

# IEMSA VOICE

A VOICE FOR POSITIVE CHANGE IN IOWA EMS



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2016 EMS MEMORIAL  
CEREMONY HELD  
MAY 14<sup>TH</sup>, 2016



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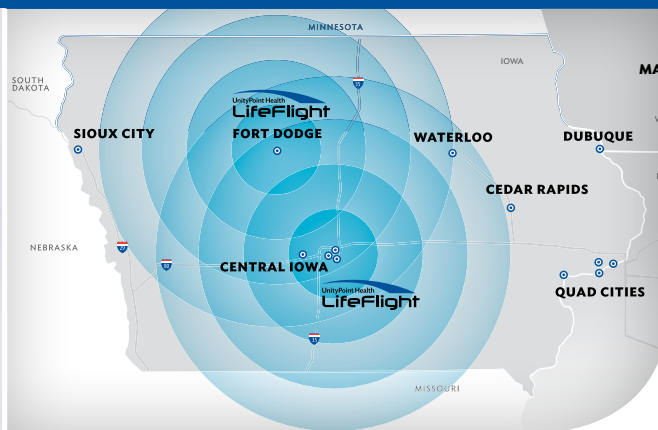
KEYNOTE SPEAKERS &  
PRESENTATIONS REVEALED

IEMSA 2016 ANNUAL CONFERENCE  
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The VOICE is published quarterly by the Iowa EMS Association covering state EMS issues for emergency medical services professionals serving in every capacity across Iowa. Also available to members online.



**Thursday, February 9, 2017**

**STAND UP AND SHOW UP ON THE HILL :**  
OUR OPPORTUNITY FOR EMS  
PROFESSIONALS TO MEET OUR  
LEGISLATORS! MARK YOUR CALENDAR!



**UH-OH! PEDS CONFERENCE:**  
**Sharpening Your Pediatric Skills**

**FEBRUARY 25, 2017-CORALVILLE, IOWA,**  
**FORMAL CES OFFERED. FEATURES**  
**HANDS-ON SKILLS WORKSHOP !**

**OUR PURPOSE :** To provide a voice and promote the highest quality and standards of Iowa's Emergency Medical Services.

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## > BOARD MEETINGS

- > **September 15, 2016**  
WDM City Hall Training Room  
1:00—3:00pm
- > **October 20, 2016**  
WDM Station 19- 1:00—3:00pm
- > **November 10, 2016**  
Iowa Events Center at the  
Annual IEMSA Conference Time: TBD
- > **December 15, 2016**  
Teleconference - 1:00—3:00pm

## > IEMSA OFFICE

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# A NOTE FROM OUR PRESIDENT

## VIBRANT 2016 AHEAD FOR IOWA EMS

BY LINDA FREDERIKSEN, Executive Director, MEDIC EMS,  
IEMSA President / Board of Directors

> **After a long winter, the Iowa EMS Association is looking forward to an incredible, vibrant 2016!** This year's

strategic initiative is to substantially increase membership. The benefits of individual, affiliate, and corporate membership are many, and the message we'd like to hear resonating throughout Iowa is, "You aren't a member of IEMSA? You've got to join!"



> **Founded in 1987**, IEMSA's vast network provides our individual members with many benefits, including:

> **Legislative advocacy** to research, support, and develop lawmaking activities that promote the advancement of the EMS profession;

> **Being a part of the unified "Voice" of EMS providers in our state**, with a seat at the table on important task forces, committees, and advisory groups and boards;

Having a front row seat in the IEMSA communication network through our member publication, "The Voice," eNews, email alerts, member surveys, and legislative call to action updates;

Discounts for multiple conference events, including the Annual Conference and Trade Show, Leadership, Pediatric, and Billing and Management Conferences, in addition to other regional conference events, and

> **The forging of friendships as well as partnerships** with the most talented and innovative EMS Providers in the nation, which serves to promote camaraderie and advancement of our profession.

> **EMS Services can also support IEMSA with an Affiliate membership.** Affiliate membership benefits include complimentary individual membership(s), discounts on IEMSA merchandise and state patches, recognition on the IEMSA website, and the ability to participate in our Group Purchasing Program!

> **Corporate sponsors have the opportunity to back the EMS providers** who are there for their emergencies at the Silver, Gold or Platinum level. These sponsorships offer tremendous marketing potential via our newsletter, with discounts on booth space at the Annual Conference and Trade Show's Vendor Hall.

> **Now more than ever, EMS Providers must advocate** for the advancement of our profession. Not sure where to begin? Let an IEMSA membership be the blueprint for our future in EMS!

> **On April 14, 2016, 73 attendees gathered at the Embassy Suites in Des Moines, Iowa for the 12th Annual Iowa EMS Association Billing and Management Conference.** As expected, Doug Wolfberg of Page, Wolfberg and Wirth gave outstanding presentation after presentation that ranged from important Medicare updates, compliance, and documentation pointers. Our deepest thanks to LifeQuest Billing Service and PCC Ambulance Billing for their support and sponsorship of this event.

### EMS Week: Time to Celebrate!

> **The 42nd annual National Emergency Medical Services Week was observed May 15-21 this year**, providing an opportunity to bring 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." The EMS Strong campaign seeks to celebrate, unify and inspire the men and women of our nation's emergency medical services, who each day are "Called to Care". Created by the American College of Emergency Physicians (ACEP) in partnership with the National Association of Emergency Medical Technicians (NAEMT), EMS Strong brings together associations, EMS services, sponsors and national media to honor the dedication of EMS practitioners nationwide.

> **The American College of Emergency Physicians (ACEP) was instrumental in establishing EMS Week** when President Gerald Ford declared November 3 - 10, 1974 as the first "National Emergency Medical Services Week." This annual observance continued for four more years and was then reinstituted by ACEP in 1982. Around this time the observance of EMS Week was moved to September. In 1992 EMS Week was again moved to the 3rd week in May. The move was made to separate EMS Week from Fire Prevention week in October. The rationale for the move was the majority of fire and EMS services felt having the two events back to back hurt the effectiveness of each program so EMS Week was moved to May.

More and more, EMS providers are relied upon as providing the default structure for both the acute and chronic health care needs of those in their community around the clock. As an EMS Provider, you have responded to the calling of a special few who work together to meet the needs of those on what might be the worst, or sometimes, the best day of their life. It's those individuals who team with one another to respond to "a call to care" for the sick and injured with the grit and determination to get them through cold suppers and missed holiday gatherings. Does this describe an Iowa EMS Provider? It does...without question.

> **National EMS Week is the perfect time to honor your local EMS professionals and promote awareness of their everyday service to the public.** As a community hero, you unquestionably personify "EMS STRONG." THANK you for your dedicated service to your patients and communities; you continue to inspire us each day.



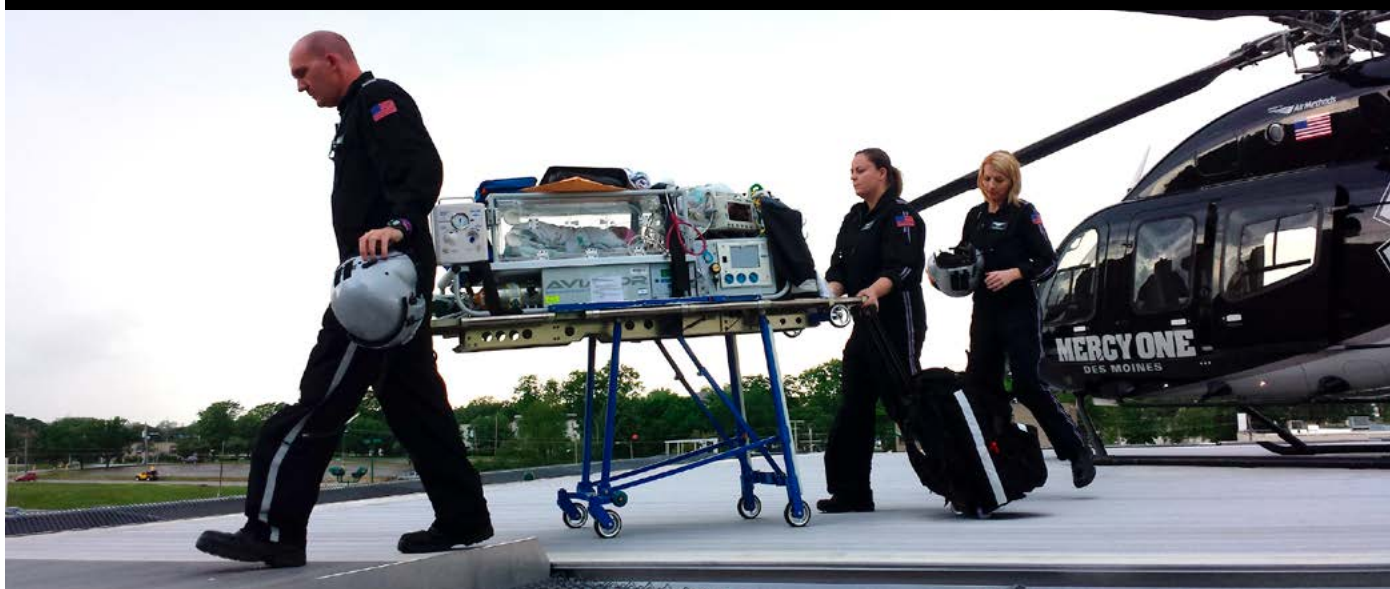
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**EMS DAY ON THE HILL**  
**FEBRUARY 9, 2017**

**BY MARK SACHEN** Legislative Chair and NC Region Board Member

# OUR VOICE ON THE HILL LEGISLATION

**their continued hard work and dedication.** Without their support, IEMSA's legislative agenda would not get the positive results we've continued to get year after year. I especially would like to thank my legislative vice-chair and IEMSA Past President, Chief Jerry Ewers for his continued efforts to go above and beyond by attending numerous meetings that come up at the last minute that I am personally unable to attend. I can always count on his wise counsel to help navigate the sometimes challenging legislative landscape.

**I would also like to express my thanks to my fellow members of IEMSA.** Your thoughts, opinions and ideas are how we develop our legislative agenda and determine what issues we as an association from year to year. The input and feedback we receive from all of you, allows us to best serve our association and is very much appreciated. Contact us by visiting [www.iemsa.net](http://www.iemsa.net). From the website, you can access your regional and at-large directors by phone or email. Thank you all again for allowing us the privilege of serving you!



**VERY IMPORTANT 2017 IOWA EMS Day on the Hill is scheduled for February 9, 2017.**

**> The 2016 legislative session was a mixed bag for IEMSA.** As the session wore on, big items like education and budget took center stage. The possibility of an extended session had lawmakers prioritizing issues to try and end the session on, or at least, nearly on time.

**For issues like fireworks,** lawmakers needed to focus on budgets and the standing appropriations bill. Specifically, finalization of the Health and Human Services (HHS) budget was a large hurdle. With unresolved budgets, fireworks, along with a number of other bills, took a backseat and ended up dying at the end of the session.

**The other side of the sword also claimed the establishment of benefitted Emergency Response Districts. (SF 2287).** This initiative also died as a result of prioritization by lawmakers. With the momentum behind this, we will definitely be revisiting this during the next legislative session.

**The statewide land mobile radio communications systems fund (SF 2155)** also fell victim to prioritization, as did the waivers for convicted criminals to gain access to a licensed profession (HF 2302). The institutional health facilities under the newborn safe haven act (SF 2206) and a bill regarding concussion/CPR requirements for certain high school sports (HF 2421) also died due to prioritization. IEMSA was registered as undecided on these bills.

**The opioid antagonist administration by EMT's and law enforcement (SF 2218)** passed both chambers and was signed into law by Governor Branstad on April 6, 2016. IEMSA supported this legislation.

**As legislative chair, I'd like to take this opportunity to thank my colleagues on the legislative committee for**

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## **BOUND TREE MEDICAL – IEMSA’S NEW GROUP PURCHASING PARTNER –**

IEMSA’s Membership Committee is excited to update you on the Group Purchasing Program. The contract has been awarded to Bound Tree Medical. Bound Tree has entered into a two-year contract with IEMSA to provide our Affiliate Members with considerable discounts on their products.

As the leading EMS distributor in the United States, Bound Tree Medical has been providing emergency medical equipment, supplies and pharmaceuticals to fire departments, law enforcement agencies, military, and other EMS organizations for over 35 years. Bound Tree offers thousands of quality products from leading manufacturers paired with innovative service to help you save time and save lives.

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# 2016 IEMSA MEMORIAL CEREMONY

MAY 14, 2016 • WEST DES MOINES STATION #19 • 8055 MILLS CIVIC PARKWAY • WEST DES MOINES



Honorary Fly-Over by AirCare2: Waterloo, Unity Point Health Life Flight and Mercy One: Des Moines



Iowa House Representative Zach Nunn gives a moving tribute to our Honorees, their families and all Iowa EMS Providers.



Indianola FD Honor Guard presents our colors in special tribute to their fallen comrade.



Family, friends and providers from across Iowa gathered for this special ceremony.

**May 14th, 2016**—EMS providers, legislators, family and friends gathered to honor four fallen dedicated EMS providers at the EMS Memorial in West Des Moines. Each year we honor and remember those that gave so much of their life to the service of others. They answered the call and although all of them would be humble and shy away from the recognition, we take time to honor their service. This ceremony delivered an emotional and sincere “thank-you!”

The distinguished panel of speakers, Zach Nunn, Iowa

House Rep.; Heather Maier, RN, CCRN, CEN, Mission: Lifeline Director-Iowa; and Rebecca Curtiss, Bureau Chief-Emergency and Trauma Services, IDPH presented eloquent speeches that assured more progress for EMS in Iowa and reflected on the sacrifice that goes beyond the provider to their families.

The Indianola EMS Honor Guard lowered the flag and there was a fly-over by AirCare2: Waterloo, Unity Point Health Life Flight and Mercy One: Des Moines to close the ceremony.

## ANNETTE M. HIRD

Annette Marie Hird, 51, of Volga, died February 16, 2016, at North Hawaii



Community Hospital in Waimea, Hawaii, due to complications of a near drowning accident.

Annette was born to Lester J. and Donna M. (Koch) Fleming on December 17, 1964, at Mercy Hospital in Oelwein. She grew up on the family farm south of Volga. She attended Central Community School in Elkader. Upon graduation, she attended Marshalltown Community College and became a Certified Surgical Tech. She worked as a Surgical Tech at Central Hospital in Elkader for over 16 years. She developed an interest and love for EMS while working in Elkader. She worked her way up the certification levels and became a paramedic. In 2002, she began working at Covenant Medical Center in Waterloo on the ambulance service. In 2010,

she was hired to a Flight Paramedic position on Air Care II, also in Waterloo. At the time of her death, she was a few months away from taking her nursing boards in her quest to become a Flight Nurse.

## BRIAN SEYMOUR

Retired Indianola Fire Chief Brian Seymour ascended to Heaven on Saturday, March 12, 2016.



Brian was born into a loving family on September 25, 1965 to the parents of Chuck and Wilma Seymour. He was the youngest of five children; Brenda Dooley of Ridgeland SC, Greg (Chris) Seymour of Martensdale IA, Brad Seymour (Lori Jordan) of St. Charles IA, and Roger (Gina) Seymour of Indianola Iowa.

On April 28, 1990 Brian was united in marriage to Chris (Mingles) and they were blessed with the birth of their son Joe on April 9, 1999. Spending time

with his family was so very important to Brian. Their travels to major league baseball stadiums, KC Chiefs games, beach destination trips and recently a 25th Wedding Anniversary trip to Europe. Brian's proudest moments however were watching Joe play baseball.

Before even graduating high school (1984 Martensdale-St. Mary's) Brian knew what his life calling would be. He joined the Martensdale Fire Department and went on to obtain his paramedic certification. He spent the next 32 years of his life dedicated to public service. From time spent with Life Line Ambulance Co, Clarke County EMS Director, and many positions within the Iowa Firefighters Association (District Coordinator Legislative Committee, work with at the Iowa Firefighter Memorial site, and as a representative to the National Volunteer Fire Council) before becoming President in 2007/2008. Brian was honored to serve the community of Indianola as first a firefighter then as their Fire Chief. Most recently Brian had joined the Cy-Fair FD Station 11 in Cypress, Texas.

Brian additionally had a love of hot air balloons. Over the past 25 years he took every chance he had to fly and always looked forward to the National Balloon Classic and the Albuquerque



Balloon Fiesta. Brian served as the President of the IBA and was honored when asked to be the Committee Chair for the BFA Convention in 2011.

Brian was a member of the Za-Ga-Zig Shrine, Scottish Rite Mason lodge 630, and Elks lodge 2814.

Brian had a full circle of close friends that he cherished as family and enjoyed time well spent with them. These relationships brought about mission trips to Israel where Brian was baptized in the Jordan, two trips to Africa to teach fire safety to children and to provide the Katete FD with a firetruck, to the honor of being a Godfather (Max Walter).

In one last act of honor of helping others, Brian was an organ and tissue donor which will impact 73 lives.

#### DENNIS I. MALLORY, D.O.

**D**r. Dennis Ivan Mallory, 75 of Toledo, Iowa passed away Monday, May 18, 2015 at Iowa River Hospice Home in Marshalltown. Dennis was born

March 1, 1940 in Council Grove, Kansas to Dr. Victor A. and Caris G. (Nutt) Mallory. Later, the family settled in the small town of Yale, Iowa, where Dennis' father was a physician and his mother was a school teacher. His early life was rich and diverse: He served at Fort Hood, TX in the Army as a 1st Lieutenant of a Calvary Tank Unit, was a professional jazz musician, drag car race driver, and completed his medical degree in 1973 at the College of Osteopathic Medicine and Surgery in Des Moines, Iowa.

In 1975, Dennis moved to Tama, Iowa, where he lived and practiced medicine as for 30 years. He served as the Chief Medical Examiner for Tama County, Chair of the County Board of Health, Medical Director



for Tama County EMS, Medical Director for Sunny Hill Nursing Home, and had been a physician for the USA Amateur Boxing Federation. He had further training in undersea medicine and aviation medicine and later became an aircraft accident investigator for the FAA, and served as Chief Aircraft Accident Investigator for American Airline flight U232 in Sioux City, IA. He was a regional consultant for Disaster Preparedness in Iowa and a member of the IACMEA Board where he served as past president. He was appointed by the Governor to the Iowa EMS Systems Standards Committee, served on several advisory boards at DMU, and was an associate Medical Director for Cottingham and Butler in Dubuque. Dr. Mallory was also a member of a partner group of the Iowa Foundation of Medical Care and was a member on the Joint Commission of the AMA.

He lived many passions and interests which included scuba diving, emergency medicine, cars, music, and was very proud to be an Inspector General Honorary of the 33rd Degree of the Scottish Rite.

#### DOUGLAS J. BUTZIER, M.D.

**D**r. Douglas J. Butzier, M.D., 59, of Dubuque died on October 13, 2014 as a result from injuries sustained in an air plane accident.

Douglas was born on June 2, 1955 in Mt. Pleasant, Iowa. He started his college career at the University of Montana, studying Forestry. While living in Missoula, Montana, he began working as a fireman and then an EMT where he found his passion for the medical community. He returned to his home state to attend the University of Iowa, to complete his undergraduate degree and then his MD from the University of Iowa Medical School, in 1984. Doug completed his Emergency Medicine internship training at Deaconess



Hospital in Spokane, Washington. He then attended his residency training at the University of Arizona Trauma Center in Tucson, finishing this training in 1987.

Following his education, Doug worked as an ER doctor in the Twin Cities and Tucson before moving to Dubuque in 1997, where he had been with Mercy Medical Center since. He remained active in Mercy Hospital administrative service duties, including serving as Medical Staff President. He was an Emergency Room physician at the time of his death. In his continuous pursuit of learning, Doug went on to obtain his MBA at the University of Iowa's Executive MBA Program, in 2007. In addition, he was the Chair of the Iowa Emergency Medical Services Advisory Council.

Doug was active in his community, volunteering his time and talent on numerous boards, committees and organizations.

Some of his many adventures, included, a six-week medical expedition to Nepal, coaching and refereeing youth soccer and other sports as his five children grew up, and traveling to Brazil to study its business economy. He served as the Medical Director for the Dubuque and Asbury Fire Departments, he was the staff physician to the Dubuque County Jail, and the medical director for Kunkel & Associates. He obtained his pilot's license, and loved flying his own plane. His most recent calling was his run for a seat in the US Senate as a Libertarian.

His greatest passion, after Ann, was flying, and he needed only the slightest excuse to go fly anywhere. He was a highly experienced and tested pilot, and was alone in the plane at the time of the accident.

He lived a full life with a deeply philanthropic spirit. He is sorely missed.

*Always missed,  
never forgotten.*

# MEDICAL DIRECTOR UPDATE



## EMS

### Documentation

#### > Have you ever played the game of telephone?

Have you ever felt like you lost a game of

telephone? (<https://www.youtube.com/watch?v=4H8hcvNeWtg> for those of you who need a tutorial.) I can tell you with certainty I have made an error when documenting a report I got from EMS, which is even more wrong in the admitting team note, which is even more wrong in the consulting provider's note. When playing or having fun this is not a big deal, but when it comes to appropriately relaying information about patient care it is not so funny. Having an accurate record from EMS is critically important to patient care in the hospital. Getting your report completed and submitted in a timely manner to the hospital will more effectively allow your patient's care providers to continue the care you started. State of Iowa law states document submission must happen within 24 hours, but the earlier this occurs the more useful the information will be.

> **In addition to accurately relaying information, your documentation serves as your safeguard.** I know you all have heard this before, but repeating it again and again is not overkill. From the Quality Assurance/Improvement process to legal action, your record serves as the major mechanism to safeguard you and the excellent care you provide. Recently one of my flight crews responded to a scene request where they saved a patient's life through some brilliant patient care. However, their documentation missed a few steps, so instead of being able to focus on how proud that makes me as a medical director, we had to re-hash everything and ask pointed questions in order to ensure all protocols were followed. Not

only does this take time for providers, managers, and medical directors; but focuses on a negative instead of all of the positives.

> **This is not just an EMS problem.** I recently had a psychiatric transfer nearly derailed because the nurse put in her record something that she thought she heard but had not confirmed. It then took almost an hour of my time during a shift to track down all of the pieces and communicate with multiple providers in order to correctly identify the actual events and convince everyone involved what had actually occurred. And you know what? It was the result of a simple documentation misstep.

> **One fallacy I hear is that nobody is going to read your report; oh not so.** Lets look at a fairly typical EMS report. For QI it will go to the peer reviewer and/or QI designee; from there it may go to the supervisor and Medical Director. On the hospital side the EMS coordinator, the ED physician, the ED nurse, the ED social worker, the admitting physician, the covering physician, the day nurse, the night nurse, the inpatient social worker, and the inpatient care coordinator may all look at your note. On the billing side your report will be read by your EMS agency's billing folks, the insurance agency's initial reviewer, and the insurance agency's authorizing reviewer if not multiple other insurance agency personnel. If there happens to be any legal action then the patient, the patient's counsel, opposing counsel, several expert witnesses, the judge, and the jury will all read your report.

> **So what do I as an ED provider or Medical Director want to see in your documentation?** The biggest key is to paint an accurate picture of what you see and what you do. In the History of Present Illness describing the accident scene so I can see the cars or carefully phrasing exactly how that foreign body became lodged where

it now resides really tells me what is going on. In the Physical Exam I expect a complete exam as much as my providers are able to obtain with constraints of patient presentation and time. In the Transport Course I know you can all document IV starts, medications, and pain assessments/reassessments. What really sets a note apart is some clinical reasoning. Knowing why you decided to intervene or not really shows your thought process and a higher level of medical reasoning skills. Critical thinking occurs by every provider on every call, so why not show it?

> **Once you have completed each of these individual components, go back through and edit your document.** It should only take a couple minutes, but making sure your spelling and grammar are accurate goes a long way towards ensuring those who are reading your document are getting an accurate picture of the high quality care you provided. Mediocre care documented in an impeccable note will give a more positive impression than flawless care documented in a mistake-riddled report. It is a fact of our lives; accurate and professional documentation is an extremely important part of EMS.

Again, if you have any questions or suggestions for articles, please feel free to contact me.

## References

1. Wolfberg, Douglas M and Wirth, Stephen R. Five Good Reasons for Better EMS Documentation . [Online] EMSWorld, Nov 1, 2005. [Cited: May 10, 2016.] <http://www.emsworld.com/article/10323583/five-good-reasons-for-better-ems-documentation>.
2. Bledsoe, Bryan. Why You Need the EMS Run Report. [Online] JEMS, Jan 31, 2010. [Cited: May 10, 2016.] <http://www.jems.com/articles/2010/01/why-you-need-ems-run-report-0.html>.





BY JERRY EWERS, IEMSA IMMEDIATE PAST-PRESIDENT

# IEMSA MEMBERSHIP UPDATE



> IEMSA budgeted, purchased, and implemented a new membership

**software program last year in order to be more efficient in our operations.** As Chair of our Membership Committee we have focused on improvements to our internal processes and are working on reviewing benefits and creating a new membership recruitment drive. As with any new software program and conversion of data I've been a part of it's not out of the norm to have hiccups or issues that arise where we need help from tech support. Lisa, our office manager, has been working diligently with our software vendor on a few issues that affected a small number of our affiliate renewal notices not being sent out. With that said, we are now in the process of making sure renewal notices are sent out so we can maintain those important memberships and provide those quality services and benefits to all our affiliate services in Iowa.

## WHAT IS MEMBERSHIP?

According to BusinessDictionary.com, membership can be defined as "belonging, either individually or collectively, to

a group." Membership is needed to help build, connect, and grow IEMSA. Membership is the second largest revenue stream for IEMSA that helps pay the expenses of the organization and our lobbying efforts. Membership enables us to offer employer benefits, such as Group Purchasing, free job postings, discounts to conferences and training, scholarships, and a free \$ 10,000 Accidental Death/ Dismemberment insurance policy to our members. For me, membership is a sense of pride and a sense of belonging to a great group of EMS professionals and a way to give back to make EMS stronger and better in Iowa.

## WHY IS MEMBERSHIP SO IMPORTANT?

Membership is valuable and critical for any organization. In this economy it is often hard to justify spending your hard earned money on membership fees for professional organizations. It may even be harder for your service or workplace to pay for your individual membership or for an affiliate service membership with shrinking budgets. Yet, that membership can provide great value to you, your employer, and IEMSA.

## WHAT ARE THE BENEFITS?

	\$ 10,000 AD&D	FREE Individual Memberships	Member Discounts	DISCOUNTED EMS EQUIPMENT & SUPPLIES FROM BOUNDTREE MEDICAL	VOICE and eNEWS	25% NAEMT Discount
Student		X	X		X	X
Active Retired			X		X	X
Individual	X		X		X	X
Affiliate		X	X	X	X	X
Corporate		X	X		X	

## WHY JOIN IEMSA?

IEMSA was established in 1987 and has been actively involved in EMS in many facets. No matter your level of service, type of department, or patch on your sleeve, IEMSA is here to serve you and help be you're VOICE in Iowa. Some join for the professional recognition and networking opportunities, while some join for the member benefits and discounted educational opportunities that are

held throughout the year across Iowa. Others join for the resources, group purchasing, quarterly VOICE publication, our strong advocacy efforts, and timely member alerts through eNews. There are plenty of other associations, such as NAEMT, IAFF, AAA, NAEMSP, NAEMSE, and many more, but only IEMSA is geared towards focusing on EMS issues in Iowa that affect all of us personally and professionally.

>>> CONTINUED ON **PAGE 12**

>>> CONTINUED FROM PAGE 11

## MEMBERSHIP FEEDBACK

Annually, through a survey, we seek feedback from our members in the Fall to gather data that helps us with strategic planning and our legislative efforts. The goal is to hear what our MEMBERS have to say so we can actively be the VOICE of EMS in Iowa. We would love to hear what you have to share with us. Are there any new benefits you would like to see? Is there a training program or event you would like us to create? What about our legislative talking points? How about social media and our website information? Again, we need your feedback and ideas to help improve YOUR organization.

## THANKING OUR MEMBERS

Whether you're new to EMS or a seasoned veteran, or a past member, I would encourage you to show your support to our state, our profession, and IEMSA by becoming a member today! For those of you that are members I want to personally say "thank you" for your support in the past and into the future. We need all of you to make a difference. I would encourage every one of you to reach out to a friend or a peer and ask them to join our great organization. The benefits easily outweigh the \$ 30.00 membership fee. I also challenged our Board of Directors to recruit at least one member this year. The more support we have in numbers the greater the associations influence will be, especially legislatively. We need your help in order to grow our organization. We can't do it alone. If you have any questions about membership please contact me directly.



# EMS BUREAU UPDATE

BY REBECCA CURTISS IDPH, Bureau Chief-Bureau of Emergency & Trauma Services



## IOWA EMERGENCY MEDICAL SERVICES STATISTICS

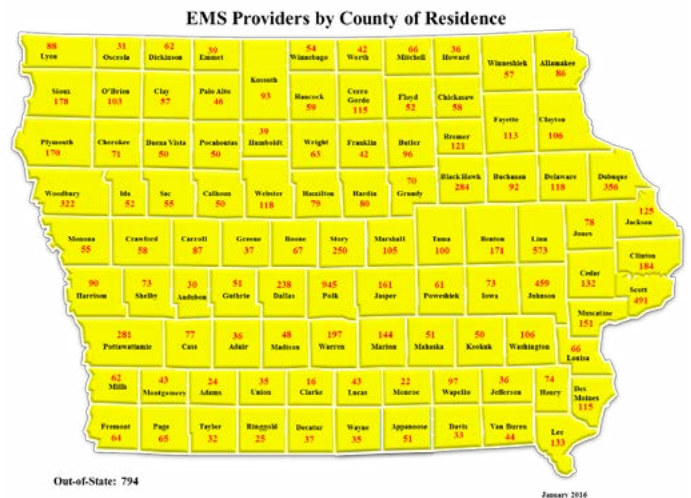
In a retrospective look at certified EMS providers from the Bureau's data base (see table below) the total number of certified EMS providers has changed very little in the past 14 years. While there has been some significant number changes in certain

levels of EMS providers the overall numbers have stayed consistent.

Year	F/EMR	EMT/B	EMT-I	AEMT	EMT-P	PS/PM	Total
2016	1,243	6,708	522	188	301	2,738	11,700
2015	1,344	6,558	539	178	303	2,654	11,576
2014	1,289	6,810	711	99	372	2,581	11,862
2002	2,504	6,135	1,203	0	652	1,153	11,647

8,458 of the 11,647 EMS Providers (72%) indicated that they are active with one or more services as of January 2016. Further data collection and analysis would be required to identify how many certified EMS providers are working in a field outside of an authorized service program that requires an EMS certification or if they obtained an EMS certification for other reasons than working in EMS. The Bureau is aware that some individuals are taking an EMS certification course solely for college credit with no intention of working as a provider of emergency medical services.

The map below indicates the number of certified EMS providers that reside within each county or out of state as of January 2016. While the map shows the certified EMS provider's county of residence, it does not capture the county where they may be providing services.



Each authorized service program as part of their authorization and reauthorization process identify staff members that are paid, volunteer, or a combination of paid and volunteer. The table below shows the staff status of each of the 917 authorized service programs as of January 2016.

Service Type	Paid	Volunteer	Paid/Volunteer
Air Ambulance	20	0	0
Ambulance	135	277	66
Non-Transport	70	338	11
Totals	225 (25%)	615 (67%)	77 (8%)





**MISSION:  
LIFELINE**

# STEMI IN IOWA

## 12-LEAD ECG EDUCATION KICKING OFF...

**Mission: Lifeline, with the assistance of Mercy School of Health Sciences is launching 12-Lead ECG education to EMS services in the state of Iowa.** All services receiving grant funding for 12-Lead ECG equipment will participate in this education, but it will also be offered to any EMS agency wishing to participate. This educational offering is free of charge and will provide 2 hours of continuing education. Please visit the Mission: Lifeline website for updates under the EMS tab at [www.heart.org/missionlifelineIA](http://www.heart.org/missionlifelineIA). For more information call Mercy School of Health Sciences at 515.643.3180 or visit [http://www.mchs.edu/aha\\_training\\_ctr.cfm](http://www.mchs.edu/aha_training_ctr.cfm).

### EMS FUNDING

- > The 2nd round of funding for EMS 12-Lead ECG equipment was announced the end of March. The website is up to date with a list of services receiving funding. Services that have applied will not need to resubmit applications for any subsequent rounds of funding.
- > Prehospital 12-Lead ECG is an extremely valuable tool in recognizing STEMI heart attacks as early as possible. Iowa is far below national average in prehospital 12-Lead ECG acquisition in rural area patients. Mission: Lifeline seeks to develop the system of care for STEMI patients in those areas. This is the key goal of funding the purchase of equipment for those services in rural areas. If you have questions about future funding opportunities or whether this is right for your service, please contact Gary Myers at [Gary.Myers@heart.org](mailto:Gary.Myers@heart.org).
- > To see the list of EMS services that receive funding and access other valuable information please visit the Iowa Mission: Lifeline website at [www.heart.org/missionlifelineIA](http://www.heart.org/missionlifelineIA) and click on the EMS tab at the bottom of the page. 37 Agencies have received funding to date.
- > The application process is now open and will remain open until all funding has been awarded. Please submit your applications as soon as possible to improve your chances of receiving a grant. The next round of funding will be announced the week of July 11th, 2016.

### REFERRAL HOSPITAL FUNDING

Mission: Lifeline has begun the funding of 12-Lead ECG receiving equipment for Non-PCI hospitals. At this time, funding is being prioritized by hospitals near EMS agencies granted funds for 12-Lead ECG monitors and hospitals in areas with EMS services that currently perform 12-Lead but cannot transmit due to the hospital not having the ability to receive. Those hospital impacted by the first two rounds of EMS funding have received their letters. We will post the names of hospitals awarded funding on our website under the hospital tab. [www.heart.org/missionlifelineIA](http://www.heart.org/missionlifelineIA).

### STEMI GUIDELINES FOR EMS

- > The STEMI Guidelines for Non-PCI Hospitals were released

in March, 2016. Interventional Cardiologists from each of the PCI Centers across the state collaborated to build this document. To print or download a copy, visit [www.heart.org/missionlifelineIA](http://www.heart.org/missionlifelineIA), under the hospital tab.

- > The EMS Advisory Committee has completed work on the Mission: Lifeline EMS Recommended Transport Guideline. You can find the entire document on the Mission: Lifeline website under the EMS tab. Below is the first section of the guideline. Remember, if you have the equipment, do the 12-Lead. If you don't have the equipment, make sure you are applying for funding. Our communities are counting on us to make sure they are diagnosed early and moved quickly to a PCI Center.

### OBTAIN 12 L ECG WITH INITIAL ASSESSMENT & VITAL SIGNS

**Goal:** First Medical contact to ECG < 10 min, Scene time: < 10 minutes to provide early identification and pre-hospital arrival notification for suspected myocardial infarction or STEMI.

- > Chest pain, pressure, tightness or persistent discomfort above the waist
- > "Heartburn" or epigastric pain
- > Complaints of "heart racing" (HR > 150 or irregular and > 120) or "heart too slow" (HR < 50 and symptomatic)
- > A syncopal episode, severe weakness, or unexplained fatigue
- > New onset stroke symptoms (< 24 hours old)
- > Difficulty breathing or shortness of breath (with no obvious non-cardiac cause)
- > ROSC (return of spontaneous circulation) post cardiac arrest
- > Recent Cocaine, stimulant and/or other Illicit drug use (patients of any age)

If initial ECG is not diagnostic but suspicion remains high for ACS (acute coronary syndrome) and symptoms persist, obtain serial ECG's at 5-10 minute intervals

### THE SYSTEM OF CARE GOALS

- > EMS performs 12-Lead ECG on all non-traumatic chest pain patients over 35 years old or any patient you suspect of having a cardiac issue
- > Non-PCI hospitals limit "Door In/Door Out" times to less than 30 minutes
- > 12-Lead ECG performed in less than 10 minutes from First Medical Contact or Door In time by both prehospital (BLS and ALS) and hospitals
- > Overlapping transport services or tier to get patient to Primary PCI quickly and effectively
- > The piece of the system of care collaborates to improve performance measures and improve patient outcomes
- > Decrease mortality rate of STEMI heart attack victims in Iowa
- > Improve the overall outcomes of patients, returning them to their normal quality of life



# IEMSA

**27TH ANNUAL  
CONFERENCE &  
TRADE SHOW**

**SAVE THE DATE  
NOVEMBER 10-12, 2016**

- > **EXHIBIT HALL : HYVEE HALL C**  
LARGE DISPLAY OF **THE TOOLS OF YOUR TRADE**
- > **ANNUAL BOARD MEETING :**  
Thursday, Nov. 10th, 11:15-12:15  
Every member is encouraged to attend the annual meeting. Votes will be taken regarding bylaw changes, new board members & reports on activity of the Association will be given.
- > **AWARDS CEREMONY :** Saturday, Nov. 12th, 1200-1300, during lunch. Awards given for EMS Service - Career and Volunteer, EMS Individual - Career and Volunteer, EMS Instructor, Dispatcher, Friend of EMS, and Hall of Fame. Go to [this link](#) for the application to nominate someone today!
- > **HONORING OUR OWN :**  
Saturday, Nov. 12th, 0730-0815  
Please join us in honoring those no longer with us at this moving ceremony.
- > **LUNCHES :** Again this year, we have elected to allow you the option and convenience of purchasing lunch during the conference, or you can purchase a lunch ticket as usual.
- > **CONFERENCE HOTEL GROUP RATES :**  
Will be at the Renaissance Savery, Marriott, Quality Inn and Hampton Inn. Reserve your room early--they sell out.
- > **KEYNOTE PRESENTATIONS :**



• **The Night Watch Experience** -- Panel Discussion with Dan Flynn NRP, RN-BSN, BS Paramedic; Holly Monteleone NREMT-P; Nick Manning NREMT-P ; and Titus Tero NREMT-P all from New Orleans EMS Service.



• **The Long View: The History and Future of Emergency Medical Services** -- Raymond Fowler, M.D. FACEP, Assistant Professor, Emergency Medicine, UTSW Medical Center and Assistant EMS Director, BioTel



• **Human Trafficking : What to expect --from an Emergency Medical Services Perspective** -- Panel Discussion



• **The S.A.V.E. Program : "Safely Addressing Violent Encounters - S.A.V.E."**-- Shawn C. Tompkins & Robert N. Poresky

**>>>>>>>>REGISTRATION TO OPEN IN AUGUST OF 2016!**

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# SPOTLIGHT ON TRAINING



**> Northwest Iowa Community College has the distinction of being the smallest community college in Iowa.** Located in Sheldon, Iowa, the EMS program at NWICC has always been focused on providing education to the rural volunteer EMS services that make up nearly 100% of the coverage area in northwest Iowa. The college serves the counties of Lyon, Osceola, Sioux, O'Brien, and a portion of Cherokee county in Iowa. Minnesota borders the college area to the north and South Dakota to the west.

**> Basic EMS programs are offered through the college, including the Emergency Medical Technician and Emergency Medical Responder levels.** College credit is provided to the students for the EMT program. Classes are held on campus or in the local communities where the demand arises. NCC has worked with Iowa Western Community College to offer the Hybrid EMT Course twice a year. The students take their lecture and on-line components through IWCC. NCC provides the skills labs and skills testing over 5 all-day Saturday sessions. In addition to the primary course offerings, NCC offers continuing education classes in a variety of topic areas including medical, trauma, vehicle extrication, CPR, CPR Instructor, hazmat, and firefighting.

**> Evan Bensley is the Program Coordinator.** He started as a volunteer EMT-A with the Odebolt Ambulance Service shortly after graduating high school. He went on to become a Paramedic while working for the Sac County Ambulance Service in Sac City. He moved to Spirit Lake in 1988 and began working for Lakes Regional Healthcare as a fulltime Paramedic on their mobile intensive care unit. While working for these services, he coordinated EMS courses for Iowa Lakes and Iowa Central Community Colleges. Evan started at Northwest Iowa Community College in November 1996 as the Emergency Services Education Coordinator. In addition to EMS training, he is the Coordinator for the American Heart Association CPR Training Center. He coordinates all regional Firefighter training, CPR courses, CPR Instructor classes, Hazmat classes, Business & Industry safety-related topics, and numerous other programs through the Continuing Education Department.

**> A handful of primary course coordinators and several assisting instructors are utilized to conduct EMT courses.** Since the Instructors are volunteer EMT's on area services, they are able to relate to the students and bring their knowledge of local EMS to the classroom. NCC has been a longtime advocate for the local community's EMS and Fire Departments. The college continues to provide top notch equipment to further enhance the hands-on training. The college utilizes competent and motivated instructors, quality training equipment, and prepares students mentally to perform to high standards and expectations.

**> In fiscal year 2015-16, NCC has certified over 4,000 people in American Heart Association CPR and First Aid classes** through the regional instructors aligned with NCC's AHA Training Center. EMS continuing education hours were awarded to 30 regional EMS & Rescue services throughout the year for various EMS training classes in-house at local squads or on campus. Volunteer shortages have seriously affected many local squads. Finding competent and willing EMS Instructors will also continue to be a challenge for a rural EMS program. By working together in a collaborative effort between the college and local communities, we strive to address these concerns. Northwest Iowa Community College will continue to be a quality resource for the northwest region's EMS providers.





# THE EMS RESPONSE TO CHEST TRAUMA

BY EVAN BENSLEY, PROGRAM COORDINATOR,  
Northwest Iowa Community College • Sheldon, Iowa



## INTRODUCTION TO CHEST TRAUMA

The thoracic area of the body contains major organs and structures essential to human survival and well-being. Chest injuries range from minor abrasions and contusions, to major blunt and penetrating traumatic events that cause compromise to the airway, breathing and/or perfusion. It is critical that EMS providers rapidly recognize and, when necessary, treat and transport chest injuries without delay.

## THORACIC CAVITY ANATOMY AND PHYSIOLOGY

The thoracic or chest cavity contains organs of the cardiovascular, respiratory and gastrointestinal systems. Twelve pairs of ribs connect posteriorly to the spinal column vertebrae with bands of ligaments that hold them in place. The first rib pair lies just under the clavicles. Anteriorly, the first seven rib pairs directly connect to the sternum through cartilaginous attachments. These are called true ribs, compared to the remaining five pairs of false ribs which do not attach directly to the sternum. In addition, the last two pairs of false ribs are known as floating ribs, as they do not attach to the sternum at all. This rather intricate connection of bones and ligaments provide the ribcage with strength, yet provide elasticity to allow the chest cavity to expand and contract during ventilation.

In between each rib is an intercostal space, consisting of muscle and connective tissue that, when stimulated by the respiratory center, contracts and pulls the ribs outward. Just below each rib lies a bundle of arteries, veins and nerves. The rest of the bony structure of the chest includes the clavicles, scapula and the spinal column.

The thoracic cavity is separated from the abdominal cavity by the diaphragm, a broad structure of muscle and fibrous tissue that is responsible for normal breathing. At rest, the superior position of the diaphragm is at the level of the fifth intercostal space. The diaphragm will move downward 1-2 cm in normal breathing.

The diaphragm and intercostal muscles provide most of the effort of normal breathing, as well as the beginning stages of respiratory distress. As breathing difficulty worsens, accessory muscles contract to elevate the upper portion of the ribcage. Abdominal muscles can also be used during active exhalation, as might occur during periods of severe bronchoconstriction.

The interior wall of the chest cavity is lined with the parietal pleural membrane. A second visceral pleural membrane covers the lungs and other structures lying within the cavity. In between

the parietal and visceral pleural membranes is the pleural space that is filled with serous fluid that allows both pleural membranes to slide past each other easily.

The majority of the pleural cavity is filled with the lungs, heart and great vessels. In addition, most of the liver, the stomach and superior portion of the large intestines reside just below the diaphragm. The mediastinum is a distinct space between the two lungs and contains the heart, great vessels, esophagus, trachea and the thymus.

## PATHOLOGIES

Both blunt and penetrating trauma mechanisms can cause minor to severe injury patterns to the chest cavity, due to the large number of vascular-rich organs and structures.

Blunt force trauma results from mechanisms of injury such as falls, motor vehicle crashes and assaults with blunt objects. The energy generated from the motion of the object is transmitted first against the skin, muscle and bones of the chest, then into the organs contained within the chest cavity itself. If there is sufficient blunt trauma, the victim may suffer commotion cordis, a sudden death following blunt chest trauma believed to be caused by ventricular fibrillation.

### **This energy transfer can result in one of two injury patterns:**

- > **Compression, where an organ is deformed** causing tearing or rupture; or deceleration, where the organ is attached to an anchor point within the chest moves abruptly, causing shearing and stretching. An example of a deceleration injury is the shearing of the aorta by the ligamentum arteriosum, which normally holds the aorta upright in the chest, but slices through it after a major front-end motor vehicle impact.
- > **Penetrating trauma differs from blunt in that an object such as a bullet, knife or other object physically penetrates the skin**, creating a temporary or permanent opening. The energy associated with penetrating trauma is more narrowly focused than blunt force trauma, and can be carried deep into the chest cavity. Depending upon the mechanism of injury, the generated forces may be so great as to cause compression of tissue surrounding the entrance wound. This is caused by cavitation and can result in serious damage to areas not directly injured by the penetrating object. For soft tissues such as the lung, cavitation forces can be devastating, causing major bleeding and loss of alveoli needed for adequate gas exchange during breathing.

## INJURY PATTERNS

Chest trauma can be broadly categorized into two areas: injuries that cause significant blood loss, and those that compromise ventilation. Major disruption to either perfusion or ventilation poses an immediate life threat to the victim. Patients can also succumb from significant infections due to a perforated esophagus or stomach, punctured lungs or ruptured trachea.

The heart, lungs, great vessels (aorta, vena cava, pulmonary veins and arteries) and liver will hemorrhage quickly if punctured or lacerated. The chest cavity can hold several liters of blood (hemothorax), displacing the lungs and other organs. Bleeding inside lung tissue (pulmonary contusion) can compromise adequate gas exchange.

Blunt force trauma to the heart can cause a myocardial contusion, resulting in decreased cardiac output, dysrhythmia or myocardial infarction. Additionally, even a small amount of blood leaking from injured myocardium into the pericardial sac that surrounds the heart can result in a cardiac tamponade that compresses against the heart chambers, reducing stroke volume capacity and cardiac output.

Air that enters the chest cavity through any means, other than through the mouth and nares will present with respiratory compromise. Normally, the pleural space is virtually nonexistent, allowing for normal chest excursion during breathing. Air that enters through a penetrating wound or a rupture in the lung tissue can create an actual space (pneumothorax) that results in the loss of negative pressure during inspiration. This can cause

part of the lung to collapse and stop exchanging carbon dioxide and oxygen.

If the sucking chest wound remains open, eventually, air pressure equalizes between the inside of the chest and the environment. However, if the wound closes after inspiration, air becomes trapped inside the chest, unable to escape into the atmosphere. Over time, the pressure inside the chest rises, causing a tension pneumothorax to form. The pressure acts as a balloon, forcing the lung on the side of injury to collapse. Additionally, the mediastinum shifts toward the unaffected side, placing pressure on the other lung, heart and great vessels. As this occurs, cardiac output falls, resulting in hypotension. Hypoxia, hypercarbia and hypoperfusion cause significant altered mental status. This condition is lethal if not corrected.

Air can also enter the mediastinum directly. Air can escape from the area, leaking into the soft tissue of the chest and causing subcutaneous emphysema to form under the skin of the face, neck and chest. A patient may show a rapid onset of what appears to be edema in these locations.

## RIB FRACTURES & FLAIL CHEST

Multiple ribs, each broken in two or more places, may cause a part of the ribcage to separate from the chest wall, creating a flail segment. If the segment is small, the intercostal muscles will “self-splint” the area. However, a large segment will “float” and move in the opposite (paradoxical) direction of normal chest movement.

>>> CONTINUED ON **PAGE 18**



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The elderly are especially susceptible to rib fractures due to osteoporosis. EMS providers often encounter rib fractures at the scene of motor vehicle accidents. Properly worn seatbelts may cause rib fractures in frontal impact collisions. Fractures to the ribs may indicate the patient has received a pulmonary contusion or pneumothorax. Fractures to the lower ribs may be associated with injuries to the spleen and liver.

## OPEN PNEUMOTHORAX & BALLISTICS

An open pneumothorax involves air entering the pleural space, causing the lung to collapse. Any open chest wound, often referred to as a sucking chest wound, should be sealed as soon as it is found, using the palm of a gloved hand at first, followed by an occlusive dressing. There are commercially made chest seals available for purchase. Other easily available products in most ambulances are AED pads, tin foil, or petroleum gauze. Mechanisms that may lead to an open pneumothorax include gunshot wounds, stabbings, impalement, and other types of blunt trauma.

The severity of a ballistic injury is directly related to the shape and size of the projectile and its kinetic energy at impact. The energy also depends on the distance it traveled before striking the victim. Bullets cause a crush and a stretch of tissue as it passes into the body. Bullets crush the tissue as it directly passes through, forming the permanent cavity. Stretch is produced by energy transferred from a bullet as it slows down in tissue, forming a temporary cavity. The temporary cavity can cause immediate rupture of tissue and organs within the area of cavitation. The temporary cavity collapses, leaving the permanent cavity as the only visible indication of the potential wound and underlying injury.

The weight of the bullet is not as destructive a factor as bullet velocity. A 9mm handgun creates over twice as much kinetic energy as a .38 caliber handgun. The temporary cavity created in the body is 2-3 times larger than a .38 caliber handgun, causing far more damage to a victim. Bullets are also designed to have a variety of flight characteristics in order to increase the amount of deadly force. The bullet may have a spiral flight, much like a well-thrown football, with a tight spin to it. Other bullets are designed to yaw, tumbling end over end in flight. Hollow point or soft point bullets will expand on impact with the body. As a general rule, the exit wound will be larger than the entrance wound. Even though the EMS provider may only see a small entrance wound, they must be aware of the potential catastrophic underlying tissue and organ damage.

## ASSESSMENT AND MANAGEMENT

Because the potential for serious harm is high, assessment of the chest occurs during the primary assessment. Based on the mechanism of injury, consider manual stabilization of the cervical spine until a more complete spinal exam can be accomplished. Establish and maintain a patent airway while determining the patient's level of consciousness using the AVPU scale. If the patient is not fully awake or alert, manual airway positioning and basic airway adjuncts such as an oropharyngeal or

nasopharyngeal airway may be needed. Suctioning an airway filled with blood or emesis may be necessary. Your initial observation is key to identify whether the victim is sick or not sick and expedite your treatment and transportation.

Obtaining a SAMPLE history may be difficult, if not impossible, for a patient suffering from serious chest trauma. When possible, try to obtain information from the patient or family members on the patient's allergies and current medications. This vital information will play an important role in the patient's surgical status and pain medication administration.

Look for signs of breathing difficulty. Tachypnea, hypopnea (shallow breathing) and accessory muscle use are key indicators of respiratory distress or failure. Expose the chest and auscultate lung fields immediately. Diminished sounds over one side may indicate a loss of lung capacity, either from a hemothorax, pneumothorax or both. Pulmonary contusions may result in crackles heard over the affected area.

Inspect the neck and chest area. Palpation of the chest may be debatable, and possibly harmful to the patient if done when the extent of a chest injury is obvious. When palpation is performed, the EMS provider may find crepitus in the affected area. Crepitus is felt as the patient breathes and the broken end of the ribs rub against each other. Jugular venous distension may indicate greater than normal pressure within the chest cavity, possibly related to a developing tension pneumothorax. Hyperinflation of the chest over one side is another sign related to a tension pneumothorax. If the patient's mental status worsens and blood pressure falls, a decompression of the tension pneumothorax using a long, large gauge angiocatheter is needed to relieve the excessive pressure in the chest.

Control any major external bleeding immediately with direct pressure. It will be difficult to create a pressure dressing, as is more commonly seen with extremity injuries. Manual pressure may be needed to stop the bleeding. Recognize that the chance of active bleeding inside the chest is significant and emergent transport to a trauma center is needed. The EMS provider must be aware that placing a patient supine may worsen respiratory distress.

**The current Iowa EMS Protocols addresses the treatment for Chest Trauma on pages 44-45. The current Iowa Protocols state the following:**

- a. Seal open chest wounds immediately.** Use occlusive dressing taped down. If breathing becomes worse, loosen one side of the dressing to release pressure and then reseat.
- b. Impaled objects must be left in place** and should be stabilized by building up around the object with multiple trauma dressings or other cushioning material.
- c. Take care that the penetrating object is not allowed** to do further damage.
- d. If concerned for symptomatic pneumothorax,** perform needle decompression.

>>> CONTINUED ON **PAGE 20**

# Join Us!

## 2016 Donate Life Conference — The Ripple Effect —

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8 AM - 4 PM

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Registration is now open!

Visit [IowaDonorNetwork.org](http://IowaDonorNetwork.org) for registration and more information.



>>> **CE: CHEST TRAUMA** --CONTINUED FROM **PAGE 18**

In general, on-scene management of chest trauma should be done with BLS interventions, with the intent to begin transport to a trauma center as soon as feasible. Pain management may vary by local protocol. With the exception of the needle decompression, other advanced level procedures are best done while en route.

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## Chest Trauma

### Continuing Education Quiz

IEMSA members can earn 1 hour (1CEH) of optional continuing education credit by taking this informal continuing education quiz. You must answer all questions, and achieve at least an 80% score.

**Deadline:** September 30, 2016

**Complete this Quiz and:**

- **mail to** IEMSA - CE Quiz  
5550 WILD ROSE LANE, STE. 400  
WEST DES MOINES, IA 50266
- **fax to** (877) 478-0926
- **or email to** administration@iemsanet

20

**1. The sound or feeling of the ends of broken bones rubbing together is called:**

- |                     |                  |
|---------------------|------------------|
| A.) Commotio Cordis | B.) Crepitus     |
| C.) Krepitus        | D.) Pericarditis |

**2. A type of closed injury in which two or more consecutive ribs are fractured in two or more places is called:**

- |                          |                       |
|--------------------------|-----------------------|
| A.) Intercostal Spasm    | B.) Cardiac Tamponade |
| C.) Tension Pneumothorax | D.) Flail Chest       |

**3. The medical term for a dressing that causes an airtight seal is a(n):**

- |                        |                        |
|------------------------|------------------------|
| A.) Occlusive Dressing | B.) Universal Dressing |
| C.) Trauma Dressing    | D.) Bandage            |

**4. The condition in which the chest cavity fills with blood is known as:**

- |                          |                        |
|--------------------------|------------------------|
| A.) Pneumothorax         | B.) Traumatic Asphyxia |
| C.) Tension Pneumothorax | D.) Hemothorax         |

**5. The medical term used to describe an open chest wound is:**

- |                         |                          |
|-------------------------|--------------------------|
| A.) Flail Chest         | B.) Paradoxical Movement |
| C.) Sucking Chest Wound | D.) Air Embolism         |

**6. What factor is more likely to cause severe internal damage in regard to ballistics?**

- |                                     |                             |
|-------------------------------------|-----------------------------|
| A.) The size of the bullet          | B.) The speed of the bullet |
| C.) The distance the bullet travels | D.) The chemical make-up    |

**7. Which organs also reside within the lower chest cavity?**

- |  |
|--|
| A.) Appendix, Spleen, Gallbladder.                           |
| B.) Stomach, Appendix, Colon                                 |
| C.) Bladder, Spleen, Uterus                                  |
| D.) Liver, Stomach, and superior portion of large intestines |

**8. According to the Iowa EMS Protocols, what is the treatment recommended for impaled objects in the chest?**

- |   |
|---|
| A.) Impaled objects must be left in place and stabilized.   |
| B.) Impaled objects should be removed immediately and an occlusive dressing applied.                    |
| C.) Impaled objects should be removed and turned over to law enforcement to aid in their investigation. |
| D.) Impaled objects will likely not cause serious injury.   |

**9. Who are more likely to sustain rib fractures from blunt force trauma?**

- |   |
|---|
| A.) A Child                               |
| B.) Adult Female – age of 15-25 years old |
| C.) Adult Males – age 15-25 years old     |
| D.) The Elderly                           |

**10. One possible sudden deceleration injury on a victim of a high speed motor vehicle impact may include:**

- |  |
|--|
| A.) Bruising behind the ears                           |
| B.) Shearing of the aorta by the ligamentum arteriosum |
| C.) Pedal Edema  |
| D.) Paralysis on the left side of the victim           |

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**BY KERRIE HULL:**

RN, EMERGENCY SERVICE COORDINATOR-CALHOUN COUNTY

**This is a common misconception with regards to EMS System Standards.** Standard 1.04 System Administration: Medical Director/Medical Direction states: The EMS system shall have an active medical director or active Medical Director System. Systems

with multiple medical directors shall form a medical director advisory council to support the system medical director.

**What does this really mean?** No service needs to change their current medical director. If you are working on developing your system and each service has a different medical director, you can still meet this standard. As a system, you need to have all of the medical directors come together at a meeting to determine the protocols and policies of the system as a whole. As a group they can discuss and come to a consensus on protocols, scene times, transfer orders, etc. They can also determine what skills training, continuing education the services should be doing and how often.

**The system can have one protocol document that all the services will use and you still have your medical director.** As you continue developing your system, you can work on one CQI policy for the system that the medical directors approve, maybe even the same forms that can be shared among the services in your system. The possibilities are endless for your system to develop that work for all of the services together.

**If you have questions,** would like to be a part of this committee or would like assistance from a member of the Iowa EMS System Standards Committee, please contact Kerrie Hull, khull@calhouncountyiowa.com or 712-297-8619.

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**To nominate a person or service for one of these awards** you must:

- 1> complete this form.
- 2> include a letter of recognition/nomination.
- 3> submit your nomination to the IEMSA office before September 17, 2016. Return the completed form by mail to IEMSA, Award Nomination, 5550 Wild Rose Lane, Ste. 400, WDM, IA 50266, e-mail to [administration@iemsanet.net](mailto:administration@iemsanet.net) or fax to 877-478-0926.

> **Individual EMS Provider of the Year**

- ☐ Volunteer
- ☐ Career

> **EMS Service Provider of the Year**

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- > ☐ **Instructor of the Year**
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- > ☐ **Friend of EMS**
- > ☐ **Hall of Fame**

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Nominating Service/Organization Name

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