VOICE

April—June 2012

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

www.IEMSA.net

IEMSA | A VOICE FOR POSITIVE CHANGE IN IOWA EMS

VOICE

Vol. 2012-02, April—June 2012

The Voice Newsletter is published quarterly by:

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION
8515 Douglas Avenue, Suite 27B ✱ Urbandale, IA 50322

2012 IEMSA Board Meetings

May—No Meeting

June 21, 2012
WDM EMS Station 19 1:00—3:00 pm

July—No Meeting

Aug., 16, 2012
WDM EMS Station 19 1:00—3:00 pm

Sept. 20, 2012
WDM EMS Station 19 1:00—3:00 pm

Oct. 18, 2012
WDM EMS Station 19 1:00—3:00 pm

November 8, 2012
Annual Meeting 6:30—8:00 pm
Annual Conference, Vets Auditorium

December 15, 2011
WDM EMS Station 19 1:00—3:00 pm

2012 IEMSA Board of Directors

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Curtis Hopper, Lee Ridge, Rick Morgan

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Jerry Ewers, Brad Buck, Brandon Smith

Education
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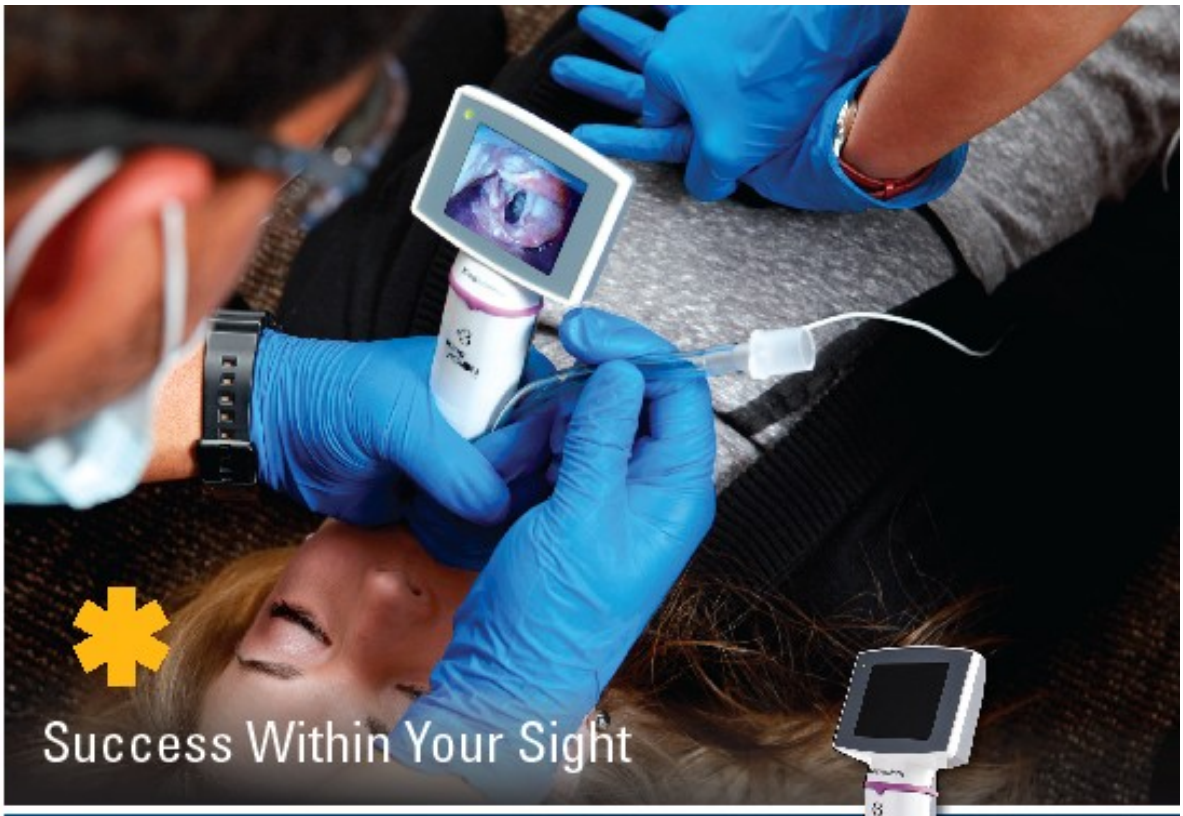
✱

Making Precious Minutes Count™



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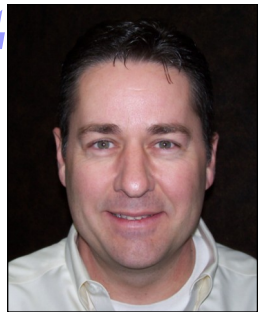
A Message from the President



Jerry Ewers, Fire Chief, EMT-PS
IEMSA President, Board of Directors

PREPAREDNESS IS THE KEY

Last year's "Message from the President" began with me saying how much I loved living in Iowa, complete with the beauty of our annual seasonal changes. Although I still love living in Iowa, it's important to note that our mild winter has meteorologists predicting higher than normal severe weather encounters in the Midwest this year. This means that the possibility of flash flooding, flooding, severe thunderstorms, straight-line winds and tornadoes should be on our radar since the likelihood of these events occurring in our hometowns and response areas are heightened this year.

What comes to mind when you hear Parkersburg, Mapleton, or Joplin, Missouri? Did you know that according to the Tornado History Project that from 1950 through 2011 Iowa has had 2,263 tornadoes, 2,249 injuries, and 84 fatalities? Did you know that Iowa ranks number 6 for frequency of tornadoes in Tornado Alley? Did you know that a catastrophic weather event will tax your people, equipment, and resources? Did you know that the event may last hours, days, or months? As an organization, even as an individual, the key is to be prepared by being proactive instead of reactive.

The National Incident Management System (NIMS) defines preparedness as "a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response." When was the last time you worked together with your local emergency manager, hospitals, Red Cross, designated shelters, and other emergency service providers in your area and surrounding communities on table top exercises and disaster drills? When was the last time you practiced or trained on triage, fully expanded the Incident Command System, practiced your communication plan on how you'll communicate with other services and providers, dealt with the special needs populations, or worked with public works or street departments on plans for clearing streets so you can actually drive through them to reach the scene? There are many other subcomponents that need to be covered, but I just wanted to bring up a few to get you thinking; are you truly prepared to respond to a catastrophic weather event efficiently and effectively?

According to FEMA, the four phases of emergency management are mitigation, preparedness, response, and recovery. As for me, I can be honest and tell you that I've trained over the years to deal with emergency management, but as an emergency responder we tend to focus more on the response phase than the others. In case you're wondering, yes I'm guilty of this also. But, this all changed on Friday, June 1, 2007 when over the lunch hour while I was working as an Assistant Fire Chief the tornado sirens activated. Fruitland and Muscatine were hit by an F2 tornado that leveled houses, knocked down trees and power lines, flipped over vehicles and semis, and caused structure fires to name a few. We all know these happen and some have experienced this first hand much worse than Fruitland and Muscatine, but my point is to be ready so you aren't caught off guard. I know many have plans and policies in place for these types of events, but how many are sitting on shelves collecting dust? Do those policies and plans replicate what you really do in the field? When was the last time they were reviewed or implemented in a tabletop or field exercise?

I just wanted to mention that while I was struggling to find a topic to write about for this publication the light bulb went off and I came up with the topic of being prepared for weather emergencies. For me personally, the hardest part of writing these articles is coming up with a topic that would be meaningful to a broad range of readers. Once I know the topic the writing part comes easier. I was going to write about EMS Week, but since I did that last year I thought I would do something different. Now I'm not kidding when I tell you that I'm sitting at home on a Saturday (April 14, 2012) night in front of the laptop because this article is due on Monday and the outdoor tornado sirens activate in Muscatine. I don't want to give you the impression that I'm a procrastinator, but I was out of town last week and needed to stay home over the weekend in order to meet my deadline. Okay, I was able to squeeze in a little fishing in between the rain, but I was able to meet the deadline for our "Voice" Committee. My gut is telling me that I must have picked an appropriate article to write about because the next morning I read about the severe weather events in the Midwest and all of the tornadoes that touched down and caused havoc, such as the one in Creston, Iowa that affected the local hospital.

My goal for writing this is just to remind everyone that we are not untouchable against Mother Nature and the moral of the story is simple, preparedness will be the key to dealing successfully with any type of weather related event. Our communities look to us to be ready in the event of any public safety emergency, and I hope that I sparked some interest, thoughts, or ideas that you can bring back to your service to either train on, discuss, or prepare for how you'll deal with an emergency of this level in your community.

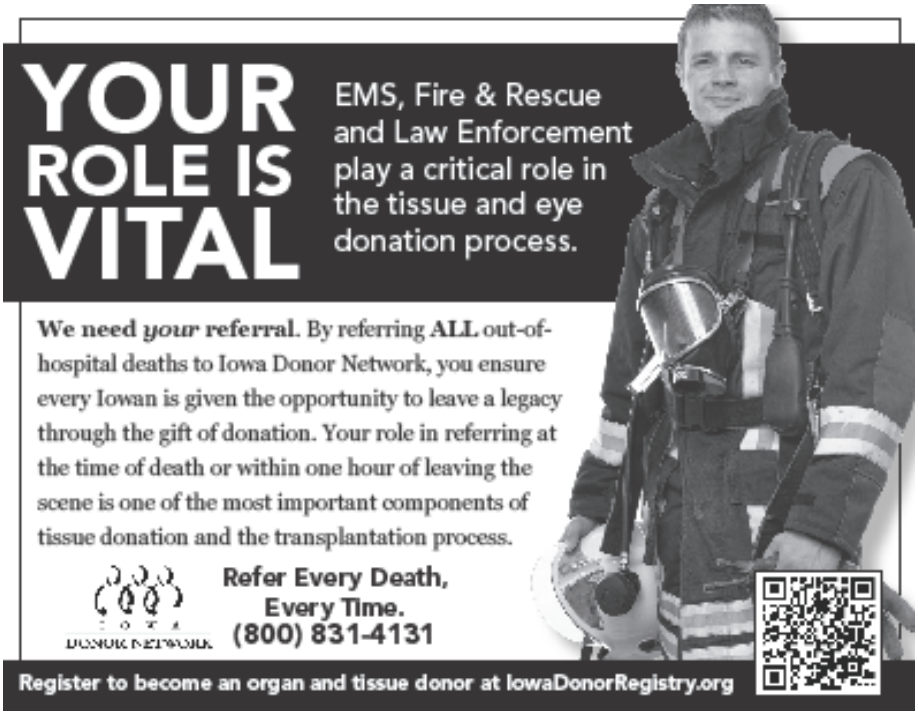
As stated in my first article as your new President, I personally welcome your input and guidance during my time as President. Please tell us what we are doing well and what we can improve upon. Again, this is YOUR organization.

Please check out IEMSA's website for upcoming programs, conferences, and events for 2011. I hope to see all of you at the upcoming EMS memorial.

Stay safe and thanks for all you do!

Gerald P Ewers

Does your department have something special planned for EMS week? Please upload your photos and/or reports from your activities to our Facebook page. Not a member on our FB page? Join today. Search Iowa EMS Association IEMSA for our page.



New World: EMS Field Lytic Therapy for Acute MI

James R. Stone, MD, MBA, CMI, FACS, FCCP, FCCM, FACFE

[Conflict of Interest Statement: The author has no conflict of interest to reveal with any private, commercial, or other healthcare organization or facility]

In 1976 Dr. John West and Dr. Donald Trunkey wrote a landmark paper outlining the results of 100 trauma patients seen at a trauma center versus 100 trauma patients seen at a community hospital. They reported a nearly 33% preventable death rate in the community hospital patients compared to the trauma center. This paper started the American College of Surgeons Committee on Trauma program to establish trauma centers and trauma systems. It was the first time medicine had developed and validated a prescribed set of resources, methodologies, and outcome expectations for a particular diagnosis or set of patients.

The success of trauma systems led to the duplication of the "trauma" principles (i.e. trauma teams, trauma alerts, dedicated resources, etc.) for other medical areas such as stroke, acute coronary syndromes (ACS), pediatrics, and hospital medical emergencies.

The diagnosis of acute MI closely parallels trauma in the sense that good outcomes require a rapid and well organized response. That resulted in chest pain centers, "door to cath lab" time guidelines, and rapid transport protocols.

But is the playing field changing? For EMS it may be. A recent study has suggested that the diagnosis and treatment of an acute MI can be accomplished in the field by EMS (1). Yep, you read it right. For certain acute MI's thrombolytic therapy in the field may be the future. And it may be more advantageous for the patient to bypass the "closest" hospital and be sent directly from the field to the most "appropriate hospital" (i.e. cardiology center with cath lab) during and after treatment in the field (2).

A few EMS organizations across the US have initiated field thrombolytic protocols for acute MI. If the response time is 30 minutes or more, there may be a significant advantage to such a protocol (3). Let's explore a typical protocol and look at evidence-based support.

The diagnosis of acute MI closely parallels trauma in the sense that good outcomes require a rapid and well organized response.

First, let's define and clarify "evidence-based" support. Evidence-based decision making means the majority of the medical literature would support the decision. However, the literature has degrees of validity. As an example, literature that is based on double blinded, randomized studies is more valid that those based on case reports. Recommendations will be graded A, B, C, etc. An "A" recommendation is based on majority of literature which is randomized, double-blinded. A "B" recommendation is based on several studies which are large case series. A "C" recommendation is based on small number of antidotal case reports. A recommendation that carries an "A" is considered more significant than a recommendation that carries a "C" recommendation. When we refer to "evidence-based" we often attach the phrase the "literature would support", but literature with a "C" is on shaky ground as being able to support a recommendation compared to literature with an "A". Just having medical studies that make a recommendation is not by itself valid evidence unless we attach its scale of validity (i.e. A, B, C, etc). So as you read medical literature keep this grading system in mind.

With an understanding of "evidence based", the current thinking is that certain MI's respond to clot-dissolving or thrombolytic drugs. If successful dissolution of the thrombosis occurs coronary blood flow is re-established and myocardium is saved. The result is better long term cardiac tolerance. If the patient is unresponsive to thrombolytics or re-thromboses occurs the patient needs to be at a cardiology center capable of emergent coronary catheterization.

Our process in the emergency department is to immediately obtain an EKG. If it meats criteria (4) and there are no contraindications, then thrombolytics are administered. Several EMS systems have applied this process to field patients. The thinking was that if time is critical then the ability to give thrombolytics as early as possible is only limited by the ability to obtain an EKG and administer thrombolytic drugs. Since we can now obtain 12-lead EKG in the field, transmit it, and have an ex-

pert interpretation, the missing ability would be thrombolytic drugs. And if all of this could occur on the arrival of EMS, it would the earliest and most optimal time for treatment.

Thrombolytic drugs have undergone transition. There are now 4 drugs approved for acute MI (alteplase, reteplase, streptokinase, and tenecteplase). All have the side affect of serious bleeding and, therefore, are contraindicated in patients at risk to bleed (4). Most emergency medical systems use TNKase (tenecteplase). The field application of this drug has some challenging issues.

This is an expensive drug (wholesale cost approximately $3,000). EMS has never dealt with billing an expensive single use item like TNKase. Developing the protocols to guide it's field use was easy; developing a billing process was difficult.

Despite obstacles such as this, Clarinda Regional EMS (Clarinda, Iowa paramedic service) undertook in late 2011 to establish a field lytic protocol for the treatment of acute MI. The cardiology group that services Clarinda is out of Lincoln, NE at Bryon LGH Hospitals. The air transport service is LifeNet out of Omaha. Clarinda Regional EMS currently has 10 paramedic specialist and 28 EMT's (7 of whom are in paramedic training). They use a Zoll E-series 12 lead monitor and transmit directly to the on-call cardiologist. In addition, they can monitor end-tidal CO2, SpO2, and non-invasive blood pressure. To start the development of a protocol, a group representing all the components of the team (EMS, medical direction, cardiology, air transport, and cardiology center) was assembled. An acute MI protocol was written which established the criteria for a STEMI (ST elevation MI) and the process for transmission and interpretation by cardiology. That was followed by a lytic protocol which outlined the process to follow to administer the drug once the cardiologist ordered it. The protocols also included a checklist of the contraindications to lytic therapy and the possible complications of lytic therapy as well as the dyrthmias which may occur with reperfusion of the coronary arteries.

If the patient has met all the criteria and the TNKase is administered, the EMS crew makes direct contact with LifeNet dispatch and they designate a rendezvous LZ (landing zone) to meet the aircraft. Three rendezvous LZ's were predetermined between Clarinda and Lincoln to facilitate the rendezvous. Once the EMS crew has advised LifeNet dispatch of the closest LZ, the EMS crew goes directly to that LZ without stopping at an emergency room or hospital. The anticipation is that the EMS crew and helicopter will arrive at the LZ with little or no waiting time. The patient is then transferred to the air crew and flown directly to Lincoln, NE and the cardiologist on-call. When the patient arrives the on-call cardiologist will have the initial field EKG and any subsequent EKG's, the initial findings of the EMS crew, the results of the TNKase treatment, and the air crew progress report.

With Clarinda's geographic position and distance from cardiology (Lincoln), it is anticipated that a patient suffering chest pain and having an acute STEMI will save 30-60 minutes from the arrival of the EMS crew until he is under the care of a cardiologist (and potentially in the cath lab). In addition the patient will have treatment for the STEMI within 20-30 minutes of the arrival of an EMS unit.

Admittedly, this type of field treatment is forward thinking and has some unique challenges not commonly encountered by EMS. But if the "patient comes first" this is the very type of treatment that may positively impact patient care by advanced and timely field intervention. Will this prove beneficial in "door to cath time" and "myocardium saved? Time will tell. We will provide an update in a year. One thing for sure: it is a new world. And where is EMS going to be in that new world

...if the "patient comes first" this is the very type of treatment that may positively impact patient care ...

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Estevez-Loureiro R, Calvino-Santos R, et al, Direct transfer of ST-elevation myocardial infarction patients for primary percutaneous coronary intervention from short and long transfer distances decreases temporal delays and improves short-term prognosis: the PROGALIAM Registry, EuroIntervention, 2010, Aug; 6(3): 343-9

Pedersen SH, Galatius S, et al, Field triage reduces treatment delay and improves long-term clinical outcome in patients with acute ST-segment elevation myocardial infarction treated with primary percutaneous coronary intervention, J Am Coll Cardiol, 2009, Dec 8; 54(24): 2296-302

Clarinda Regional EMS (Clarinda, Iowa) Protocols, Bureau of Emergency Medical Services, Iowa Department of Public Health, July, 2010

Complete quiz on the next page and submit by deadline for 1 optional CEH.

Field Lytic in Acute MI

1. Trauma systems represent the first time organized medicine has:
A. Described a payer system
B. Mandated levels of care
C. prescribed resources, methodologies, and outcome expectations
D. none of the above

2. Emergent patient care systems depend on:
A. Appropriate consultants
B. EMS
C. Emergency departments
D. Rapid and organized response

3. A patient with an acute STEMI who is 40 minutes from the nearest hospital:
A. May benefit from field thrombolytic therapy
B. Should be air lifted to the hospital
C. Should have the 12-lead EKG sent to the nearest hospital
D. Should have on-line medical control

4. TKNase is an approved drug for coronary thrombolytic therapy and is expensive.
A. True
B. False

5. You arrive at a 53 year old male who complaining of crushing sub-sternal chest pain. He has diaphoresis and nausea. He states he had a motor vehicle accident and a subdural hematoma 3 weeks ago. He has:
A. No bleeding risk and can have thrombolytic therapy
B. Some minor bleeding risk but could have thrombolytic therapy
C. Significant bleeding risk and thrombolytic therapy is contraindicated
D. None of the above

6. A 60 year old female is having an acute STEMI and is given TNKase as ordered by the cardiologist. After 10 minutes she develops SVT with short runs of VT. All respond to drug therapy. It is likely this patient had:
A. Re-thrombosis
B. Reperfusion arrhythmias
C. Pulmonary embolism
D. Hypoxia

7. Which is the best evidenced-based support:
A. Isolated case reports
B. Large case series
C. Large randomized trial
D. Large double-blinded, randomized trial

8. As a paramedic your acute STEMI patient says he wants to go to his usual critical access hospital which is 13 minutes away. You have already administered TNKase and set-up a rendez-vous with the helicopter for direct transfer to the cardiac center (which is 25 minutes away from your scene location)
A. You should take the patient to his critical access hospital
B. Call medical control for direction
C. Continue to the rendez vous point and call medical control for confirmation
D. None of the above

9. Many EMS services are providing field lytic therapy for acute MI.
A. True
B. False

10. 12-lead EKG transmission to a hospital or physician is:
A. Difficult
B. Unreadable
C. Dependent on the patient
D. Available by many services

IEMSA CONTINUING EDUCATION
Answer Form

(Please print legibly)

Name _____

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IEMSA members completing this informal continuing education activity should complete all questions 1 through 10, and achieve at least an 80% score in order to receive the 1 hour (1CEH) of optional continuing education. ***Deadline: June 30, 2012***

Mail completed form via mail, email or fax to:

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administration@iemsa.net Fax: 515.225.9080

Check which box is the correct answer				
1	A ☐	B ☐	C ☐	D ☐
2	A ☐	B ☐	C ☐	D ☐
3	A ☐	B ☐	C ☐	D ☐
4	A ☐	B ☐		
5	A ☐	B ☐	C ☐	D ☐
6	A ☐	B ☐	C ☐	D ☐
7	A ☐	B ☐	C ☐	D ☐
8	A ☐	B ☐	C ☐	D ☐
9	A ☐	B ☐		
10	A ☐	B ☐	C ☐	D ☐

Leadership Academy Sept. 29-30

Mark your calendars and start planning for the Leadership Academy to be held Sept. 29 and 30th in West Des Moines, Station #19. IEMSA is offering this program that will focus on strengthening Iowa's public safety leaders, whether career or volunteer, by providing tools to better run their organizations. The intended audience for the Leadership Academy is anyone either currently serving in or interested in obtaining a management position in the Fire, EMS, Police or Dispatch services. We will attempt to enroll a balance of volunteer and career providers from various public safety disciplines. **Registration Fees, which** includes tuition, breaks and lunch each day will be $250 for Affiliate Members, and $350 for non-members.

Jon Politis, MPA, NREMT-P, will be returning to lead the academy. Jon is an engaging speaker and educator who has presented at many State and National conferences across the US and Canada. Starting in emergency services in 1971, he has served in many capacities: Firefighter, Ski Patroller, Field Paramedic, Paramedic Program Coordinator, State EMS Training Coordinator and EMS Chief. He has served on the Board of Directors of the National Registry of EMTs, Committee on Accreditation for the EMS Professions and numerous national EMS curriculum projects. He holds a BA degree from Castleton State College,VT and a Masters Degree in Public Administration from Marist College, Pougkeepsie, NY. Jon is passionate about the outdoors and is an avid mountaineer, technical climber, cyclist and telemark skier. He also volunteers with the Jenny Lake Rangers for a few weeks a year in Grand Teton National Park. Jon stays active as a paramedic, flight paramedic, rescue instructor, and ski patroller. He lives in Latham, NY and has served as the Chief of the Town of Colonie EMS Department since 1989. In 1999 Colonie EMS was recognized as the NAEMT National Paramedic Service of the Year.

E-News

All IEMSA members should be receiving the weekly E-News from IEMSA. The E-News keeps you up-to-date on current events, important legislative activities, and more. If you are an IEMSA member and you aren't receiving the E-News, please send an email to our Office Manager, Tammi, at Administration@iemsa.net.

BY ANITA J. BAILEY, PS

What's New with the Bureau

EMS Advisory Council (EMSAC) News

Mariannette Miller-Meeks, B.S.N., M.Ed., M.D., Director of the Iowa Department of Public Health (IDPH), recently appointed Jason C. Griffin of Wapello and Traci Smith of Brooklyn to serve on EMSAC. These new members will serve as At-Large Volunteer EMS Providers through June 2015. The appointments bring the number of EMSAC members to twenty. The primary function of EMSAC is to advise the director and develop policy recommendations concerning the regulation, administration and coordination of EMS. The list of members is available at www.idph.state.ia.us/ems > Bureau > EMS Advisory Committee & Councils > EMS Advisory Council – Membership. Welcome Jason and Traci!

At the April 11, 2012 meeting, EMSAC voted unanimously to write a letter of support for the IDPH submission of the competitive Center for Disease Control Paul Coverdell National Acute Stroke Registry grant. If funded, the program activities will work to improve:

- the quality of emergency medical services for acute stroke,
- the quality of handoff from EMS to hospitals,
- the quality of acute stroke care in hospitals, and
- the transition from hospital to home or rehabilitation and from stroke specialist care to primary care provider.

The purpose of the program is to support and strengthen state health departments' heart disease and stroke prevention programs to develop stroke systems of care that span the continuum of care.

Transition:
During renewal of their certification by March 31, 2012; 36% of the 3,396-eligible EMT-B's transitioned to the EMT level during this first opportunity. Of the 1,000 eligible Paramedic Specialists, 48% transitioned to the new Paramedic level.

Jeff Messerole presented well-researched evidence to the Quality Assurance Standards and Protocols (QASP) subcommittee of EMSAC regarding the use of Continuous Positive Airway Pressure (CPAP). Twenty-eight states include CPAP within the EMT Scope of Practice. The National Association of EMS Physicians released a position Statement in December of 2010 supporting rigorous quality improvement activities in agencies that implement CPAP. QASP recommended and EMSAC voted to recommend that the IDPH modify the Iowa EMS Scope of Practice to include CPAP for the EMT and AEMT level with physician medical director approval and documented training. Following Director Miller-Meeks approval, changes to the Iowa Administrative Code can be expected to take a minimum of six months.

Protocol Workgroup

The January 2012 Iowa EMS Adult & Pediatric Protocols are posted at www.idph.state.ia.us/ems > Services > Protocols. The Protocol Workgroup continues to develop consistent language and formatting throughout the protocols and set priorities to focus the work to meet timelines. They even discussed posting updates every other year. "We can always develop a process for posting protocols that show an immediate benefit to patients. Following the considerable format revisions in 2011, it is obvious that we need to step-back and prioritize updates." said Dr. Forslund. Priorities for the 2013 revisions include adding cardiac arrest, including post-resuscitation care and shock protocols. The group plans to meet in Des Moines on July 10, 1:00-5:00 pm. All EMS providers are welcome to attend. Contact Joe Ferrell for more information at joseph.ferrell@idph.iowa.gov

EMS Week 2012

The American College of Emergency Physicians has selected May 20 – 26th, 2012 as National EMS Week. The theme is ***"EMS: More Than A Job. A Calling."*** Wednesday May 23 has been designated EMS for Children Day. EMS Week brings together local communities and medical personnel to publicize safety and honor the dedication of those who provide the day-to-day lifesaving services of medicine's "front line." A planning packet is available at emsweek@acep.org.

Protocol Workgroup
Back Row L-R: Jim Steffen, Kerrie Hull, Jason Griffin, Jeff Messerole
Front Row L-R: Brian Rechkemmer, Dave Hunt, Joe Ferrell, Dr. Forslund

We are pleased to announce that Lt. Gov. Kim Reynolds will honor Iowa's EMS community by signing an EMS Week Proclamation. You are invited to attend the celebration at Brooklyn, IA on May 22 at 10:00 am. Stay tuned for details…

…and finally,

We salute Donas Charbonneau for her 5-years of representing Iowa's EMS Regions on EMSAC. Donas faithfully attended nearly every meeting and provided thoughtful commentary to discussions. Her quiet and courteous contributions will me missed.

Legislative Success!

Volunteer Tax Credit Passes!

The bill authorizing a $50 tax credit against individual Iowa income taxes was signed by Governor Branstad April 27, 2012. This is a HUGE step for EMS in Iowa. Special thanks to our IEMSA Lobbyist, Mike Triplett, and Legislative Committee Chair Thomas Craighton and all who helped make this a reality.

AFFILIATE PROFILE | Essex Fire & EMS

This quarter IEMSA is featuring the volunteer fire-based EMS department in Essex, an active town of about 800 people in Page County in southwest Iowa. Roger Looker is the EMS Supervisor on the department which includes 6 paramedics, 1 EMT-I, and 7 EMT's. Firefighters respond with EMS on each 911 call answered and the department ran over 100 911 calls last year.

Essex EMS has two ambulances equipped to provide care at the Critical Care Paramedic level, including LP12s with EKG and waveform capnography, CPAP, IV pumps, transport ventilators, and other essential equipment. They also utilize power cots and have on-board laptops. Medication refrigerators are in their near future. Progressive? You bet. In fact you could say they have been leaders in progressiveness, becoming what they believe was the first non-transport paramedic service in Iowa back in 1990, and one of the first volunteer services to offer CCP level care years later.

"...what's really unique about the Essex department.... In addition to those 100+ 911 calls, they also did 237 hospital to hospital transfers last year."

Some people may be wondering why or how a small town volunteer service manages to have such a status. That question brings us to what's really unique about the Essex department. In addition to those 100+ 911 calls, they also did 237 hospital to hospital transfers last year. While there is no hospital in Essex, they are situated within 10-50 miles of several towns that do have hospitals—Shenendoah, Clarinda, Red Oak, Corning, and Hamburg—and are frequently called for their transfer services.

IEMSA is pleased to recognize the Essex crew for their dedication and hard work in becoming a department that provides not only an essential service for their community, but also their important role in the interfacility care they provide to the patients from their extended area.

Essex EMS Crew: Front L-R Beckie Jones, Saundra Marion, Becki Franks, Lisa Royer, Sam Jones, Todd Franks.
Back L-R Jim Marion, Roger Looker, Jon Rupp, Rod Riley, Chris Bradfield, Al Thornburg. Not pictured: Tim Bowers, Misty Ott

2012 Conference Preview

The 2012 IEMSA Conference and Tradeshow will be one you won't want to miss!

For instructors, the NEMSE Instructor I class will be offered. This is a 3 day course. Last year's Instructor II class received rave reviews, and the Instructor I class is expected to be as popular.

National Speakers that will be presenting include Bill Justice, Dwight Polk, Mike Grill, Kirk Mittleman, Margaret Mittleman, and Scott Bolletor. You've let us know in the past that you enjoy these speakers, and they're coming back.

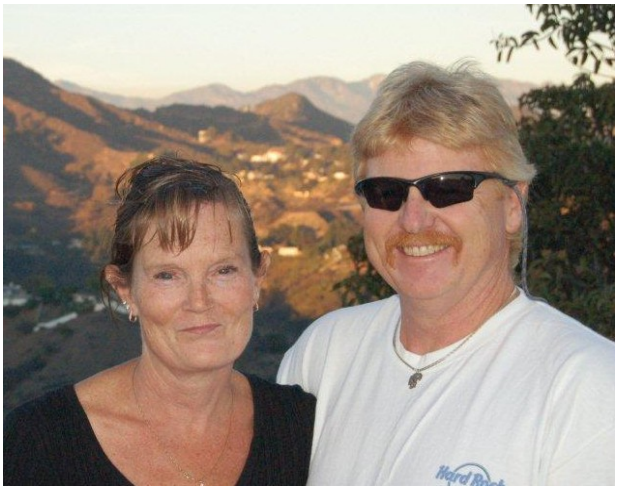
Dwight Polk

Local favorites include Rosie Adam, Jamie Temple, Rick SyWassink, Amy Franken, Dr. Lamasters, Sarah Seehasse, and others.

The preconference schedule includes the Medical Director Workshop, Service Director Workshop, Critical Care Paramedic track, and a new track for Supervisors, Training Officers and Preceptors. There's something for all to benefit from on Thursday.

On Friday, IEMSA is offering for the first time a hands-on cadaver lab! You will definitely want to register early for this if you're interested, as space will be limited and we expect interest to be high.

We will be offering a General Track, Basic Track, and Advanced Track Friday and Saturday, with a wide range of topics, from ACLS for Basics or OB Emergencies, to My Achy Breaky Heart or Capnography. Many of the classes will satisfy transition requirements for the different levels of EMS scope.



Margaret & Kirk Mittleman

Change in Venue

Don't forget, with the renovation of Vet's Auditorium and sale of the convention complex, the location of the conference will be new this year.

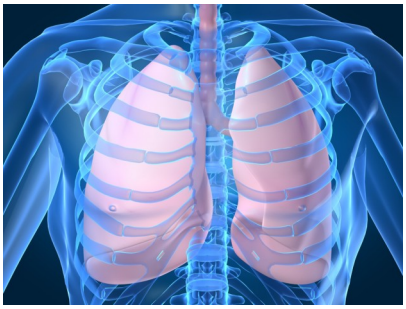
The IEMSA Board visited our new venue in January and are excited about being in the renovated Vets Auditorium, now known as the Community Choice Credit Union Conference Center, a part of the Iowa Events Center.

The Conference Center allows for more flexibility in set-up, has space to seat all conference attendees at the same time for lunch, and will provide more space for our vendor hall, which we expect will be bigger than ever this year! All of our classes and entertainment will be in the same building.

Keep watching the E-News, information on our Website (www.iemsa.net) and watch for the next Voice and conference brochure for all of the details.

In the meantime, put Nov. 8-10, 2012 on your calendar and plan to attend the annual conference and tradeshow.

Medical Director's Protocol Review: Asthma
Dr. Forslund



Asthma Protocol: Indications
The asthma protocol is indicated when a person has difficulty breathing, wheezing, or reduced air movement and they either have a history of asthma or symptoms suggest asthma. One thing to remember is that just because a patient has wheezing does not mean it is asthma. Congestive heart failure can cause wheezing, for example, and should be considered as a possible diagnosis.

Overview
Asthma is a disease that is characterized by hyper-responsiveness of the airways that may result bronchospasm (spasms or prolonged contractions of the bronchial smooth muscle).
A common cause of asthma attacks in sensitive individuals are allergens. Allergens can include pet dander, dust mites, molds, pollens or cockroach allergens. Other triggers for asthma attacks can be respiratory infections, exercise, cold air, tobacco smoke and other pollutants, stress, food, or drug allergies can also trigger asthma symptoms. Aspirin and other non-steroidal anti-inflammatory medications (NSAIDs) can also provoke asthma in some patients. Asthma attacks can last for minutes to days and can become if the airflow becomes severely restricted.

Patient Assessment: History
Here are the important items to ask when obtaining the history from a patient with an asthma attack. First determine onset and duration of the symptoms. Was there something that seemed to trigger the symptoms? How quickly have the symptoms progressed? What treatment has been given and what was the response to treatment, Has the patient done any home monitoring of lung function such as a peak flow meter. If not what is the patient's subjective assessment of the attack. Have they had this much trouble before?

Patient Assessment: Exam
Observe for the following findings
General Appearance: tripod positioning, purse-lipped breathing,severity of the distress
Skin: cool, moist and pale, warm, dry and flushed, urticaria cyanosis
Respiratory Effort: use of accessory muscles, any signs of fatigue, using two-word sentences?
Lung Sounds: wheezes, rales, rhonchi or stridor, decreased lung sounds, prolonged expiratory phase, absence of wheezing
Heart Sounds: rate and regularity
Lower Extremities: any pitting edema
Neuro: lethargy or somnolence

Patient treatment:
Follow your general patient care protocol and your scope of practice. Address any life threatening problems immediately.
The goal of therapy is to improve oxygenation and ventilation and to reduce the patient's distress and the work of breathing.
Make sure that oxygenation is maintained and reduce bronchospasm by using oxygen and a bronchodialator.

BASIC CARE GUIDELINES
a) If patient has a physician prescribed hand-held metered dose inhaler:
Assist patient in administering a single dose if they have not done so already.
Reassess patient and assist with second dose if necessary per medical direction

ADVANCED CARE GUIDELINES
b) Administer albuterol 2.5 mg via nebulizer
c) Evaluate the need for epinephrine 1:1,000 concentration 0.3-0.5 mg IM. d) Evaluate the need for CPAP, if available
e) Evaluate the need for intubation

CQI:
Consider monitoring for these items in your run reports
From the history it is important to note the onset and associated symptoms.
From initial assessment the work and difficulty of breathing and the oxygen sats if you can check them.
From the treatment response to low sats and the initial treatment should be documented
For transport make sure the patient is transported in a timely manner to the appropriate facility.

Hello and Happy Spring!!! NAEMT has had a busy winter and early spring beginning with the election of two new board members last October. Bruce Evans, CO is the newest board member for Region IV. Some of you may know Bruce very well as he hails from Iowa originally! Scott Matin from New Jersey is our new board member for Region I. Both Scott and Bruce bring a wealth of experience to NAEMT in both the management and provider areas. They are terrific additions to the board.

NAEMT also set a new strategic plan for the next 3 years based on a survey of the membership. Advocacy will remain one the highest priorites for NAEMT. The membership also identified the area of social media for NAEMT to become more active in as a means of keeping current with the issues EMS practitioners face every day. In response, NAEMT has established a new committee: The Social Networking committee of which I have been named Chair. There will be much more exciting information concerning this committee coming over the next several months, so stay tuned. If you have any questions, concerns, comments or ideas you'd like to share on Social media, please feel free to contact me or NAEMT with your suggestions.

The NAEMT Advocacy Committee continues to work through legislation as it is introduced in Congress which may have any impact on EMS. The passage of the **Allocation of the D-Block Broadband spectrum to Public Safety is** one of the current victories for EMS at the Federal level. NAEMT's grassroots efforts through the state advocacy coordinators networks played an instrumental role in getting this key piece of legislation passed! NAEMT continues to focus on Medicare reimbursement, PSOB. Additionally, NAEMT in collaboration with other organizations involved with EMS has been busy these past few weeks working on the Drug Shortages Issue. NAEMT has signed on to two letters to Congress outlining how critical this issue has become for EMS and our patients as well as suggestions some possible solutions that will enable manufacturers to resume production on the drugs vital to treating patients.

EMS on the Hill Day took place on March 21, 2012 . Now in its third year, EMS on the Hill brought together 198 EMS practitioners from 42 states and the District of Columbia. These attendees conducted 246 meetings with their U. S. Senators, House of Representatives and their congressional staff. This year's event, again hosted by NAEMT, advocated for legislative priorities including the **Medicare Ambulance Access Preservation Act**, **Public Safety Officers Benefits Improvement Act and HR 3144--The Field EMS Quality, Innovation and Cost-Effectiveness Improvement Act**, which is the long awaited "EMS Field Bill" introduced in October 2011. Additionally, an information packet was left behind with all legislators containing additional information about these three priorities as well asking for support for the **Military Veteran's to Civilian EMS** program. For a listing of the legislation being tracked and NAEMT's level of action on that legislation use the following link http://capwiz.com/naemt/home/.

At EMS Today in March, President Connie Meyer and Gary Wingrove, Center for Leadership, Innovation and Research in EMS launched the **EMS Voluntary Event Notification Tool (E.V.E.N.T)-**a system to report near-miss and line of duty death (LODD) incidents. NAEMT collaborated with the Center for Leadership, Innovation and Research in EMS through the Near Miss Task Force to develop a system to collect and aggregate data that could be analyzed and used to develop policies and procedures and be used in training and education to prevent similar events from occurring in the future. These two online reporting forms are geared to encourage reporting from any individual who has the knowledge of a near-miss event or LODD. These tools are now live at www.emseventreporting.org. The data collected will be provided to state EMS offices and appropriate federal agencies with jurisdiction over EMS on a quarterly and annual basis.

The NAEMT Health and Safety committee continues to work on the development of suggested EMS Fitness guidelines and has partnered with American Council on Exercise (ACE) to begin work on a project to develop EMS Fitness guidelines. ACE will begin by observing the work practices of select EMS services around the country to collect data on the various models of EMS and how the areas of diet, exercise and body mechanics affect the EMS practitioner while on shift. There will be much more to come from this innovative project in the future.

EMS Week is May 20-26 this year and NAEMT is again hosting the National EMS Week Ideas web site, www.emsweekideas.org, sponsored by EMS World, which provides opportunities for EMS practitioners to explore new ways to celebrate and promote their profession. This site presents a wealth of ideas for EMS week activities including tips on using social networking as a professional tool, EMS career options and ways to advance careers in EMS as well as great project ideas for providing community education and increasing public awareness.

Additionally, the National EMS Memorial Bike Ride will again be taking place beginning in Boston, MA on May 19 and ending in Alexandria, VA on May 25. I am honored to be the route/event coordinator for the third year in a row and the participants will be riding to remember 35 individuals from across the nation who have died in the line of duty and those who have passed that have given much their lifetime in service to EMS. There will be an ending ceremony held on May 26, 2012 in Alexandria, VA to honor those who were ridden for throughout the week. This year will be especially poinent for the Muddy Angels as one of our own-Lori Mayfield-Foster, a Paramedic from Reno, NV and a rider for the past two years died suddenly at home in January of this year at the age of 35 immediately following her shift. For more information on the memorial bike ride go to www.muddyangels.org and to see the list of the individuals who will be inducted into the National EMS Memorial "Tree of Life" in Colorado Springs on June 23, 2012, www.nemsms.org

Finally, NAEMT would like their members to be aware of a program that lets EMS practitioners qualify for homes at 50% off, under the Good Neighbor Next Door (GNND) program. HUD offers certain single family properties for sale to EMS practitioners and other public servants at 50% off the list price so they can contribute to community revitalization while becoming homeowners. You must commit to live in the property for 36 months as your sole residence and other requirements do apply. To learn more go to www.hud.gov.

I wish you all a healthy, safe and wonderful Summer!!! If you have any questions, comments or concerns or would like to be more actively involved in the NAEMT organization please contact me at jkscadden@gmail.com.

Best Regards!

Jules

Jules Scadden, PS, NAEMT-Director-at-large

www.naemt.org

Spotlight on Training

WESTERN IOWA TECH COMMUNITY COLLEGE
SIOUX CITY, IA

Western Iowa Tech Community College (WITCC) was organized in August 1966, when the Iowa State Board of Public Instruction accepted a plan submitted by the counties of Ida, Monona, Plymouth and Woodbury to merge for the creation of an Area Vocational- Technical School as provided in Chapter 280A of the Iowa Code.

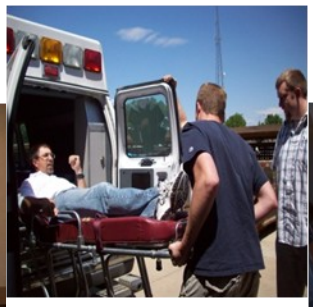
The first classes began on January 27, 1967 and when the fall term began on August 28, 1967, seventeen full-time programs were in operation. WITCC's boundaries were expanded on July 1, 1969, when Crawford County joined Merged Area XII. The boundaries were extended again in April 1971, when Willow Community, Aurelia Community School D istrict, and Cherokee Community School District were added.

In 1973 WITCC received approval to offer liberal arts courses in Denison, and thus was designated as a community college. When the college received permission to offer a two year Associate of Arts degree at the Sioux City campus, the college curriculum became fully comprehensive, serving both full and part time and evening students throughout the six county service area. The college has continued to expand program offerings in all divisions, with the arts and sciences division continuing to represent one of the fastest growing areas of the College.

WITCC offered the first EMT class held in the State of Iowa in March of 1972 at the Ida Grove campus and has offered Paramedic Training programs since 1981. Today the EMS Department provides credit courses in Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) and Paramedic. The EMS Department does continuing education for EMS, is an American Heart Association Training Center for CPR, ACLS, PALS, Pre-hospital Trauma Life Support, and Advanced Medical Life Support.

On March 20th, 2009 The EMS Department received accreditation from the Commission on Accreditation of Allied Health Education Programs for the Paramedic Program and December 14, 2009 became accredited as a National Disaster Life Support Foundation Regional Training Center.

LaDonna Crilly is the EMS Program Director, starting at WITCC in 2006. She has been a nurse since 1973 and came into EMS in 1974 as a volunteer, later becoming an EMT and obtained a Paramedic certification in 1997. She earned her BA from Briar Cliff University in 2011. LaDonna worked at St. Luke's Regional Medical Center in Sioux City for 18 years as a burn nurse/ critical care nurse and in education / St. Luke's School of Nursing before coming to WITCC. The EMS Department has two part time EMS coordinators; Robert Welte, and Randy Ross along with one full time faculty Terry Sudrla. Steve Ebsen is Department Chair of Public Services at Western Iowa Tech. Diana Herbold and Cleo Spence is part-time administrative support staff. The EMS Department has numerous EMS Adjunct Instructors that have many years of experience and work in the EMS field.

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Details on our November 9th Hands-On Cadaver Lab, co-sponsored by Life Flight, will be coming soon. For more information, visit www.iowahealth.org/lifeflight.

LifeFlight

CORPORATE PROFILE | LIFE LINE EMERGENCY VEHICLES

Life Line is a family business that has strived to build the best and the safest ambulances possible since opening its doors twenty six years ago. They build high end custom built ambulances, worth the extra money that is put into it in safety, quality, warranties and customer service. When it comes to setting ambulance standards, Life Line is an active member of the Ambulance Manufacturer Division of the NTEA as well as strongly involved with NFPA 1917. They take their responsibility seriously and use everything they learn to continue an on-going commitment to proven innovation and continuous product improvement. Life Line is proud to be one of the original twelve ambulance manufacturers in the United States to submit vehicles for testing. Life Line continues to be one of the few to offer proprietary aluminum extrusions that add strength, improve stability, and contribute to the quiet comfort of every vehicle they build. They were the first to offer Labyrinth-style door construction, a double aluminum insulated floor and a two-piece aluminum crash rail. Their vehicles are also known for their state of the art TST electrical system. The bottom line of Life Line's quality is an ambulance that performs at a high level for a long time. Greater body integrity pays off in safety, comfort, and convenience. Better engineering, fit and finish reduce wear and lower maintenance costs. Options like their slant side configuration improve aerodynamics and save fuel. All adding up to a lower cost of ownership over the life of every Life Line vehicle.

Dependability, strength and innovation have been built into every Life Line vehicle since 1985

It's not just the design, engineering, and the manufacturing standards used during the production of a Life Line Emergency Vehicle; it's also the people, the dedication of every employee owner that truly reflects the quality of their work.

"The Next Generation of Ambulances Will Follow Our Lead!"

Annual Award Nominations Open

It's not too early to be thinking about nominations you may want to make for the annual IEMSA Awards. The awards are announced at the annual conference for the following categories: Individual EMS Provider of the Year: Volunteer and Career, EMS Service Provider of the Year: Volunteer and Career, Instructor of the Year: Full Time and Part Time, Dispatcher of the Year, Friend of EMS, and Hall of Fame.

EMS Providers give of themselves every day, with little or no recognition of show of appreciation. If you know someone who has given above and beyond, please nominate that person for this prestigious recognition.

NOMINATION FORM

In order to nominate a person or service for one of these awards, you must **1)** complete the Award Nomination Form, **2)** include a letter of recognition/nomination and **3)** submit your nominations to the IEMSA office any time between now and September 18, 2012. Don't miss this opportunity to recognize excellence in EMS!

__Individual EMS Provider - Volunteer
__Individual EMS Provider- Career
__EMS Service-Volunteer
__EMS Service-Career
__Instructor-Full time
__Instructor-Part time
__Dispatcher
__Friend of EMS

Mail to: **IEMSA – Award Nomination**
8515 Douglas Ave., Suite 27B,
Urbandale, IA 50265
Fax: 515-225-9080
administration@iemsa.net

Explain here why this nominee should receive the selected award (or attach your letter of recommendation).

Nominee's Name _____
Company/Service _____
Address _____
City/State/Zip _____
Phone Number _____

Nominator's Name _____
Phone Number _____

Annual EMS Memorial Service May 19 in WDM

IEMSA will host the annual EMS Memorial Service May 19, 2012, at the West Des Moines Public Safety Building (Station #19) to kick off EMS week in a moving ceremony to honor those EMS providers who are no longer with us, and whose names will be engraved on the EMS monument at the event location.

The beautiful monument, pictured on the cover of the Voice, holds the names of EMS providers we have lost. This year, three EMS providers' names will be added to the memorial and honored at the May 19th ceremony: Kelly Schubert, Jesup Ambulance Service; Charles "Jack" Atkinson, Community Ambulance; and Louise Ann Peterson, Adair Ambulance.

Please join us, along with the honorees' families, in paying tribute them.

Featured speakers will be Larry Noble, Commissioner of Public Safety, and a representative from the Bureau of EMS.

Iowa EMS Memorial Service
Sat., May 19
10 a.m.
West Des Moines Station #19
Please come join us in this moving tribute to those we have lost.

The ceremony will include a medical helicopter fly-over.

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION
8515 Douglas Avenue, Suite 27B
Urbandale, IA 50322