



Medical Q&A With Dr. William Koenig

Q. Should NTG and Aspirin be ordered and administered to a patient with a positive STEMI who has no chest pain?

A. Yes! Patients may have ST segment elevation MI without experiencing chest pain. While our guideline for application of the 12 lead is for patients with chest pain of suspect cardiac cause, 12 leads are sometimes applied to patients with other complaints. When a STEMI is determined, these patients will benefit from similar treatments as those patients with both chest pain and STEMI. Even though the Base Hospital Treatment Guideline is currently titled Chest Pain, administering NTG and ASA to a patient presenting with a positive STEMI who does not complain of chest pain is appropriate. Increasing myocardial oxygen supply and decreasing platelet aggregation are potential benefits of using this combination of medications. Providing this care is within the scope of practice for prehospital care and is consistent with the standard of care in treatment of an acute MI. The title of the Base Hospital Treatment Guideline will be changed to Chest Pain or STEMI to clarify. (Ref. Base Hospital Treatment Guideline M4)

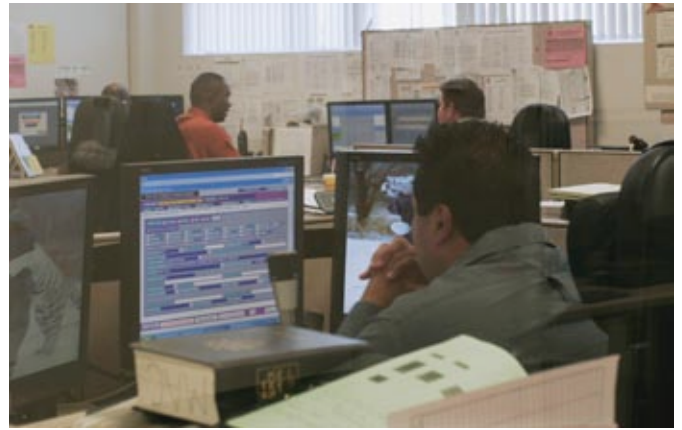
Q. Can morphine sulfate be administered to a patient who is complaining of abdominal pain?

A. Yes. Medical literature over the last ten years has shown that IV analgesia can be safely given to patients with abdominal pain, and does not impair the physician's ability to evaluate and treat the patient. Indeed, if initial pain is not managed early, it may become increasingly difficult to control. To quote an article from 2000, "early and appropriate pain relief for patients with acute abdominal pain is humane, does not adversely affect diagnostic acumen or clinical decision making, and should be considered as part of the initial management." ¹ The base hospital treatment guidelines now specifically address abdominal pain. (Ref. Medical Control Guideline – ALS/BLS Pain Assessment)

(continued on pg.7)

The Medical Alert Center EVOLVING ROLES AND RESPONSIBILITIES

By Stephanie Raby, RN, MAC Nurse Consultant



I imagine that you have been called to respond to a multiple vehicle accident on the freeway. Upon arrival you find yourself with ten patients all in need of medical attention. Incident Command is established and you assume the role of Medical Communications Coordinator (Med Comms). Your next step is to contact the Medical Alert Center (MAC) to inform them about the incident and obtain hospital bed availability for the patients on scene.

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THE MEDICAL ALERT CENTER (continued from pg.1)



EPTC Chris Hamilton



EPTC Mary Perrault conducting MCI drill with Culver City Fire



Nurse Consultant Stephanie Raby and EPTC Jose Felix review patient transfer

The MAC responds by sending out a Rapid Emergency Digital Data Interface Network (ReddiNet) Multiple Casualty Incident (MCI) poll to the hospitals surrounding the incident to obtain bed availability. Under the authority of the EMS Agency medical director, staff can authorize you to utilize Ref. 806, Procedures Prior to Base Contact and use of 1:1 staffing. As first responders triage and begin treatment, hospital availability and patient destination information is shared between the MAC and the Med Comms. The MAC then notifies the hospital of incoming patients from the MCI via the ReddiNet System.

This is just one of the many roles and responsibilities of the Medical Alert Center. If you work in the Los Angeles County Emergency Medical Services (EMS) system, chances are you are going to need to contact the MAC at some point in your career. The MAC serves as a central communications center for the EMS System in Los Angeles County and is staffed 24/7. Over the years, the role of the MAC and the responsibilities of the Emergency Patient Transfer Coordinators (EPTC) have greatly evolved since its inception in 1971.

The primary function of the Medical Alert Center is to coordinate patient transfer activities to all licensed acute care hospitals operated by the Los Angeles County Department of Health Services, which include LAC+USC Medical Center, Harbor-UCLA Medical Center, Olive View-UCLA Medical Center, and Rancho Los Amigos National Rehabilitation Center.

The MAC is also responsible for:

- * coordinating transfers of patients that are in emergency departments or have been admitted to private acute care hospitals.
- * handling air ambulance destinations
- * helping place patients into Burn Centers, and
- * coordinating the activation of the USC Catalina Hyperbaric Chamber team for patients that are rescued from diving accidents.

The MAC essentially provides a single, consistent method of entry into the County medical system 24 hours a day.

The MAC also serves as the communications corridor during a disaster, serving as the central point for the ReddiNet and Hospital Emergency Administrative Radio (H.E.A.R.) systems. They coordinate activation of numerous disaster resources including pharmaceutical caches, CHEMPACK, Disaster Resource Center (DRC) equipment and supplies, Hospital Emergency Response Team (HERT) activation, Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) incidents such as Radiation Management, and is the communications center for the Department of Health Services Departmental Operations Center (DOC).

The MAC participates and assists with conducting disaster exercises, such as Triage Tag Tuesday, with hospitals and prehospital providers to ensure disaster readiness. They support real time events as well, such as the Los Angeles City Marathon, by conducting hospital bed capacity polls and working with the LA City Fire Department to determine patient destinations in an effort to evenly spread patients to surrounding hospitals during the event.

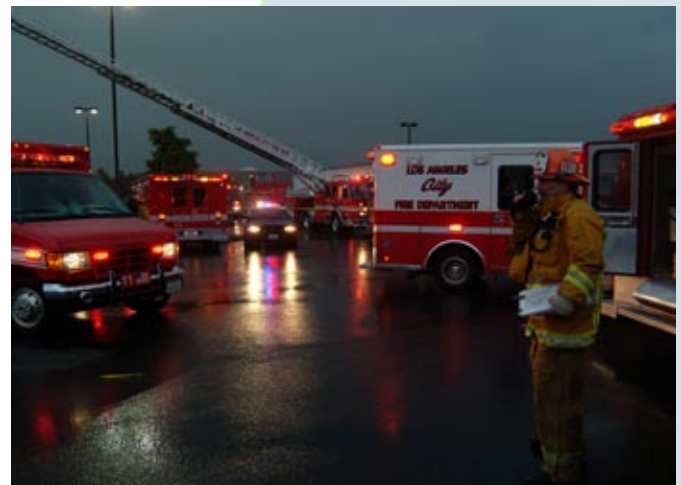
Recently with the closure of Martin Luther King, Jr. – Harbor Community Hospital (MLK-Harbor), MAC staff helped coordinate the placement of all in-house patients and emergency department patients into the County hospital system. They did an excellent job in ensuring patients were placed in the most appropriate facility to meet their acute care needs and continue to support hospitals that have been impacted by the closure by working to place those patients back into the County system. Norie Kassam, Soma Webb and Olester Santos, all nurses from MLK-Harbor Medical Center, have joined the MAC to help coordinate this project.

There are seventeen Emergency Patient Transfer Coordinators at the Medical Alert Center, who are all ex-military corpsmen or former paramedics. The MAC management includes Program Director John Quiroz, RN, Interim Operations Manager Carl Hernandez, and Nurse Manager Michele Heatly, RN, BSN, MICN and Nurse Consultant Stephanie Raby. EMS Agency administrators and the Medical Director can be contacted through the MAC after hours.

The Medical Alert Center continues to be an integral link in the Los Angeles County EMS System, whether it is coordinating patient transfers, MCIs and disaster readiness, or serving as the central communication center for the Department of Health Services.



Senior EPTC Dave Bunge in the Medical Alert Center



MCI with LA City Fire



USC Catalina Hyperbaric Chamber

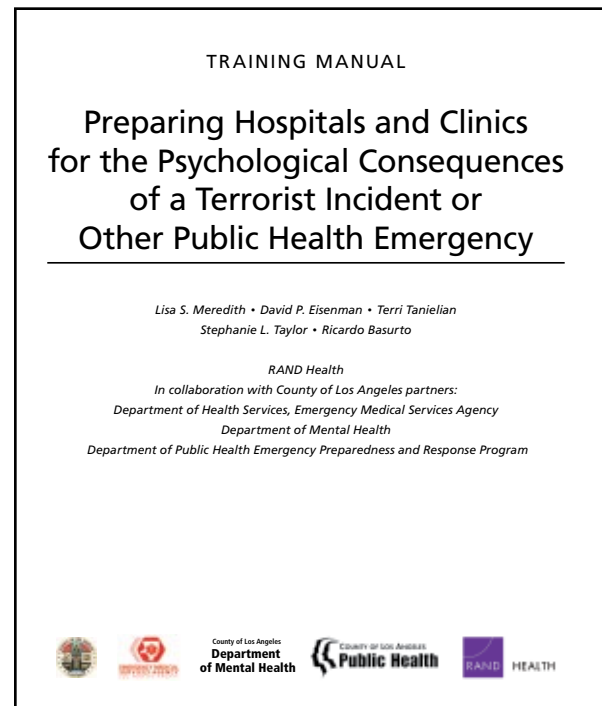
Los Angeles County Develops Training on Preparing for Psychological Casualties

By Sandra Stark Shields, LMFT, CTS

Terrorist incidents, disasters and other public health emergencies, such as severe acute respiratory syndrome (SARS) or pandemic flu, have the potential to create huge numbers of psychological casualties. Past disasters, such as the radioactive cesium isotope incident in Brazil (1987), the Sarin gas attack in Tokyo (1995), and the anthrax attack in Washington, DC (2001) generated a large surge of people with mental health effects presenting to hospitals—at least four times greater than the total number of patients with medical effects from exposure.

The surge of psychological casualties is likely to stress the response capacity of hospitals and clinics to deal with the mental health impact of these types of disasters – not only for patients and their families but for staff as well. Existing disaster plans typically address the medical consequences of disasters. Few plans offer guidance to hospitals and clinics about responding to the psychological consequences (emotional, behavioral, cognitive, and physical/somatic) of these types of disasters. In addition, existing “disaster mental health” training is not usually geared specifically for hospitals and clinics and may require lengthy courses, which does not allow most healthcare facilities to easily accommodate during work hours.

To respond to the need to prepare hospitals for the psychological consequences of disasters, the EMS Agency contracted with RAND and worked with other County partners including the departments of Public Health and Mental Health to develop the training: *Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency*. The training materials are the result of



data RAND collected from interviews with staff at three selected hospitals and one clinic in Los Angeles County, literature reviews, government documents, input from experts, and pilot testing of the course materials at the beginning and end of the development process. The project was funded by the Hospital Preparedness Program and took two years of collaborative effort to complete.

This training is now posted and available for download from the EMS Agency’s website at: www.ladhs.org/wps/portal/ems (then click on Manuals & Protocols).

It contains two one-hour modules (Module 1 and Module 2) that can be given in traditional lecture format or as a self study guide. A third two-hour training (Module 3), developed specifically for

the Los Angeles County Department of Mental Health staff but may also assist affected health care facilities during disasters, is also available on the website. Each of the modules is intended to be flexible so that hospitals and clinic disaster coordinators may tailor training sessions to meet the needs of staff.

Module 1 was specifically developed for administrative and disaster planning and response staff in hospitals and clinics and contains basic information on the psychological consequences of large-scale emergencies; triggers of psychological reactions for patients, families, and staff; disaster planning strategies to prepare staff and facilities; and tools and resources that can be used to improve facility disaster plans to manage psychological casualties. A tool “Algorithm for Triaging Mental Health Needs” is also included in Module 1.

Module 2 was developed for hospital and clinic clinical, mental health, and non-clinical staff and provides information on integrating mental health into the disaster team; planning a “mental health” response; psychological reactions to expect; psychological first aid; special needs populations; self care in disasters; and materials and tools to help with facility disaster planning and response.

Module 3 is tailored for the Department of Mental Health and provides more detailed information on expected psychological reactions and reassurance and treatment methods. All three modules include practice scenarios.

Forty hospital and clinic education and disaster management staff completed the “train-the-trainer” sessions offered by the EMS Agency on October 30 and November 2, 2007. For questions on how to use the training or if your facility does not have training staff and you would like the training, please contact Sandra Shields

IS YOUR HOSPITAL OR CLINIC PREPARED TO RESPOND EFFECTIVELY TO A SURGE OF PSYCHOLOGICAL CASUALTIES?

Download and complete the “Tool: Readiness for Events with Psychological Emergencies Assessment (REPEAT)”.

This tool can be found on our website: www.ladhs.org/wps/portal/ems. Click on Manuals & Protocols to locate: Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public

Basic disaster planning tasks include:

- Adding one or more mental health (and Spiritual Care) professionals to your facility disaster planning team
- Pre-identify one or more mental health staff or clinical staff for the two mental health positions in HICS (Mental Health Unit Leader and Employee Health & Well Being Unit Leader)
- Recruit staff for your facility “disaster mental health” response team
- Train staff in “psychological first aid”
- Adding the surge of psychological casualties in your annual exercise program to test your mental health response plans

Readiness for Events with Psychological Emergencies Assessment Tool (REPEAT)

Purpose: REPEAT is designed to help hospitals and clinics assess their capacity to deal with the surge of psychological casualties resulting from large-scale emergencies, (including terrorist incidents, natural disasters, and other public health emergencies). Key members of your facility’s disaster response team (e.g., disaster response coordinators, department directors) should complete this assessment periodically to identify which preparedness and response activities have been implemented. Results can be used to evaluate disaster planning and to identify areas to target for improving the facility’s response capability.

Instructions: REPEAT is organized around three structural and four process elements (shown in the rows) that are necessary to ensure an optimal response to a surge of psychological casualties. For each psychological element, we provide an example for each level of implementation. Select the example and associated score, then circle the answer that comes closest to describing your facility’s current capacity. Each team member circles the point value that he or she believes corresponds to the facility’s level. After each individual team member completes the assessment, the entire team should review the individual ratings and agree on an assessment. Rate each element from 0-2: “0” indicates no implementation, “1” indicates some implementation, and “2” indicates full implementation. At the end of each section, enter the total score for that section. Then enter the score for your overall level of preparedness. Finally, review the assessment to identify areas that need attention (scored as 0) or that need strengthening (scored as 1).

Psychological Element	Full Implementation (Score = 2)	Some Implementation (Score = 1)	No Implementation (Score = 0)	Your Score and Areas to Improve
Structure				
Internal organizational structure and chain of command	<ul style="list-style-type: none"> • The leadership recognizes the need to address psychological consequences • A disaster plan includes mental health (MH) in the incident command structure/job action sheets • A deployable multidisciplinary MH team is formed (psychiatrists, psychologists, social workers, LMF Ts, psychiatric nurses, technicians, chaplains, EAP) • Clear roles are identified for direct MH services to survivors, family, and staff • A lead is designated for public information efforts and media interface related to MH issues 	Some of these structures are in place to address psychological consequences	There is no infrastructure to address psychological consequences	2 1 0 ----- ----- -----
Resources and infrastructure	<ul style="list-style-type: none"> • Agreements with Disaster Resource Center group, or other local organizations and/or County Department of Mental Health • The disaster plan is reviewed to ensure availability of adequate MH staffing and resources • A resource list is available with information on whom to contact (county DMMH) • Disaster supplies (PPE, medications, or other equipment) are available to reduce personal risk • The facility can handle an MH surge at least four times the number of physical casualties (including waiting areas for family) 	Some but not all resources are in place to address psychological consequences	Resources available are inadequate should a disaster occur	2 1 0 ----- ----- -----
Knowledge and skills	<ul style="list-style-type: none"> • MH staff are trained for roles in command structure and familiar with job action sheets • Staff are educated about MH risks/consequences of exposure and about self-care principles • MH staff are trained in MH assessment and early psychological intervention – Psychological First Aid (PPA) • Volunteers receive basic disaster training • Staff receive hands-on training (exercises, drills) to test plans that include MH response 	Some staff have received some training activities on MH reactions and response	Staff have not received training on MH reactions and response	2 1 0 ----- ----- -----
Subtotal REPEAT score (structure; possible range = 0-6)				



Tina Crews, RN, MICN

Congrats to our EmergiPress Survey Winner

During the last issue of Emergi-Press, we asked our readers to help us improve our newsletter by answering survey questions about content, layout, and distribution. The winner of our \$25 drawing was Tina Crews, RN, MICN, who works as the Pre-hospital Care Coordinator for Little Company of Mary Hospital. Congratulations Tina, and thank you to all those who answered the survey!

April is Earthquake Awareness Month

Are You Prepared? By Jim Eads

As you lay in bed half awake in the early morning hours you experience moving which heightens your senses. You are startled wide awake by the realization that the ground is starting to shake violently. You hear objects breaking all throughout your house. In the back of your mind you wonder if this is a fore-shock of a much larger quake to come, whether you are near the epicenter, or if it is in some other county.

Reality strikes! You are supposed to report to your shift in a couple of hours. You know your day is going to be long. A personal assessment reveals your property is damaged but you are unscathed physically and have a responsibility to serve. Your wife and kids are awake with all the commotion and they know you are bound to report to work and help in any way you can. Are you prepared to leave? Do you and your family have the necessary disaster supplies set aside to cope with such a disaster? Do you have a personal disaster plan in place?

Historically Los Angeles County has seen many large earthquakes but “great” quakes are rare. In recent times we have seen earthquakes in Sylmar (02/1971-mag 6.6), Whittier Narrows (10/1987-mag 5.9), and Northridge (01/1994-mag 6.7). These quakes although deadly, were small in comparison to the “The Great Fort Tejon Earthquake” which occurred in the morning on January 9, 1857. These larger faults have historically released their destructive energy about every 150 years. We are at that end of that time span since the last major temblor.

April is Earthquake Preparedness Month--All citizens of Los Angeles County (and beyond) should maintain essential disaster supplies and have a personal disaster plan in place so that you can assist in the disaster response and recovery efforts. As a member of the EMS community you need to be prepared mentally, personally and physically to respond to all natural and human caused disasters. Your preparedness begins at home.



To download a disaster preparedness list at our website, please visit: www.ladhs.org/wps/portal/ems click on Disaster Program, and then “Disaster Preparedness Materials.” More information on disaster preparedness can be found on the Emergency Survival Program (ESP) website: <http://lacoa.org/esp.htm>

Start your personal disaster plan today, before we get our next “wake up” call. **BE READY!**



Medical Q&A (continued from page 1)

Q. When should a paramedic attempt intubation on a patient suffering from a cardiac arrest?

A. A paramedic may attempt intubation anytime during resuscitation. Because of the emphasis on continuous, non-interrupted compressions during CPR, the traditional airway first sequence now is replaced with more judgment as to when to place an advanced airway. With adequate bag mask ventilation, it may be appropriate to delay endotracheal intubation to minimize interruptions of chest compression in patients undergoing CPR, rather than attempt it initially in the traditional ABC approach. The following decision points are appropriate in deciding to place an endotracheal tube during resuscitation:

1. Return of spontaneous circulation (ROSC) occurs
2. An unmanageable airway
3. The paramedic determines an advanced airway is necessary for transport.

Q. Is the EMS Agency advocating the use of tourniquets as a first line of treatment?

A. No. Recent application of tourniquets in extremity injuries in the Iraq war has increased our understanding of their use in the military setting. Care under fire, multiple casualties, and an increase in percentage of life-threatening extremity injury puts unique demands on the military medic trying to render care. It has been estimated that isolated extremity injuries account for approximately 9% of military fatalities, and 0.02% of civilian injuries.² Tourniquets have been devised to make self application easier for the injured soldier. Rapid extrication of the injured to definitive care has minimized complications commonly attributed to prolonged tourniquet use. The control of hemorrhage in the civilian setting is much more able to follow the traditional stepwise approach recommended by national trauma courses in care of the trauma victim: direct pressure, elevation, and tourniquets utilized when these measures fail. (Ref. EMS Skill - Circulation Emergency – Bleeding Control)

¹ Brewster GS, Herbert ME, Hoffman JR. Medical myth: analgesia should not be given to patients with acute abdomen. West J of Med 2000, 172: 209-210.

² Richey, SL. Tourniquets for the control of traumatic hemorrhage: a review of the literature. World Journal of Emergency Surgery 2007, 2:28

Los Angeles Metropolitan Medical Center Joins 911 Receiving Center Network

This January, Los Angeles Metropolitan Medical Center's (LAMMC) Emergency Department was approved to become a 911 receiving center for Los Angeles County. Located in the City of Los Angeles, LAMMC adds four additional emergency department beds to our network. There are currently 75 emergency departments approved to receive 911 transports.



CEO John Fenton with staff from LA City Fire

Los Angeles County's Multi-Casualty Burn Disaster Plan Presented at International Burn Symposium

An abstract entitled: "Multi-Casualty Burn Disaster Planning for Los Angeles County, California, USA: Update 2008" was accepted for presentation at the 30th Annual John Boswick Burn and Wound Symposium that was held on February 18-22, 2008 in Maui. The symposium was for physicians, researchers, investigators, nurses, therapists, and others interested in development of techniques, drugs, and devices in the study and management of wound healing, wound management and burn care.

Warren Garner, MD, Medical Director of the LAC+USC Burn Center and Victoria Vandenberg, RN, Burn Consultant, presented details on the planning and implementation of a burn surge plan specific to Los Angeles County. The Multi-Casualty Disaster Burn Plan establishes a system to provide triage, treatment, and initial stabilization of multiple burn patients as a result of a terrorist incident or natural disaster. This project was developed by the Burn Task Force, which is comprised of representatives from the Trauma Hospital Advisory Committee and burn centers from Los Angeles, Orange and San Bernadino counties and is being funded by the Hospital Preparedness Program.

Save the Dates



May 6 - 12, 2008
National Nurses Week: Making a Difference Every Day

May 18 - 24, 2008
National EMS Week: Your Life is Our Mission

May 27 - 28, 2008
EMSAAC Conference: California EMS Juggling Priorities



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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EMS Update 2008 Training Schedule

EMS Update 2008 training is scheduled to run from March 1st through June 13th. This annual training is mandatory for all Los Angeles County certified MICNs and accredited Paramedics. This year's Update includes the multi-casualty burn care plan, treatment of congestive heart failure with CPAP, external jugular IV's, morphine, and pediatric case studies.

EMS Update 2008 will be available at base hospitals and provider agencies approved by the EMS Agency to conduct this training. A calendar of scheduled classes open to the public will be posted on the EMS Agency web page at www.ladhs.org/ems. Space is limited, so please contact the course coordinator in advance to schedule your attendance.

Personnel who do not obtain EMS Update 2008 by the June 13th deadline will be unable to function as an MICN or Paramedic until verification of EMS Update 2008 attendance is submitted to the EMS Agency. Suspensions will be effective July 7, 2008. For any questions contact, Yolanda Ramirez in the Office of Prehospital Certification at (323) 890-7528 or yramirez@dhs.lacounty.gov