**For all paramedics: important REMAC CME and exam changes below**

Continuing Medical Education - News & Information
October – November, 2014 - Volume 19, Issue 10-11
Multi-Agency Edition

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Journal CME Newsletter
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From the Editor

To ensure the highest-possible quality of patient care in NYC, REMAC has raised CME and exam requirements for all re-certification and new candidates.

**All candidates must now meet CME requirements**

- All REMAC paramedics and candidates should review page 3 of this journal and plan accordingly.
- All upcoming exam candidates, see registration instructions at the bottom of the last page of this journal.
- Candidates who will not have a CME letter at the time of their REMAC exam must email Christopher.Swanson@fdny.nyc.gov ASAP.

**The exam format has changed for all candidates**

- Part A is 100 multiple choice questions on the GOP, BLS, ALS and Appendices only, including 12-lead ECG interpretation.
- Part B is one Adult Medical Scenario and one Pediatric Scenario, 10 multiple-choice questions each.
- The scenarios will be challenging, going into deep detail on protocol and patient care.
- Parts A and Part B require a score of 80% to pass.
- Part A failure ends your participation, requiring a future exam.
- Part B failure allows one retest on the full exam, Parts A and B.
Outline of May 2014 NYC REMAC protocol changes
see REMAC Advisories 2014-01 & 2014-02 at nycremsco.org

General Operating Procedures

• Medical Control at the Scene
  o deletes AED note
  o clarifies non-solicited intervention

• Prehospital Sedation
  o increases Etomidate dose
  o adds O₂ via nasal cannula

• Transport Procedures
  o deletes stroke center distance
  o deletes LBBB to PCI facility
  o adds LVAD as specialty care

• CPR
  o adds medical criteria
  o clarifies CPR for pediatrics

• Pediatric Patients
  o clarifies age of patients

• IO Administration
  o adds shock indication
  o limits attempts
  o adds Lidocaine

• IN Administration
  o adds Glucagon & Fentanyl

• Drug Guidelines
  o adds Ondansetron caution

• Pediatric Protocols
  o adds Broselow tape

BLS Protocols

• 400 – WMD
  o updates table

• 411 – AMS, 413 – Seizures, 415 – Shock
  o removes note on immobilization

• 414 – Poison/Drug Overdose
  o removes obtaining sample
  o updates venousous bite

• 426 – Soft Tissue Injuries
  o adds tourniquet

ALS Protocols

• 503A, 503-B – Cardiac Arrests
  o changes vasopressin to if available

• 507, 554 – Adult & Pediatric Asthma
  o clarifies MCO epinephrine

• 510 – Allergic/Anaphylactic Reaction
  o changes name of protocol

• 515-B – Septic Shock
  o new protocol

Appendices

• Appendix H – Specialty Care
  o updates specialties

• Appendix I – Hospital Listings
  o adds available services

• Appendix U – Septic Shock
  o new appendix
**REMAC Exam Study Tips**

REMAC candidates have difficulty with:
- Epinephrine use for ped patients: 15%
- 12-lead EKG interpretation: 10%
- Ventilation rates for ped & neonates: 10%

**REMAC Written exams are approximately:**
- 15% Protocol GOP
- 10% BLS
- 15% Adult Trauma
- 15% Pediatrics

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**Certification & CME Information**

- **By the day of their exam,** all REMAC paramedics and candidates must present a letter from their Medical Director verifying fulfillment of CME requirements.

- **Upcoming candidates** without a CME letter must ASAP email Christopher.Swanson@fdny.nyc.gov

- **FDNY paramedics,** see your ALS coordinator or Division Medical Director for CME letters.

- **CME letters must indicate the proper number of hours,** per REMAC Advisory # 2007-11:
  - 36 hours - Physician Directed Call Review
    - ACR Review
    - QA/I Session
    - Emergency Department Teaching Rounds - **Maximum of 18 hours**
  - 36 hours - Alternative Source CME - **Maximum of 12 hours per venue**
    - Online CME (see examples below) - Clinical rotations
    - Lectures / Symposia / Conferences - Associated Certifications – 4 hours each:
      - BCLS / ACLS / PALS / NALS / PHTLS

- **Failure to maintain a valid NYS EMT-P card** will suspend your NYC REMAC certification until NYS is recertified.

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**REMAC certification exams** are held monthly for new and expired candidates, and for currently certified paramedics who may attend up to 6 months before their expiration date.

**REMAC CME and Protocol information** is available and suggestions or questions about the newsletter are welcome. Call 718-999-2671 or email Christopher.Swanson@fdny.nyc.gov

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REMSCO:  [www.NYCREMSCO.org](http://www.NYCREMSCO.org)  

Online CME:  [www.EMS-CE.com](http://www.EMS-CE.com)  
[www.MedicEd.com](http://www.MedicEd.com)  
[www.EMCert.com](http://www.EMCert.com)  
[www.WebCME.com](http://www.WebCME.com)  
[www.EMINET.com](http://www.EMINET.com)
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Kornelia Haynes Hector Arroyo / Lisa Desena

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Alexandrou, Nikolaos 80282 Jacobowitz, Susan 80297
Asaeda, Glenn 80276 Kaufman, Bradley 80289
Barbara, Paul 80306 Lai, Pamela 80311
Bayley, Ryan 80314 Munjal, Kevin 80308
Ben-Eli, David 80298 Redlener, Michael 80312
Freese, John 80293 Rotkowitz, Louis 80317
Friedman, Matt 80313 Schenker, Josef 80296
Giordano, Lorraine 80243 Schneitzer, Leila 80241
Gonzalez, Dario 80256 Silverman, Lewis 80249
Hansard, Paul 80226 Soloff, Lewis 80302
Hegde, Hradaya 80262 Van Voorhees, Jessica 80310
Hew, Phillip 80267 Williams, Alan 80316
Huie, Frederick 80300 Zabar, Benjamin 80323
Isaacs, Doug 80299 Zimmerman, Jason 80824
EBOLA VIRUS DISEASE

Introduction

This Journal CME will review many of the clinical issues surrounding Ebola Virus Disease (EVD) as well as to review the current plans for EMS response in New York City. EMS is on the front lines of this battle, and I think you will see that we are prepared, and will be able to contain the spread. Over the past weeks, it seems like panic about EVD has greatly increased. Yet, we must react by what we know, and not what we fear. We must focus on ensuring the safety of all the medical providers who may be involved in caring for an infected patient, including the CFRs, EMTs and Medics, as well as the nurses and doctors at the hospital. We must protect our future patients by appropriately decontaminating the ambulance, and protect those who are involved in removing potentially contaminated waste.

The content of this journal installment has been revised in the past days in response to changing circumstances. For instance, initially there were two patients with EVD in the United States, both were Americans who acquired the disease in Africa and were returned to the U.S. by a coordinated medical retrieval so that they could receive more advanced care. This fact changed when Thomas Eric Duncan was diagnosed in Dallas with EVD at the end of September. He reportedly acquired the disease in Liberia and subsequently traveled to Dallas to visit his family. For the first time, we could no longer say that we had never had a new case of EVD diagnosed in this country. Subsequently, two health care workers who treated the patient in Dallas were diagnosed with EVD and are being treated. Most recently, Dr. Craig Spencer here in New York City has been confirmed to have EVD. He got infected with the virus while treating patients in Guinea. The situation will continue to change, and so will our response. This journal will hopefully provide useful information, but please continue to follow all the updates and information that will continue to be disseminated by the Department on this subject.

Epidemiology

EVD is one of several viral hemorrhagic fevers, and is a particularly concerning disease for many reasons. Worldwide, the average case fatality rate for EVD is around 50%. The case fatality rate of a disease is the percentage of people who are diagnosed and who die during the course of that disease. Case fatality rates have varied from 25% to 90% in past outbreaks (according to the World Health Organization). This rate may be lower if optimal medical care and treatment are provided. In comparison, the case fatality rate for influenza A (H1N1) is less than 1%. So that certainly shows that EVD is a really bad disease to acquire. However, consider that many times more people will die from influenza A than will die from EVD. This is because so many more people will get influenza A than will get EVD. So even though the case fatality rate for EVD is higher, it will not kill as many people.
Another major concern about EVD is that it is transmitted from human to human, unlike some other diseases, like malaria which requires the bite of a mosquito. Human to human transmission of EVD occurs through direct contact with body fluids (saliva, blood, breast milk, sweat, semen, and other body substances) or following contaminated sharps injuries (e.g. needle sticks). This certainly puts EMS providers and other healthcare workers at risk, and in fact, hundreds of healthcare workers in Africa have died during this current outbreak of EVD. There is currently no proven vaccine or treatment, although it seems some are in the works.

Now here is some good news. Patients are only infectious when they are symptomatic. Many other infectious diseases can be transmitted before the patient has a symptom, which means that in those cases, you may not realize that you were exposed to an infectious person. This is not the case for EVD. After a person is infected with the virus, they may be asymptomatic for up to 21 days, with 8 to 10 days being the most common. During that asymptomatic period, they cannot transmit the disease. This is the main reason that many public health experts believe that EVD can be more easily controlled than other diseases. We should always know when someone is symptomatic and infectious, and be able to take appropriate precautions.

Also in the good news category is the fact that Ebola is hard to catch and is not an airborne virus. Of note, none of the family members who had contact with Mr. Duncan have been infected. Neither have any of the Emergency Department staff that evaluated and treated him. To transmit infection, the infected body fluids would need to get into the nose, mouth, eyes, or an open wound. Let’s again compare this to influenza, which can be spread by droplets made when infected people cough, sneeze, or talk. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. You can see how droplet transmission can create a much higher risk for unprotected EMS providers. Since EVD is not routinely spread by droplets, one should be able to stand three feet away from a patient with EVD without protection (not that we would advise this) and not get infected if there is no direct contact with bodily fluids. To make this point, Judge Clay Jenkins, a government official in Dallas, conspicuously wore no biohazard gear when he entered the apartment in which Thomas Eric Duncan and his family had been living, drove Duncan's family which was being quarantined for signs of infection, and then appeared before the press in the same clothes to stress the point that there was no risk of infection with his actions.

**Patient Presentation**

EVD symptoms include fever, typically greater than 101.5 degrees Fahrenheit (38.6 degrees Celsius), headache, muscle aches and weakness, vomiting, diarrhea, abdominal pain, or unexplained bleeding. Some patients have developed a rash, red eyes, cough, sore throat, chest pain, and difficulty breathing. As the disease progresses, patients can develop multiple organ failure, severe bleeding, jaundice, delirium, seizures, shock, and coma.

The early signs and symptoms are very similar to other commonly occurring infections such as malaria, typhoid fever, and infectious gastroenteritis. Patients with suggestive symptoms and positive travel history are often referred to by public health officials as a **person under investigation (PUI)** for potential EVD. Laboratory testing is required to confirm EVD.
Exposure Risk Levels

Levels of exposure risk are defined as follows:

**High risk exposures**

A high risk exposure includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of EVD patient
- Direct skin contact with, or exposure to blood or body fluids of, an EVD patient without appropriate personal protective equipment (PPE)
- Processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring
Low risk exposures

A low risk exposure includes any of the following:

- Household contact with an EVD patient
- Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as:
  - being within approximately 3 feet of an EVD patient or within the patient’s room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (i.e., standard, droplet, and contact precautions; see Infection Prevention and Control Recommendations(http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html))
  - having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment.

- Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact

No known exposure

- Having been in a country in which an EVD outbreak occurred within the past 21 days and having had no high or low risk exposures

Emergency Medical Dispatch (EMD)

When an Assignment Receiving Dispatcher (ARD) is able to talk to a 9-1-1 caller, they ask a series of scripted questions to determine the most appropriate call-type. For many years, and in response to previous infectious disease concerns, the ARDs have been able to use an FC (fever and cough) or RF (rash and fever) suffix to selected call-types to give the responding providers an indication of the concern of an infectious disease. On such calls, the CFRs, EMTs, and Medics are to don their isolation PPE prior to making patient contact. In response to the current EVD concerns, an FT (fever and travel) suffix has similarly been added to selected call types, and again will require the responding providers to don isolation PPE prior to making patient contact.

<table>
<thead>
<tr>
<th>FT Call-Types</th>
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<tbody>
<tr>
<td>ABDFT</td>
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<tr>
<td>CHOKFT</td>
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<tr>
<td>RESPFT</td>
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<td>ALTMFT</td>
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<td>CVACFT</td>
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<td>SEIZFT</td>
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<td>ANAPFT</td>
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<td>CVAFT</td>
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<td>SICKFT</td>
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<tr>
<td>ARREFT</td>
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<td>DIFFFT</td>
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<td>STATFT</td>
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<td>ASTHFT</td>
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<td>INBLFT</td>
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<tr>
<td>UNCFT</td>
</tr>
<tr>
<td>CARDFT</td>
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<tr>
<td>PEDFT</td>
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In order to have the FT suffix, the caller must report that the patient has a fever and had traveled within the past month to Guinea, Liberia, or Sierra Leone. Travel to any other country, even those in West Africa, are currently not classified as risk factors for EVD. Also, it is not currently considered a risk factor if the patient had contact with someone who traveled to those countries. Finally, travel to those index countries prior to a month
before symptom onset is also not considered a risk factor, since the patient would have become symptomatic by then if he or she was infected with Ebola.

To expedite the response to selected calls, the priority for certain call-types with FT suffixes that previously had priorities of 4 or greater, have now had their priority upgraded to priority 3. Note that these priority upgrades are only for the FT version of that call-type.

<table>
<thead>
<tr>
<th>Call-Type</th>
<th>Previous Priority</th>
<th>Current Priority</th>
<th>Response</th>
<th>CFR</th>
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</thead>
<tbody>
<tr>
<td>ABDFT</td>
<td>5</td>
<td>3</td>
<td>BLS</td>
<td>No</td>
</tr>
<tr>
<td>CVAFT</td>
<td>4</td>
<td>3</td>
<td>BLS</td>
<td>No</td>
</tr>
<tr>
<td>PEDFT</td>
<td>4</td>
<td>3</td>
<td>BLS</td>
<td>No</td>
</tr>
<tr>
<td>RESPFT</td>
<td>4</td>
<td>3</td>
<td>BLS</td>
<td>No</td>
</tr>
<tr>
<td>SICKFT</td>
<td>6</td>
<td>3</td>
<td>BLS</td>
<td>No</td>
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**EMS Response**

The best and safest strategy for treating any communicable disease, but particularly EVD, is:

- Assure **early identification** of the infected patient.
- Assure proper use of **personal protective equipment (PPE)**.
- Assure proper **cleaning and decontamination**.

Firstly, EMS providers must be alert for and suspect patients as possibly having EVD who have (1) fever and/or any of the symptoms listed above and (2) have traveled to one of the West African countries affected by the EVD outbreak within the three weeks prior to the onset of symptoms. Only a very small number of EMS assignments will have FT call-types and will not have patients meeting potential EVD criteria. Of course, it is possible that a patient is found by the responding EMTs or Medics to be suffering from symptoms consistent with EVD, and recent travel to an index country, but did not get assigned an FT call-type. No matter how conscientious our ARDs, the call-type is dependent upon the caller’s answers, which are not always accurate. Therefore, during this time of heightened concern, we are asking all providers to make a **three-foot assessment** of a patient before making physical contact, while at the same time asking the patient and family questions regarding symptoms and travel history. If potential EVD presents, the providers should exit the location and contact the borough dispatcher, advising that there is a patient with fever and recent travel to an affected country. In all cases, a Haz-Tac ambulance will be assigned to all FT call-types as these EMTs and Medics have additional training in operating in biohazard environments. A non-Haz-Tac ambulance will be dispatched, by request of the Haz-Tac unit, to serve as a “clean” unit to assist in vehicle movement. CFR units will not be dispatched to any known FT calls.

Secondly, if the patient is coughing, Haz-Tac members shall have the patient wear a surgical mask to limit droplet transmission. Patients **should not** wear an N-95 respirator. If indicated, administer high concentration oxygen via non-rebreather mask (NRB). Fit-tested N-95 respirators and eye protection (goggles or face shields), PPE/Bunker-style pants and gowns should ALWAYS be worn by EMS personnel performing any **aerosol-generating procedures** on patients with febrile respiratory illness. Aerosol-generating procedures include **nebulized treatments, intubation, tracheal suctioning, and laryngoscopy**. Administration of nebulized (aerosolized) medications (e.g. Albuterol) may only be done via a nebulizer with a one-way valve (e.g. Aerocclipse II Breath Actuated Nebulizer) or via a disposable metered dose inhaler (MDI) with spacer. Use of the bag valve mask and endotracheal intubation may continue per current REMAC protocols, unless otherwise notified through future directives.
The Center for Disease Control (CDC) is performing enhanced screening of selected travelers at JFK airport and can quarantine a patient if need be. The CDC will be coordinating with the NYC Department of Health and Mental Hygiene (DOHMH) for patients that require EMS transport to a hospital for continued care or monitoring. FDNY EMS will be performing these transports. The process will be as follows: DOHMH physician will contact the FDNY Telemetry physician to discuss the case. If appropriate, Telemetry will coordinate an ambulance response with EMD. Similarly, the DOHMH physician may coordinate interfacility transfers of PUI or confirmed EVD cases through Telemetry.

**Infectious isolation PPE**

Complete protection for EVD requires that 1) all providers undergo training that involves donning and doffing PPE, and continuously drill in the steps until practice becomes “hard-wired,” 2) no skin is exposed while wearing PPE, and 3) a trained observer (as pictured below) to monitor the donning and doffing. In recognition of the importance of the PPE, the CDC has made recent changes that are being reviewed and implemented. We have focused on the donning and doffing procedures in recent weeks, and are working with our Academy training staff to assure it is compliant with the newest standard.

![PPE Image](image)

The Department is acquiring an ANSI 1671 compliant garment and training providers in their use.

**Treatment**

Currently, all REMAC protocols must be followed. Only a Breath-Actuated Nebulizer (BAN) should be used in suspected EVD patients, if inhaled albuterol is required. Again, providers should be in appropriate isolation PPE whenever making patient contact, and should be particularly careful when performing high risk procedures such as BVM ventilation or intubation.

The current goal of hospital treatment is to balance the patient's fluids and electrolytes, maintain the patient's oxygen status, blood volume, and blood pressure, while also treating any presenting medical complications (e.g., bacterial infections). Dialysis may be needed for kidney failure, and intubation and positive pressure ventilation for pulmonary dysfunction.

In order to minimize body fluid contamination from patients potentially infected with EVD, we are instructing all providers to use ‘Patient Protective Isolation’ when transporting a patient. This basically entails wrapping the patient into a burn sheet. All providers will be receiving training in this in the near future.
Transport

The Fire Department has been informed that six 911-receiving hospitals are capable of safely caring for a patient with EVD. The six designated hospitals for the treatment of EVD are:

- Bellevue H02
- Mount Sinai H13
- NYP Allen Pavilion H16
- Montefiore H29
- North Shore LIJ H35
- North Shore Manhasset H78

The only exception is for those patients for whom DOHMH has requested transport to a specific hospital, as discussed above. Again, this request will be assessed by the Telemetry physician, and ambulances should only divert to a specific hospital when these approvals occur.

For suspected EVD patients, you must give a hospital notification through the EMD notification frequency. Only the patient is to be transported in the ambulance (i.e., no other individuals besides the crew) unless the patient is a minor, in which case parents or guardians may accompany the patient. The patient and provider with the patient should remain in the ambulance until the hospital is prepared to have the patient brought directly into an isolation room. If no hospital personnel are awaiting the patient when the ambulance arrives at the Emergency Department, the driver should enter to notify the triage nurse and ensure appropriate arrangements are made before moving the patient.

Decontamination of personnel and ambulance

All disposable materials should be left at the destination hospital whenever possible. All non-disposable equipment used in the treatment of the patient should be cleaned in accordance with normal procedures (See EMS OGP 125-04 – Infection Control Procedures).

Aggressive hand washing with soap and water as soon as possible is essential in limiting disease transmission. Members should wear full PPE when cleaning non-disposable equipment.

REMEMBER TO PROTECT YOURSELF FROM CONTAMINATION:

- Keep hands away from face
- Limit surfaces touched (similar to crime scene operations)
- Change gloves when torn or heavily contaminated
- Perform hand hygiene
Conclusion

This journal article reviews EVD patient presentation and management, and summarizes our current plans for the EMS management of potential EVD patients here in New York City. As I mentioned at the beginning, the situation has changed and may continue to evolve. We have a confirmed EVD patient here in New York City, and may need to take additional precautions, realizing that these could delay life-saving care to some patients. Our highest priority is to protect all of you, the medical providers on the streets.

In the 1800s when cholera hit New York City, I would presume that New Yorkers had similar concerns to those faced today. I know that to be the case when we faced the swine flu outbreak of 2009. It is okay to remain a little spooked about the disease if you can channel that fear into being incredibly meticulous about infection control. Our EMS system is one of the best in the world, and we will continue to do our best to help those in need.

References:

http://www.cdc.gov/vhf/ebola/
http://www.cdc.gov/vhf/ebola/hcp/case-definition.html
EMS OGP 108-15 – Aeroeclipse II Breath Actuated Nebulizer
EMS OGP 109-13 – Hospital Notifications Frequency
EMS OGP 125-04 – Infection Control Procedures
EMS OGP 125-09 – Respiratory Protection Program
MAD 2010-02 – Aeroeclipse II Breath Actuated Nebulizer
NYS DOH Policy Statement 03-11, Respiratory Disease Precautions

Written by: DR. BRADLEY KAUFMAN, First Deputy Medical Director, FDNY EMS
            Lt. Joan Hillgardner, FDNY EMS
            Capt. Matthew Lindner, FDNY EMS

CME JOURNAL 2014 QUIZ J10-11: EBOLA

All 11 questions for ALS and BLS Providers

1. Ebola is a:
   a. Bacteria
   b. Virus
   c. Parasite
   d. Chemical agent

2. Ebola can be transmitted
   a. Via airborne route
   b. By needlestick
   c. By contact with an asymptomatic patient
   d. Through PPE

3. Which of the following is not a typical symptom for a patient with EVD?
   a. Hematuria
   b. Fever
   c. Diarrhea
   d. Facial droop

4. PUI stands for
a. Person under the influence
b. Person under investigation
c. Potential underestimated infection
d. Pickup Using Isolation

5. In order for a patient to be determined Ebola–free they must be asymptomatic for:
   a. 7 days
   b. 14 days
c. 21 days
d. 24 days

6. If a patient returned from Liberia one week ago and now has symptoms consistent with EVD, he should be transported to one of the NY State DOH designated receiving facilities at the direction of the OLMC physician.
   a. True
   b. False

7. A passenger arrives at JFK International Airport from Liberia and the person is cleared of possible infectious disease by the CDC staff at the airport. The passengers who traveled on the same plane during the flight have had which level of exposure risk:
   a. High risk exposure
   b. Low risk exposure
c. No known exposure
d. Close contact exposure

8. Calls through 9-1-1 that are screened by ARDs in Emergency Medical Dispatch are assigned the suffix FT if the caller states that the patient has had recent travel to which three countries:
   a. Nigeria, Senegal, Liberia
   b. Zimbabwe, Kenya, Nigeria
c. Spain, Nigeria, Senegal
d. Sierra Leone, Guinea, Liberia

9. Asymptomatic patients:
   a. can transmit Ebola if became infected within the past week
   b. can transmit Ebola if living in a shelter
c. can transmit Ebola if not on antibiotics
d. are unable to transmit Ebola virus

10. Certain travelers are being screened for EVD at JFK Airport. Which agency is responsible for contacting FDNY Telemetry to request the transport of a potential patient to Bellevue Hospital?
    a. DOHMH
    b. OEM
c. NYPD
d. CDC

11. Have you completed Department training on EVD response? (For Voluntary Hospital providers, have you received specific training on EVD response?)
    a. Yes
    b. No
Based on the CME article, place your answers to the quiz on this answer sheet. Respondents with a minimum grade of 80% will receive 1 hour of Online/Journal CME.

Please submit this page only once, by one of the following methods:

- FAX to 718-999-0119 or
- MAIL to FDNY OMA, 9 MetroTech Center 4th flr, Brooklyn, NY 11201

Contact the Journal CME Coordinator at 718-999-2790:

- three months before REMAC expiration for a report of your CME hours.
- for all other inquiries.

Monthly receipts are not issued. You are strongly advised to keep a copy for your records.

Note: if your information is illegible, incorrect or omitted you will not receive CME credit.

Check one: EMT Paramedic other

Name ________________________________

NY State / REMAC # or “n/a” (not applicable)

Work Location ________________________________

Phone number ________________________________

Email address ________________________________

Submit answer sheet by the last day of December 2014

October – November 2014 CME Quiz

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11. 

Questions 1-11 for all providers
# Citywide CME

*Sessions are subject to change without notice. Please confirm through the listed contact.*

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<th>Boro</th>
<th>Facility</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
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<tr>
<td>BK</td>
<td>Kingsbrook</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>ED Conference Room</td>
<td>Dr Hew</td>
<td>718-363-6644</td>
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<td></td>
<td>LICH</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Avram Conference Rooms</td>
<td>Dr Brandler</td>
<td>Aaron Scharf 718-780-1859</td>
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<tr>
<td></td>
<td>Lutheran</td>
<td>4th Wed</td>
<td>1730-1930</td>
<td>Call Review RSVP →</td>
<td>Contact for location →</td>
<td>Dr Chitnis</td>
<td>Dale Garcia 718-630-7230 <a href="mailto:dgarcia@lmcmc.com">dgarcia@lmcmc.com</a></td>
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<tr>
<td>MN</td>
<td>Mt Sinai Hosp</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Contact for location →</td>
<td>TBA</td>
<td><a href="mailto:eunice.wright@mountsinai.org">eunice.wright@mountsinai.org</a></td>
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<td></td>
<td>NY Presbyterian</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: RSVP →</td>
<td>Weill Cornell Campus TBA</td>
<td>Dr Williams</td>
<td><a href="mailto:ssamuels@nyp.org">ssamuels@nyp.org</a> Ana Douis 212-746-0885 x2</td>
</tr>
<tr>
<td></td>
<td>NYU School of Medicine</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Schwartz Lecture Hall 401 E 30 Street</td>
<td>TBA</td>
<td>Jessica Kovac 212-263-3293</td>
</tr>
<tr>
<td>QN</td>
<td>Elmhurst Hosp</td>
<td>1st Wed</td>
<td>1300-1400</td>
<td>Call Review: Trauma Rounds</td>
<td>A1-22 Auditorium</td>
<td>TBA</td>
<td>Anju Galer, RN 718-334-5724 <a href="mailto:galera@nychhc.org">galera@nychhc.org</a></td>
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<td>Flushing Hosp</td>
<td>TBA</td>
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<td>Call Review RSVP →</td>
<td>Contact for location →</td>
<td>Dr Crupi</td>
<td><a href="mailto:kortiz@jhmc.org">kortiz@jhmc.org</a></td>
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<td></td>
<td>Mt Sinai Qns</td>
<td>last Tues</td>
<td>1800-2100</td>
<td>Lecture or Call Review</td>
<td>25-10 30 Ave, conf room</td>
<td>Dr Dean</td>
<td>Donna Smith-Jordan 718-267-4390</td>
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<tr>
<td></td>
<td>NYH Queens</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>East bldg, courtyard flr</td>
<td>Dr Sample</td>
<td>Mary Ellen Zimmermann RN 718-670-2929</td>
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<tr>
<td></td>
<td>Queens Hosp</td>
<td>2nd Thurs</td>
<td>1615-1815</td>
<td>Call Review</td>
<td>Emergency Dept</td>
<td>TBA</td>
<td>718-883-3070</td>
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<td>St John’s Episcopal</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Board Room</td>
<td>TBA</td>
<td>Judith Brown 718-869-7223 <a href="mailto:jbrown@elis.org">jbrown@elis.org</a></td>
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<tr>
<td>SI</td>
<td>RUMC</td>
<td>TBA</td>
<td>1400</td>
<td>TBA: contact to inquire →</td>
<td>MLB conf room</td>
<td>TBA</td>
<td>William Amaniera 718-818-1364</td>
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<tr>
<td></td>
<td>SIUH North</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Regina McGinn Center 475 Seaview Ave</td>
<td>TBA</td>
<td>Andrea Kleboe 718-226-7878</td>
</tr>
<tr>
<td></td>
<td>SIUH South</td>
<td>---</td>
<td>---</td>
<td>Online CME</td>
<td>---</td>
<td>Dr Barbara</td>
<td><a href="http://www.statenislandem.com">www.statenislandem.com</a></td>
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### 2014-2015 NYC REMAC Examination Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>Registration Deadline</th>
<th>Refresher exams(^1)</th>
<th>Basic exams(^2)</th>
<th>NYS/DOH Written(^3)</th>
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<tr>
<td></td>
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<tr>
<td>December</td>
<td>12/1/14</td>
<td>12/08 @18:00</td>
<td>12/15 @18:00</td>
<td>12/18/14</td>
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<tr>
<td>January</td>
<td>1/1/15</td>
<td>1/12 @18:00</td>
<td>1/14 @18:00</td>
<td>1/15/15</td>
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<tr>
<td>February</td>
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<td>2/18 @10:00</td>
<td>2/11 @18:00</td>
<td>2/19/15</td>
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<tr>
<td>March</td>
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<td>3/16 @18:00</td>
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<td>May</td>
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<td>5/13 @18:00</td>
<td>5/21/15</td>
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<td>June</td>
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<td>July</td>
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<td>August</td>
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<td>9/14 @18:00</td>
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<td>November</td>
<td>11/1/15</td>
<td>11/18 @10:00</td>
<td>11/16 @18:00</td>
<td>11/19/15</td>
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</table>

\(^1\) REMAC Refresher examination is offered for paramedics who meet CME requirements and whose REMAC certifications are either current or expired less than 30 days. To enroll, go to the REGISTER link under “News & Announcements” at nycremsco.org before the registration deadline above. Candidates may attend an exam no more than 6 months prior to expiration.

\(^2\) REMAC Basic examination is for initial certification, or inadequate CME, or certifications expired more than 30 days. Seating is limited. Registrations must be postmarked by the deadline above. Exam fee by $100 money order to NYC REMSCO is required. All Basic candidates must meet new education requirements. Email Christopher.Swanson@fdny.nyc.gov for instructions.

\(^3\) NYS/DOH exam dates are listed for information purposes only. Scheduling is through your paramedic program or contact NYS DOH for more information.