medical aid. Thankfully, most racers are treated and released on scene by a contingent of California Hospital Medical Center staff working a chain of medical aid stations plotted along the race course.

Historically, on race day the coordination of 9-1-1 patient transports was handled similar to any Multiple Casualty Incident (MCI). Under the Incident Command System, LAFD personnel assigned to the Medical Branch contacted the Medical Alert Center (MAC) via the Hospital Emergency Administrative Radio (HEAR) to obtain emergency department bed availability. MAC personnel initiated a ReddiNet MCI Poll and provided bed availability back to LAFD. Patients were transported accordingly.

With years of patient transport coordination experience shared between the EMS Agency's MAC and LAFD at the event, the thought occurred to establish a MAC presence at the LAFD Incident Command Center (ICC) to directly assist with patient destination activities. The idea had worked

well for previously scheduled MCI drills with paramedic providers; this would be the first application to a live ongoing MCI. Here's how it came together for the LA Marathon:

- MAC personnel were assigned to the ICC as Agency representatives and seated with the Medical Branch.
- MAC personnel at the ICC established telephone and HEAR (radio) communication with the MAC along with mobile computer and internet access to the ReddiNet.
- MAC initiated a ReddiNet MCI poll with surrounding hospitals.
- LAFD personnel in the field contacted the Medical Branch to request an emergency department destination for patient(s).
- MAC personnel at the ICC referenced their list of receiving hospital destinations ready to receive patients.
- Medical Branch relayed the information to paramedics in the field and the patients were transported accordingly.

During this event, there were 34 patient transports to area hospitals, including:

Brotman Medical Center
Cedars Sinai Medical Center
Childrens Hospital of Los Angeles
Glendale Memorial and Health Center
Good Samaritan Hospital
Hollywood Presbyterian Hospital
LAC+USC Medical Center
Olympia Medical Center
St. Johns Health Center
Santa Monica UCLA Medical Center
Ronald Reagan UCLA Medical Center

Placing MAC personnel in the ICC was very successful and turned out to be a win/win arrangement for everyone involved. Benefits to the collaboration included:

- Eliminated the cumbersome HEAR radio or telephone communications between LAFD and the MAC, therefore improving communication.
- Improved MAC situational awareness of the event to better anticipate destination/resource/needs of the EMS providers.
- Face to face interaction reduced miscommunications
- MAC personnel would immediately notify a receiving hospital via ReddiNet MCI poll or Messages of patients en route to the hospital.
- Developed a positive working relationship and trust between the departments.
- Established a successful practice which could be applied to future events or incidents.

The MAC's teamwork with LAFD at the 2010 LA Marathon can serve as a model and proven strategy for other paramedic providers that may find their department responsible for delivery of EMS for a large public event. Strategies to

see MAC (concluded on page 6)

EDAP

Celebrating 25 years in Los Angeles County



by Karen Rodgers, RN MICN, Pediatric
and SART Program Coordinator

June 2010 marks the 25th Anniversary of the Los Angeles County Emergency Department Approved for Pediatrics (EDAP) program. An EDAP is a licensed basic or comprehensive emergency department that is approved by the County of Los Angeles to receive pediatric patients from the 9-1-1 system. To date, there are 44 approved EDAPs: 42 in Los Angeles County, one in Ventura, and one in Orange County. The EDAP program recognizes that children require specialized medical procedures and equipment that take into account their size and stage of development.

Historical Perspective

The pediatric healthcare providers in Los Angeles County first approached the EMS Agency in the early 1980's with the EDAP concept, and ultimately assisted in the development and implementation of standards specific to the pediatric care provided in hospital emergency departments (EDs). Many 9-1-1 receiving hospitals throughout the County stepped up to meet these standards and be approved as an EDAP. It was recognized that EDs would have many challenges to meet in the quest for EDAP approval – many did not have the required equipment and supplies; staff would need to obtain additional training in the specialized care of children; and policies would have to be developed specific to the new standards. In addition, formalized processes would be required to address interfacility transfers to a higher level of care when applicable.

In June of 1985, with approval of the Board of Supervisors, the EMS Agency approved 62 hospitals as EDAPs. Paramedic and base hospital guidelines were developed to provide pediatric patient medical direction and destination guidelines. *Reference No. 510 – Pediatric Patient Destination* established the EDAP as the most accessible receiving (MAR) facility for pediatric patients.

Requirements for Designation

In order to obtain EDAP designation, hospitals must collaborate with the EMS Agency and submit the required application and supporting documentation. An on-site review and inspection is then conducted, and if approved, EDAP status is valid for a period of three years.

The administration and coordination of the EDAP program at each hospital requires qualified individuals to oversee the program: an EDAP Medical Director, a designated pediatric consultant, and a Pediatric Liaison Nurse (PdLN) to coordinate the program requirements and ensure that the standards are met at all times.

The responsibility of the EDAP Medical Director is to ensure that the ED maintains twenty-four hour physician coverage, and that 75 percent of the physicians are board certified in emergency

medicine or pediatric emergency medicine – or demonstrate active progression in the certifying process. They also oversee pediatric quality improvement, and assist in the development and implementation of required pediatric policies. The EDAP Medical Director may also serve as the Pediatric Consultant or a specialist in pediatrics may provide consultative services in the care of the pediatric population.

The pediatric liaison nurse (PdLN) works closely with the EDAP Medical Director; reviewing the care of pediatric patients through chart review, trending and analyzing data; monitoring and tracking educational requirements; educating staff to the pediatric policies and standards, and ensuring that the required pediatric equipment, supplies, and medications are easily accessible, labeled, and logically organized. Collaboration among the entire team is needed to ensure that the ED is prepared to provide care to children at all times.

The EDAP standards also require that at least 75 percent of the ED's nursing staff maintain current Pediatric Advance Life Support (PALS) certification; that at least one registered nurse per shift has completed a two-day pediatric emergency nursing course within the past four years; and that all nursing staff have completed eight hours of continuing education in pediatric emergency care within the past two years. Also, at least one PALS certified respiratory therapist must be in-house at all times.

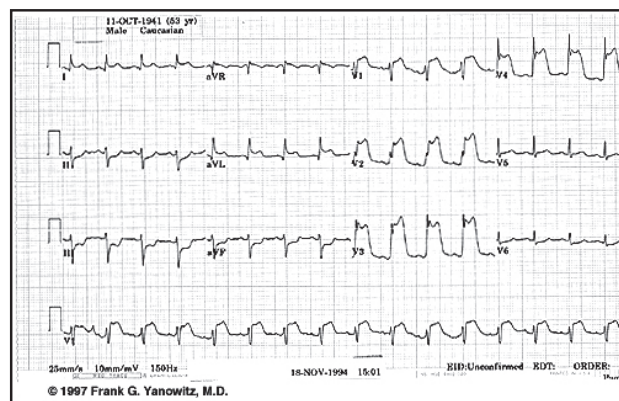
Commitment to Pediatric Care

Over the years, the EDAP Standards have undergone change and revision, and additional requirements have been added. Unfortunately, some EDAPs have relinquished their status due to a variety of reasons: being unable to meet the physician or nursing requirements; hospital closure, and/or closure of their pediatric units. Even with the loss of some EDAPs, the concept of specialized pediatric destination has endured and become a standard of care. Like all aspects of medicine, there is a constant need to evaluate and improve the quality of care for our pediatric community on an ongoing basis.

EDAP hospitals have been proven to provide an essential public service that saves the lives of children of all ages, from neonates to adolescents, by providing specialized pediatric care. Dedicated pediatric emergency medicine physicians, leaders, and advocates continue to give their time to improve the prehospital and emergency department standard of care delivered to our pediatric patients through outcome data and best practice. Resources have been developed to assist in providing patient care; pediatric Base Hospital Treatment Guidelines (BHTGs), Standing Field Treatment Protocols (SFTPs), and Color Code Drug Doses/L.A. County Kids medication chart. Currently, a Midazolam study is being conducted with the EDAPs and Base hospitals in the interest of delivering the highest quality of prehospital care to the pediatric patients of Los Angeles County.

The EDAP standards and other pediatric resources are located on the EMS web page <http://ems.dhs.lacounty.gov>. Questions regarding the Hospital EDAP designation or pediatric destination should be referred to Karen Rodgers, EMS Agency Pediatric and SART Programs Coordinator at (562) 347-1654 or email krodgers@dhs.lacounty.gov.

1. Antelope Valley Medical Center
2. Beverly Hospital
3. Brotman Medical Center
4. California Hospital Medical Center
5. Cedars Sinai Medical Center
6. Centinela Hospital Medical Center
7. Childrens Hospital Los Angeles
8. Citrus Valley Medical Center-Queen of the Valley Campus
9. Downey Regional Medical Center
10. East Los Angeles Doctors Hospital
11. Encino Hospital Medical Center
12. Glendale Adventist Medical Center
13. Glendale Memorial Hospital and Health Center
14. Greater El Monte Community Hospital
15. Henry Mayo Newhall Memorial Hospital
16. Huntington Memorial Hospital
17. LAC Harbor-UCLA Medical Center
18. LAC Olive View-UCLA Medical Center
19. LAC + USC Medical Center
20. Long Beach Memorial Medical Center
21. Memorial Hospital of Gardena
22. Methodist Hospital of Southern California
23. Northridge Hospital Medical Center
24. Pacifica Hospital of the Valley
25. Pomona Valley Hospital Medical Center
26. Presbyterian Intercommunity Hospital
27. Providence Holy Cross Medical Center
28. Providence Little Company of Mary Medical Center San Pedro
29. Providence Little Company of Mary Medical Center Torrance
30. Providence Saint Joseph Medical Center
31. Providence Tarzana Medical Center
32. Ronald Reagan UCLA Medical Center
33. San Gabriel Valley Medical Center
34. Santa Monica-UCLA Medical Center
35. Sherman Oaks Hospital
36. St. Francis Medical Center
37. St. Mary Medical Center
38. Torrance Memorial Medical Center
39. Valley Presbyterian Hospital
40. Verdugo Hills Hospital
41. West Hills Hospital & Medical Center
42. White Memorial Medical Center
43. La Palma Intercommunity Hospital (Orange County)
44. Los Robles Hospital & Medical Center (Ventura County)



Acute Anterior MI-KH

acute MI, obtaining a 12 Lead ECG allows for transport of the patient to the most appropriate facility, whether it be the most accessible receiving (MAR) or the SRC for patients with a 12 Lead ECG identifying an acute MI before or after a cardiac arrest.

Another policy has been changed (Reference No. 513, STEMI Patient Destination), which allows paramedics to establish direct contact with the receiving SRC if they are also a Los Angeles County base hospital, even if it is not the provider's assigned base hospital. A new policy, Reference No. 513.1, *Interfacility Transport of Patients with STEMI*, addresses the transport options for hospitals without emergent PCI capability, when a STEMI presents to them. This policy will allow the sending facility to utilize their contracted ALS provider for transport if a unit is available within 10 minutes of the transport request and the patient is ready for transport or to utilize the jurisdictional 9-1-1 provider agency if a private ALS transport unit is not immediately available. Expediting the transport of a STEMI patient from a non-PCI capable facility to a SRC is imperative for saving heart muscle and patients' lives.

Base hospital contact or base hospital notification by SFTP providers is still mandatory on all STEMI patients, whether the patient is being transported from the field, an emergency department, doctor's office or clinic. It is equally important for the MICNs to document all STEMI runs/calls on a Base Hospital Form, even though the pertinent patient information may be limited from the SFTP providers. When an acute MI is identified on the 12 Lead ECG the date, time and result should be documented on the EMS Report Form, communicated to the base hospital and documented on the Base Hospital Form. The initial chief complaint on the forms should be documented as "MI" followed by the complaint or reason why the patient actually accessed 9-1-1, i.e., "SY", "CP", "SB", "WE", "DI", etc., with the "Transport To" option of SRC as the specialty center.

see STEMI (concluded on page 7)

Crush Syndrome (from page 1)

applied pressure prevents normal perfusion of the entrapped tissues. The perfusion process may be stopped at the artery, vein or the capillary beds depending on the situation but the end result is the same. The non-perfused tissue begins a death spiral. Generalized hypoxia forces cells to perform anaerobic metabolism in an attempt at survival. This process generates lactic acid and disrupts normal pH balances. As individual cells eventually succumb, the cell walls break and the intracellular elements of potassium and myoglobin are spilled out into the interstitial spaces. During compression the body adapts its circulatory patterns to the new smaller volumes and maintains normal blood pressure and pulse rates. Overall, this adaptive process works to ensure survival of the most vital of organ systems.

When the external pressures are relieved the occlusions that previously prevented flow through the vascular system open up and blood again flows into the affected body parts. This first life threatening event is the loss of perfusion pressure that is nearly identical to distributive shock. Because of traumatic changes, fluids can be expected to exit the vessels into the third spaces. As the blood flows through the previously non-perfused areas, it picks up all the toxins that were produced or released and moves them back into the central circulation. The acidic components lower the blood pH and the released potassium causes hyperkalemia, both contributing to cardiac dysrhythmias. The myoglobin impedes filtration through the kidneys which can result in renal failure.

To prevent inadvertent release of toxins into the system, EMS Treatment Guideline T8 *Traumatic Crush Injury/Syndrome's* first consideration is to not perform rapid removal and tissue decompression. Rather, the extrication should be slow and methodical and include treatment throughout the process and not just after complete removal.

When examining situations that involve the rescue and removal of survivors from collapsed structures, it must be remembered that the vast majority of victims are not rescued through complex time consuming technical operations but may be quickly dug out by untrained bystanders. The people who are quickly removed are unlikely to develop crush syndrome. It is the people who have been entrapped for long periods that are at the most risk. In Los Angeles County, providers should consider treating for crush syndrome if entrapment has lasted for longer than four hours or if ECG monitoring shows changes suggestive of hyperkalemia, which include peaked T waves, absent P waves and widened QRS complexes.

The first treatment is to re-hydrate or even over hydrate the patient through the administration of 20cc/kg of NS IV. This additional fluid can help support fluid redistribution and dilution of the toxins. It is not always possible to successfully

start an IV on an entrapped person. Because of materiel shortages in Haiti, fluid was commonly given PO instead of IV. Currently, the use of PO fluids to combat crush syndrome during rescue is not covered by Guideline T8 but may be a consideration during disaster conditions.

Another modality of treatment is nebulized albuterol. This can be delivered throughout the rescue process. In this case the albuterol is not used to open airways but to invoke a little known action of lowering serum potassium levels. Calcium chloride 1 gram IV may also help to move potassium into functioning cells. Sodium bicarbonate administered at 1 mEq/Kg added to the first liter of saline can aid in raising the blood pH level toward normal. Control of both pain and panic during the rescue process can be treated with the use of morphine.

We hope that a devastating earthquake never happens in Los Angeles. But should that occur, seismic building codes may prevent complete building collapses and major entrapments. Realistically, it is impossible to ignore what has been happening throughout the "Ring of Fire" in the Pacific Rim and so crush syndrome is something we need to understand and be prepared to care for in California. ■

MAC (from page 3)

consider when planning for such an event include the following:

- 1) Develop an Event Action Plan that includes MAC in the communication plan for patient destination information.
- 2) Whenever possible, initiate a MCI with the MAC prior to the start of the event to obtain hospital bed availability.
- 3) Consider asking for a MAC representative to staff the ICC to assist the Medical Branch with patient destination activities. This can free up fire department personnel to handle other important duties.
- 4) Discuss the potential need for temporary lifting of Hospital Service Area Boundaries with the EMS Agency in advanced of the event.

Should you have any questions or need more information regarding MACs services during MCIs or large public events, please contact John Quiroz, RN, MAC Program Director at (562) 347-1512 or the MAC at (562) 347-1789 and ask to speak with the administrator on duty. ■



Neonatal resuscitation is a low frequency occurrence in the prehospital setting but comes with many high risk implications. In order to properly assess and resuscitate a newborn delivered in the field setting, it is necessary to understand normal fetal development.

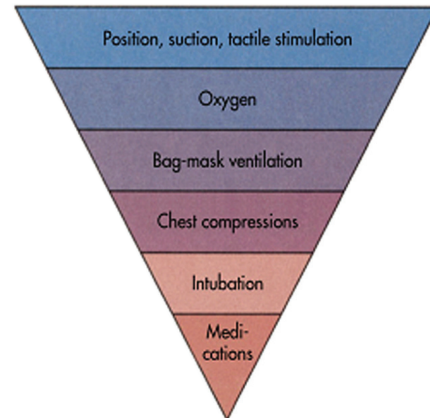
Fetal development consists of three stages: conception, embryonic development and fetal development. These stages are marked by significant milestones in the development of the fertilized egg as it grows into an embryo and finally a fetus. Each stage is significant due to the immense changes that occur in preparation for the delivery of a healthy baby.

- The **conception** stage begins when the egg and sperm join to form a zygote or fertilized egg and implantation in the uterus occurs.
- The **embryonic development** stage is from 1 week to 12 weeks. In this stage, there is massive development from a ball of cells to a formed fetus.
 - Week 3 – begin central nervous system development
 - Week 5 – the nose and lips form and the brain and spinal cord are beginning to become specialized organs
 - Week 8 – most major organs are developed and the embryo is reactive to the environment
 - Week 12 – the placenta is well-developed and weighs more than the embryo, which signals the end of the embryonic stage.
- The **fetal development** stage is from the 2nd to the 3rd trimester. Organ maturation and specialization occur in this stage.
 - Week 16 – fetal heart beat can be heard, fetal gender can be distinguished and the fetus weighs about 6 ounces
 - Week 23 – fingerprints and taste buds are forming, the fetus is able to move its eyes and weighs about 1 ½ pounds
 - Week 28 – the fetus is normally in breech position, can open its eyes and weighs 2 ½ pounds
 - Week 32 – the fetus is practicing breathing, approximately the same size as the placenta and weighs 3 ½ pounds
 - Week 36 – the fetus weighs around 5-6 pounds, almost fully developed and primarily only gaining weight
 - Week 40 – considered full term and the fetus weighs an average of 7 pounds.

Resuscitation of the neonate can be complicated by many factors in the prehospital setting. Language barriers and lack of

prenatal care are just a few of the more common challenges.

Below is the inverted pyramid which illustrates the steps to take to resuscitate a neonate in the prehospital setting. The top of the pyramid shows the first step in resuscitation and is frequently all that is needed to resuscitate a neonate. Subsequent steps are less frequently required but each step must be completed before proceeding down the pyramid.



The EMS Agency's Prehospital Care Policy Manual contains two policies with information pertinent to emergency childbirth:

- **Reference No. 511, Perinatal Destination** – defines perinatal patients as those who are 20+ weeks pregnant and recommends transport of patients less than 34 weeks pregnant with a pregnancy-related complaint to a perinatal center that also has a NICU
- **Reference N0. 814, Determination of Death/Pronouncement in the Field** – BLS measures are to be initiated immediately on infants in cardiopulmonary arrest while base contact is established for further medical direction

Emergency childbirth in the prehospital setting is not a frequent occurrence but comes with many potential complications. Knowledge of fetal development, neonatal resuscitation concepts, and applicable policies and procedures will aid the prehospital care provider in delivering optimal care to both infant and mother. ■

STEMI (from page 5)

The American College of Cardiology (ACC) and The Joint Commission (TJC) hospital accrediting bodies have instituted a goal of 90 minutes from the time the patient enters into the emergency department to the time of cardiac intervention. As stated above, Los Angeles County EMS, as a system, has achieved a median prehospital 12 Lead ECG time to cardiac intervention of 79 minutes. This outstanding accomplishment demonstrates exceptional performance in the field, emergency department and cardiac cath lab, not to mention the countless lives saved. The SRC program is truly making a difference and YOU are the key players. Congratulations! ■

EMS WEEK



ANYTIME. ANYWHERE. WE'LL BE THERE.

It is wonderful to have a week to recognize the work of our EMS providers. Even though EMTs and paramedics are the first to come to mind, we must remember that EMS is a system and everyone who works toward the goal of ensuring quality emergency patient care should be recognized and thanked. This includes our doctors, nurses, clerks, QI and data coordinators, information technology, educators and administrators. Think about who in your operation works to ensure that the EMS system functions smoothly and take a minute to say thank you.

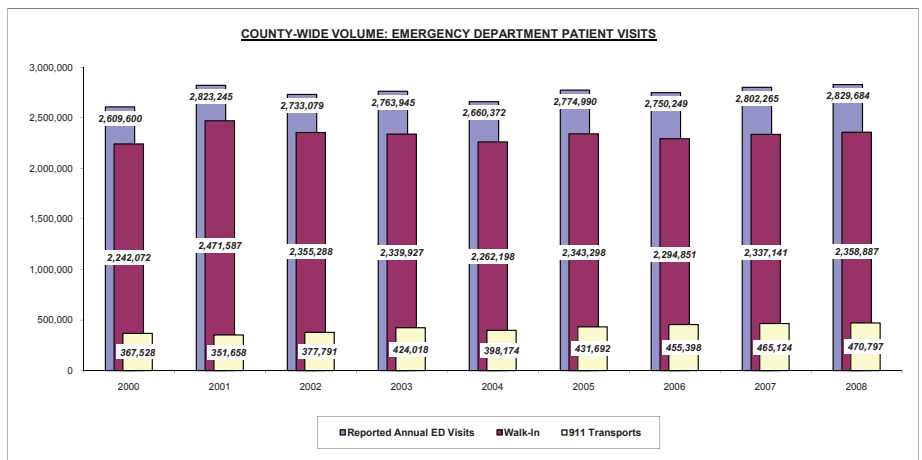
EMS is a great mission, helping people during their emergency to feel better and advocating for quality care, but we understand that it is not an easy job. Some days take their toll, so during the Month of May take time to do something special to celebrate the work you do for your community as an EMS provider.

On behalf of the EMS Agency, thanks to all of you who make our system work!

Statewide Medical and Health Exercise

The 2010 Statewide Medical and Health Exercise is scheduled for November 18, 2010. The scenario for 2010 is a detonation of an improvised explosive device resulting in mass casualties. Los Angeles County will utilize the State's scenario, multi-phased approach and timeline. The EMS Agency, in coordination with the Disaster Resource Centers, has formed an exercise planning team to develop LA County specific objectives which will be distributed as they become available. Any questions, please contact Gary Chambers at gchambers@dhs.lacounty.gov.

SYSTEM FACTS



Los Angeles County
Emergency Medical Services Agency
Provider Agencies Approved for Optional Scope of Practice



Provider Agency	TCP	IO	CPAP	CPR Assist Device
Alhambra FD	X	EZ		
Arcadia FD	X	EZ		
Beverly Hills FD	X			
Burbank FD	X	BIG	Port-O-Vent	
Culver City FD	X	EZ	Port-O-Vent	
Compton FD	X			
Downey FD	X	EZ	Port-O-Vent	
El Segundo FD	X	EZ		
Glendale FD	X	Application in Progress		
Hermosa Beach FD	X	EZ	Port-O-Vent	
La Verne FD	X	EZ	WisperFlow	
Long Beach FD	X	BIG	Port-O-Vent	
LAFD	X		App. in Progress / Boussignac	
LACoFD	X		Application in Progress	
LACo Sheriff	X	EZ		
La Habra Heights	Application in Progress			
Manhattan Beach FD	X			
Monrovia FD	X	EZ		
Montebello FD	X	EZ		
Monterey Park FD	X	EZ	Port-O-Vent	
Pasadena FD	X	EZ	Port-O-Vent	LUCAS
Redondo Beach FD	X	EZ		
San Marino FD	X	EZ		
San Gabriel FD	X	EZ		
Santa Fe Springs FD		EZ		
Santa Monica FD	X	EZ	Port-O-Vent	
Schaefer Ambulance	Application in Progress			
Sierra Madre FD	X	EZ	Port-O-Vent	
South Pasadena FD	X	EZ	Port-O-Vent	
Torrance FD	X	BIG	Port-O-Vent	
West Covina FD	X	EZ	Port-O-Vent	



The EMERGIPRESS is a newsletter providing the Los Angeles County prehospital care personnel with informative and educational articles, updates, announcements and resources of current interest.

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