

# NCEMSF NEWS

## Inside this issue:

President's Message	1
A Review of Air Medical Operations	2
Alumni Resources	3
Regional Roundup	4-5
NCEMSF Year-in-Review and Leadership Opportunities	6
EMS on the Hill Day	6
Bandaging is Just the Beginning	7
NCEMSF Research	8

*"NCEMSF is about making connections...It is about our members...It is about helping you to share information..."*

## Message from the President

Dr. George J. Koenig, Jr., NCEMSF President

Welcome to the 19th annual NCEMSF Conference!

If someone asked you to describe the function of your campus organization, you would probably start with the type of service that you provide. You might tell them about the number and type of calls you respond to or the campus population that you serve. However, other than maybe telling them that you are a volunteer organization, you will probably not discuss your most valuable resource, your personnel.

I recently found myself answering the same question about NCEMSF. I was contacted by a reporter who was writing an article on campus EMS. The interview started with the typical question of asking me to describe NCEMSF. Having answered this question numerous times, I replied with an almost reflexive answer. Our mission is to support, promote, and advocate for emergency medical services on college and university campuses. We provide a forum for the exchange of ideas of campus-based emergency response issues.

In the back of my mind, I thought, does this really describe NCEMSF? I asked myself, how would our members describe NCEMSF? Some of our members would tell you that NCEMSF hosts a conference. They would reminisce about their conference experiences by highlighting the educational lectures and the colleagues that they met from across the country. Others may direct you to our website or to our other resources such as NCEMSForum.org or to our Collegiate EMS Week packet. While these answers are correct, they only scratch the surface. NCEMSF's true strength lies within you, our members. Our strength is based on our collective knowledge of campus based EMS.

Your attendance at NCEMSF's annual conference is the starting point for you to expand your network. The sharing of information should not stop when you depart to return home at the end of the weekend. You can continue to share your ideas on our

website and on NCEMSForum.org throughout the year. It is by sharing this information that, together, we can continue to strengthen collegiate EMS.

Perhaps, I should have told the reporter that NCEMSF is about making connections. It is about our members. It is about helping you to share information about collegiate EMS.

In addition to our on-line resources, I encourage you to become active in your region. During the conference reach out to your regional coordinator and ask them how you can get involved. If your region does not have a regional coordinator, e-mail Steve Lanieri, our National Coordinator at [nc@ncemsf.org](mailto:nc@ncemsf.org).

Lastly, I wanted to share with you several exciting changes within our organizational structure. Michael Hilton, our previous National Coordinator, has assumed the role of Director-at-Large with the intent of focusing on the development of research goals for campus EMS. If you have ideas for research projects, email him at [director1@ncemsf.org](mailto:director1@ncemsf.org). Les Polk, our previous Pennsylvania Regional Coordinator, will now be responsible for developing corporate sponsorship as a Director-at-Large. They will be replacing Mark Milliron and Eric MaryEa. I wish to thank both Mark and Eric for their many years of service and contributions to campus EMS.

I look forward to meeting each of you. I hope that we exceed your conference expectations. I extend many thanks to our NCEMSF friends, the Regional Coordinators, and the Board of Directors for their never-ending dedication and assistance.

The network of friends and colleagues that you build today will allow you to strengthen your organization in the future. If there is anything that I can assist you with, please do not hesitate to ask during the conference or email me at [president@ncemsf.org](mailto:president@ncemsf.org).



## Call for a Helicopter: A Review of Air Medical Operations

Dr. Michael T. Hilton, NCEMSF Director-at-Large, and Stephen J. Lanieri, NCEMSF National Coordinator

It's the call you'll never forget. You're on scene of a major car crash on the interstate with a critical patient entrapped in an overturned vehicle. The patient is screaming, sirens are blaring, and your radio's scanner is struggling to keep up with the transmissions. Above all of the chaos, you hear the unmistakable "whoosh" of rotor blades cutting through the air as a helicopter lands. You stare and point like a child. The flight crew, exiting the aircraft, flight suits on, helmets donned, visors down, coming to the rescue, are among the best of the best in EMS and aviation. "This is awesome! We should request a helicopter on every call," you think to yourself. Or maybe you think, "I want to do that, that's going to be me someday." Whether it's your dream job or your favorite kind of call, the air ambulance industry provides us with many benefits, but it's not all fun and it's not all about the glory.

One of the biggest myths about the air medical industry is that every company or flight program is the same. Nothing could be further from the truth. There are three main types of programs: government sponsored, hospital-affiliated, and private - and each is uniquely funded and operated.

Safety remains the most controversial subject surrounding the air ambulance industry. Between 1998 and 2008, there was an average of 13 accidents per year. Some of the key factors affecting safety are: weather, night-time flying, mountain flying, crew fatigue, desire to save a life, desire to get back to base, and pressure to make money for the company. Many crashes have been attributed to one or more of these factors and only recently have they begun to be addressed at a national level.

It is up to each individual air medical program to maintain safe operating practices. At the safest programs, pilots are given a "blind dispatch" where they are only provided with the patient's pickup and drop-off locations and no information about the incident or patient. This is to prevent the pilot from being influenced by incident details prior to checking if weather is good enough to take the mission and landing at a marginally safe landing zone. Additionally many programs have adopted the "3 to go, 1 to say no" theme that if just one crewmember feels uncomfortable taking

the mission, the whole crew declines the mission. Furthermore, safe programs have approachable management teams that do not punish pilots for refusing to take a flight.

Additional risk mitigation techniques require significant financial investment. Twin-engine helicopters provide an extra cushion of safety in the case of an engine failure. Night Vision Goggles (NVGs) worn by each crewmember allow potentially deadly hazards such as power lines or trees to be seen at night. Flying with two pilots adds redundancy and an extra set of eyes for safe flying. Also, cockpit technologies such as GPS, ground proximity warning system, and traffic collision avoidance systems assist pilots in preventing collisions with the ground or other aircraft. Finally, Instrument Flight Rule (IFR) ability allows pilots to fly based upon instrument readings (heading, bearing altitude - like a plane). This gives them the ability to fly higher and to fly without visual flight rules (flight mode where the pilot navigates by vision, like in driving a car looking through the windshield).

The number of air medical programs and the number of aircraft they operate continues to grow each year. This growth brings with it increased competition for market share and geographic regions for neighboring programs, especially those that are specifically profit-driven. Turf battles have begun across the country where programs dispatch themselves and launch as soon as they hear of a car accident or overfly another program that has declined a mission for weather, just to make money for their company. Territoriality and neighboring competition was a factor in a 2008 Maryland State Police (MSP) helicopter crash. During the mission's extensive weather check, the pilot commented that he recently heard a medevac helicopter operated by a neighboring private company complete a mission in the same area, and said, "if they can do it we can do it", and he accepted the mission. The MSP helicopter crashed during that flight due to bad weather, killing all 3 crewmembers and 1 of 2 patients on board. (NTSB Accident Report, 9/27/2008).

Pennsylvania is one locale where private and hospital-based companies are known to compete for patients and business. The land area and population of

Pennsylvania and New England are similar. However, there are 40 air ambulance aircraft in PA while New England only has 10. Air medical programs in New England have forged a unique coalition that ensures constant communication and safe operations among the various New England programs. If one program receives a mission request from the other's primary territory, the call is referred to the closer program. If a mission is declined for weather in an area near another's primary territory, they advise the other program. Additionally, any time an aircraft is flying into another program's primary area, the aircraft communicates with that program's communication center in order to ensure situation awareness and separation from other air medical aircraft operating in the area or landing at the same helipad.

Lack of Inter-agency cooperation isn't the only problem behind the air medical industry's poor safety record. Safer technologies and methods all require substantial funding. Private programs that operate on slim profit margins are not incentivized to invest their revenue in these safer technologies and methods.

Until recently, the NTSB and FAA have remained silent regarding the air medical industry's safety record. A few years ago the NTSB sent the FAA a list of recommended changes for the air medical industry, including requiring the use of night vision goggles, changes in weather minimums, and new training. The FAA has approved only a few of the NTSB recommendations, none of the most important ones that would require substantial investments in technology.

Aircraft safety also includes landing-zone operations. The most important safety measure to reduce these incidents is having pre-established landing zones in the community that are well known to all local providers and to the flight crew and pilot. Familiarity with a landing zone and its hazards (fences, wires, ground type, debris) allows for safer landing and landing zone operations.

Once the landing zone is secure, as an EMS provider, you should keep the patient in the ambulance a short distance from the landing zone and park to the front of the aircraft (nose-side). In order to

*(Continued on page 3 - Helicopter)*

## Keeping In-Touch: Alumni Resources

Joshua E. Glick, NCEMSF Alumni Coordinator

As the spring semester progresses, the majority of collegiate squads begin the difficult process of electing a new group of leaders, as more experienced members graduate to pursue professional and post-graduate endeavors. While these members may no longer serve as active members of your collegiate squad, it is important that you keep them involved with your organization through a well-developed and maintained alumni network.

Alumni not only provide a rich source of advice on organizational management for new board members, but can also serve as a valuable career development tool for seniors and undergraduate members who are looking for academic and

professional opportunities during the summer months and after graduation.

A well-maintained alumni network can serve as an important resource for a collegiate squad. NCEMSF recognizes that the initial development of such a program can be difficult for both young and old organizations. In order to facilitate the creation of these networks, we have developed a helpful packet of information on the website that provides step-by-step instructions on how to set up a network as well as a list of activities and methods to keep in touch with alumni. Please feel free to use this resource and provide us with some of your own ideas on successful alumni programming!

Enjoy conference and please feel free to approach me with any questions regarding alumni affairs!

### **Attention Alumni:**

Please join me on Saturday evening at 7:00 PM for our annual Alumni Social. All campus EMS alumni are invited to join our organization's leadership for an hour of refreshments. The event is a great opportunity to network with speakers and catch up with old friends.

Please remember your alumni badge and an ID.



*(Continued from page 2 - Helicopter)*

prevent pilot blindness during approach to the LZ, turn off the strobes lights on your vehicle and never shine a spotlight at the helicopter. Wait for the flight crew to approach you – do not approach the flight crew or aircraft without direct orders from the flight crew. This is for your safety due to the many hazards associated with the aircraft rotor blades. Once the flight crew enters your ambulance, they will begin their assessment and begin providing care and setting up their equipment. Following this, they will transfer the patient to their stretcher. Keep in mind that aircraft stretchers are different than ambulance stretchers. Typically, they have only one set of wheels that steer and are taller and thinner. Therefore, their center of gravity is higher and they are more likely to tip over, potentially injuring the patient. In fact, this is the most frequent cause of injury to patients in air medical operations. Only help with stretcher operations if trained or briefed on how to use it and under the direct request of the flight crew.

If you are asked to assist in loading a patient into a helicopter, keep in mind some important safety points. Only enter the rotor arc (the area under the spinning rotor blades) from the front -- within the pilot's view. When under the rotor arc, you must wear a helmet and eye protection at all times. When loading the patient, never move beyond the rear body of the aircraft (or center of the aircraft in a side-loading helicopter) or move under the tail. The flight crew will set-up a tail guard to prevent you from

moving too close to the rear rotor that can cause serious bodily harm or death. Once told to clear the rotor arc, follow the same path out as you entered. At all times, be cognizant about ground hazards such as mud, rocks and ditches and maintain situational awareness. Identify any hazards to the flight crew. If your squad requests air medical services at any point throughout the year, then your squad should provide annual landing zone training in association with a local air medical service.

With so many hazards associated with air medical services, it is important to request these services appropriately. Air medical services provide two benefits to patient morbidity and mortality. The first is time to definitive care. Aircraft can travel faster and farther to bring patients to regional care centers with speed. This improves survival in cases of trauma, ST elevation myocardial infarction and stroke. Refer to your local protocols and guidelines as to criteria for appropriate helicopter response. The other benefit is the advanced training and expanded protocols of these flight crews. Flight crews are typically composed of flight nurse and paramedic. Prior to being flight crewmembers, they must have between 2 and 5 years of outside work experience. Flight nurses typically must have Intensive Care Unit, nurse-anesthetist or Emergency Department experience. Flight medics and nurses undergo national flight medicine and critical care training courses. Other crewmembers may include physicians, physician-assistants and respiratory therapists. The flight crewmembers act

under state-wide critical care protocols or under expanded scope intra-agency protocols. They can use medications and performs certain skills not available to ground EMS.

Regular training and interaction with your local flight medicine provider will allow you to ensure your own and your patient's safety when utilizing these services and will help you to make the best choice as to when to request a helicopter. Most air medical services perform regular outreach with local EMS squads and fire departments. They should provide you with training on landing-zone safety, helicopter transport criteria and with opportunities to fly on an observational basis – perhaps the best way to see how air medical crews works and to learn about aircraft operations and safety. They can also provide you with resources if you are interested in becoming a flight crewmember.

Danger is inherent in air medical operations, but so is the benefit to specific patient populations, such as major trauma, ST-elevation MI and stroke. Using air medical services wisely will benefit your patients.

*For More Information*  
*On Air Medical Resources:*

[www.aams.org](http://www.aams.org)  
[www.adamsairmed.org/public\\_site.html](http://www.adamsairmed.org/public_site.html)  
[www.camts.org](http://www.camts.org)  
[www.EMSflightcrew.com](http://www.EMSflightcrew.com)



## Regional Roundup

News from Around the NCEMSF Regions

### From the National Coordinator

The Regional Coordinator (RC) network facilitates communication between NCEMSF and its constituents. It is through the RCs that NCEMSF is best able to accomplish its mission of advocating and supporting campus based EMS. The RCs are equipped to assist each squad with the day-to-day issues it faces and to help publicize squad achievements. There are few issues that the NCEMSF leadership has not seen before and for which it is not equipped to offer advice and guidance. If you are a CBEMS leader and have not met your Regional Coordinator, please contact me (Steve Lanieri, NCEMSF National Coordinator) and I will gladly introduce you to your RC.

This winter, we welcomed the addition of Ian Feldman and Ryan Hay as the new Central and Pennsylvania Regional Coordinators. Regional Coordinator vacancies still exist, however, in the Northern New England and Southeast regions. If interested in applying for either please find me at conference and email me your application (available online).

Also, please join your RC at the regional roundtable discussions on Saturday morning and chat informally with your RC and other squads from your region throughout the conference weekend.

### Canada

*McGill Student Emergency Response Team (M-SERT)*, formerly known as the



*McGill First Aid Service (MFAS)*, is now part of the Student Society of McGill University. The name change more accurately reflects the higher level of care that the team now provides.

*Trent University Emergency First Response Team (TUEFRT)* is hosting the ACERT (Association of Campus Emergency Response Teams of Canada) conference this year that runs concurrently with the NCEMSF conference. The conference, known as NCCER (National Conference of Campus Emergency Responders), this year is themed 'Beyond the Call of Duty'. Hundreds of members from teams across Canada are expected to converge on Peterborough and enjoy a weekend of great seminars and the flagship skills competition.

*University of Windsor Emergency Response Team (UWERT)* has settled

into its new housing, which it shares with the Campus Police Department. The group has revised its training program to focus more on practical skills stations and scenarios, while shifting some of the theory portions to online delivery.

### Massachusetts

*Eagle EMS of Boston College* has been licensed as an ambulance service and began operating its new non-transporting Class V ambulance on February 16th! After a decade of research and proposals, Eagle EMS has finally obtained an emergency response vehicle - a specially-outfitted 2012 Ford Explorer XLT (picture above) - that will allow EEMS to give initial medical care to patients anywhere on any one of Boston College's three campuses in the time before an ambulance is able to arrive.

### Midwest

*Case Western Reserve University EMS* is looking to expand its service with plans to purchase an ambulance this semester. In addition to emergent transport, Case EMS is working towards expanding its standby crew services and expanding its hours of operation to encompass all hours when University Health Services is closed. To facilitate these expansions, Case EMS has started a new on campus EMT class run through University Hospitals that is significantly more convenient for Case students and has resulted in an increased enrollment over previous classes.

*John Carroll University EMS* will be bringing in 17 new responders after this semester. Some of its responders are becoming CPR Instructor certified as well so that the group can begin teaching classes to the John Carroll community. Recently the group also worked with

*(Continued on page 5 - RR)*



(Continued from page 4 - RR)

Resident Assistants of JCU to create mock calls for training purposes.

#### North Central

*Macalester College Emergency Medical Services (MCEMS)* is officially up and running! This group of students is starting its second semester as a campus first response service. MCEMS currently staffs one EMT and one First Responder to be on call from 6pm-2am on Friday and Saturday nights. The group is ready to respond to any campus emergency during this time, and will also be staffing campus special events. MCEMS is equipped to provide basic life support and emergency care until medical personnel arrive. Welcome MCEMS to NCEMSF!

#### Northern New England

*Dartmouth EMS* will host its third annual New England Collegiate EMS Conference in the beginning of April at Dartmouth College in Hanover, NH. Collegiate squads in the New England states are welcomed to attend this one day event. Last year, Dartmouth EMS hosted two mass casualty incident (MCI) drills as part of the day long gathering, one of which featured a full HazMat team. Dr. George Koenig, NCEMSF President, was the 2011 keynote speaker and Dr. Michael Blayney provided training about EMS HazMat response (Picture of last year's gathering below).

This year Dartmouth EMS will offer a morning series of advanced skills stations and speakers and the afternoon will culminate with another MCI drill. Skills stations will focus on advanced assessment of altered mental status, ALS skills awareness for the BLS provider,

and ICS training. The MCI drill will incorporate all squads and licensures, ensuring that everyone can participate in and learn from the simulated catastrophic event. There is no required participation fee. If you would like more information or are interested in attending this regional training session, please contact: Dartmouth.EMS@dartmouth.edu

#### Pennsylvania

*Juniata College EMS* held various fundraising activities and events this past semester including a TGI Fridays Fundraiser, Sheetz Coupons, a Dodgeball tournament and a Mock crash/Whack-A-Car. It also worked on fostering a positive relationship with Huntingdon Ambulance in order to better serve the greater community and organized new bimonthly training opportunities

*Lehigh University EMS* is proud to welcome into service its new QRS vehicle, 8041 (picture opposite page) After years of fund raising and 6 months of planning, phone calls, quotes, re-quotes, meetings, and many designs, the squad is proud to put its new 2011 Ford Expedition into service!

#### West

*Santa Clara University EMS* has had a successful first half of the academic year. During the fall quarter, the squad responded to a total of 123 calls on its campus. One of the team's main goals for the year has been community outreach and creating awareness about its squad on campus. The group has a newly created Facebook page to keep the community up to date on safety/health tips and any updates about the squad. During the holiday season, SCU EMS

hosted a free photo session with Santa EMT on its EMS golf cart. It was a success in creating a positive image of the squad with the student body. In the larger community, SCU EMS has stayed involved by working at a Pop Warner children's football tournament and cooperating with a local urban educational garden to teach basic health tips to kids in the area. Additionally, members are in the process of reaching out to past squad members who have graduated and creating a stronger SCU EMS alumni network.

*Willamette University EMS* is excited to welcome 13 newly-certified First Responders, bringing total membership to an all-time high of over 40 members. The group recently expanded its hours, and is reevaluating and revamping its protocols to improve safety while aligning more closely with other local EMS agencies to ensure high quality of care for mutual aid and transports. Co-Director Bartholomew Grabman is researching and evaluating call data collected since 1997 to determine factors that affect response time by WEMS, and hopes to further improve service by reducing response time. He is also looking for information from other colleges and universities nationwide - if you are interested in knowing more about his research or participating in sharing data, contact: BGrabman@willamette.edu.



**Do you have news about your squad you'd like to share? Contact your RC and look for it in the next issue of NCEMSF News.**



## NCEMSF Year-In-Review and Future Events

Since we convened last year, NCEMSF has made significant advancements. Most notably, the Foundation's online presence underwent a complete overhaul with the launch of the new Web site. Although plagued by a few technical glitches over the summer, the kinks have been worked out and the end product offers all of the most up-to-date information regarding collegiate EMS in an ordered, user-friendly format. Furthermore, NCEMSFForum was ported over so that all of campus-based EMS is now housed under one roof. Other communications infrastructure systems were upgraded as well.

This past year also saw a leadership restructuring within the Foundation. Several people assumed new roles and others joined the Foundation's volunteer leadership team. With new energy, the Foundation was able to update various resources including alumni and research support materials as well as focus on supporting regional events and trainings. We sponsored a successful EMS Week and CPR Day as well.

NCEMSF looks forward to an even more productive and exciting year ahead as we gear up for our 20th anniversary and expand our academic and research focuses.

### June 1, 2012:

#### New Membership Year Begins

All conference attendees automatically become NCEMSF members for the duration of the academic year, which ends on May 31. Renew your membership online and indicate your continued support for campus-based EMS and NCEMSF programs.

### November 12-18, 2012:

#### Collegiate CPR Day and Annual Collegiate EMS Week

Help educate as many college students as possible in a single day in the basic principles of how to save a life and celebrate campus based EMS' contributions to the campus community all week long. An information and activity packet is available online.

### February 22-24, 2013:

#### 20th Annual NCEMSF Conference - Washington, DC

Begin the budgeting and fundraising process now and plan on joining us again next year for our 20th Anniversary. Help us break 1,000 attendee mark as we celebrate with an extraordinary gala.



## Join the Entire EMS Community this Spring in Washington!

EMS on the Hill Day is hosted by NAEMT to help ensure that EMS has a strong voice in the nation's capital and in government decisions that affect its practitioners and their ability to provide quality patient care to their patients.

2012 program highlights include:

- March 20, 2pm: attend AAA Reimbursement Task Force meeting
- March 20, 5pm: meet with other participants, attend the pre-Hill visit briefing
- March 21, morning/afternoon: attend scheduled appointments with Senate and House leaders and their staffs
- March 21, 5pm: attend the post-Hill visit reception

It is critical that we educate our congressional leaders on EMS issues and advocate for the passage of key EMS legislation. All EMS professionals are invited and encouraged to attend and participate!

**For More Information Visit:**

[www.NAEMT.org](http://www.NAEMT.org)

### *Become More Involved!*

## NCEMSF Leadership Positions Available

The NCEMSF Board of Directors is accepting applications for several collegiate EMS leadership positions including:

*EMS Week Coordinator  
Mid-Atlantic Regional Coordinator  
Northern New England Regional Coordinator  
Southeast Regional Coordinator*

Interested candidates for the EMS Week Coordinator should submit a current resume/curriculum vitae along with a brief essay (max 250 words) highlighting prior leadership experience, goals of being involved and specific ideas for the position to [secretary@ncemsf.org](mailto:secretary@ncemsf.org).

Prospective RCs should contact [nc@ncemsf.org](mailto:nc@ncemsf.org) introducing yourself and to request a formal application.

**The Board desires to fill all openings by March 31, 2012**



*"...there is a more valuable skill that can't easily be taught in the classroom:*

*The ability to communicate well!"*

### **About This Publication**

NCEMSF NEWS is an official publication of the National Collegiate Emergency Medical Services Foundation (NCEMSF). This newsletter is published as a service to the Foundation's members and the national EMS community.

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E-mail articles to be considered for publication to [info@ncemsf.org](mailto:info@ncemsf.org)

## **Bandaging is Just the Beginning**

Dr. Scott C. Savett, NCEMSF Vice President

If I asked you to name just one thing that makes a good campus-based pre-hospital care provider, you'd probably say something like "proficient clinical skills." There's no doubt that a skill such as measuring a blood pressure accurately is essential. The same can be said for any practical skill such as using an AED or inserting an IV catheter. These skills are taught in the classroom and honed in the field.

I would argue that there is a more valuable skill that can't easily be taught in the classroom: the ability to communicate well. To some degree, communication skills are innate parts of our personality. That's not to say that we can't hone them with guidance and practice, but it's a lot tougher than mastering something like slinging and swathing.

How vital is communication to EMS? Here are just some of the communication "touch points" during a typical campus emergency run:

### Dispatch and Radio Communication:

As a South Carolina EMT, I learned to refer to various maladies in statewide "signals" that were used on every patient care report. For example, a "signal 45" was "impairment similar to alcohol." Our campus dispatchers understood these signals and used them when dispatching EMS calls. However, city dispatchers who didn't generally deal with medical issues didn't know what a "signal 45" signified. They had their own proprietary radio signals and codes dealing with police matters that I didn't understand, either.

What is the solution to such a breakdown in communication? Plain speak. Under this system everybody speaks in commonly understandable terms. A "signal 45" becomes a "suspected intoxicated subject." No more memorizing codes; just say what you need to and do it professionally and succinctly while respecting patient confidentiality.

### Crew Coordination:

Assuming your dispatcher has clearly told you the nature and location of the emergency, you may have to coordinate with your fellow crew members for transit to the scene. Even before getting on scene, there must be clear communication among crew members for expected actions and responsibilities. Who is crew chief? Who will carry what equipment to the scene? Whether it's done in real-time or pre-planned, this communication must take place or mayhem will ensue on scene.

### Gathering the Facts and Planning Treatment:

This is perhaps the most challenging part of an EMT or paramedic's verbal communication.

Straddling the college student realm and the healthcare professional realm, you need to speak two languages. Communication with the patient and bystanders should be in common language they understand. If you ask a patient "Did you have a syncopal episode?" you'll probably be met with a blank gaze. If you ask "Did you pass out?" your chances are much better that you'll get a usable response.

What may seem routine to you probably isn't to the patient, and they deserve to understand what's going on. As you care for your patient, you should be communicating what you and your crew are doing in plain language and what they should expect (e.g., "When I start this intravenous line, you'll feel a prick, but I need you to keep your arm relaxed.").

### Care Transfer:

If the patient is transported, you will have to do a patient care transfer, either to the transporting ambulance or to the ER staff. At this point, the correct translation of the patient's condition and treatments you've provided into medical jargon is important. If EMTs and paramedics want to be respected as medical professionals, we must speak in the language of medical professionals. While telling the intake nurse that your patient "broke his arm" probably sums it up nicely, it would be better to say something like, "We suspect a fracture of the humerus." Learn the terminology and use it correctly.

### Patient Care Report:

Now we get to put pen to paper (or fingers to a keyboard) and document what was done, how it was done, and by whom. This is perhaps the most challenging part of EMS communication.

We all know the adage that if it's not properly documented, it wasn't actually done. If you are called into court about a patient's care, a well-written patient care report is your best defense. Memories fade over time. Instead, rely on your "external memory" of the PCR to paint the picture and communicate in unmistakably clear terms what you saw, what you did, and what happened as a result.

NCEMSF conference weekend is about freely communicating with your fellow campus-based EMS responders. I encourage you make the most of this opportunity and open the lines of communication between your organization and others. When you return to campus, take a moment to think critically about the communication that happens during an EMS call and identify where communication could be improved.

♫

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*National Coordinator*  
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ncemsf](http://www.facebook.com/ncemsf)**

**National Collegiate EMS Foundation**  
**PO Box 93**  
**West Sand Lake, NY 12196-0093**

***Please visit the Membership section of the NCEMSF Web site and update your contact information. Thank you for your ongoing support of campus based EMS and NCEMSF!***

***The NCEMSF Database of Collegiate EMS Providers is an excellent resource in the event of natural disaster or other public health emergency. Please keep your information up-to-date so that should the situation arise, we can contact you and collectively as campus based EMS answer the call to act!***

## **NCEMSF and Campus Based EMS Research**

NCEMSF remains committed to scholarship and research activities. By pooling together the resources of our constituent colleges and universities and the academic curiosity of our members, NCEMSF aims to help further the realm of EMS research. Dr. Michael Hilton, NCEMSF Director-at-Large, directs NCEMSF's research initiatives and serves as a liaison to those pursuing their own campus based EMS research goals. At this year's conference, we have introduced presentations of original student research to run concurrently with the Richard W. Vomacka Student Speaker Competition. We will also be hosting a roundtable forum focused on research development. Future conferences will continue to include additional original research focused talks and tracks. We are also solidifying details surrounding NCEMSF-sponsored research grants for interested members - stay tuned for further details.

From time-to-time NCEMSF also conducts its own research projects, but is most interested in assisting members in developing their own ideas and both mentoring them through the process and providing them with access to valuable data.

To that end, NCEMSF again invites you to participate in a pilot project to collect data on campus-based EMS (CBEMS) response to out-of-hospital cardiac arrests.

To upload your organization's patient information visit:

**[www.ncemsf.org/research](http://www.ncemsf.org/research)**

The data entry form is designed to be filled out once for each patient being entered. The form consists of 30 data points per patient. Please enter data on all cardiac arrests from September 1, 2008 to present.