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IEMSA

January – March 2006

VOICE

A **VOICE** FOR **POSITIVE** CHANGE IN **IOWA** EMS

Iowa Emergency Medical Services Association

PLANNING *for a* PANDEMIC

The Worst Case Scenario Sometimes Does Happen

BY BRAD MADSEN, IEMSA BOARD MEMBER, SC REGION

As you sit at home or at the ambulance station, try to imagine what you and your EMS service would do if your call volume increased by 20% (arbitrary number), but half of the department was unable to respond for a good 2-3 weeks. Would your service be burdened? If your service is like mine, the undoubted answer is yes. If the first thing you thought about is simply using your 28E agreement with the neighboring town, try to imagine that they are in the same boat.

To act as your official doomsday prognosticator, I am obliged to tell you that this scenario is likely to happen in the event of an Avian Influenza Pandemic. Fresh back from the Governor's Summit on Avian Flu held in Des Moines on Friday, February 3, I bring news from the State and Federal Governments. That news is…You'd better do some planning.

The main message from the summit is that pandemic planning (just like any sort of contingency planning) needs to happen locally - it falls to folks like you and me. U.S. Secretary of Health and Human Services Mike Leavitt assures us that the Feds are working on plans, but we can't count on FEMA to mobilize and take control in the event of a pandemic. The Feds simply cannot be everywhere at the same time.

Many people have scoffed at the idea of Pandemic Planning and said: "Our County has a biological emergency plan in place and all we have to do is pull it out if a pandemic hits." My response to this is two fold. First, have you actually seen the plan? If not, don't be so certain it will fit your actual needs in the event that the worst-case scenario hits. Second, the bio-emergency plans currently in place in many communities deal strictly with bio-terrorism. Remember that a bio-terrorism event would be relatively isolated, the very definition of a Pandemic, on the other hand, is that it's global, it affects everyone. Counting on neighbors to come through for you in the event of a pandemic is pretty foolish. Most EMS services and hospitals will be swamped with their own patients; it's not likely that they would be available to bail you out. You know, that whole "Lack of planning on your part doesn't constitute an emergency on my part" thing? Yeah, it applies here.

The Federal Government has pledged funding (just a little over a million dollars) to help Iowa plan, but echoing Secretary Leavitt's warning…"Iowa Governor Tom Vilsack essentially warned that the State Government does not have the resources to come in and take over in the event that a pandemic reaches Iowa." The State and Federal Governments are both working on making it easier for those of us in need to access the proper resources in the event of an emergency, but local government and businesses need to be at the center of planning ahead to maintain day to day operations.

In describing the virulence of the H5N1 Influenza virus, CDC Director Julie Gerberding warns that IF the US is to be affected by an Avian Flu Pandemic (and the possibility exists), employers should count on 30% of the workforce to be out sick and another 10-20% to be home taking care of sick family members or simply too scared to come to work. Contingency planning must begin by addressing projected absenteeism. In other words, how will your organization cope with potentially losing half of the workforce and seeing an increased EMS call volume?

These numbers are backed up by history. In 2003, the City of Toronto Canada suffered a SARS Epidemic spread by travelers returning from China. The death rate from SARS was around 15%, the death rate from Avian flu, as it stands now is 50%. Toronto had (at the time) 850 paramedics/EMTs. Of those, 1166 potential exposures were recorded. 436 (over half of the workforce) were placed on a 10-day home quarantine. Fortunately, only 62 became ill and only 4 were hospitalized. SARS affected more than just the medical establishment in Toronto - businesses closed down, millions of dollars were lost and their local economy tanked. Remember, the SARS epidemic was relatively isolated.

Planning for something like flu pandemic needs to happen locally. The question must be raised: How will your entire city (or hospital, or whatever) stay "in business" if 50% of the workforce is not available? What about public works? People need clean water. Facilities

(Continued to page 13)

IEMSA VOICE

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2600 Vine Street, Suite 400 • West Des Moines, IA 50265

2006 IEMSA MEETINGS

Board Meetings:

THE IEMSA BOARD OF DIRECTORS WILL MEET ON THE FOLLOWING DATES IN 2006. EACH MEETING (WITH THE EXCEPTION OF THE ANNUAL MEETING) WILL BE HELD AT THE RACCOON RIVER NATURE LODGE, 2500 GRAND AVENUE, WEST DES MOINES. ALL MEETINGS, WITH THE EXCEPTION OF THE ANNUAL MEETING WILL BE HELD AT 1:00 P.M.

2006

- March 16
- April 20
- May 18
- June 15

NO JULY MEETING!

- August 17
- September 21
- October 19
- **November 9 ANNUAL MEETING**
- December 21

Additional Important Dates:

Annual Conference & Trade Show
November 9 – 11, 2006
Des Moines, Iowa

NEWS *to* SHARE

Are you working on an exciting program that needs to be shared with the membership of IEMSA? Do you know of an EMS-related educational program that needs to be showcased? Has your service won an award or done something outstanding? Do you want to honor a special member of your staff or of the community? If so, you can submit an article to be published in the IEMSA newsletter! In order to do this, just prepare a press release (and pictures, if appropriate) and e-mail it to iemsa911@netins.net by the following dates: May 2 (to be mailed by May 23), August 1 (to be mailed by August 18), November 17 (to be mailed by December 15).

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

The Scoop on Scope
Devices, Decisions, Delusions

BY ROSEMARY ADAM

Since the Scope of Practice Sub-Committee was formed (as part of the Advisory Committee), the group has been striving to set up committee guidelines, discussing questions on practice, and fielding questions from the EMS community. We continue to try and educate EMS and Medical Directors in the State of Iowa so that the providers can deliver great care within their knowledge AND skills scope.

This article will summarize some of the issues and discussion from the most recent meeting, held on January 11, 2006 in Des Moines.

Devices: The EMS sales representative is at your door, delivering the best "song and dance" about the most recent device available for him or her to sell to you and your service. You are hearing all the right stuff: it's cool, it's new, and it might even work. Should you buy it? Can everyone on the service use it? Is it good for our patients?

Decisions: Your decision to purchase a new device (or therapeutic agent) should be based on whether your medical director wants you to have it, you have a protocol to use it, you have been educated to provide that level of care (scope), and evidence that the device or agent works.

How do you evaluate a new device or agent for evidence of good outcome? Learn how to read research for evidence of good outcome. The company representative who shows you an abstract (abbreviated paper) on a study, sponsored by that company, with very few study subjects – most of whom are not homo sapiens – is suspect. Ask for a second research paper to verify results from the first study. Ask for end-outcome studies on the device or agent.

The literature that proves your device or agent will do "good" must reflect that the study was done on lots of real-live patients with a control group and complies with the standards of human research. A second research that confirms the results would be icing on the cake.

Delusions: One of my EMS peers fell under the spell of a sales representative recently. He was handed an article on a device not commonly marketed to EMS agencies and the study was not done on humans. The advertising slick touted American Heart Association (AHA) recommendations. What it didn't say was that the recommendation from AHA was for use of this device under completely different patient care settings. This sales rep. was selling the product for a purpose not approved by the FDA.

Be careful. Make sure you ask for and understand how to do a preliminary search for evidence of good outcome before buying the sexy, new device. Don't make snap decisions to buy and then write a protocol after the fact. Talk it over with your peers, medical director and employees. Look at your patient population for evidence that a need exists.

Don't be delusional in making decisions on devices! ■

New Devices, New Decisions, New Confusions

Greetings to the Iowa EMS community. I have recently been given the honor to serve IEMSA as the medical director and am truly pleased to have this forum for discussion. I am a graduate of Iowa State University, Des Moines University and Regions Hospital Emergency Medicine Residency Program in St. Paul, MN. I completed a one year academic faculty development fellowship in Dayton, Ohio and returned to Iowa to be a part of the inaugural emergency medicine training program at the University of Iowa. Thank you for this wonderful opportunity.

The face of Emergency Medical Services is changing at a dramatic pace. With the development of the Iowa Emergency Medicine Residency Program and with a growing voice from emergency physicians across the state, prehospital patient care is evolving. The evolution is occurring on a multitude of fronts, both academically and technologically. The state of Iowa is recruiting more residency trained, board certified emergency medicine physicians that bring a new perspective to their individual EMS services. New devices and technologies are pouring into the prehospital healthcare arena and older protocols and skills are being interrogated.

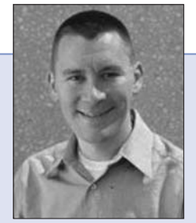
The substantial amount of information and change that is occurring can easily disrupt a focused approach to patient care. It is understandable, with constantly evolving protocols, position statements and research, that a system may feel overwhelmed and confused when evaluating the best evidence for providing patient care.

EMS is seeing a volume of new devices that are promoted to optimize patient care. One such device is the ResQPOD™ Circulatory Enhancer. This device, developed by Advanced Circulatory Systems, Inc., is currently the focus of study by the Iowa Resuscitation Outcomes Consortium (ROC). Anecdotes have surfaced from providers that distributors have been marketing the device to systems in Iowa.

The ResQPOD™ Circulatory Enhancer is designed as a patient powered pump to create greater negative thoracic pressure during inspiration. Thus, during the patient or ventilator inspiratory phase, more blood will be returned to the heart via the venous system, leading to improved cardiac output. The ResQPOD™ has received approval from the Federal Drug Administration (FDA) for use in physiologic states where blood flow may be compromised. The FDA 510(k) Summary and Indication for Use Form states:

"The ResQPOD™ Circulatory Enhancer is indicated for use in people with poor circulation."

"…is contraindicated in persons with: chest pain; shortness of breath; dilated cardiomyopathy and/or congestive heart failure; pulmonary hypertension and/or aortic stenosis; and, flail chest."



Christopher S. Russi, DO
IEMSA Medical Director,
Assistant Professor of
Emergency Medicine,
Department of Emergency
Medicine, University of Iowa

Diminished circulatory states include distributive shock or hypotension secondary to toxicologic etiologies. What is not known is how well the device will function in adult human cardiopulmonary arrest. The Iowa ROC is one of 10 North American (8 US; 2 Canadian) centers to study the effectiveness of the device in cardiopulmonary arrest. Patient enrollment is anticipated to begin spring/summer 2006. This is the largest monetary award for prehospital resuscitation research. To date, the device has passed all bench tests performed by the American Society for Testing Materials and shown promise in animal models of cardiac arrest with active compression/decompression CPR. Recent trials in Milwaukee, WI using standard CPR during swine cardiac arrest showed improved hemodynamics and survival. There is growing excitement for the device, but it remains unclear as to its effectiveness on reducing mortality.

In addition to using the ResQPOD™ with endotracheal intubation, it is proposed that in combination with bag mask ventilation (BMV) or supraglottic airway devices such as the Combitube,™ equivalent or near equivalent cardiac output may be achieved. To date, however, no published trials exist using the enhancer with BMV.

I write with some concern that the ResQPOD™ may be embraced mainstream prior to any published trials providing evidence of its effect — either positive or negative. The state of Iowa EMS Advisory Committee shares these concerns, as well and they are based from the following:

As outlined above, it is unclear what effect the device will have on the cohort of patients being studied.

Training and ongoing CQI, as with any device, is pinnacle.

If the device is used with BMV during CPR, it is imperative that mask seal remain constant or function will be lost. I see this as a challenge with only a two-person crew.

The addition of a new device may complicate or delay appropriate therapy during cardiopulmonary arrest. The American Heart Association 2005 ACLS guidelines call for quality CPR, and as mentioned above, two person CPR while using the ResQPOD™ may be inappropriate. This point may be especially true for systems that manage no more than one to two cardiac arrests per year.

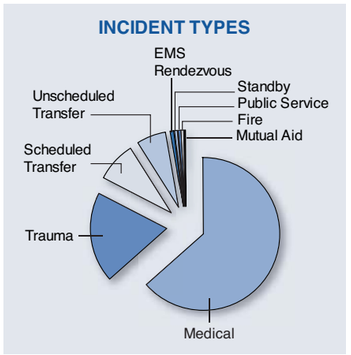
The company's position that "…states of poor circulation…" is consistent with cardiac arrest remains true. However, the very reasons patients have cardiac arrest might be secondary to the contraindications outlined by the FDA. Is it not true that patients with cardiac arrest from a myocardial infarction may have had chest pain or shortness of breath?

I see great potential for the ResQPOD™ Circulatory Enhancer in prehospital patient care. However, I stress objectivity when evaluating new technology and the current science that accompanies prior to protocol and system integration. ■

The State of EMS Data Collection

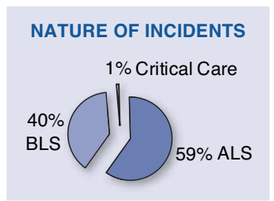
With 2005 slowly fading into the rearview mirror, we can safely say that it was a very good year for the Bureau of EMS in terms of data collection. Over 270 ambulance and ambulance (TA) services submitted data in the proper format as outlined in the Iowa EMS Patient Registry Data Dictionary. This comprises approximately 70% of the transporting services in the state.

This chart depicts the most frequent Incident Types reported in 2005.

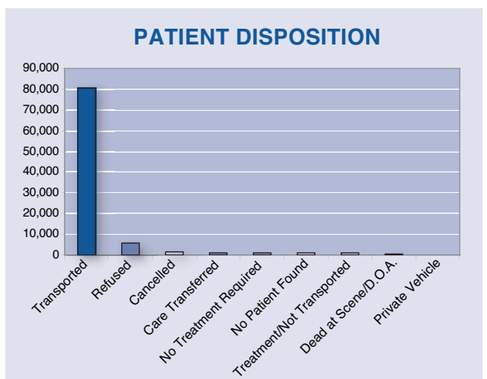


It should be noted again that EMS Services are not required to use any particular software but their data must be organized in a format that can be accepted by the data warehouse. Services may choose to either enter data directly via WebCUR or select an EMS data collection software package. There are a variety of applications to choose from. Prices and applications vary greatly.

The chart below depicts the Nature of Incidents reported in 2005.



The chart below depicts the most frequent Patient Disposition types reported in 2005.



Services using a desktop application other than the Med Media product must log into ia.webcur.com to submit their data.

Where is the data going?

The data being submitted is being put to a meaningful use. The System Evaluation Quality Improvement Committee (SEQIC) is using EMS data along with trauma patient registry data to evaluate the structure, process and patient outcomes of Iowa's EMS system. SEQIC evaluates structure by monitoring hospitals, ambulance services and overall resource availability of the system. They evaluate process by looking at patient triage and transfers, transport times, appropriateness of receiving facilities, over and under triage of trauma patients, and examining how all of the components of the EMS system work together. SEQIC evaluates patient outcomes by tracking morbidity, mortality, disability, hospital charges and monitoring the effectiveness of the entire system. The Bureau of EMS has committed to participate in the National EMS Information System, NEMSIS, a national version of the EMS patient registry. Another example of how data is being used is the Iowa Resuscitation Outcome Consortium(IROC). IROC will be analyzing data for a multi faceted grant through the National Institute of Health.

It is the goal of the Bureau of EMS to have all data submitted electronically within the next year. ■

Welcome New IEMSA Members

NOVEMBER 2005 – JANUARY 2006

CORPORATE SPONSORS:

Life Net Air Medical Services

Mercy Hospital

AFFILIATES:

Elkhart Fire Department
Humboldt Ambulance
Iowa Lakes Community College
Kirkwood Community College
Monroe County Hospital Ambulance
Palo Alto County Ambulance Service
Readlyn 1st Responders
Sherrill Fire Department
Western Iowa Tech Community College

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Randy Allman
Brett Almburg
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Rob Ankney
Mike Arndorfer
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Sharon Divis
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Membership Announcements:

GROUP PURCHASING

Affiliate Members — Don't forget to check out the discounts available through IEMSA's Group Purchasing program. Visit the Group Purchasing Page of www.iemsa.net to get connected with Alliance Medical, Inc. and Tri-Anim Health Services, Inc.

NAEMT MEMBERSHIP DISCOUNT

Members of IEMSA receive a 25% savings on individual membership dues. Call (800) 34-NAEMT to learn more.

MEMBERSHIP DATABASE

Occasionally, we make our membership list available to carefully screened companies and organizations whose products and organizations may interest you, as well as board candidates who wish to solicit your vote. Many members find these mailings valuable. However, if you do not wish to receive these mailings (via postal service or e-mail), just send a note saying "do not release my name for mailings" to the IEMSA office via fax (515-225-9080) or e-mail (iemsa911@netins.net) or regular mail (2600 Vine St., Ste. 400, West Des Moines, IA 50265). In order to ensure the correct adjustment to our data base, please include your name, address and membership number.

INDIVIDUAL MEMBERSHIP RENEWALS

You can now renew your membership online with your credit card! Visit the Membership Information page of www.iemsa.net and click on the "Renew or Establish an IEMSA Individual Membership" link. If you want to know what your membership expiration date is, you can click on the "IEMSA Membership List" link, find your name and check out when your membership expires. This list will be updated monthly.

CONTINUING *education*

CHANGES IN RESUSCITATION SCIENCE: AN OVERVIEW

BY ROSEMARY ADAM, RN, PS

November 28th of 2005 heralded the launch of a new set of Emergency Cardiovascular Care (ECC) guidelines for resuscitation reflecting a process that took approximately 2 years. The International Liaison Committee on Resuscitation (ILCOR), including the American Heart Association's ECC, completed an extensive, evidence-based review. Because of prior criticism, the process was designed to be transparent to manage and minimize potential conflicts of interests between science and commercial ventures. The overall goal was to simplify the process of CPR and ALS. The majority of changes are to adult resuscitation with the exception of a few special notes on infants and children.

Changes to Basic Life Support

In adults, assess the patient while assigning someone to notify the emergency code or response team in your facility. If in the pre-hospital setting, call 911. If by yourself, activate EMS before starting CPR. Once the response is formally initiated, the rescuer opens the airway, assesses for normal breathing and gives 2 ventilations **(one second each)**.

In children, the solo health care provider (HCP) should provide CPR for 2 minutes prior to initiating a team response if alone. This recommendation is different than for adult. Asphyxial arrest is the most common precipitator of cardiac arrest in children, especially within the inpatient environment. If more than one rescuer is present, the response team may be notified while the second HCP rescuer provides the initial pediatric CPR.

Avoid hyperventilation at all times during the resuscitation event. There are 2 ways to hyperventilate: giving the individual breaths too fast and administering too many ventilations in a time period. Both have been proven to cause harm to patients. Delivering a ventilation too forcefully causes most of the breath to insufflate the esophagus, leading to aspiration of gastric contents. Providing too many ventilations per minute does not allow complete exhalation creating a positive end expiratory pressure (PEEP). This has been shown to decrease preload to the heart in the setting of CPR thus decreasing cardiac output overall. Team members are asked to observe one another and to give constructive feedback during the code about the adequacy of ventilations and compressions.

For the adult, ventilation rates are now recommended at 10-12 per minute before intubation. Once an advanced airway is in place, adult ventilation rates decrease to 8-10 per minute delivered between compressions. **For children, the ventilation rate should be 12-20 per minute.** The rescuer should deliver the ventilation so that there is visible chest rise. The advice given in the recommendations in 2000, simply stated to deliver ventilations "slow and low." This advice is still pertinent today.

Pulse checks for healthcare providers should not exceed 10 seconds. Bystanders (non-healthcare) will be taught not to check pulses as all unconscious people who are not breathing are in need of bystander CPR.

The compression to ventilation ratio is now 30:2 in both adults and children (but not neonates), with approximately 100 compressions per minute. This major change in the compression/ ventilation ratio was a compromise based on the following data: 1) in the first few minutes of cardiac arrest, the value of compressions and good blood flow far outweigh ventilations; 2) compressions need to be hard and fast with complete chest rise/recoil, but the rescuer becomes fatigued quickly and will soon demonstrate incomplete recoil – critical to good blood flow. **Thus, the new recommendation is to change the provider performing chest compressions every 2 minutes;** 3) simplification of CPR is important with a streamlined procedure so a universal compression/ventilation for all (other than the newly born) is warranted.

These new compression recommendations are critical to good outcome. This represents the most research ever in adult CPR methods. The rescuer needs to complete 30 compressions in 23 seconds with very slight compression-hand lift upon upstroke – this allows heart refilling before the next compression.

There will be no pause in chest compressions except for the following reasons: rhythm/pulse check (no more than 10 seconds), defibrillation, and AED analysis. Healthcare providers are infamous for many long interruptions in compressions for therapy that may not be warranted. This has been proven to decrease good outcome.

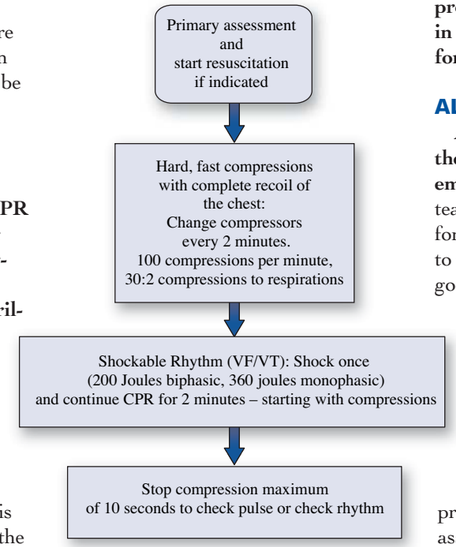
Defibrillation

Shock First or CPR First? If no CPR has been started prior to defibrillator arrival, the EMS provider should perform BLS for at least 2 minutes until/while the AED or manual defibrillator is prepared. Ventricular fibrillation or pulseless ventricular tachycardia (VF/PVT) is common in sudden arrest situations in both children and adults. Early defibrillation remains crucial to survival of these patients. However, early defibrillation cannot work without quality CPR. This provides that necessary blood flow for the heart and prepares it for an improved condition for successful conversion.

One shock sequence instead of 3-shock: (See flow chart 1). There is good science behind these recommendations. Prior generations of defibrillators have been monophasic. That is, they delivered a shock in one direction only. Newer defibrillators are biphasic; they deliver a first shock from one paddle to the next and a rapid second shock in the opposite direction. The goal is to completely depolarize the heart and (hopefully) allow the pacemakers of the heart to restart organized activity. The newer biphasic defibrillators have been shown to convert VF/PVT greater than 90% of the time. This conversion statistic doesn't mean that the patient has been converted to a regular rhythm – rather, they are usually converted to a pulseless arrhythmia. However, the patient may be salvageable if good blood flow is re-established quickly. **The need for immediate, quality compressions to re-establish good blood flow far outweighs the value of subsequent shocks (the old-fashioned, 3-stacked shock sequence).**

In the one-shock sequence, how much energy should we use? With the dissemination of a wide variety of biphasic defibrillator waveform technology, it has been confusing to healthcare providers trying to understand what dose should be used.

Flow Chart 1



Each biphasic defibrillator manufacturer should make it clear to the healthcare provider what energy is required with their machine. **If not otherwise indicated on the biphasic machine, a universal energy of 200 J is recommended as the initial dose.** Pediatric defibrillation energy levels have not changed – 2J/Kg initially, then 4J/Kg for subsequent defibrillation.

If the defibrillator available is monophasic, the rescuers should use a higher energy level for all defibrillation attempts — 360 J. Note that the escalating doses of energy (200J, 300J, 360J) are no longer recommended.

AED manufacturers are making arrangements to revise all protocols within their machines. Those who use AEDs should go that company's web site or contact the manufacturer to find out how and when they can revise the 3-shock sequence into 1-shock.

Choking Procedures

There are essentially no differences in the procedures for the conscious patient who has a foreign body airway obstruction (FBAO). There has been a major change in recommendations when the patient becomes unconscious. **If a choking patient becomes unconscious, the provider should perform CPR, looking in the mouth prior to each ventilation for the FBAO – no blind finger sweeps.**

ALS Resuscitation

Advanced airways and medications in the cardiac arrest patient are being de-emphasized. In most cases, the code team and leader need to weigh the need for an advanced airway against the need to perfuse the heart appropriately with good compressions. In all cardiac arrest management, the recommendation is to defer advanced airway management until later in the code, based upon patient condition, resources available and other circumstances. The recommendation in VF/PVT is to wait until after the second or third defibrillation in the CPR-shock-compressions (for 2 minutes) – pause- for-assessment (and decisions) sequence before inserting an advanced airway (e.g. Endotracheal tube). Thus, the decision to use or not use an ET tube or other advanced airway does not come until at least 4-6 minutes into the code.

Do not interrupt CPR to give medications. All drugs should be given by the intravenous or intraosseous route and should be given during the 10 second break in CPR which occurs every 2 minutes. A fall-back plan is to administer certain drugs via an endotracheal tube, but current evidence is lacking for the correct dose via this route; epinephrine has an unusually predominant beta effect if given in this manner and may be harmful.

Vasopressors

If the code team has evaluated the arrest patient, has initiated good CPR and defibrillated the patient, consideration can be given to the use of a vasopressor. This recommendation has not changed; give 1mg of epinephrine every 3-5 minutes or vasopressin 40 units IV/IO given one time only. **Neither drug seems to make much difference in outcome.**

Antiarrhythmics have not been proven to be of benefit in cardiac arrest. Amiodarone, however, has been shown to increase short-term survival in comparison studies (to hospital admission only; there is no difference in discharge rates).

(Continued to page 10)

(Continued from page 9)

There are essentially no changes in the recommendations for antiarrhythmics in VF/PVT with the exception that procainamide has been deleted from the algorithms because of a lack of good outcome data combined with difficulty in administration.

Asystole

No benefit was shown in pacing the patient during asystolic cardiac arrest. The goal in asystole and pulseless electrical activity is to perfuse the heart with good CPR and find a reversible cause.

Bradycardia

The bradycardia algorithm has very little change except for a new dose for atropine as the first-line drug: 0.5 mg while awaiting pacemaker. A total of 3mg of atropine may be given in 0.5mg aliquots. There are recommendations for decreasing the dose of dopamine should the patient require support after or during pacing. Dopamine has been recommended at 2-10 ug/kg/minute vs. previous guidelines that followed the standard administration of 2-20 ug/kg/minute.

Non-Cardiac Arrest Algorithms

As stated in the introduction, streamlining and simplification was the goal; no where was this more needed than in the tachycardia algorithm. A new, one-page flow chart separates tachycardic patients into three groups; those with symptomatic tachycardia, those with narrow complex tachycardia and those with wide-complex tachycardia. Treatments are unchanged from the recommendations in the 2000 guidelines. The recommendations for cardioversion are unchanged, even in children.

Acute Coronary Syndromes recommendations should also be familiar to healthcare rescuers familiar with 2000 recommendations. There is some additional information on the risk stratification, and an emphasis has been placed on early administration of aspirin – even during the initial 911 call to the dispatcher.

The Stroke Algorithm is essentially unchanged with recommendations that tPA be administered to those patients who meet the protocol criteria in facilities with a clear protocol and a commitment to stroke care. Dedicated stroke units improve outcomes for this patient. ■

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- *Berg RA, et al, Adverse Hemodynamic Effects of Interrupting Chest Compressions for Rescue Breathing During Cardiopulmonary Resuscitation for Ventricular Fibrillation Cardiac Arrest, Circulation. 2001; 104:2465*
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10 QUESTION POST-ARTICLE

Quiz

1) The new compression/ventilation ratio is:

A) 30:2 for all ages
B) 30:2 for all except neonates
C) 100:2
D) 15:2

2) Hyperventilation has been banned. Choose the correct statement about hyperventilation.

A) There are 2 ways to hyperventilate: too fast and too many. Each ventilation should not exceed 1-1/2 to 2 seconds at 10 cc/Kg.
B) There are 2 ways to hyperventilate: too fast and too many. Each ventilation should not exceed 1 second and a rate of 20/min. for all.
C) There are 2 ways to hyperventilate: too much force and too fast. There is no need to ventilate for several minutes in a "code."
D) There are 2 ways to hyperventilate: too fast and too many. Each ventilation should not exceed 1 second and should be just enough to make visible chest rise.

3) Chest compressions have never been more important in the resuscitation. Choose the correct statement about how to perform these compressions.

A) hard and fast at about 120 per minute (15 compressions in 12 seconds)
B) hard and fast with complete recoil of chest at 100/minute (30 compressions in 23 seconds)
C) hard and fast at 120 per minute (30 compressions in 30 seconds)
D) hard and fast at 80 per minute (15 compressions in 15 seconds)

4) If the patient has had an advanced airway inserted during the cardiac arrest management, the rescuers should:

A) reduce the ventilation rates to 8-10 per minute – that is one breath every 6 to 8 seconds, over 1 second. The compressor does not pause for ventilations.
B) increase the ventilation rates to 12-20 per minute – one breath every 3 to 5 seconds, over 1-1/2 seconds. The compressor pauses for ventilations.
C) reduce the ventilation rate to 12-20 per minute – one breath every 3 to 5 seconds, over 1 second. The compressor does not pause for ventilations.
D) Ventilate only. No compressions.

5) Choose the best way to deliver good blood flow during cardiac arrest:

A) 100 compressions per minute for 5-10 minutes at a time.
B) 100 compressions per minute for 1 minute at a time.
C) 100 compressions per minute, switch compressors every 2 minutes.
D) Pause compressions for rhythm/pulse check every minute.

IEMSA CONTINUING EDUCATION CHANGES IN RESUSCITATION SCIENCE

Quiz

(Continued)

6) Biphasic defibrillators:

A) successfully convert ventricular fibrillation about 50% of the time at 100 joules.
B) successfully convert all pulseless rhythms about 80% of the time.
C) successfully convert ventricular fibrillation about 90% of the time at 200 joules.
D) are new devices that should not be trusted.

7) Choose the correct statement about advanced procedures during cardiac arrest management:

A) Medications and advanced airways are important and should be done first.
B) Medications and advanced airways are de-emphasized and should be sequenced around the compressions.
C) Advanced airways are de-emphasized, but medications are still important.
D) Medications are de-emphasized, but advanced airways are still important.

8) When a patient calls 911 with a complaint of chest pain, the dispatcher should:

A) advise the patient to take aspirin (as long as there are no contraindications) (medical control approval).
B) advise the patient to drive themselves to the hospital as it is faster.
C) advise the patient to rest and then call 911 again if symptoms persist.
D) advise the patient never to take aspirin until they reach the hospital.

9) A 57-year-old male collapses outside a restaurant early one morning. Bystanders find him a few minutes later and call EMS. Upon your arrival, no one is doing CPR. You should:

A) apply the AED, analyze and shock, then reanalyze. If shock indicated, the rescuer should shock at a higher energy then reanalyze.
B) apply the AED, analyze and shock – begin compressions immediately for 2 minutes then reanalyze.
C) perform good CPR for 2 minutes while your partner sets up the AED. Analyze and then shock once with immediate compressions for 2 minutes then reanalyze.
D) perform good CPR for 1 minute, apply the AED, analyze and shock, analyze then shock and then deliver one more shock before doing one minute of CPR.

10) During the call above, 911 has been notified of another call at this same restaurant. A second ambulance is dispatched for a man with difficulty breathing. When you arrive, the waitress states she performed the "Heimlich" maneuver and this patient then collapsed. The patient is unconscious and is not breathing. Your initial attempts at ventilation are unsuccessful. You should:

A) perform CPR at 30:2 and look in the mouth prior to each ventilation for the obstruction.
B) perform abdominal thrusts until the obstruction is cleared.
C) perform back slaps and abdominal thrusts — attempting a ventilation after each round.
D) perform CPR at 30:2 and sweep the mouth prior to each ventilation attempt.

IEMSA
CONTINUING EDUCATION
answer form

CLIP AND RETURN

(Please print legibly.)

Name _____

Address _____

City _____

State _____ ZIP _____ – _____

Daytime
Phone Number _____ /_____–_____

Iowa EMS Association
Member # _____

EMS Level _____

E-mail _____

1.	A. ☐	B. ☐	C. ☐	D. ☐
2.	A. ☐	B. ☐	C. ☐	D. ☐
3.	A. ☐	B. ☐	C. ☐	D. ☐
4.	A. ☐	B. ☐	C. ☐	D. ☐
5.	A. ☐	B. ☐	C. ☐	D. ☐
6.	A. ☐	B. ☐	C. ☐	D. ☐
7.	A. ☐	B. ☐	C. ☐	D. ☐
8.	A. ☐	B. ☐	C. ☐	D. ☐
9.	A. ☐	B. ☐	C. ☐	D. ☐
10.	A. ☐	B. ☐	C. ☐	D. ☐

IEMSA Members completing this informal continuing education activity should complete all questions, one through ten, and achieve at least an 80% score in order to receive the one hour of continuing education through The University of Iowa Hospitals' EMSLRC, Provider #18.

For those who have access to email, please email the above information, along with your answers to: adamr@uihc.uiowa.edu

Otherwise, mail this completed test to:
Rosemary Adam
University of IA Hospitals and Clinics
200 Hawkins Drive, EMSLRC So. 608GH
Iowa City, IA 52242-1009

The deadline to submit this post test is **MAY 2, 2006**

Disaster Services Minimum Standards Committee

Draft Document Completed – Your Comments Needed

BY JULIE SCADDEN

The Iowa Department of Public Health established a multi-disciplinary workgroup, consisting of public health, healthcare (hospital) and EMS in May, 2005 for the purpose of establishing the minimum standards necessary in the event of a major public health disaster, regardless of funds, staffing and other impacting issues. This Baseline Criteria Workgroup for EMS will be writing these guidelines to "prepare for, respond to and recover from public health threats, emergencies and disasters" in Iowa. Feedback from EMS providers is crucial to the group.

The following is a summary of the work that has been done on the EMS document over these past 8 months. The group will be collecting comments over several weeks with a goal of having these guidelines developed and into final draft for submission to IDPH by June 1, 2006.

The guidelines and measurable objectives have been determined and written into separate categories. Please note as you read through this summary that these guidelines are not tied to funding. The primary goal of this workgroup is to determine standards that are achievable with the funding that is currently in place and sustainable for a time when funding will no longer be available.

1. **Planning:** Establishment of an EMS disaster/mass casualty plan that integrates into each county's multi-hazards plan and includes a seat in the Emergency Operations Center. This can be measured through a review process and updated annually by all stakeholders. Quarterly meeting minutes, testing of compliance during exercises and actual events will assist in this plan. There will be participation on Emergency Operations Center by EMS and utilization of ICS/NIMS for all events (actual and exercise).

2. **Disease surveillance:** The implementation of a disease surveillance plan will be measured through documentation of training in trend recognition and uniform reporting guidelines as well as the appropriate entities receiving alerts from the surveillance system as warranted. This will include development of educational criteria and uniform reporting guidelines for volunteer providers to

recognize and report disease trends to appropriate healthcare agencies.

3. **Communication:** These guidelines require the development of an inter-operability plan with appropriate redundancy. The objective is measurable through periodic testing of the communication system, including any redundant systems. EMS will participate in local and regional response group meetings twice a year with documentation of attendance. Integration of EMS in the Health Alert Network (HAN) system with a minimum of 1 contact entity per county and a plan for the dissemination of alerts was determined to ensure a redundant communication for all entities.

4. **Public Information:** All EMS services shall be educated in Public Information Officer (PIO) responsibilities, insuring the appropriate information is being shared by the most qualified individual. This individual may be a designee outside of your agency. An EMS PIO's responsibilities will be measured by addressing the issue in the EMS annex of the county multi-hazard plan during the annual review process.

5. **Training/Education/Exercises:** All EMS providers shall receive a minimum level of training and exercises in disaster preparedness and response, measurable through record- keeping of all involved stakeholders participating in the education, planning and exercise of the multihazard plan. This will include training of all EMS providers in ICS/NIMS and Weapons of Mass Destruction (WMD) as required and determined appropriate.

6. **Surge Capacity for EMS:** This requires the establishment of Memorandums of Understanding (MOUs) and/or Iowa Mutual Aid Compact (IMAC) agreements to address handling of mass patient flow. The development of partnerships between EMS agencies to manage mass transports can be measured through periodic review of surge capacity MOUs and/or IMAC memberships.

7. **Decontamination:** Appropriate and applicable training and equipment for all EMS personnel will be insured and measured through record keeping for all stakeholders as defined by local Hazardous Material Teams.

8. **Isolation and Quarantine:** EMS will develop a written policy for transportation of isolated and/or quarantined patients that integrates into the county multi-hazard plan. The written policy will be reviewed and updated annually by all stakeholders and will include policies specific to (a) treatment and transport of isolated patients and (b) treatment and transport of patients from a quarantined area.

9. **Equipment:** EMS services will assure appropriate and adequate equipment and supplies for training and disaster response through record keeping of periodic inspections and inventories of supplies and equipment as determined by local service directors.

10. **Structure:** The development of sustainable funding and staffing for EMS through implementation of Code requiring EMS service availability proportionate with Fire Service and Law Enforcement. This required legislative involvement of regional, municipal, county and state representation for EMS funding and continued documentation of the status of EMS funding and staffing.

The draft document will be transmitted over the EMS listserve over the next several weeks. Active feedback from EMS through regional and county associations as well as individuals is vital. Feedback needs to be sent to your regional representative or to me if you are unable to contact your regional representative. ■

(Continued from page 2)

PLANNING *for a* PANDEMIC

— who will order your supplies and handle shipping? Obviously EMS, Police, Fire & Dispatch could be greatly affected. But what about the accounting department? Paychecks are needed, bills must be paid. How about if 50% of truck drivers were off for 2-3 weeks? This could trickle down and potentially cause local fuel shortages, local food shortages, shortages of medical supplies and delayed shipments of essential supplies. Planning needs to consider the global implications of a Pandemic. It's easy for us to think that an outbreak or epidemic in China or Taiwan isn't an immediate concern for Iowa, but we need to remember that a lot of our disposable supplies are actually manufactured in those countries, which creates the potential for shortages here at home.

The point of this is to make sure that everyone is taking contingency planning beyond his or her particular EMS department. I liked the analogy used by James Caverly of the Department of Homeland Security: "An influenza pandemic should be imagined like a "snow day" but 2-3 weeks long…schools & daycares closed, people stranded at home (in this case at home sick, home with sick family or home watching the kids because school is closed), grocery stores slow to restock staples, an increased burden on public service (us), many businesses closed down, mass gatherings cancelled." Sobering, isn't it?

I'm sure some of you remain unconvinced. "Surely, this idiot is exaggerating this; this sort of thing doesn't happen in our day and age." I say to you…those who ignore history are doomed to repeat it. Most of us are too young to remember that in the twentieth century alone, three pandemics were recorded. Millions of people died around the world. Yes, medical technology has gotten better. We have ventilators and anti-viral drugs and positive pressure isolation rooms, but we don't have nearly enough of any of these things. According to the CDC, the Government has roughly three million doses of Tamiflu in the strategic national stockpile (and they are not even sure how well it will work on H5N1). Do the math: 300 million people in the US; if even a tenth of us fall ill, only one in ten of us will get a dose of Tamiflu. Tough decisions will need to be made by doctors and government officials on who will get the medicine and who will not.

As I review this, it looks pretty "doomsdayish" and I apologize. The fact is, if we discuss contingency planning and no influenza pandemic happens, people will say that we

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Your Legislative *Issues in* Lawmakers' *Hands*

BY RIC JONES, IEMSA LEGISLATIVE COMMITTEE CHAIR

Your Iowa EMS Association was well represented by nearly a hundred members at our annual EMS Day on the Hill lobbying event. Over sixty lawmakers shared concerns with us and us with them as we formally presented our 2006 Legislative agenda.

We were able to gather some support for several of our positions. Our lead-off position is one of equity for EMS providers who are covered by the Iowa Public Employees Retirement System (IPERS). IPERS has a "Protection Class" that includes most public safety personnel who are not covered under the Municipal Fire and Police Retirement System of Iowa (MFPRSI). EMS providers should be in the protection class. Protection class employees earn their benefits with less years of service than regular IPERS employees do.

There is a move to increase the cost of IPERS pensions for the employee. Currently the public employer must pay 60% of the cost, and the employee contribution is 40%. Employers want a 50-50 split. Our position has been that the protection class issue is one of fairness and needs to be corrected. Any change in contribution levels needs to be negotiated between the public employers and the public employees. MFPRSI was created in a similar atmosphere and serves employers and employees very well. Simply put, an increase in employee costs should come with an increase in benefit levels.

For the first time ever, the Bureau of EMS appears in the Governor's budget proposal. This would provide general fund support for EMS. Historically all funding for public health including EMS came from a federal health & human services block grant that has been diminishing. Also, for the first time ever, we are getting calls from lawmakers on issues.

Our proposal to provide a reward for public safety volunteerism has some legs. There are at least four bills that seek to provide a $500 tax credit for active public safety volunteers. The lost revenue from this is significant (though I believe manageable), and it is unlikely it will pass intact. We suggested that a starting point might be to provide a tax credit for the out-of-pocket expenses borne by volunteers. This could have a cap on it and likely a very low one to start out with. Even if the first $ 50 - $ 100 were credited, it would be a great foot in the door.

A rumor of public access defibrillators being destroyed and their batteries stolen by meth makers swept through one of our partner organizations turning up the heat for our proposal that statute should punish those who would tamper with defibrillators at a higher level. We cannot substantiate the rumor, but the idea is a good one. We would like it to be at least an aggravated misdemeanor to steal or vandalize an AED. This proposal could be expanded to protect all life safety systems and tools, such as fire extinguishers, life preservers, alarm systems, first aid kits, rescue tools and egress systems.

There is a bill that would exempt law enforcement from having on-duty collisions count against their driving record. Roger Thomas has offered to amend the bill to include fire and EMS. The thinking here is that people are judged by the law against the "reasonable person" standard. In some weather conditions, the "reasonable people" are in front of their TVs watching the less reasonable slide into each other on the Weather Channel. Law enforcement, Fire and EMS are out in the middle of it, reasonable or not.

There is also a bill that exempts on-site emergency care from IDPH supervision. This relates to industrial first aid stations, Ski Patrols and other non-transport patch 'em up and call EMS scenarios. This is a good bill as it keeps the Bureau focused on us. Without this bill, one could interpret current rules and statute to mandate that ski patrol type operations become EMS entities. That's just not realistic. Maybe some day.

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(Continued from page 13)

Your Legislative *Issues in* Lawmakers' *Hands*

Other than the proposal to increase the employees' contribution to IPERS, there have not been any bills introduced that have a negative impact on EMS. That is a fairly good position to be in.

Here's your assignment:

If you were at legislative day, please call or email the folks you met and thank them for their time and see if they have any questions. If you were there and did not meet your local lawmakers contact them and tell them you are sorry you missed them. Tell them that Cal Hultman is your lobbyist, that Cal has copies of our legislative agenda, and we need their help.

If there are Saturday morning Cracker Barrel sessions in your area, attend them and keep our issues in front of the lawmakers.

In two weeks (about Valentine's Day), contact them again to see if we are making any headway.

Senate Switchboard: 1-(515) 281-3371
House Switchboard: 1-(515) 281-3221

A list of all legislators with e-mail links can be found at:
http://www3.legis.state.ia.us/ga/legislators.do

Keep the heat on! We will prevail on a few good issues! Call me or email with any issues or concerns.
Ric Jones (563) 556-3490

(Continued from page 13)

PLANNING *for a* PANDEMIC

over-exaggerated and caused unnecessary worry. And if we discuss contingency planning and a pandemic DOES happen, people will still say we didn't do enough. We're in a no-win situation. This being the case, don't you think we should err on the side of caution and think about the continuity of operations for our respective areas? In doing so, keep in mind that even if nothing happens with the H5N1 virus this winter, the work we do on contingency planning this year may help us next year or in ten years. It's not a matter of if another pandemic occurs, it's most assuredly a matter of when.

For more information on pandemic influenza and pandemic contingency planning check out the following websites:

http://www.avianinfluenzainfo.org/
http://www.cdc.gov/flu/pandemic/
http://www.protectiowahealth.org/

Iowa EMS *Generosity*

BY JULIE SCADDEN, NREMT-P, PS
NW REGIONAL REPRESENTATIVE TO IEMSA BOARD OF DIRECTORS

"Because I want to make lots of money," is not what you hear when you ask someone why they became an EMS provider. "Because I want to help people," is the more common answer. These two statements came together for EMS providers attending the annual IEMSA conference in November.

NAEMT established a fund to specifically aid the families of affected EMS and rescue workers following the terrorist attacks on September 11, 2001. The monies are distributed in their entirety, with NAEMT assuming all administrative costs. NAEMT Foundation's EMS & Rescuer Relief fund was re-activated following the devastation inflicted by Hurricane Katrina. The need for this fund expanded with hurricanes Rita and Wilma and the destruction they left in their wake. The EMS providers from these areas in the south continued to do what they were trained to do, taking care of the citizens of the communities where they lived, worked and raised their families; knowing they had lost at least as much as the people they served.

The board of directors of the Iowa EMS Association embraced this cause with enthusiasm and a spirit of fun, raising $2,685 through a silent auction held outside of the Marriott Pitcher's bar during the welcome party following the IEMSA annual meeting. For a small donation, you could sing your heart out (alone or with friends) with "Tiny," an awesome DJ who made the evening fun. If you attended the annual meeting, you received a nifty glass with flashing lights and the IEMSA logo. For individuals not in attendance, those same glasses were available for a small donation during the party. Many new and fun ways of making the lights flash were shared as the evening progressed. Mardi Gras beads where sold towards the effort, with many of the board of directors making persuasive and active salespeople throughout the night.

Lee Ridge and Melissa Sally-Mueller, chair and co-chair of the entertainment committee and members of the IEMSA board of directors, developed the idea for a silent auction to be held in conjunction with the welcoming party. Donation requests for auction items were sent out over the Iowa EMS list serves that resulted in numerous donations from conference vendors, EMS bureau staff, IEMSA membership, as well as individuals throughout Iowa. There were "toy" ambulance collections, EMS memorabilia, sweatshirts, books, coats and brief cases, just to name a few of the items offered for sale. Steve Berry posters were distributed throughout the conference for a small donation of $5.00 or more.

An EMS quilt, designed to show the various faces of EMS in Iowa, was made and donated by three women from Northwest Iowa. The idea for the quilt was born out of a desire to put a face to EMS providers who dedicate themselves everyday to aiding others. The quilt was made in just three days through the expertise of Tami Moffitt-Glienke, RN, PS, veteran quilter, Colleen Grimes RN, FR, veteran artist of the group, and Julie Scadden, acting as ancillary staff. We felt the quilt told a story of the quiet dedication to "helping people" EMS providers demonstrate everyday and was an appropriate means for raising funds for our colleagues in the south. We were extremely pleased with the $250 the quilt added to the fundraising effort.

Iowa has done an OUTSTANDING job raising money and awareness for this Fund. Sioux Center Ambulance in Northwest Iowa donated $5000, Black Hawk County EMS Association donated $1000, and Sheldon A & W donated their gross profits from the day of October 13, 2005 and challenged other A & W owners from around the country to do the same. The IEMSA board of directors voted at their December meeting to donate $2,315 to add to the monies raised, making a total donation of $5000 from the conference to NAEMT. There were many large and small contributions from all over the state.

(Continued to page 15)

The NAEMT Foundation distributed the $119,978.63 collected before the holidays equally among 403 eligible EMS providers who received disbursement checks to help offset losses they suffered when their Gulf Coast area homes were devastated by Hurricanes Katrina, Rita and Wilma in 2005. According to EMS & Rescuer Relief Fund Administrator Jim Allen, the fund will continue to collect donations and will make a subsequent distribution in Spring, 2006. NAEMT has voted to keep this fund active following the spring distribution for the further needs of EMS providers and their families who may be affected by a disaster at any time.

Thank you to all who have diligently worked, raising awareness as well as money, for this very important project. The generosity displayed in response to a simple email sent out in early September demonstrates the dedication, compassion and 'best practices' of Iowa EMS and the communities we serve. ■

"Goodness is the only investment that never fails."
— Henry David Thoreau

EMS Leadership Conference *ReCap*

BY JEFFERY D. DUMERMUTH, PS
PRESIDENT, IEMSA BOARD OF DIRECTORS

Nearly 150 ambulance service directors and supervisors from around Iowa gathered in Des Moines for an EMS Leadership Conference sponsored by IEMSA and the EMS Bureau of the Iowa Department of Public Health.

The morning began at the State Capitol for the annual EMS Day on the Hill. This effort, coordinated by Legislative Chair Ric Jones, was a great success with several Representatives and Senators visiting with our EMS providers about legislative efforts being promoted by your EMS Association (for a full list of our legislative agenda for this year, visit our web site).

The group then moved to the Embassy Suites on the River for our Leadership Conference. The conference started with a presentation by the Nebraska EMS Department outlining the leadership academy that they have recently developed and implemented.

A panel of EMS experts was then gathered for a discussion with questions being posed by the audience. This forum was a great success with a lot of information and education shared, covering a variety of EMS issues.

The afternoon session was presented by a National Management expert Tom Holman and was entitled Leadership in Turbulent Times. Mr. Holman did a great job of providing timely information for EMS leaders to use in their day to day operations.

Comments received so far have been very successful. Look for a repeat of the Leadership Conference next year and for our Billing and Management Seminar to be presented this spring. Watch our web site for further details. ■

Wallingford Rescue

IEMSA's Newest Affiliate

January and the beginning of a New Year - this always means change in the form of resolutions. The small northwestern community of Wallingford saw a significant change as the New Year began. This was not a change that was prompted as the ball dropped in New York City on December 31st or from a television ad during the Rose Bowl. The caring hearts of a few people, concerned with the welfare and well being of the citizens and visitors of their community, coupled with the knowledge that early access to emergency medical care during an emergency is crucial, set out over a year ago to make this resolution a reality.

Four fire fighters completed the First Responder class through Iowa Lakes Community College in Estherville, two other members of the community were currently certified EMTs and Wallingford Rescue started operating as an EMT-B, non-transport service on January 3, 2006.

The service is grateful to Anita Bailey, Regional Coordinator from the Bureau of EMS for her guidance during the process. Other thanks go to Gene and Avis Haukoos of Estherville for the education and skills during class and the support from local officials. ■