

NCEMSFS NEWS

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“Lucky people generate their own good fortune via four basic principles...”

Message from the President

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

For over two decades, a man stood on the academic quad at Bucknell wishing all that passed “Good Luck”. To the campus community, he became known as “Good Luck John”. Every morning regardless of the weather he walked on to campus with his brown paper bags to take his post in front of Vaughan Literature Building. Many made it a ritual to walk by to receive his positive wishes before a test or presentation. He has since passed, but he left his mark on many that walked past.

I have always been fascinated by the concept of “luck.” Why do some people seem to have better luck than others? Are they just luckier or do they create circumstances that make them luckier? Several times a year, students approach me for career advice on how to pursue a career in surgery. I almost always begin with the statement that I am probably not the best person to give advice because my career path is due to luck.

I have been fortunate to have many mentors that have believed in me and encouraged me to succeed. My advisor in college, an organic chemistry professor, felt that if he had to do it all over again he would have been a physician. His insistence on choosing medicine as a career probably had the greatest impact on my choice in going to medical school. However, my admittance to medical school was probably most credited to a successful businessperson, who refused to believe that my application to medical school was not strong enough. He encouraged me to apply. In medical school, my mentor was a physiology professor who encouraged me to think outside of the box and a residency director who supported my goal of matching into surgery. Finally, in residency, I met a chief of trauma who provided the encouragement and mentorship to pursue a career in trauma. I believe that many of these circumstances were because of luck and simply being at the right place at the right time.

A psychologist, Richard Wiseman, who has studied “lucky” and “unlucky” people over the past 10 years, concluded that lucky people

generate their own good fortune via four basic principles. They are skilled at creating and noticing chance opportunities, make lucky decisions by listening to their intuition, create self-fulfilling prophecies via positive expectations, and adopt a resilient attitude that transforms bad luck into good.

Morris Helzberg, the founder of Helzberg diamonds, was on a street corner when he heard someone call out Mr. Buffett. At the time, Helzberg was 60 and was thinking about selling his business. He wondered if that man was Warren Buffett. Helzberg walked over and struck up a conversation with him. That conversation turned into a sale of his company about a year later. “Lucky” people have the tendency to create their luck.

Wiseman also found that lucky and unlucky people deal differently with the ill fortune in their lives. Olympic medalists that win bronze medals tend to be happier than those that win silver. Instead, athletes that win silver medals focus on why they did not win the gold. Whereas, bronze medalists tend to focus on if their performance was slightly worse then they would not have won a medal at all.

As the New Year starts, I encourage you to think about whether you are a “lucky” or “unlucky” person. If you are unlucky, I challenge you to think differently: open your mind to new opportunities, find the upside of situations in your life, and learn to be lucky. I do believe that if my college chemistry professor encouraged me to pursue a career in organic chemistry that I would have been just as lucky.

I wish you all the best of luck in the New Year.

See you in February, in Baltimore!



Ebola: What You Need to Know and Other Things You Might Want to...

Michael T. Hilton, MD, MPH, NCEMSF Director-at-Large and Research Coordinator

Listening to the news, Ebola seems like a one-of-a-kind threat – but there are many others just like it. It is a rare, but not unique threat. The lessons learned preparing for Ebola can be extended to other threats...and to more common ones, such as influenza. Ebola is one of the many “Viral Hemorrhagic Fever” illnesses, which include: lassa fever, hanta virus, rift valley fever, yellow fever and degue fever. Ebola is one of two groups of viruses in the Filovirus family. Ebola actually is not one virus. There are five distinct species of Ebola, four of which infect humans.

There have been 9 epidemics of Ebola, including the current one. The first was in 1976 in South Sudan. An epidemic occurs when a disease is found in a population in greater numbers of people than is typically found.

When analyzing infectious diseases in a population, it is important to review the patterns of infection to identify who might be at highest risk of becoming infected. Ebola infects men and women of all ages equally. There is an increased risk of infection for healthcare workers, animal workers, and those providing care in the community during an outbreak.

It is also important to review where the virus is found naturally. For the Ebola species that infect humans, these areas are the Republic of Congo, Cote d'Ivoire, Democratic Republic of Congo, Gabon, Sudan and Uganda. The current outbreak has been in Guinea, Liberia, Senegal and Sierra Leone and not the countries where Ebola is found typically.

In the U.S. all cases have been associated with travel to one of these countries. Those infected have been from the expected high-risk groups – healthcare providers and those providing care in the community with an outbreak.

It is also important to review how Ebola is transmitted. When not causing an outbreak, the Ebola virus circulates – just not among humans. Its “natural reservoir” is among fruit bats living in Africa. Humans and non-human primates are only incidental hosts. Primates can become infected by being bitten by an infected fruit bat, consuming partially eaten fruits dropped by fruit bats or humans may consume infected bushmeat

(this latter mechanism is how the current outbreak began). Some of these outbreaks are small and contained, and some are large-scale.

Ebola can be transmitted from human to human through inhalation of aerosols or droplets (i.e., particulate matter created when coughing or sneezing). The spread via this route can be prevented with N-95 masks. Ebola can be spread via direct contact with infected body fluids (saliva, tears, blood, urine, vomitus, feces, semen). Transmission through this route can be prevented by using contact precaution personal protective equipment, such as surgical gowns, surgical hoods, face masks with eye shields, and full leg and shoe coverings. Finally, Ebola can be transmitted through indirect contact, which is contact with a surface contaminated by one of the above listed fluids. This form of transmission can be prevented by cleaning and disinfecting exposed or potentially exposed surfaces with bleach or other CDC-approved disinfectant.

Ebola has an incubation period of one to twenty-one days. This means that after an exposure to the virus, the infected person can remain asymptomatic for this period. In some illnesses, patients can infect others during the incubation period. However, for Ebola, this is not the case. Asymptomatic patients cannot transmit the Ebola virus. After this incubation period, the first 3-5 days of illness are represented by flu-like symptoms: headache, fatigue, and muscle aches. On the 4th day, if the disease becomes severe, the patient will develop a spiking fever, bloody vomiting, and lethargy. This is quickly followed by bruising of the skin and bleeding from orifices. Finally, 1-2 days after the bleeding phase begins, patients will develop seizures, massive internal bleeding, loss of consciousness and death. In non-severe cases, patients will not develop the spiking fever or bleeding manifestations. Rather, they will experience a three-week phase of general weakness, headaches and joint pain after the flu-like symptoms resolve.

The presumptive diagnosis of Ebola initially is made by history and symptoms. Those positive on a travel and symptom screen then have their blood tested at a state Health Department laboratory or at the CDC for confirmation of infection. In

the U.S. nearly all patients with positive screens will ultimately receive a diagnosis other than Ebola.

Treatment for Ebola is supportive. For severe cases, this includes intravenous fluids, blood transfusions and, if necessary, medications to support blood pressure and endotracheal intubation with ventilator support of breathing. For mild cases, it means anti-emetics and analgesics and intravenous fluids. In all cases, supportive care includes isolation of the ill patient until recovery or death.

There are vaccines in development, although none currently available. There are also a few experimental treatments, such as ZMapp - a genetically engineered antibody. It has never been tested so it is not clear that it is effective.

There are a few important lessons to be learned from the Ebola outbreak for the college-based EMS provider. First, many of our campuses have an international population. For patients with flu-like symptoms, it is always important to ask a travel history and report this as part of your hand-off to the ED. Second, it is important to review and practice how to don and doff PPE and to inventory your PPE to see if you are prepared for infectious diseases. Many of our services will find our skills at donning and doffing to need improvement and our stock of PPE equipment to be lacking. Although we are unlikely to use these skills and equipment for Ebola, they are likely to be needed for influenza. Finally, Ebola has forced many of our EMS, Health Service and Environmental Health leaders to reassess our campus preparedness by reviewing policies and procedures in place for public health emergencies.

Despite all of the media attention on Ebola, it is highly unlikely that any of us will ever come across a patient with this viral illness. Preparing for Ebola prepares us for the common illnesses when infectious disease is a concern, from influenza to a bloody trauma scene to a projectile vomiting intoxicated patient.



Who Gets the Keys to the Castle?

Scott C. Savett, PhD, NCEMSF Vice President and Chief Technology Officer

Think back to when you applied to be a member at your campus EMS squad. How would you describe the experience? Was it nerve wracking? Was it formal or informal? Did it take weeks to navigate the process or was it quick?

Each of the 250 organizations under the NCEMSF umbrella has a unique membership process. As the first glimpse that an outsider may have of your group, it can foreshadow the tone for the group – either in a good or bad way.

In addition to being on the NCEMSF board, I'm also a trustee of a 9-1-1 ALS ambulance squad in suburban Philadelphia. It's a blended career/paid and volunteer organization. While the recruiting and vetting of paid personnel falls under the purview of the chief (a career/paid position), prospective volunteer members are interviewed by the board of trustees, all of whom are volunteers. The application for membership is very straightforward, asking about how the applicant found out about the organization and requesting several references. After filling out the form electronically, the prospective member is contacted by the head trustee and an interview is scheduled.

After a brief interview with the trustees, the applicant is introduced by the head trustee to the general membership at the business meeting. It typically sounds something like this: "This is John Smith, who is interested in joining our organization as a volunteer. He's currently taking the EMT class at the County Training Center and he's looking to gain some real-world EMS experience." If there is no opposition, the applicant begins six months of probationary membership.

In recent months, my fellow trustees and I noticed a trend. The number of people that made it through the entire six month probationary period was dismal. In most cases, the new member would either not commit to any shifts or would show up a few times for scheduled shifts and then stop coming without any warning. We wanted to understand where the process was failing and how to remedy the situation. In dissecting the membership process, there were several opportunities for improvement.

First, we looked at the interview itself. We

felt it was too short, informal, and did not properly set the expectations for a volunteer member. The purpose of the interview is to ensure the candidate is a good fit for the organization and vice-versa. Simply verbally verifying the information on the application is not worthwhile. Instead, the information on an application should be the launching point for a discussion to get a sense of somebody's personality and motivations.

While our squad has a casual and familial nature, EMS is a serious business. The interview should have an air of formality, but not so stiff that the prospective member feels like they are being interrogated. All of the trustees have been in the shoes of the prospective member, so we certainly feel some empathy. Unfortunately, the interviews had gotten too casual and it felt like we were simply going through the motions.

Second, in terms of setting the expectations for the level of commitment, it's usually been very vague. Traditionally people have been asked to "give whatever time you can" as opposed to something more specific such as, "we expect 24 hours of volunteer time from you per month." Of course, people have busy lives. By leaving the request so open, it gives the prospective member an opportunity to select a "zero" time commitment, which makes the entire membership process pointless.

Third, assuming that an applicant was voted in as a probationary member, the next hurdle is assigning them shifts. Past experience has shown that the "drop in when you'd like" method does not work. Many shifts already have three providers, including an EMT or paramedic student. The ambulance starts to look like a clown car when a fourth crew member is added. However, the addition of a second scheduled crew increased the number of available slots, making it easier to schedule probationary members.

Finally, new members were sometimes dismayed at the lack of calls. In recent years the squad has typically run approximately 1,500 calls per year, which equates to 3-4 calls per day. With typical transport times of around ten minutes, a call lasts about an hour from start to finish. That means a lot of down time at the station. Unfortunately, the crews did

not typically take advantage of the down time to review skills or do other training with probationary members. We theorized that this lack of mentorship led to disinterest and apathy, leading to eventual withdrawal from the organization. We are currently in the process of formulating a probationary member packet. This document will provide clear learning objectives for new members and will hopefully encourage them to engage the crews to acquire the knowledge between calls or during retrospective call reviews.

Many of the same challenges my squad has been facing are completely applicable to the campus EMS environment. The key in both environments is striking balances. To recap:

- You don't want to be too elitist and selective, but on the other hand you don't want to expend valuable resources (e.g., time, money, effort) on recruiting people who ultimately won't be committed long-term members of the organization.
- Don't be unreasonably demanding (e.g., 20 hours on call per week), but you should impose some reasonable minimum requirement to prevent having a large crew roster with just a few folks who really pull their weight.
- Before taking on new members, ensure there are available shifts where those new members can accompany a seasoned crew to gain experience.
- It is highly desirable to have a formally documented advancement process and have experienced crews that are willing to assist a probationary member in navigating that process.

As with many aspects of campus EMS administration, the NCEMSF board is available to assist with your membership policies. Feel free to contact your regional coordinator (RC) or any of the foundation board members for assistance.



Regional Roundup (September to December 2014)

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 Regional Coordinators that NCEMSF best accomplishes its mission of advocating and supporting campus based EMS. The Regional Coordinators 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.

NCEMSF has a **grant program** to provide financial support for regional events and special projects that directly further the NCEMSF mission. Sponsored activities must be educational in nature and provide direct benefit to campus EMS. For further information, eligibility requirements, program rules or a grant application contact your RC.

Regional training events and single day conferences are great ways to harness the energy of campus EMS at the local level. Contact your RC to coordinate goals and dates with the NCEMSF national agenda.

Regional Coordinator **vacancies** exist in the Canada, Midwest, Southeast and West regions. If interested in applying please contact nc@ncemsf.org.

Central

Rice EMS (REMS) was recognized at EMS Expo this fall as the 2014 Volunteer

Service of the Year. Rice is the first Collegiate EMS Agency ever to receive this award sponsored jointly by EMS World Magazine and the National Association of Emergency Medical Technicians (NAEMT). REMS was invited to attend the annual NAEMT conference held in Nashville, Tennessee. Lisa Basgall (EMS Director), Mark Escott (Medical Director), Cameron Decker (Medical Director), Amol Utrankar (Alumnus), and Mollie Ahn (Captain) were present to receive the award and recognized during the keynote address at the opening of the conference.

San Jacinto College System is a community college system near Houston. It has been one of several EMS Education providers for years, but earlier this year, one of its EMS faculty decided to pilot a response group. In addition to first-responding to emergency calls on its campus, San Jac is also attempting to do more for the health of its students. The campus primarily serves low-income students. The area is not served by public transportation, and many if not most students lack access to health care. As such, San Jac North opened a student health clinic staffed by EMT students. EMT-B students work the registration desk and take written histories. EMT-/AEMT students take vitals and perform a physical exam, and report that information to EMT-P students. The Paramedic students are responsible for a diagnosis and formulating a treatment plan, which is submitted to a faculty member for approval. Currently, the clinic

is only providing wellness exams, but hopes to expand its services through partnerships with Harris County Public Health and Environmental Services and the local Medical Reserve Corps unit. If successful at the North campus, the program will be expanded to San Jac's Central and South campuses.

University of Colorado EMS participated this fall with other regional partners in moving all patients from Boulder Community Hospital to the hospital's new facility, Foothills Hospital.

Massachusetts

Collegiate EMS week was a huge success in Massachusetts with participation from many schools including *Tufts (TEMS)*, *Boston College (BCEMS)*, *Brandeis*, and *UMass Lowell*. Boston College EMS, formerly known as Eagle EMS, officially changed its name to better suit the needs of the college and surrounding communities. This change will solidify the group's role as a respected college agency, similar to that of the Boston College Police Department. In addition to kicking off EMS week with the name change, BCEMS also offered courses to students all week including medical malpractice lectures from an experienced lawyer, combat casualty care, and a round table with BCEMS alumni. Tufts used the week to educate and raise awareness about CPR and college EMS with a station set up to be visible to the public. Additionally, TEMS offered courses to certify students in CPR and had a table set up in a central location for students to be quickly trained in hands only CPR. Similar to the other schools, Brandeis and UMass Lowell had stations set up to educate and display their services to the public.

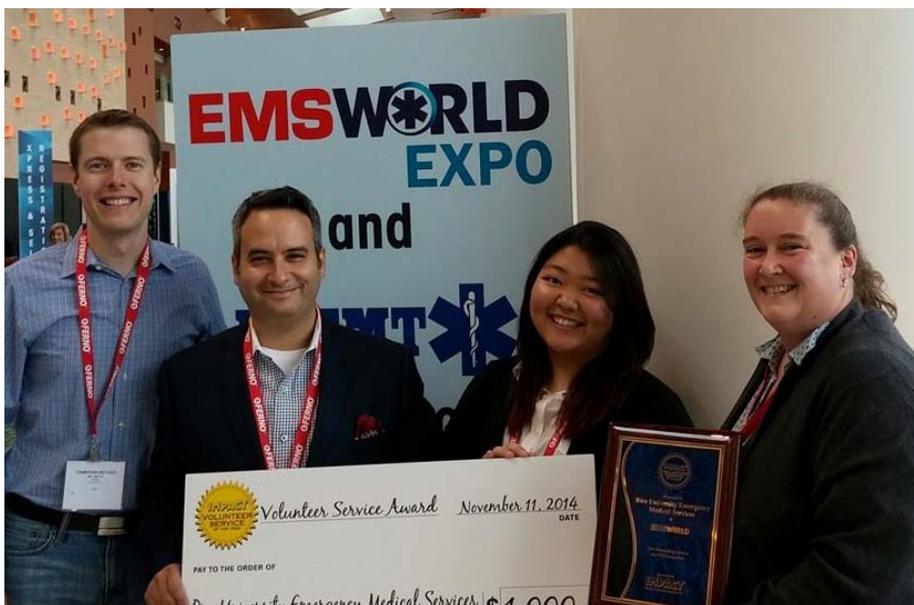
Mid Atlantic

Georgetown University's GERMS hosted a Mid Atlantic Regional Training Day on November 15th to celebrate Collegiate EMS Week. There were approximately 50 attendees from five schools (Georgetown, George Washington, Johns Hopkins, Lynchburg and University of Delaware).

Midwest

With the addition of a second ambulance, a class of new EMTs, and a huge spike in call volume, *Case Western Reserve University (CWRU) EMS* has been focused on increasing training and

(Continued on page 5 - RR)



(Regional - Continued from page 4)

education within the agency. CWRU EMS has introduced a hands-on shift training curriculum and has begun hosting weekly lectures and run reviews on a variety of EMS topics with physicians, nurses, and paramedics from the community. In September, the group held a successful mass casualty incident drill in conjunction with CWRU Police, Cleveland EMS, Cleveland Fire, and the Cuyahoga County Office of Emergency Management. Other recent projects include expanding AHA CPR training, assuming monthly maintenance for 39 campus AEDs, participating in local health fairs, and teaching disaster medical units for the CWRU CERT team.

John Carroll University EMS has 19 students currently in an Emergency Medical Responder course and is looking forward to working with them in the spring. The group recently held its third annual mock mass casualty incident on its campus in collaboration with campus police and the local fire department, and teamed up with the city's fire department to have joint training days.

Ohio University EMS (OUEMS) is a new start up organization created in 2014. The initiative to create a collegiate emergency medical service has been approved and affirmed by the Office of Student Affairs and Department of Environmental Health and Safety. Currently, the executive board, consisting of five members, is actively evaluating fiscal plausibility, liability, and initial education opportunities.

New York

Harpur's Ferry Student Volunteer Ambulance Service at Binghamton University hosted a regional training day during EMS Week. 82 attendees, from local community & four area colleges including Oneonta, Oswego, Binghamton, and Syracuse attended this successful event.

SUNY Oneonta, with mutual aid from *Harpur's Ferry*, provided standby coverage for the annual fall concert featuring Big Sean that drew over 2,000 attendees.

North Central

Macalester First Aid recently staffed an event held on their campus involving a visit from former Secretary of State Hillary Clinton. They provided standby EMS service for this event.



University of Chicago EMS celebrated Collegiate EMS Week by holding Hands Only CPR sessions and having open house events to allow students to see different skills and equipment which are utilized by their EMTs.

University of Minnesota EMS had a busy fall semester. In addition to its usual responsibilities of providing coverage for its campus and sports teams, the Minnesota Vikings Football Team played at the University of Minnesota stadium this year and UM EMS provided event coverage for all of these events.

Northeast

Brown EMS focused on its outreach and integration into the greater Brown University community this past semester. In October, Brown EMS participated in an annual safety event and gave ambulance tours and provided Hands Only CPR lessons. Most recently Brown EMS has been working with its administration and campus health to define protocols and plans in the event of a suspected Ebola case on campus. The group provided training to its members on proper protective measures.

Stockton College EMS completed its fall new membership intake process, accepting seven EMTs and nine non-EMTs into the organization. The organization now has a membership approaching forty, with over half holding a EMT certification. Cooper University Hospital has continued to provide medical direction and training services for the organization and completed the following training courses over the last several months, Blood Borne Pathogens, EMS Documentation, Managing Multiple Patients, and Extreme Sports Injuries.

Northern New England

October was breast cancer awareness

month and *University of Vermont (UVM) Rescue* supported the cause by wearing pink duty shirts. UVM Rescue is also fundraising for the construction of new quarters. The service operates 365 days a year, 24 hours a day, and is autonomous from the university, meaning that they do not receive funding from UVM. Income is generated exclusively through billing. The squad has outgrown its current quarters. They are able to cover a significant portion of the project with a reserve fund they have been growing for several years along with generous gifts from alumni. If they continue to demonstrate strong private support, UVM will consider offering a loan for the remaining cost of the project at the February meeting of the Board of Trustees. Their goal is to raise an additional \$70,000 through private contributions and are reaching out to the public, alumni, and friends of UVM Rescue for support.

Colby College is looking forward to its spring regional training day on April 4th.

University of New England (UNE) EMS created a "Let's get physical" video for EMS week. A link to the video is posted to the group's Facebook page.

Pennsylvania

Villanova EMS reported that it has begun to use an open source CAD software for dispatching and incident management. The software is called ticketsCAD.

Muhlenberg EMS celebrated its 15th anniversary this past semester.



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*.

ePCR Hardware

Ian Feldman, NCEMSF Central Regional Coordinator

As many squads transition to electronic medical records, questions arise. In the Fall 2014 issue of *NCEMSF News*, we discussed software options, this quarter we look at the hardware on which those systems run.

The biggest question related to ePCR hardware is whether to go with a "rugged" computer. These machines are designed to take abuse above and beyond what a regular computer, tablet, or phone can. As a result, they tend to be bulkier and heavier. While these machines are tested to withstand harsher conditions, they are also usually much more expensive than a comparable commercial laptop. So which is better? The answer depends a lot on the people who are using the machines. A non-rugged laptop can survive just as long as or longer than a rugged laptop if the users take care of it. Today's non-rugged laptops may also come with options to help make them more durable, including after-market cases, spill protection, and hard drives that do not get damaged due to drops or vibrations. Even with these additions, the price of a non-rugged laptop is still usually less than the price for an off-the-shelf rugged laptop.

Next, we need to consider the type of device used: laptop, tablet, or phone. This depends as much on your ePCR software as it does on your EMTs' preferences. Some ePCR companies offer mobile and tablet apps, while other systems must be run on a full computer. Web-only systems can run on any device, but if their website is not optimized for mobile viewing, trying to enter data on a phone may be next to impossible. Phones have the advantage of coming with a data connection built in. Tablets often come with WiFi, but 3G or 4G data service can be an optional extra. Laptops are the least likely to have cell data service built in, and may require more coordination with your cell provider to get set up. On the flip side, laptops offer more rugged options, their screen size is larger (making them easier to enter data on), they often come with physical keyboards (a plus when writing a long narrative), and they are usually easier to repair. Also consider how you will interact with the system. Tablets and phones rely heavily on the touchscreen; ePCR software that is designed for a touchscreen interface works well here.

While some laptops may be available with touchscreens, the ePCR software that runs on laptops may not be designed to take advantage of the touchscreen's utility, and a laptop with a quality touchscreen is often much more expensive than one without. After seeing which devices meet your ePCR software's requirements, start looking at how your EMTs enter their data. If you collect only basic information on scene and do most of the report-writing after the fact, a phone or tablet may be better (and the full report is then entered later from another computer). For services that require that the report be completed by the time the call ends, ensure your device allows your medics to quickly and easily enter all data they need.

Regardless of which option you choose, you may be faced with the question of whether or not to allow your staff to use their personal phones, tablets, or laptops with ePCR software. BYOD (Bring Your Own Device) has its advantages: there is less cost for the service, EMTs are using a device they are familiar with, and reports can be done at any time since the ePCR computer isn't being shared. But there are disadvantages as well. It is harder to control security when the computer or phone isn't owned by the EMS service. If the EMT's device gets infected by malware, is that malware stealing patient information? You also need to think about whether allowing EMTs to use their personal technology could allow Protected Health Information to sit unencrypted on their device. This may represent a violation of healthcare data storage standards. By using machines owned or leased by the squad, the squad has control over security features, such as installing and updating antivirus software, requiring data encryption, and picking which network connections are allowed.

If you choose to go the BYOD route, work with your University's IT department to develop training on cyber-security and find ways to ensure that personal devices used for ePCR purposes remain free from malware and storage encryption features are activated. BYOD policies can also bring up certain legal questions. If you are requiring an EMT to use a personal device for work purposes, you may be required to reimburse them for the cost of the device and any data

services associated with it. If a medical call goes to court, their personal device could also be subpoenaed as evidence. These last two issues can be mitigated by working with your University's legal and IT departments to develop policies and procedures which work for your situation.

If you choose to go with machines owned by the squad, you need to look at how those machines are acquired. Many Universities have contracts with a preferred hardware vendor. This can result in savings compared to off-the-shelf shopping, but it can also restrict your options. You may also want to look into purchasing versus leasing. Some ePCR systems will provide you with a device to use their software on for a set monthly fee. This helps spread out the cost of the device, but does result in higher ongoing costs.

Finally, there is the question of what to do if the device breaks. In an ideal world, any issues will be immediately reported so they can be fixed before they turn into larger problems. One issue that EMTs in the field face is the inconvenience of working with an ePCR system when their laptop or tablet is not available. If EMTs have to do a paper report and then transcribe that into an electronic system after the fact, they will be very reluctant to turn in broken machines for repair. When left unfixed, small issues can easily become worse. Having a spare device available can prevent this behavior, but there is usually an added cost for this. Another way to prevent the hiding of broken equipment is to not punish people for normal wear-and-tear, and encourage reporting of damage. The machines should also undergo a regular inspection and have various types of preventive maintenance done. All of these steps will ensure that the ePCR machines remain in service as much as possible.

Just as is the case with ePCR software, ePCR hardware presents several choices. Consider your staff, your operations, your resources, and the policies of your University when deciding what hardware to use for your ePCR software. With proper forethought, you can make a transition from paper to electronic charting easier and more beneficial for your EMTs.



How were Collegiate EMS Week and CPR Day celebrated on your campus???

Email stories, photos, videos, press releases and local press coverage to:

**emsweek
@ncemsf.org**

About This Publication

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EMS Week 2014

The 16th Annual National College EMS Week was held November 10-16. Modeled after National EMS Week in May, Collegiate EMS Week is a week-long recognition and celebration of campus based EMS and provides an annual opportunity for campus-based EMS organizations to highlight their activities and educate their communities.

Five Quad Volunteer Ambulance Service at The University at Albany (SUNY) went all out this year marking the annual event:

On Monday, Collegiate CPR Day, they focused on CPR. They started off the day by having a flash CPR mob in a crowded area on their campus. They had the song "Staying Alive" playing through loud speakers while members slowly entered with CPR mannequins doing compressions. For the next 7 hours they taught hands-only CPR to approximately 150 people on campus ending the day with a CPR competition in which the winner received a gift card.

On Tuesday, they focused on promoting a Good Samaritan video, which they made explaining the New York State Good Samaritan Law. The goal of the video was to attempt to lower the incidences of unreported drug and alcohol related emergencies. Their video was promoted through social media sites, e-mail, and YouTube reaching over 52,000 people.

On Wednesday, they focused on Blood Pressure checks and promoting the organization. For 7 hours they set up a table in a busy part of campus and offered to check anyone's blood pressure while teaching them about being heart healthy.

On Friday, they donated food and clothing to the Albany Capital District Rescue Mission. About a month prior to the donation day they had been collecting food and clothing from students and staff from all around campus. On donation day they were able to fill the ambulance with donations.

On Sunday, they ended the week with a "thank you" pot luck dinner for their membership. The event included fun games and great food. Dinner concluded with an opportunity for each member to speak and say for what they were thankful.



Pictures (L to R): Brandeis BEMCO with EMS information table; Penn MERT participating in an MCI drill with the Philadelphia Fire Department; Five Quad CPR Flash Mob; Stockton College Hands-Only CPR.



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Please visit the Membership section of the NCEMSF Web site to keep your contact information up-to-date. Renew your membership for the current academic year 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!



Why Attend?

- 3 days of exceptional conference programming
- Over 50 expert lectures in at least 9 concurrent tracks
- Multiple moderated roundtable and panel discussions
- Several hands-on skills labs
- Vomacka student speaker competition
- Young alumni speaker series
- Three general sessions - including a closing keynote by *AJ Heightman*
- Collegiate EMS skills competition
- NCEMSF awards ceremony - view list and eligibility requirements online
- *Lowest cost conference of its kind in the country!*
- Opportunity for discounted *JEMS EMS Today* access (Feb 25-28 @ The Baltimore Convention Center - NCEMSF is presenting!)
- **Network with 1,100+ of your peers from over 100 schools**

Online conference registration is currently open!

More information, including lodging at the host facility - the Hyatt Regency Baltimore - available online @ www.NCEMSF.org/conf2015

It Takes a Village

A new campus EMS video is now available online under New Startup Resources

From a thirty-year vantage point, a founder of a collegiate EMS, Dr. James Meisel, describes the eight steps - and one secret ingredient - that resulted in an institutional transformation successful beyond any of the founders' imaginations.

Given as the Major John P. Pryor, MD memorial lecture on March 1, 2014 at the 22nd Annual NCEMSF Conference in Boston, MA