



JANUARY-MARCH 2003

Iowa Emergency Medical Services Association

NEWSLETTER

A V O I C E F O R P O S I T I V E C H A N G E I N I O W A E M S

It's Time To Repair Iowa's Safety Net

By Gary Ireland, IEMSA Executive Director



Iowa's system of delivering emergency health care in the out-of-hospital setting or Emergency Medical Services (EMS) has grown rapidly since its birth in the 1960s. Although Iowa's larger communities currently enjoy the advantages of full time, paid, career EMS service programs, the fact remains that the majority of Iowans depend on the volunteer system to provide out-of-hospital emergency medical care.

The volunteer system is a noble attempt by community-minded individuals to take care of its own. It is a system that has served Iowans very well over the past thirty years but its future, as we know it today, is in jeopardy. As the backbone of Iowa's EMS system, volunteerism is no longer able to keep up with the increased demands placed on EMS providers and service programs. Higher training standards, changing expectations by the public and EMS community, and the financial burdens of the volunteer service program have taken their toll on the system.

Although the volunteer EMS provider has been resilient over the years in meeting the increased demands, the biggest inherent problem of the volunteer

system of EMS is recruiting new volunteers and then being able to keep the existing ones. The pool of potential volunteers that are available in any given community has shrunk over time. Job requirements, childcare responsibilities, employer restrictions and the cost of training are a few of the reasons daytime coverage in some rural Iowa communities has reached a dangerously low level. Many volunteer EMS service programs are just one person away from a disaster. That is, one person on the squad becomes sick, moves away or for some reason can't respond, and Iowa's

EMS safety net fails. Since the events of September 11, 2001, our awareness has definitely been sharpened with respect to the threat of terrorism. However, what should strike terror in the hearts of Iowans is not the remote possibility of a hijacked plane crashing into a local high-rise but rather the likely possibility of no one responding to your 911 request for an ambulance in rural Iowa.

The funding for Emergency Medical Services has been primarily provided by the Iowa Department of Public Health, Bureau of EMS. A state appropriation

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Health Department Plans Smallpox Vaccinations

IDPH responds to President's announcement

The Department of Public Health and its public health and medical partners are committed to prepare and protect Iowans in the unlikely event of an outbreak of smallpox. It is developing the framework to help the state begin a voluntary program to vaccinate a strategic reserve of health care and public health workers in advance of any actual cases.

The department is working with local health departments, the Iowa Hospital Association, the Iowa Emergency Management Division, University of

Iowa Hygienic Lab, and state medical and nursing associations to determine the most appropriate front line health care professionals who will actually respond in the event of a smallpox case. They would be involved in the treatment of cases, as well as those who will investigate cases, track contacts, vaccinate those who have been exposed and those who will help prevent the spread of the disease.

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PRESIDENT'S MESSAGE

The Bus Stops Here.

As the driver of the IEMSA bus, my tenure has ended. I have served the maximum time allowed as your president and am ready to turn the wheel over to another. I am privileged to have had the opportunity to serve as your president, and rather than toot my own horn, I'd like to toot the horn of the IEMSA bus.

As I reflect back on the last four years as your president, there were many IEMSA accomplishments, most notably:

- Signing of HF2333 allowing EMS providers to work where healthcare is provided. EMS providers may now work outside the ambulance, wherever healthcare is provided, opening up an entirely new job market.
- Assisting with the Critical Care Paramedic and Transport issues;
- The hiring of Gary Ireland as the IEMSA Executive Director will enable us to increase our membership, visibility, and allow us to work more closely in the Des Moines area where the rubber meets the road;
- Lobbying for and successfully keeping state training funds at a time when all funds are being cut or eliminated completely;
- The establishment of a non-reverting fund within the Department of Public Health specifically for EMS, providing a safe haven for the money Iowa volunteers have relied on over the years for equipment and training;
- The improvement of the look, content, and educational offering of this newsletter;
- The offering of an outstanding and highly-attended annual conference;

- Being able to send two Iowa representatives annually to Washington DC for the Stars of Life program;
- Being able to help shape state policy, procedures, and protocols;
- And gum!

As I look forward (yes I'll be riding in the bus), I am excited about these projections:

- A continuous funding mechanism for EMS so we will no longer have to beg, borrow and plead for funds to volunteer our time to help save the lives of Iowans;
- Lobbying for a tax break for volunteers;
- Increasing the board of directors positions by 6 members indicating the need for more board involvement as IEMSA becomes increasingly more active;
- Increasing membership on all levels as more EMS providers become aware of the importance of membership;
- Continued system development in our rural areas linking it to the need to be more prepared for a large scale incident;
- Directing the hundreds of thousands of dollars coming to Iowa as part of the federal initiatives to make Iowa safe in the face of a natural or terrorist disaster;
- And let's not lose sight of why we are all doing this – to ensure Iowans receive timely and expert care with proven technology that saves lives.

We've taken great strides in moving EMS forward. As your voice in EMS, we will continue to ensure EMS is visible and its needs do not fall on deaf ears. This is possible because of the commitment of the IEMSA Board of Directors to the mission of IEMSA. I am honored to have served with some of EMS's biggest and brightest as they volunteer their time and expertise in shaping EMS for you – our members. I've learned many valuable lessons these past four years like coming to consensus with a room full of EMS providers can be tougher than nailing jello to a tree!

Thank you for your continued support of IEMSA and its board of directors. Without your paid memberships, the bus would have run out of fuel a long time ago.

So sit down, make yourself comfortable and enjoy the ride! May the new year find you healthy, happy and doing what you enjoy. Take care and God bless!

Your friend in EMS,
Jeff J. Messerole

Press Release from the Governor's Office Dr. Gleason Reassigned from IDPH

Governor Vilsack announced in late 2002, that Dr. Stephen Gleason, who has served as Iowa's Director of Public Health for the past four years, has agreed to serve as Chief of Staff. Vilsack announced that Dr. Gleason has provided strong leadership in challenges from upgrading emergency preparedness for possible bioterrorism attacks to combating the West Nile Virus. He also co-chaired our successful effort to redesign and streamline state government, to make it serve Iowans better.

It's Time To Repair Iowa's Safety Net

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established in the late 80s has provided \$660,000 annually to Iowa counties for the training of EMS providers. The training fund has remained constant since FY88, however training costs have not. In the middle 80s you could expect to pay \$200-\$300 for the training of a basic emergency medical technician (EMT). Today that cost is approaching \$1000 in many training programs.

The EMS Bureau has a total budget of approximately \$2.5 million with sources including both federal and state dollars. A recent legislative initiative has required the EMS Bureau to combine the training fund with existing system development money, making the entire fund available to counties on a competitive grant application basis. This has resulted in fewer dollars going to the counties for training and limited money available to counties for EMS system development.

New strategies must be developed to improve the way EMS is being delivered. Initiatives to that end began in the middle 90s with *Response 2020* system development grants available from the Department of Economic Development. Later, as a result of the tobacco company's settlement with Iowa, the Bureau of EMS also made system development grants available to counties. Both these programs proved successful however, funds are no longer available from Economic Development and the amounts available from the Bureau of EMS will not sustain the effort necessary to improve Iowa's volunteer system. These types of initiatives must be continued and made available to all counties if Iowa is to enhance and improve its volunteer EMS system.

The goal of EMS system development initiatives is to enable communities to identify, modify or enhance local resources to reduce suffering, disability and death from injury and illness while

ensuring access, quality and affordable out-of-hospital EMS. To accomplish that goal, a collaborative effort of EMS stakeholders needs to be made to secure a mechanism to establish an ongoing dedicated funding source for Iowa's EMS system. Such funding will support existing EMS program activities and encourage necessary system development.

The Iowa Emergency Medical Services Association, in cooperation with the Iowa Fireman's Association is seeking legislative action to establish a dedicated funding source to support fire and EMS. The proposed legislation would attach a \$5 surcharge on all vehicle license plates issued each year. The results would generate \$15 million annually to support Iowa's EMS and fire response systems. This end user fee would create a continuous source of funds that would eliminate the uncertainty of federal funds, grants and state appropriations. In fact, this proposal would return over four million state-appropriated dollars back to Iowa's depleted general fund.

The Iowa Emergency Medical Services Association believes that the EMS portion of the proposed funding must support four primary components: 1) provide initial education/training for Iowa's volunteers; 2) provide system development grants to all counties to encourage new strategies; 3) support Iowa's 117 Trauma Care Facilities with data reporting and personnel training, 4) and support the lead state agency for EMS, the Iowa Department of Public Health, Bureau of EMS.

According to the National Highway Traffic Safety Administration's EMS Agenda For The Future document, *"Emergency Medical Services of the future will be a community-based health management that is fully integrated*

with the overall health system."

To accomplish that vision, Iowa must ensure that dedicated funding is available to guarantee that EMS will remain the public's emergency medical safety net. Iowa's volunteer system of delivering EMS is in trouble.

It is time to repair the safety net and invest in the future.

The issue of continuous funding was among IEMSA's legislative priorities that were presented to Iowa's Legislators at the February 11th EMS Day on the Hill.



UPCOMING IEMSA MEETINGS

IEMSA's Board of Directors will meet on the following dates. Each meeting (10:00 a.m. – 1:00 p.m.) will be held at Fire Station #17, 1401 Railroad Avenue, West Des Moines (515-222-3422). All members are welcome to attend. Minutes of each meeting will be available at www.iemsa.net.

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|------------------------------|
| March 13 |
| April 17 |
| May 15 |
| June 19 |
| NO JULY MEETING! |
| August 21 |
| September 18 |
| October 16 |
| November 13 – ANNUAL MEETING |
| December 18 |



Conference News 2002/2003

“Fantastic conference; all sessions I attended were definitely worthwhile.....”

While many of you have been busy tabulating your hours for March 31st recertification, the conference committee has been busy evaluating the 2002 conference and planning the 2003 conference. Overall responses from the 2002 evaluations showed that we need to make efforts to get more vendors in the vendor hall – particularly ones selling shirts and books. Audio-visual glitches still plagued us, and breakfast and breaks need to be enhanced. Participants liked the tables at the keynote sessions, most approved of the move to having lunch provided both days, and pre-conference workshops were a success! The evaluations also showed that the board meeting should be moved up in time, and some other minor schedule changes are needed. Moving the dance back to a hotel last year was such a success that the dance room at the Savory, which is the biggest room they have, was not big enough and so, this year the dance will need to be moved to the Marriott. The Marriott and Savory will again be the host hotels.

We are pleased to report that in 2003 we will be bringing in some very prominent national EMS speakers. Mike Helbock, Dr. Brian Bledsoe and Dr. Peter Pons have all agreed to participate, and Baxter Larman will be making a return engagement! Mike Helbock will bring his highly acclaimed and published “Sick / Not Sick” program to our conference. Dr. Brain Bledsoe, whom you probably recognize as the author of numerous EMS textbooks and publications, and Dr. Peter Pons, who is also a well renowned EMS authority, will bring their wealth of knowledge to share with you. Many of you will remember Baxter Larmon from previous IEMSA conferences. Baxter educates while making his presentations entertaining and humorous. Half-day pre-conference workshops will return in 2003 and two additional workshops will be added. One will concentrate on topics of Disaster Preparedness and another will offer Critical Care Paramedic level continuing education. All CCP’s must have 8 recertification hours, specifically in critical care topics, and this workshop will provide 4 hours of that. The 12-lead pre-conference workshop will be modified to a workshop offering advanced level topics.

Don’t get caught looking for last minute continuing education credits. If you don’t already have your calendars marked, be sure to reserve November 13-15, 2003 for the best IEMSA conference ever!

EMT-B Offered For Teens At Des Moines Central Campus

*By: Sheila Starkovich Lingwall RN,
BA, EMT-B*

The Des Moines schools have had a long history of offering health-related courses to students. An opportunity arose several years ago to rethink those course offerings and, following conversations with the State, the decision to offer EMT-B to seniors in high school was made and an affiliate was sought. A call was made to Mercy School of EMS, and the answer to the question, “Would you be interested in supporting a high school EMT class” was met with a firm, “Yes.”

The course requirements are:

- Must be a 17 year old senior in high school.
- Must maintain a GPA of 2.5
- Must meet with the instructor to understand the requirements of program.

The course work takes place at Central Campus. The Class meets every day from 11:35 a.m. to 2:35 p.m. The students spend one day a week with the Paramedics at Mercy School of EMS learning skills. The requirements for passing are the same as the adult class. All expenses are the responsibility of the student. Thanks to Mercy School of EMS, the tuition is a fraction of the cost for an adult.

Through the Shared Programming Act of Iowa, the students also receive six community college credits. When the students successfully complete this semester program, pass all the required tests, and turn 18, they can become

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EMT-Bs. This program offers students a wonderful opportunity to enter the field of EMS and learn life-long skills. It also prepares them for other health-related fields.

Not enough can be said for the support, dedication and professionalism of the staff at Mercy School of EMS. Without them, this opportunity would not exist.

Any student, meeting the aforementioned criteria and who has transportation to Des Moines can enter this program. Call the Central Campus counselor Steve Carnahan @ 515-242-7676 for details.



AMBULANCE FOR SALE

For Sale: 1989 Ford E350, Type 3 Ambulance, XL Diesel, automatic, approximately 210,000 miles. Very clean. Well kept. Used as a First Responder vehicle. Would make a great First Responder/Rescue or Back-Up Unit. Runs good. Good tires. Cheap buy at only \$3,500. For more information, call 641-483-2823 and ask for Brad, or 641-483-4046 and ask for Kim in State Center EMS. Hurry – this one will go fast!

IEMSA BOARD OF DIRECTORS ELECTS OFFICERS



Jeffrey D. Dumermuth, EMT-P and Rosemary Adam, RN, EMT-P(Spec.) were elected, unanimously, to the positions of President and Secretary (respectively) of the IEMSA Board of Directors at the January 16th, 2003 Board Meeting. Cindy Hewitt (Vice President) and Bruce Thomas (Treasurer) will continue to serve in their respective positions until December 31, 2003.

Jeff Dumermuth, Director of West EMS (a collaborative effort between the City of West Des Moines and Dallas County), represents the South Central Iowa Region. He formerly served as Secretary of the IEMSA Board of Directors during 2001 and 2002. In addition to his EMT certifications, Jeff is an LPN and holds a BA in Public Administration. He is certified as a Critical Care Paramedic, an EMS Instructor for the State of Iowa as well as Instructor for Advanced Medical Life Support, CPR, First Aid and Pediatric Pre-hospital Care. Jeff has been a member of IEMSA since 1997.



One of the first members of IEMSA, **Rosemary Adam** has served on the Board in various capacities since 1997. She is currently one of the "At-Large" Board members and, most recently, has been actively involved as the Chairperson of the Newsletter and Awards Committees as well as IEMSA's representative to TSAC.

Rosemary has been an EMS Nurse (RN, Paramedic Specialist) since 1976 and is actively involved in ground and air transport, emergency medicine and education.

IEMSA Legislative News

By David Cole, Legislative Committee

Founded in 1987, IEMSA is your voice in EMS. Its Legislative Mission includes: the ability to promote and advance the quality of care and professionalism of those who deliver emergency medical care throughout Iowa. The best way to deliver our message is to communicate to each other as well as to our Local Legislators.

This year's legislative session certainly has many priorities. EMS is also important! In order to get our message out, we must contact our legislators at home and at the capitol. The IEMSA web site and office will keep you updated on the issues. You can help by contacting your local Senators and Representatives and let them know your feelings.

You can e-mail them as follows:

First name.last name@ legis.state.ia.us

Example: Stewart.Iverson@legis.state.ia.us

To contact them in writing or by phone:

Name of Legislator

Senate Switchboard

(515) 281-3371

State Capitol

House

(515) 281-3221

Des Moines, Iowa 50319

For a listing of your legislators you may call (515) 281-5129 or visit their web site at www.legis.state.ia.us.

CORPORATE SPONSORS AND AFFILIATE MEMBERS

SUPPORT IEMSA'S MISSION

Many thanks are extended to IEMSA's Corporate Sponsors and Affiliate Members. As Corporate Sponsors and Affiliate Members, these organizations provide support for the work that IEMSA does for EMS throughout the State of Iowa. That support provides funding, leadership and commitment to IEMSA as the Association strives to:

- Provide a forum for Service Directors to voice their concerns about issues such as Medicare reimbursement, OSHA requirements, etc. through the EMS Service Directors Committee meetings;
- Offer up-to-date information at the Iowa EMS Annual Convention & Trade Show.
- Provide quarterly newsletters to all members to keep them current on issues affecting them, as well as an opportunity to gain CEHs from the self-study article.
- Create change by retaining a lobbyist to be your voice in the Iowa legislature to promote a retirement bill for EMS volunteers, as well as continuous funding for EMS providers and the Bureau of EMS.

Please join us in thanking our Corporate Sponsors:

Iowa Donor Network
Life Line Emergency Vehicles
LifeQuest
Medic EMS
Mary Greeley Medical Center
Mercy School of EMS

And our Affiliate Members:

Adair Fire & Rescue
Adel Fire & Rescue
Algona EMS
American Medical Response
American Ambulance
Ameristar Casino
Anamosa Area Ambulance Service
Area Ambulance Service
Asbury Community Fire Department
Belmond Volunteer Ambulance Service
Bennett Ambulance Service
Bettendorf Emergency Services
Buffalo Center Ambulance
Carroll County Ambulance
Cedar County EMS Association
Cedar Falls Fire & Rescue
Cedar Rapids Fire Department
City of Tama
Clarke County Hospital Ambulance Service
Clarksville Ambulance Service
Clinton Fire Department
Clive Fire Department
Council Bluffs Fire Department
Covenant EMS Service

Dallas County EMS
Danbury Community Ambulance
Davis County Hospital
Delaware C Memorial Hospital
Denison Medical & Surgical Association
Des Moines Fire Department
DeWitt Ambulance Service
Dunkerton Ambulance Service
Dysart Ambulance Service
E. Poweshiek Co. Ambulance Service
Farmington EMS
Fraser Medical Services
Hawarden Ambulance
Heartland Regional Paramedic Service
Henry County Health Center-EMS
Indianola Fire Department
Iowa City Fire Department
Iowa County Ambulance Service
Isle of Capri Casino
Jackson County Hosp./Ambulance
Jesup Ambulance Service
Johnson County Ambulance Service
Kanawha EMS Advisory Board
Keokuk County Ambulance Service
Keystone First Responder
Lakes Regional Healthcare
Laurens Ambulance Service
Lee County Ambulance, Inc.
Lester Rescue Squad
Lifeguard Ambulance
Little Rock EMS
Lohrville Ambulance
Lone Rock First Responder
Long Grove Fire Department
Mahaska Hospital Ambulance
Marcus Fire Department

Mary Greeley Medical Center Ambulance
Service
Mechanics Ambulance Service
Midwest AmbuCar
EMSAR
Monroe County Hospital
Monroe Fire Division of EMS
Moorhead Rescue
New Sharon Fire & Rescue
Norwalk Fire Department
Pella Community Ambulance
Preston Community Ambulance
Readlyn First Responder
Remsen Ambulance
Riceville Ambulance Service
Royal First Responder
Sartori Paramedics
SE Iowa Ambulance Service
Sibley Ambulance
Sioux Center Ambulance
Solon Fire Department
St. Ansgar Rescue Squad
Stuart Rescue Unit
Thompson Rescue Unit
Toledo Fire & Emergency Services
Traer Ambulance Service
Trinity Ambulance Service
Tripoli Ambulance Service
Urbandale Fire Department
Van Buren Ambulance Service
Washington County Ambulance
Wellman Ambulance
West Des Moines EMS
Wheatland Medical Service
Whittemore Ambulance Service
Windsor Heights Fire Department
Winfield Fire & Rescue

Health Department Plans Smallpox Vaccinations

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Following the statements by the President and the Centers for Disease Control and Prevention (CDC), the smallpox vaccine is not being recommended to Iowans at large. That could change should the risk become more imminent. This prevention effort – a process to protect those who are going to protect the public – is designed to reduce the state's vulnerability to a smallpox terrorist attack.

The current smallpox vaccine is very different from other flu vaccines. Based on historical data, it's expected that 14 to 52 people per million vaccinated will suffer life-threatening reactions. As such, decisions about which Iowans to be offered the vaccine will not be made lightly.

Besides the complications, about 25 percent of the population cannot receive the vaccine because of health conditions. Those include pregnancy, skin disorders, organ transplantation, or treatment for HIV or cancer. It will also not be offered to anyone who is a family or household contact of someone with the above conditions.

The department is forming regional smallpox response teams to be the first offered the smallpox vaccine. One group, formed by the department, consists of six regional public health response teams. The teams are expected to include disease investigators, epidemiologists, health lab workers and public health nurses and administrative personnel. Besides the public health response, hospital-based teams will also be established.

Iowa's smallpox response proposal has been submitted to the federal Centers for Disease Control and Prevention (CDC). No vaccinations will begin in the state until the CDC allocates vaccine to Iowa and the Homeland Security

Act becomes effective. The earliest, therefore, that vaccinations for anyone in Iowa could begin is January 24, 2003.

For more information on smallpox and the smallpox vaccine, see the department's web site at www.idph.state.ia.us

Ray Jones Named IDPH, Bureau of EMS Chief

Ray Jones, long-time Paramedic and EMS Regional Coordinator from Southeast Iowa was named EMS Bureau Chief in late 2002.

Congratulations, Ray!

EMS 2002 Gold Award Winner

EMS Magazine - Volunteer Service

Pleasant Hill Emergency Services was selected as EMS Magazine's 2002 Gold Award Winner for Volunteer Service!

Pleasant Hill Emergency Services was officially launched in the 1950's and joined the Fire Department as an ambulance service 10 years later. In the late 1980's, it became a paramedic level unit. At present, 30 volunteer members respond to 420 calls annually, in addition to teaching numerous classes in the community and within the fire and EMS services. In 2001, these volunteers donated more than 10,000 hours of service to the community.

Pleasant Hill, a community of about 6,000 just east of Des Moines, has the first 12-lead capability in central Iowa as a volunteer service. In current operation are two ALS ambulances, equipped for multiple levels of communication and mass casualty events; a rescue truck with various extrication capabilities; and water rescue equipment.

In the last three years, in response to a decline in volunteers, Pleasant Hill FD has hosted four EMT-B classes and an EMT-I course. As a result, the number of EMT's has tripled from 6 to 25 and from 1 to 10 Paramedics.

Pleasant Hill medics are very visible in their community, participating in events like the Winter Light Parade, St. Patrick's Day parade, the annual Easter egg hunt and Summerfest – a three day community celebration. In May, an open house allowed citizens to see the new 12-lead defibrillator, have their blood sugar tested or blood pressure screened, and obtain a "Vial of Life" for personal medical information. EMS personnel offer free CPR courses to staff in local medical facilities, as well as to the community. They are heavily involved in injury and fire prevention in local schools and at the Iowa State Fair. At its annual pancake breakfast, EMS personnel served more than 1,400 people.

Although no compensation is received for serving on this squad, there is currently a waiting list of eight who want to join.

**CONGRATULATIONS, PLEASANT HILL
EMERGENCY SERVICES!**

Annual Awards Presented at IEMSA Conference and Trade Show

November, 2002



EMS Instructor of the Year

Judy Rurup

Judy Rurup has been a member of the Southwest Webster EMS program for approximately 15 years and teaches 2-3 EMT classes per year along with several continuing education programs annually. Judy is an EMS nurse who is the Southwest Webster EMS Service Director.



Friend of EMS

Gerald Brown

Gerald Brown has worked with the Union Area Ambulance Service for more than 15 years as a driver along with serving over the years as Assistant Fire Chief, Medical Death Investigator and Mayor. Gerald was nominated because of his unique abilities in the areas of public relations, volunteerism and compassion for all patients.



Volunteer Individual EMS Provider of the Year

David Kleis

David Kleis has volunteered an average of 68 hours per week with the Anamosa Area Ambulance Service as a Basic EMT since 1976, along with his full-time job as a Captain at the Iowa State Penitentiary. David's ability to go "above and beyond the call," along with his tremendous rapport was emphasized.



Career EMS Service of the Year

*Muscatine Fire
Department EMS*

Muscatine Fire Department EMS took over all EMS activities for the city of Muscatine in 2000, operating as the First Response Paramedic Unit prior to that date. With 15 Paramedic Specialists, 4 Iowa Paramedics, 16 EMT-Basics and Intermediates with 11 EMS Instructors, Muscatine Fire Dept. EMS provides high quality patient care, specialized services and community betterment programs.



Volunteer EMS Service of the Year

*Humboldt County
Memorial Hospital's
Ambulance Service*

The Humboldt County Memorial Hospital's Ambulance Service provides all EMS coverage for approximately 2/3 of Humboldt County with approximately 500 calls per year with 30 volunteers. This nomination came with 12 letters of support from various community leaders that stated that this service is actively involved in many community events, good public relations, along with good patient care.



Career Individual EMS Provider of the Year

Gerald Ewers

Gerald Ewers has been a paramedic for 12 years and is a current member and now assistant Chief of the Muscatine Fire Department EMS program. Since the fire service has taken over all aspects of EMS within the area, Gerry has been busy with new protocols, a new organizational structure and credentialing the crew with all the new courses available. He is actively involved in safety and prevention activities within the community, as well. Nominated as being "the best that he can be" and a mentor.

CONGRATULATIONS, AWARD WINNERS!

Incident Command, Triage and Use of the START Technique

With the recent focus on disaster preparedness in emergency services, it's a good idea for all services and EMS personnel, including Dispatchers, to reintroduce themselves to Incident Command principles, use of Triage and specifically, use of the START system of sorting patients. The START system has become the nationally recognized Triage system that has been written into Iowa's State EMS protocols.

Disasters have historically been associated with man-made or natural events that were called by emergency services when the number of patients, the geographic area or the amount of damage was too significant for the local resources to handle. In this day and age, it is important for us to note that man-made, terrorist activities may initiate mass casualty incidents that may overwhelm even our State or Federal resources.

When a mass casualty incident (MCI) or Disaster is called, the resources of several agencies must be organized in order to limit further damage, rescue, resuscitate, sort, and transport those injured. These agencies may include EMS, Fire, Rescue, Law Enforcement, Federal Emergency Management Agency (FEMA), and other resources that, if operated independently in one incident, would create chaos. Incident Command was established in order to prevent the chaos that many times is associated with MCIs and Disasters. **Incident Command System (ICS)** is a single entity that organizes all interagency functions and responsibilities during an MCI. Cooperation and preplanning are keys to success in this system.

How to Declare a Major Incident

EMS should follow their local protocols for declaring an MCI or Disaster. As Dispatch and EMS personnel gain initial information from bystanders, both should communicate early warnings to all pertinent agencies, but then EMS should confirm it once on the scene. This allows Fire and Police to gain early warnings for gathering resources. This early communication should go to local hospitals and Medical Control, as well.

In general (please follow your local protocols), an MCI should be called in the following situations:

- Any situation that requires more than two ambulances, particularly in rural areas;
- Any situation involving hazardous or radioactive materials or chemicals in significant quantities;
- Any situations that requires special EMS resources, such as helicopters, rescue teams, or multiple rescue or extrication units;
- When in doubt – declare it.

The first EMS unit to arrive at the scene should make a “windshield assessment” and augment any information already pre-warned to the communications center. A complete assessment should be performed as soon as safety and time permits.

Incident Command

FEMA has a national standard for the development and use of an Incident Command System and it is built around 5 major components: Command,

Planning, Operations, Logistics and Finance/Administration, (C-FLOP).

One person is in charge. This person is called the Incident Commander. Incident Command must be familiar with the ICS and all aspects of responding agencies.

Command must be established immediately, commander identified and all on scene notified of that assignment. Command will do the following:

- Assume effective command mode and position
- Transmit brief reports to the communication center and relate location of the ICS.
- Evaluate the situation rapidly and develop a strategy to manage the scene.
- Request additional resources and provide assignments.
- Implement a personal accountability system.
- Assign and control sectors as needed with supervisors that are working towards a common goal
- Review and revise operations as needed on a continuous basis.

Communications

An Emergency Operations Center (EOC) in charge of communications may be part of your Disaster Plan. Whether using the standard communications center or the EOC, taking control of communications is a must. Radio traffic may be very distracting and all personnel must observe strict radio procedures during MCIs. All radio traffic must be short and to the point.

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Gaining Resources

The communications center or EOC must immediately follow their Disaster Plan, request Mutual Aid and additional resources as requested by the first units on the scene and then the Incident Commander.

Staging Sector

Once ICS is established, a sector supervisor must set up responding resources and identify a formal staging area to include the following steps:

- line vehicles up to facilitate egress
- stage near large volume highways

If your service is called to an MCI, you must first report to this staging area for direction and your vehicle/crew logged with the Supervisor. News media and support services should be contained and organized by this sector supervisor. Blocking off streets and highways are coordinated with Police.

Extrication Sector

It is essential that the supervisor of this sector provide safety equipment to emergency personnel as they arrive. This sector provides rescue for victims, initial triage, primary treatment, categorization, and tagging and then transfer onto the treatment sector. Patient care activities are confined to assessment and treatment of life-threatening injuries only – basic airway maneuvers, control of bleeding, and covering open chest wounds. The supervisor of this area must organize the patients' movement to the treatment sector.

Treatment Sector

The personnel within this sector must work closely with those in the Extrication Sector in categorizing and organizing patient care. Most advanced level and hospital personnel responding to the MCI should be assigned here. Treatment zones may be established

within this sector, identifying those patients with life threatening vs. less severe injuries. Triage is a continuous process throughout all of these patient care areas.

Rehabilitation Sector

If a long rescue effort is expected, a "rehab" sector should be established away from the patient care and operations areas for emergency personnel to rest. This supervisor must log personnel in and out and provide monitoring for safety purposes if hazardous materials are involved.

Transportation Sector

This sector communicates with receiving hospitals, ambulances and aeromedical services for transport. The personnel within this area must work with the supervisors in the staging and treatment areas in order to determine which patients need to be transferred where and by whom.

Support Sector

This sector organizes and distributes equipment and supplies for all other sectors.

Triage

Triage is a continuous process of sorting patients for priorities of treatment during a major incident. This assessment is based on abnormal physiological signs, obvious anatomical injury (including mechanism of injury), and concurrent disease factors that might affect the victim's outcome. Constant monitoring of the patient's status will warrant changes in the initial category and priority of treatment.

There is a primary and secondary classification of triage. Primary triage is used at the site as the EMS provider documents the location of the patient and the transport needs. A triage tag is applied and no care, other than

immediate life threatening, is rendered during this phase. Primary triage is used to sort patients quickly. Secondary triage is used at the Treatment Sector. Re-triage is done and tag documentation is added.

START Triage

The START plan (Simple Triage and Rapid Treatment) was developed by the Hoag Hospital, and the Newport Beach (CA) Fire Department to be used in the event of an MCI. The plan is based on three observations:

- Respirations
- Circulation
- Mental Status

The START plan calls for rescuers to correct the main threats to life then use METTAG Triage Card, which classifies patients into four categories for treatment. (NOTE TO READERS: Please follow your service protocols for color-coding triage.)

Deceased: Black.

No ventilations present even after attempting to reposition the airway

Immediate: Red.

Ventilations present only after repositioning the airway or respiratory rate > 30 per minute.

Capillary refill delayed. Patient unable to follow simple commands.

Delayed: Yellow.

Any patient who does not fit into either of the other categories.

Minor: Green.

"Walking Wounded." Should be separated from the injured group at the beginning of the triage operation. Direct these patients away from the scene to a designated safe area. You may use these patients to control bleeding and assist in airway maintenance of the immediate patients.

The START Procedure

1. Assess the patient's ability to walk. Classify as DELAYED (Green) and direct the patient to a safe, designated area. If the patient cannot walk – assess respirations
2. Evaluate breathing and rate. If breathing is absent, even with airway open, classify them as DECEASED (Black). A respiratory rate of < 10 or > 30 in the adult indicates IMMEDIATE (red). If respirations are adequate, don't classify until perfusion is assessed.
3. Assess pulse/perfusion. If no pulse, classify as DECEASED (Black). If the carotid is present but not the radial with inadequate perfusion (cool, clammy skin & delayed capillary refill), classify the patient as IMMEDIATE (red). If the patient is not walking, but breathing and perfusion are adequate, assess mental status.
4. Assess mental status. Ask the patient to perform two simple tasks. For instance, ask them to touch the finger to the nose or stick out the tongue. Assess orientation to name, date, year. Those unable to perform any of the tasks are classified as IMMEDIATE (RED). Patients unable to perform one of the tasks are classified as DELAYED (yellow). If the patient's respirations, perfusion and mental status are OK, classify as MINOR (green).

Basic airway maneuvers and direct control of external hemorrhage are the ONLY treatment measures completed in primary triage. In an MCI, these treatment measures should NEVER delay triage of other patients. Occasionally, the walking wounded can assist in providing these two interventions.

Sample MCI and START Triage Situation

You have two ambulances staffed with on-duty and on-call personnel today with Paramedic Specialists available to both trucks. You have a third ambulance in quarters that might be staffed with some assistance from off-duty personnel (and lots of phone calls from Dispatch).

Your on-duty ambulance is on a transfer and is 50 miles away as the on-call team gets dispatched to a multi-car accident. The Dispatcher insinuates that this may be "bad" and asks if you want her to go ahead and request Mutual Aid. Law Enforcement on the scene 2 minutes after your activation reports a school bus and 2 cars involved – approximately 20 patients.

The on-call ambulance announces to Dispatch that their MCI (Disaster) Plan should be instituted. The phone tree is initiated and all pertinent agencies are notified, including local hospitals. This

ambulance arrives, along with local Law Enforcement and the volunteer fire department (which also provides rescue). A "windshield assessment" is done and the Dispatcher is told that MCI is confirmed. Radio communication now will shift to the Incident Commander (Fire Chief).

The National Standard EMT-Intermediate and Paramedic begin to provide primary triage. Of the possible 20 patients, 10 are seen up and walking around the area. You have one school bus, 1 mini-van and 1 car involved. No obvious hazards are sensed.

Dispatch notifies Incident Commander that four ambulances and two helicopters will be arriving on this scene within 20-30 minutes. The Incident Commander immediately assigns a senior Fire Fighter to assume the role of Staging Supervisor.

Please use the START system to triage the following patients encountered in the primary round:

(continued on page 12)

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| Victim | Type of Injury | Pertinent Information | Category | Rapid Treatment Needed-Reason |
|---------------|--|--|-----------------|--------------------------------------|
| #1 | Unable to move legs | Resp < 30 | | |
| #2 | Scalp wound, est. blood loss=500cc | Resp. > 30 Cap.Refill< 2 sec. Awake | | |
| #3 | Severe difficulty breathing, paradoxical chest | Resp. > 30 Radial pulse present Awake | | |
| #4 | Bruise on forehead Blood in ears/nose | Resp. < 30 Cap. Refill < 2 sec. Awake | | |
| #5 | Blood in Rt. Eye | Resp. < 30 Radial pulse present Unconscious | | |
| #6 | Diabetic Pt Skin moist & clammy; feels shaky | Resp. < 30 Cap. Refill > 2 sec. Awake | | |
| #7 | Very pregnant; Leg fracture | Resp. > 30 Radial pulse absent Cap. Refill > 3 sec. Awake | | |
| #8 | Child with open arm fracture | Resp. > 30 Radial pulse absent Cap. Refill > 4 sec. Awake | | |

Summary

Planning, practice and re-planning for any multi-casualty incident, whether from Mother Nature or a Human, cannot be emphasized enough. As Iowa EMS and other emergency service agencies re-investigate and learn about the needs of their service area and State in regards to education in bio-terrorism, weapons of mass destruction, and other disaster situations with this new directive from our Federal government, a personal incentive to reeducate ourselves in the simple systems already in place should be completed.

Bibliography/Additional Resources

M. Sanders Ed., "Paramedic Textbook", 2nd Edition, Mosby, 2000, Chapter 49.

Rescue, World Wide Web: "Rescue – First Aid – Simple Triage and Rapid Treatment (START)", pages 1-4,
<http://www.techrescue.org/firstaid/firstaid-ref2.html>

Incident Command and START Triage Post Test

Iowa EMS Association members who achieve 80% on this 10-question post test after reading the attached article will receive 1 informal hour of continuing education through Hawkeye Community College, EMS Education, Provider Number 07, Waterloo, Iowa. If there are any questions regarding continuing education, please e mail: jelang@hawkeyecollege.edu or call (319) 287-5257.

Please send completed post-test to:
Hawkeye Community College
Attention: Julie Lang-Gesie
3576 Lafayette Rd.
Evansdale, IA 50707.

All questions are referenced within the article and many questions deal with the sample situation described.

1. While referring to the START system of triage in the primary triage phase, patient #4 requires the following:
 - A. Basic airway maneuvers, apply a red tag and move onto other patients.
 - B. Control bleeding, apply a red tag and immediately move this patient to Treatment Area.
 - C. Basic airway maneuvers, apply a yellow tag and move onto other patients.
 - D. Immediately apply a black tag as this patient is beyond your resources to help.
2. Secondary triage should be performed:
 - A. in the Staging Area.
 - B. in the Treatment Area.
 - C. in the Transportation Area
 - D. in the Triage Area.
3. Using the START system, what category should be assigned to patient #5?
 - A. black
 - B. red
 - C. yellow
 - D. green
4. In an MCI, advanced EMS providers and designated hospital personnel should be assigned to:
 - A. Primary triage in the Extrication Sector.
 - B. Secondary triage in the Treatment Sector.
 - C. Staging Sector only for MCI.
 - D. Transportation Sector to go with patients.
5. Using the START system, all 10 of the walking wounded should be designated with a _____ tag and:
 - A. black; moved to the local hospitals immediately to get them out of the way.
 - B. yellow; moved to the Staging Sector to get them out of the way.
 - C. green; assigned simple life saving tasks in primary triage if necessary.
 - D. red; discharged from the scene to get them out of the way and to facilitate care.
6. START triage uses three (3) assessment parameters. They are:
 - A. Mechanism of injury, Environment and Numbers of Victims.
 - B. Mechanism of injury, Number of Rescuers, and Number of Victims.
 - C. Response to Airway Maneuvers, Respirations, and Circulation.
 - D. Respirations, Circulation & Mental Status with METTAG assignment.
7. Using the START triage system, patient #3 in primary triage should:
 - A. be tagged red and no primary triage treatment rendered.
 - B. be tagged yellow and intubation performed immediately.
 - C. have oxygen applied, intubation performed and be tagged red.
 - D. have a rescuer assigned to take him off the scene immediately.
8. Using the START system in the primary triage, patient #7 should have:
 - A. the first priority of all patients due to her pregnancy.
 - B. uterine displacement to the left and tagged red.
 - C. no treatment in this area, but should be tagged red.
 - D. a yellow tag once her uterus is displaced and oxygen on.
9. In the START system in primary triage, patient #8 should have:
 - A. hemorrhage controlled and be tagged red.
 - B. assistance walking to the Treatment Sector.
 - C. a yellow tag once bleeding is controlled.
 - D. a green tag once bleeding is controlled.
10. In the MCI described in the article, patient #6 should be treated and tagged as follows:
 - A. no primary treatment, tag is yellow and treated in the Treatment Sector with glucose.
 - B. no primary treatment, tag is green and walked to the Treatment Sector for glucose.
 - C. no primary treatment, tag color is black and she should be left in the Triage Area.
 - D. oxygen in primary, tag is red as this patient will become unconscious if untreated.

Dallas County, Iowa, Residents Learn First There, First Care

Dallas County is a mostly rural area west of Des Moines, Iowa. Roads are long, straight and flat – the perfect speedways for bored teenagers in fast cars and drivers in a hurry to get home from work. Dallas County residents also favor other motorized vehicles for transportation and recreation, including all-terrain vehicles and motorcycles, causing Dallas County to have a high incidence of vehicle-related trauma. Frequent accidents combined with rural ambulance response times of up to 15 minutes make Dallas County the perfect place to educate residents on the importance of calling for help after an accident, how to provide the right information to dispatchers and how to care for injured patients until help arrives. The First There, First Care Bystander Care of the Injured Program seemed like a good way to make this happen, so Deb Hrubes, EMT-PS, a Paramedic with Dallas County EMS, with the support of EMS Director Jeff Dumermuth, applied for a \$2,500 grant from NAEMT and the National Highway Traffic Safety Administration to start a program in the county. The county was one of 10 rural agencies to win a grant. “Our biggest hope is that people would be able to recognize when something happened and call 911,” she said. “We want to make them feel that they’re not just paying taxes [for EMS services] but that they can participate in helping others, too.”

To implement First There, First Care (FTFC), Hrubes recruited one or more

First Responders from each of the county’s 12 volunteer agencies, who came together to learn the FTFC curriculum and serve as liaisons in their communities. Dallas County has a strong first responder program that is supported by the local volunteer fire departments that initiate patient care in advance of the ambulance arrival. “We have an amazing group of First Responders that support all our efforts to provide quality EMS care for our residents,” said Hrubes.

Hrubes created a PowerPoint presentation to teach the FTFC program, and assembled 200 mini first-aid kits for students enrolled in FTFC classes. The kits are packaged in a small pencil pouch imprinted with the Dallas County EMS logo and include gloves, a roll of one-inch tape, two 5x9 bandages, trauma shears and a plastic Laerdal Resuscimask. “It’s a perfect size to throw in the glove box,” Hrubes said.

The First Responders arranged classes in their communities for groups as small as eight people to as large as 40, with students ranging from 8 to 80. Some classes were held in conjunction with school programs; one recruited during a town festival, and another recruited students who attended a Prom Night safety class.

Hrubes relies on the First Responders to bring the program to their communities where they are trusted and familiar with local needs, but she and another Paramedic, Jodi Scharingson, from the county provide the slide presentation and equipment and teach

the clinical portion of the classes. First Responders are called upon to relate their experiences with trauma in the community. About one-quarter of FTFC students also report having personal experience with or past involvement in a serious accident.

In a community in which county Paramedics rely heavily on First Responders to provide pre-hospital care until arrival, and First Responders rely heavily on citizens to provide accurate information about the patient and accident location, FTFC meets an important need, but Hrubes said that the program also has application in the suburbs. “Having detailed information when a call comes in and having people there so we can find the patient is a valuable thing,” she said.

Dallas County plans to continue the FTFC program after the initial grant money runs out, and has committed its support to Hrubes by picking up mailing and administrative expenses and covering the medics’ shifts if they have to teach a class while on duty. Hrubes said that she hopes to use donations to a county EMS trust fund to pay for additional first-aid kits.

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May 1 (to be mailed by May 20),

August 1 (to be mailed by May 20),

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The Newsletter Committee will review all articles submitted and reserves the right to edit the articles, if necessary.

