

IEMSA

January – March 2008

VOICE



A VOICE FOR POSITIVE CHANGE IN IOWA EMS



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I o w a E m e r g e n c y M e d i c a l S e r v i c e s A s s o c i a t i o n

Welcome New IEMSA Members

OCTOBER - DECEMBER, 2007

AFFILIATES: Calhoun County EMS

INDIVIDUALS:

Mark Addy
Brad Agan
Jerry Ahrens
David Akers
Anthony Aldrich
Bruce Amdahl
Thomas Ament
Rachel D. Anderson
Jake Anderson
Annette Bacon
Mindy Barber
Robert Barber
Joshua Beal
Jerad Becker
Jerry Ben
Jonathan Bergman
Ashely Bills
Boh Bodish
Ryan M. Brannen
Jody A. Brincks
Don Bringmann
Tammy Brink
Elizabeth Brittain
Bradley Brody
Sonia Bryant
Derek Bucy
Ken Buelt
Megan Burnhardt
Michael Buscher
Phillip Campbell
Joyce Cogdill
John Colligan
Ryan Conley
Deanna Conley
Christopher Cooper
Jeremy Corbin
Bobbie Davis

Sheli Desplanque
Brian Desplanque
Sheri Diercks
Andy Donnolly
Carrie Draper
Elizabeth Dullin
Dr. William E. Durbin
David Eilderts
Christopher Eilers
Alyssa Enns
Kevin C. Esser
Linda Fangmann
Teresa Fischer
Susan Foose
Christopher Foster
Sara B. Foster
Teresa Fowler
Christina Gage
Samuel Gillip
Jay Gochenouer
Shirley Goemaat
Tracy Gotto
Melissa Grocholski
Anita Grunder
Jessica Hannig
Brook Hansen
Paul Hansen
Nick Hanus
Wistel Harper
Shannon Hartwig
Randy Hatch
Gene Haukoos
Sonya Henderson
Adryana Henderson-Castillo
Kari J. Hines
Heather Houg
John Hougen

Derek Houser
Michelle Howey
Dan Howington
Larry Huffman
Mike L. Huffman
Kerrie Hull
Dawn Huntman
Doug Janssen
Dawn Jennings
David Johnson
Allison Kimball
Sarah Kirchner
Brenda Kueter
Derek D. Lagrange
Ed Lahey
Justin Ledesma
William Leggio
Craig Liscum
Michael Lorenzen
Kevin Loug
Kim Lovig
Jeremy Loving
Nick Lucchesi
Heidi Lusson
Jerod Lynch
Michelle Lynch
Dr. Tavi Madden-Leduc
Michele S. Madsen
Christin Manuel
Daniel March
Melissa Marlar
Paul Maxheimer
Greg Mccarty
Dennis McGinn
Merle Mckinzie
Lisa Meeks
Chris Melvin
Becky Miller

Michael Miller
Kendra Mobley
Brett Moeller
Marti Morgan
Anne Moser
Elizabeth Nemeth
Chris Newby
Dr. Patricia Newland
Ervin Nikkel
John Norris
Laurie Novotny
Matthew Novotny
Jill Ohm
Shawn Page
Jeff Palmer
Elizabeth Paradise
Brent Pauls
Jed Petersen
Raymond Posey
Chris Rausch
James Raymond
Ryan Rees
Matt Ringgenberg
Jory Ringler
Jeanette Riniker
Carey Roberts
Clint Robinson
Robert Saf
Robert Schmitter
Kelli Schneckloth
Troy Schutt
Valerie Shippy
Jeff Silver
Dave Smith
Marc Smith
Larry Spalia
Mark Spray
Barry Stahl

Shannon Starn
Joel Steenhoek
Maggie Strong
John Stutzman
Robert Sullivan
Ashley N. Symonds
Mark Tennison
Robert Thomas
Shantelle Thomas
Matt Thompson
Darrin Thompson
Terry Thomsen
Darci Thornburg
Tiffany Timmerman
Marlene Traux
Rick Tresnak
Linda Tribble
Dan Van Fossen
Matt Van Wyk
Michelle Van Wyk
Dan Vander Beek
Ryan Ward
Verdeen Waterman
Lori Wearmouth
Sherry Welte
Kevin Wheatley
Eldon Whitaker
Grace L. White
Ryan White
Dustin Whitmore
Joan Whitson
Marla Williams
Nicholas Williams
Norm Woods
Denise Woods
Staci Worley
Rhonda Younge
Todd Zell



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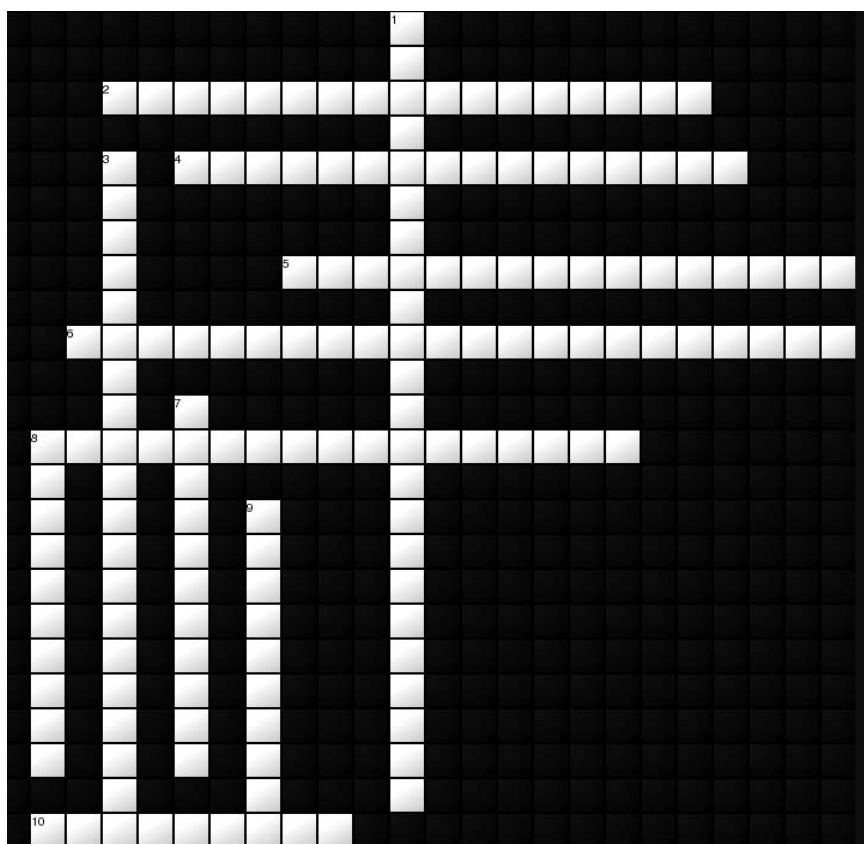


Iowa Emergency Medical Services Association Newsletter is Published Quarterly by:

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

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

IEMSA CROSSWORD PUZZLE *Challenge*



ACROSS

- 2** A rhythm that has consistent P waves, consistent P-R intervals, and a regular heart rate between 60 and 100 beats/min.
4 A rhythm that has consistent P waves, P-R intervals, and a regular heart rate that is less than 60 beats/min.
5 A rhythm that has consistent P waves, consistent P-R intervals, and a regular heart rate that is more than 100 beats/min.
6 The presence of three or more abnormal ventricular complexes in a row with a rate of more than 100 beats/min.
8 The act of viewing the electrical activity of the heart through the use of an ECG machine or cardiac monitor.
10 The four leads used with a 4-lead ECG; placed on or close to the right arm, left arm, right leg, and left leg.

DOWN

- 1** A rapid, completely disorganized ventricular rhythm with chaotic characteristics, no specific pattern, and no discernible P, QRS, or T waves.
3 An electronic tracing of the heart's electrical activity through leads, which originate in the electrocardiograph machine and contain electrodes that attach to the patient's chest and/or limbs.
7 A rhythm in which the SA node acts as the pacemaker.
8 The leads that are used only with a 12-lead ECG and must be placed exactly; includes leads V1, V2, V3, V4, V5, and V6.
9 An abnormal rhythm of the heart, sometimes called a dysrhythmia.

Crossword puzzle solutions printed on page 13. Reprinted with permission from Jones & Bartlett Publishers.

2008

IEMSA MEETINGS



Board Meetings:

The IEMSA Board of Directors will meet, either in person or via teleconference, on the following dates. All meetings, with the exception of the Annual meeting, will be held at 1:00 p.m.

2008

- **February** – NO MEETING
- **March 20**
Teleconference
- **April 17**
WDMEMS
- **May 15**
WDMEMS
- **June 19**
Teleconference
- **July** – NO MEETING
- **August 21**
WDMEMS
- **September 18**
Teleconference
- **October 16**
WDMEMS
- **November 13**
ANNUAL MEETING
Polk County Convention Complex
- **December 18**
WDMEMS

To participate in the teleconference meetings, call the IEMSA office for instructions.

Additional Important Dates:

May 7, 2008

Billing and Management Conference
Bettendorf, Iowa

November 13 – 15, 2008

Annual Conference & Trade Show
Des Moines, Iowa

A Message from the President



John Hill, EMT-PS
IEMSA President
Board of Directors

Since the 1960s, EMS has witnessed many great improvements in its approach to regulated and standardized delivery of education and patient care. However, medicine and medical technology are evolving at a very rapid pace. Because of this, the EMS profession must review and make necessary changes to ensure that appropriate and current knowledge, skills and abilities are employed to deliver the highest quality prehospital care on a National Level. For these reasons there has been a National EMS Scope of Practice Model developed. This process is an essential element in implementing an integrated, systematic approach to regulation, education and certification/licensure as defined in the *EMS Education Agenda for the Future: A Systems Approach* published by NHTSA in 2000.

Scope of Practice vs. Standard of Care

There has been some confusion between these two terms, so let's take a minute to review the difference between scope of practice and standard of care.

A Scope of Practice is a legal description of the distinction between a licensed healthcare provider and the lay public, and between different licensed healthcare providers. It details and establishes which activities and procedures can, and cannot, be performed by a particular type of healthcare provider. It defines the boundaries and distinctions between the various types and levels of providers while ensuring comprehensive control over the appropriate delivery of healthcare service. Essentially, a scope of practice is a set of skills (intubation, starting IV, taking a blood pressure, etc.) that a state legally allows to you perform under your license or certification. Usually, the range of skills is established in a state law, statute, rule or regulation.

The Standard of Care is the degree of care that a reasonably prudent person would exercise in the circumstance in question. This is a practical guideline, directing the healthcare provider as to what must be done in a given situation.

In 1996, the EMS Agenda for the Future identified at least 44 different levels of EMS provider certifications in the United States. It is highly likely that the number has increased

since 1996. For example, as an EMT, in one state you may be allowed to insert a combi tube, but in another state, you may not. The goal of this scope of practice model is to standardize EMS providers nationally and increase efficiency within the entire community. The National EMS Scope of Practice Model is an attempt to provide a consistent definition on a national level for titles of EMS providers and what set of skills each provider level can do. Because states have the final say on authorization of medical licenses or certifications, it is each state's decision whether to accept the new titles and what set of skills the EMS provider can perform.

It is easy to see how such a wide variation would be problematic. Further, it has been identified that this problem "creates public confusion, reciprocity difficulties, poor provider mobility, duplication of effort (poor efficiency), and ultimately, decreased credibility" of the EMS system.

What is driving this effort, how will you be affected and why would you want a say in the matter?

It all started in 2000, when the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) created a consensus-based document called *National EMS Education Agenda for the Future: A Systems Approach*. The purpose of creating this agenda was multifaceted. First, EMS provider levels vary from state to state. One state may call an EMT who is trained and licensed to start IVs an EMT-I, while another state calls that person an EMT-IV. Also, skills that are currently performed by EMTs and paramedics are determined by the national standard curriculum, instead of the medical needs of the community. This is especially true in rural communities.

Here are the titles and skill levels in the National scope of Practice:

Emergency Medical Responder (EMR)

This is more closely associated with the current title of Medical First Responder. This title would perform basic lifesaving procedures for critical patients on scenes while waiting for additional EMS response. This title would not typically transport a patient to a hospital. This title would be allowed to

use AEDs, apply oxygen through a bag-valve mask, suction, use oral and nasal airways, do basic assessment skills, use auto-injectors for themselves or another emergency person, and do rapid extrication.

Emergency Medical Technician (EMT)

The next level in the recommendation is Emergency Medical Technician (EMT). The EMT's skills would focus on acute management and transportation of critical patients either on a scene or in an ambulance enroute to a healthcare facility. The EMT would be allowed to use pulse oximetry, do blood glucose monitoring, use multi-lumen airways, assist patients with physician-prescribed or over-the-counter medications, administer some medications such as nitroglycerin and epinephrine for an anaphylactic reaction, IV maintenance, ET confirmation, and rate and volume-controlled automatic ventilators.

Advanced Emergency Medical Technician (AEMT)

The next level would be Advanced Emergency Medical Technician (AEMT). The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency healthcare system.

Educational Requirements: One of the eligibility requirements for licensure at this level requires successful completion of an accredited Advanced Emergency Medical Technician course.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide

advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system. **Educational Requirements:** Because of the amount of complex decision making, one of the eligibility requirements for licensure requires successful completion of a nationally accredited Paramedic program at the Certificate or Associates Degree level.

Recently at the state QASP meeting, Joe Ferrel of the IDPH gave a preliminary report on the options of moving forward with the new Scope of Practice. I must emphasize the word preliminary as Iowa is ahead of most states in their discussions on how the state should move forward due to the Bureau's active involvement in the process. I think we can all safely say that the option of doing nothing and keeping all levels where they are is not an option. Iowa would have to develop their own curriculum, write and validate their own exams, and reciprocity would be a nightmare. QASP has made the recommendation to have the Bureau prepare a document for public comment on the options. The document will be reviewed in April, and if approved posted on the web for public comment. Further discussion will occur in July.

A Final Note and Duty to Act

How does this affect you? Regardless of whether you are a First Responder, EMT, Paramedic, Administrator, Educator or Medical Director, you will have a chance to have input on the final document. Each level of knowledge, skills and ability in the scope of practice model represents a continuum of increasing complexity and risk. As provider levels increase from EMR to Advanced Practice Paramedic, so does the required knowledge and skill complexity and acquisition and, most importantly, the potential for harm. Each community of interest should assess their needs and determine the necessary and appropriate resources to deliver prehospital care services under the final adopted EMS Scope of Practice model.

Whatever comes out of the whole process, the bottom line is that the patients and patients' families do not care what title you have. What they do care about is that you show up and provide consistent quality care at the time when it's needed. Please stay safe. ■



Welcome Dr. Ahmed!

The IEMSA Board of Directors is pleased to announce Azeemuddin Ahmed, MD, FACEP as the new Medical Director. Dr. Ahmed, a native of Bettendorf, currently serves as a Flight Physician and the Medical Director for the University of Iowa AirCare. In addition, he also serves as the Medical Director of the EMSLRC. Dr. Ahmed serves as the Vice Chairman of the Emergency Medical Services Advisory Council (EMSAC) for the Bureau of EMS and also as the Chairman of the Air Medical Transport Sub-Committee of EMSAC.

Dr. Ahmed attended Augustana College in Rock Island, IL for his undergraduate degree and the University of Iowa College of Medicine for his M.D. degree. He completed an Emergency Medicine residency at the Michigan State-affiliated program at Spectrum Health-Butterworth Campus in Grand Rapids, MI and is a board certified emergency medicine physician.

Dr. Ahmed's past EMS experience includes five years as a volunteer firefighter/EMT on the Bettendorf Fire and Rescue Department, three years as a Flight Physician for Aero Med at Spectrum Health (Grand Rapids, MI), and one year as the Medical Director of the Newaygo County (MI) Medical Control Authority.

The Board of Directors would like to welcome Dr. Ahmed to the organization! ■

We Must Say Goodbye



It is with great regret that we must say goodbye to Karen Kreider, IEMSA's Administrator for the past six years. Karen and her husband Bob will be returning to Pennsylvania to pursue new opportunities.

We wish Karen and Bob the very best of luck and many good wishes as they return home to Pennsylvania. We would also like to thank Karen for all she has done for IEMSA. ■

Iowa EMS Memorial

Engraving Update

In preparation for the 2008 Iowa EMS Memorial Service, IEMSA is asking for submissions of those names to be added to the memorial. Submissions must be received by the office no later than March 15, 2008 to be included in the 2008 ceremony. An Application for Name Placement can be downloaded from the IEMSA website at www.iemsa.net.

Information regarding the Memorial Service will be forthcoming. ■

CALLING FOR EMTS IN ACTION

Please email your EMT action photos to
communications@iemsa.net.





All That *Wheezes*

BRIAN HELLAND

You are called to a residence for a 67-year-old male patient with difficulty breathing. While en-route, your partner says he is familiar with this patient – “he has lots of respiratory problems, we ran him a couple of months ago and he was admitted to the ICU.” As you drive to the residence, your mind begins thinking of all the differential diagnoses for respiratory

difficulty, and you start to formulate a care plan in your mind. You know that it is easy to develop tunnel-vision and key in on his respiratory complaint, and you remind yourself to put the patient on the monitor and get an early 12 lead just in case he is having “the big one.” A few years ago, before your service became ALS, you would have asked for an ALS response from your neighboring

service to help evaluate and provide treatment of his respiratory problems.

On arrival, you meet the patient sitting at his kitchen table. He is leaning forward on one elbow and nods in your direction acknowledging your presence. He is breathing rapidly and greets you in short sentences, telling you that he is having a lot of trouble breathing. He seems to be oriented

to person, place, and time even though he is not much on conversation. You are able to find out that he has emphysema as well as congestive heart failure. He denies any allergies, and he is able to convey to you that this episode began gradually this morning and has been increasing in severity all day.

As you begin asking him questions, your partner slips the pulse oximeter on his finger, which shows a reading of 91%.

You take hold of his wrist to find that his skin is warm and moist, and he has a full, regular radial pulse that you estimate to be slightly faster than 100 per minute. You have already noted that his skin color appears normal for the most part – no obvious pallor, cyanosis or mottling is present.

As your partner is getting a blood pressure, you grab your stethoscope to listen to breath sounds. He is diminished in both bases, and if you use your imagination, you think you hear some diffuse wheezing in the bases on both sides. You continue to whittle away your differentials for this patient, and you decide that he is either experiencing an acute exacerbation of COPD or increased pulmonary edema from his CHF. However, your protocols have recently changed and there are distinctly different treatment choices you need to make about managing your patient.

Wheezing can be caused by several pathologies. In bronchial asthma, it is thought that the constriction of the smooth muscle, along with excess mucus production and relative dehydration, reduces the size of bronchioles. This causes a high-pitched whistling of air as it passes through the constricted passages, usually more prominent on expiration. This whistling is heard as the classic wheeze on auscultation, and can sometimes be heard audibly without the aid of a stethoscope.

Chronic obstructive pulmonary disease or COPD typically encompasses the disease processes of emphysema and chronic bronchitis. These disease processes may be

closely related in origin, yet result in different appearances for our patients. Two major pathologies are thought to initiate the process of COPD. First, airflow through many of the terminal bronchioles is obstructed. Second, many of the alveolar walls are destroyed. Chronic infections in portions of the lung cause areas of bronchiolitis, or inflammation of the smaller air passages.

This inflammation also involves the walls separating the alveoli and can eventually weaken or destroy them. Additionally, obstruction to expiration can cause increased alveolar pressures, adding to alveolar damage. The two different results: bronchioles can become permanently obstructed resulting in chronic bronchitis, or the total surface of the

alveoli can be decreased leading to emphysema. In many cases, patients may actually have both disease processes present. Their overall appearance depends on the relative amounts of bronchial obstruction, resulting in air trapping and a muscular or “barrel” chest, (a.k.a. “blue bloater”) vs. the amount of alveolar destruction resulting in decreased surface area for gas exchange – sometimes up to 75%. This impairs the body’s ability to oxygenate the blood or remove carbon dioxide. On exam, these patients also experience wheezing due to the inability to force air out through obstructed bronchioles and damaged alveoli (a.k.a. “pink puffer”).

Over time, this loss of lung tissue also contributes to a decrease in the pulmonary capillaries. Since the heart continues to try to pump the same amount of blood through the pulmonary circulation, this results in pulmonary hypertension. The increased workload on the right ventricle can cause right sided heart failure.

In contrast, left sided heart failure causes a decrease in systemic cardiac output. The right side of the heart continues to churn away, pumping blood through the pulmonary vasculature at a normal pace. The left side of the heart cannot keep up, resulting

in a fluid overload in the lungs. With an increase of pressure in the pulmonary vessels, congestion eventually causes plasma to cross cell walls and create pulmonary edema, or fluid within the alveoli. This is usually found on examination by auscultating rales or crackles in the dependent fields of the lungs. Oftentimes, the only thing found on auscultation will be diminished breath sounds if there is not enough tidal volume or respiratory effort to open up some of the fluid filled passages.

Occasionally, the fluid in the alveoli and bronchioles can cause bronchospasm, which will lead to the finding of wheezes. Additionally, fluid in the alveoli causes increased work of breathing. Increased expiratory effort exerts pressure on the lungs, which can squeeze bronchioles and result in the finding of wheezes, even in the absence of other pathologies of bronchoconstriction.

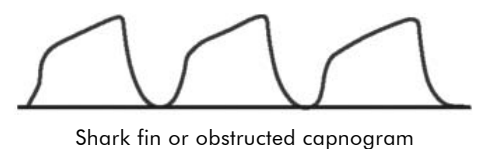
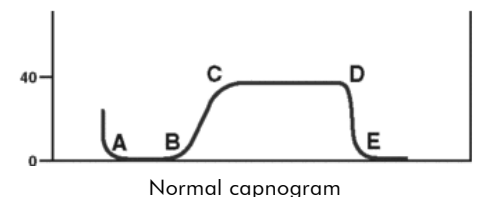
Pulmonary edema also leads to hypoxia, which increases respiratory effort, increasing heart rate and the workload of the heart. Treatment for difficulty breathing in a patient who already takes beta agonist inhalers, such as Proventil, Advair or Ventolin, usually involves administration of albuterol, either with or without ipratropium. However, some more recent studies have shown that our beta-selective inhalers still do have some effect on the heart. Increasing this patient’s heart rate and left ventricular workload if he is in CHF may be counterproductive and lead him into worse respiratory failure.

Signs and symptoms can be misleading in the diagnosis of CHF vs. COPD in patients with acute dyspnea. Additional diagnostic tools and history gathering can make a difference in your treatment path for these patients. If you have access to waveform capnography, you can look at the capnogram to determine if your patient is experiencing bronchoconstriction. In the case of a shark fin shaped

OBJECTIVES:

Each participant should be able to successfully complete a 10-question quiz after reading this piece and be able to:

1. Review pathophysiology of respiratory compromise
2. Define differences in signs and symptoms of CHF and COPD
3. Discuss treatment options for patients in respiratory compromise



capnogram, you have evidence that bronchoconstriction is present. This helps make the decision to use bronchodilators, even though the patient may not have enough tidal volume to create a good wheeze. The capnogram may also tell you that the patient has a decreased cardiac output because of a low amount of CO₂ being exhaled. In the presence of a normal shaped waveform with decreased CO₂ production, you have a "graph" of someone in CHF.

Good history taking can also lead you down the correct treatment path. What was your patient doing when this episode started? Was he watching football and eating potato chips or Chex mix? Increased salt intake can cause increased pulmonary edema in patients with underlying CHF. Has your patient been snowed in for the past week and has not had the opportunity to get medications refilled? Have they not been using their nebulizer regularly for the past few days? COPD patients are frequently on a regimen of regular breathing treatments to help keep their disease in check. Missing some of these treatments may cause exacerbation of their symptoms leading to a 911 call. Pertinent past medical history can also lead you to the correct path. Patients may be able to tell you that it feels just like the last time their COPD flared up, or they may tell you they have been having a problem with fluid buildup and their physician is altering their dose of diuretics. Listening well to your patients can give you a great advantage in choosing your treatment plans.

"Listening well to your patients can give you a great advantage in choosing your treatment plans."

As a basic provider, your treatment paths may be fewer, but are still very important. Patients who take inhalers oftentimes cannot use them correctly, especially when experiencing respiratory distress. Remember, most of the inhalers you are assisting them with are a dry powder that is aerosolized when the actuator is depressed. Patients in respiratory distress often end up squirting the inhaler dose directly on

their tongue or the back of their throat as they attempt to match their quick, shallow inspiration. Providing oxygen, positioning and reassurances can make a difference in the effectiveness of their inhaler use. Use of an aerosol chamber with the inhaler greatly enhances its effectiveness, as well. Remember to make sure it is the patient's own inhaler, and check to make sure it is not out of date. Good history taking is also well within the realm of a basic provider.

The clues you gather regarding the onset of symptoms, treatments the patient may have tried at home, etc., are great details to help the receiving physician treat the underlying cause of your patient's dyspnea – especially after you have made them better!

Of course you remember the basics – you position your patient as comfortably as he can be on an ambulance cot. You begin administering oxygen and note that his SpO₂ increases to the mid 90s. You apply a cardiac monitor showing a sinus tachycardia, and you even remember to do the 12 lead you promised yourself you would not forget. You apply a cannula for capnography and note that his waveform looks like a shark fin, with the CO₂ reading in the 60s. En route to the hospital, you provide your patient with a nebulizer treatment, which clears up his wheezes and he begins talking in complete sentences again. You deliver the patient to the receiving ED in much improved condition, and you get the warm fuzzy feeling that reminds you why you love EMS. ■

References

1. Cazzola, M, M G. Matera, and C F. Donner. "Inhaled Beta2-Adrenoceptor Agonists: Cardiovascular Safety in Patients with Obstructive Lung Disease." *Drugs* 65 (2005): 1595-1610. 10 Jan. 2008 <http://www.ncbi.nlm.nih.gov/pubmed/16060696?ordinalpos=15&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum>.
2. Guyton, Arthur C. *Human Physiology and Mechanisms of Disease*. 3rd ed. Philadelphia: W.B. Saunders Company, 1982. 325-327.
3. Mueller, C. "Emergency Diagnosis of CHF: Impact of Signs and Symptoms." *Canadian Journal of Cardiology* 21 (2005): 921-924. 10 Jan. 2008.

IOWA CERTIFIED PARAMEDIC

Franklin General Hospital is seeking an Iowa Certified Paramedic or Paramedic Specialist to work full-time or part-time. This position is primarily a 3p – 11p with call and additional shifts as needed. Qualified candidates will have current Iowa paramedic license as well as current BLS and ACLS certifications upon hire. Franklin General Hospital offers an excellent benefit package including IPERS, Health and Dental Insurance, Paid Time Off, Life Insurance and flexible spending accounts.

If interested, fill out an application at the hospital or print an application online at www.franklingeneral.com and send it to:

VICKI KRUZE

Human Resources
Franklin General Hospital
1720 Central Avenue East
Hampton, IA 50441

1/18/08

EMS Educators!

IEMSA is in need of authors for its quarterly continuing education articles in this newsletter! Please consider sharing your expertise with the IEMSA membership through this venue. All you will need to provide is an article on a topic of your choice (with appropriate references), a 10-question post test, and a biographical sketch of your background. Contact Angie Moore at administration@iemsanet.net regarding your interest in this project. ■

10 QUESTION POST-ARTICLE

Quiz

- 1) Which of the following can cause wheezes?
 - A) Bronchoconstriction
 - B) Increased mucus production in bronchioles
 - C) Fluid in alveoli
 - D) All of the above
- 2) What is the potential risk of using beta agonist inhalers for patients with CHF?
 - A) There is no risk
 - B) Cost too much for too little benefit
 - C) Patient may have an allergic reaction to the inhaler
 - D) Increase in cardiac workload may worsen CHF
- 3) A "shark fin" shaped capnogram indicates which of the following?
 - A) Bronchoconstriction
 - B) Bronchodilation
 - C) CHF
 - D) Seafood allergy
- 4) A normal waveform on the capnogram would be more consistent with which of the following causes of dyspnea?
 - A) COPD
 - B) Asthma
 - C) CHF
 - D) None of the above
- 5) The four "rights" of administering a patient medication include the right patient, right dose, right drug and what else?
 - A) Right container
 - B) Right medic
 - C) Right route
 - D) Right time
- 6) According to the article, creating the diagnosis of COPD or CHF can be aided by additional diagnostic tools and:
 - A) Good history
 - B) Physical exam
 - C) Lung sounds
 - D) Patient's medications
- 7) Pulmonary hypertension can be caused by:
 - A) Right sided heart failure
 - B) Too much salt
 - C) Left sided heart failure
 - D) Administration of a breathing treatment
- 8) Destruction of alveolar walls resulting in decrease in surface area of alveoli for gas exchange is a characteristic of:
 - A) Chronic bronchitis
 - B) Asthma
 - C) ARDS
 - D) Emphysema
- 9) Patients who display severe respiratory distress may:
 - A) Talk continuously due to stress
 - B) Have very loud, distinct lung sounds
 - C) Speak in short, one or two word sentences
 - D) None of the above
- 10) Basic treatment for patients with dyspnea includes:
 - A) Position of patient comfort
 - B) Oxygen at 15 lpm via non-rebreather mask
 - C) Pulse oximetry
 - D) All of the above

IEMSA

CONTINUING EDUCATION

answer form

CLIP AND RETURN

(Please print legibly.)

Name _____

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Iowa EMS Association _____

Member # _____

EMS Level _____

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 Indian Hills Community College in Ottumwa, Provider #15.

For those who have access to email, please email the above information along with your answers to: administration@iemsas.net.

Otherwise, mail this completed test to:

Angie Moore
IEMSA
2600 Vine Street, Ste. 400
West Des Moines, IA 50265

**The deadline to submit this post test is
APRIL 18, 2008**

EMS Day on the Hill

BILL FISH, LEGISLATIVE CHAIR

January 31 was the Annual EMS Day on the Hill sponsored by the Iowa EMS Association. Iowa's EMS providers had the chance to interact with their elected officials to share concerns and promote the 2008 EMS Legislative Agenda.

The Association was well represented with well over 60 members present. Many lawmakers shared concerns with us and vice versa as we formally presented our 2008 EMS Legislative Agenda.

The IPERS issue is being presented as a part of the IPERS sub-committee bill and will be advanced to the State Government Committee before coming onto the floor. We'll let you know as

soon as we have a number attached to the bill.

Several bills are being considered for volunteer provider tax credit. We're watching which one will be presented as a floor bill.



Follow-Up Needed

If you were available to attend the legislative day, please call or email the officials you met and thank them for their time. If you were there and did not meet your local lawmakers, contact them and tell them that you are sorry you missed them. Tell them that Cal Hultman and Mike Triplett are your lobbyists and that they

have copies of our legislative agenda and that we need their help.

Call them in a couple of weeks and see if we are making any headway.

You can reach the senate switchboard at (515) 281-3371. The house switchboard can be reached at (515) 281-3221 ■



MEMBERSHIP ANNOUNCEMENT

IEMSA Website Instructions

Both the Members Only website and the IEMSA Forum require separate login information procedures in order to access the respective sites. However, you may choose for these login/ usernames and passwords to be identical.

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What's *New* with the *Bureau*

ANITA J. BAILEY, PS

AED Grant Coordinator

Please welcome John Halbrook to the Bureau of EMS. John will serve Iowans as the new AED Grant Coordinator. John has extensive background in EMS and is eager to work with the advisory council and all of Iowa's EMS community. Although the first round of FY 2008 AED grants have been submitted, John recommends you routinely visit the Grants, Bids and Proposals page at www.idph.state.ia.us for additional postings. John can be contacted at jhalbroo@idph.state.ia.us or 515-281-0923.



New AED Grant Coordinator, John Halbrook

Iowa EMS System Standards Request for Proposal (RFP) is Posted

This is a tremendous opportunity to evaluate and locally develop the eight critical areas of EMS systems as defined in "Iowa EMS System Standards, What Every Iowan Can Expect From Emergency Medical Systems." County and multiple-county EMS associations are urged to visit the Grants, Bids and Proposals page at www.idph.state.ia.us. Scroll down the list and select Bureau of EMS Iowa System Standards RFP. The purpose of the RFP is to enable the Bureau to select the most qualified applicants to provide data for the development and implementation of a statewide EMS system delivery model based on the minimum standards completed by the diverse workgroup of EMS stakeholders. To ensure statewide representation, the Bureau anticipates funding at least

one award to each of the following jurisdictions:

- **Rural:** EMS systems serving counties of less than 20,000.
- **Urban:** EMS systems serving counties of more than 50,000.
- EMS systems serving counties of greater than 20,000 and less than 50,000.

The total funding available is \$120,000. No more than four contracts will be awarded. Proposals are due February 27, 2008.

Renew Your Certification Online

The EMS certification for nearly 5,000 EMS providers will expire March 31, 2008. Postcards were mailed reminding providers to renew online. Visit www.idph.state.ia.us/ems, then click on System Registry, and then EMS Student/Provider. You will be prompted to enter your last name, social security number and date of birth to access your information. Providers are required to keep their contact information in the System Registry current. First Responders and EMT-Bs will be renewed within 24 hours of requesting renewal via the System Registry. Renewal fees for the EMT-I (\$10) and EMT-P and Paramedic Specialist (\$25) must be received before their certification request will be processed. If you need a name change or have questions about the System Registry, contact Katie Linn at 1-800-728-3367, or klinn@idph.state.ia.us

Remember to renew before expiration and only after you have acquired the required number and type of continuing education hours.

National Scope of Practice Model

Joe Ferrell, Bureau of EMS Regulations Coordinator, made a presentation to the Quality Assurance, Standards and Protocols (QASP) committee regarding the options for Iowa EMS to transition to the four levels of

EMS providers as defined in the National Scope of Practice Model. This complex issue is influenced by several factors, including timelines. Joe anticipates the education standards will be finalized by fall of 2008. Federal approval by the National Highway Traffic Safety Administration is expected by Spring of 2009. Most vendors believe they will have textbooks and other educational materials available by Winter of 2009. Finally, the National Registry of EMTs will have exams ready for the 2010/2011 academic calendar. Chief Schmitt presented an unfiltered list of reported skills by certification level from the 280 services that provided data in 2006. It is anticipated that QASP will ask the bureau to filter the data to provide information pertinent to the transition. QASP made a recommendation to the Iowa EMS Advisory Council (EMSAC) to direct the Bureau to develop talking points for the options and post the document for public comment following approval at the April 9, 2008 EMSAC meeting. At this point, we strongly encourage everyone to stay involved, stay informed and read all the documents posted on the Scope of Practice page, which can be found in the Providers section at www.idph.state.ia.us/ems. Take an educated stance and let your voice be heard by contacting your representative on QASP or EMSAC.

And Finally...

"Your life is our mission" is the logo for EMS Week, May 18-24, 2008. This is the 35th year the American College of Emergency Physicians has spearheaded a week-long celebration to raise community awareness and promote injury and illness prevention. While you locally promote EMS, take a moment to pat yourself and your team on the back. You deserve high praise and gratitude for the work you do serving Iowans. Thank you. ■

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Affiliate Profile

MEDIC EMS

In the early 1980s, the Scott County medical community identified a need for the consistent delivery of pre-hospital care at the advanced life support level. To accomplish this, the Scott County Health Department, in conjunction with two Davenport hospitals, St. Luke's and Mercy, founded MEDIC EMS in 1982 as a 501c3 private, not for profit paramedic ambulance service. The new service began operation out of St. Luke's Hospital (now Genesis Medical Center, East Campus) with four ambulances and 32 employees.

In 1986, Davenport Osteopathic Hospital (now Trinity at Terrace Park), another Davenport hospital, became a part of the corporation. Today, MEDIC EMS serves a primary area of 450 Square miles with over 200,000 residents with a staff of 150 employees, supported by a fleet of 16 ambulances, three command vehicles, two shuttles, and two ancillary vehicles.

The mission of our company is to provide high quality, high value, Emergency Medical Services and Health Care Transportation to the Eastern Iowa and Western Illinois Region. We strive to provide a high degree of professionalism and quality care through highly trained employees, state of the art technology and equipment. Our vision will be realized through:

- High quality personnel
- Collaboration with all First Responder Agencies, other Health Providers, and our payers
- 911 paramedic ambulance service and non-emergent ambulance service
- Delivering our care through the most cost effective manner possible
- State of the art emergency and non-emergent dispatching services
- Well maintained, quality equipment

As the Scott County Community grew, so did the need for Emergency Medical Services. In

1989, MEDIC EMS reached an annual call volume of 10,000. The year 1995 brought about the advent of several new services at MEDIC EMS, including a Wheelchair Shuttle operation, in addition to 24-hour dispatching from MED-COM, a secondary Public Safety Answering Point located at our headquarters facility. Call volume also increased to 15,000. MED-COM continues to grow in service to our bi-state community with the following enhancements:

- **1997** Dispatchers begin giving Emergency Medical Dispatch (EMD) instructions to callers in Bettendorf and Davenport, offering life-saving pre-arrival instructions.
- **1999** Dispatch services begin for Illini Ambulance, located in Silvis, Illinois, with an annual call volume of 5,000. EMD instructions are also given to callers from the Illini Ambulance district.
- **2000** Dispatch services begin for MED-FORCE Helicopter, with two bases located in Colona, Illinois, and Burlington, Iowa.

In 1996, MEDIC EMS was accredited by the Commission on Accreditation of Ambulance Services (CAAS) for five years. MEDIC EMS was the fifty-first ambulance service in the nation, as well as the first in Iowa and Illinois, to achieve this accreditation. MEDIC EMS successfully achieved reaccreditation in 2001, 2004, and 2007, and appreciates the opportunities it has realized from being a CAAS accredited service. MEDIC EMS was also named as the 1996 Iowa EMS Association Career Paramedic Service of the Year.

In addition to responding to emergencies, MEDIC EMS identified a need for community safety and prevention. To address this need, MEDIC EMS initiated the "Mikey Medic" 911 Education Program, specifically



Mikey Medic was introduced in 1996.

designed to develop public safety awareness for elementary school children. As a very well-known ambassador for our company, "Mikey," a spirited robotic ambulance, visits each second grade class annually with his 911 education message, as well as making guest appearances in parades and other community gatherings and events.

In 1997, MEDIC EMS further enhanced community safety by starting its very successful Bike MEDIC program. This program depends upon specially trained Bike MEDICs who ride the local bike trails, offering aid when needed. The Bike MEDICs are well recognized and utilized in the community at large special events, including the BIX 7 road race and the Quad City Air Show.

In 1998, MEDIC EMS became a member of the Technical Advisory (or TAC) committee. This group, which meets on a monthly basis at the MEDIC EMS Headquarters facility, offers a multidisciplinary approach to public safety issues and operates in a consensus manner. With a group of six members at its inception, the TAC Committee routinely draws 35 to 40 participants, and is seen as a bi-state regional best

practice delivery model for getting things accomplished in the public safety sector.

In 1998, MEDIC EMS also purchased LifePak 12 monitor/defibrillators with 12 Lead electrocardiogram technologies. All paramedic personnel were trained to interpret EKGs, and protocols were modified to rapidly advise local receiving facilities about patients' STEMI tracings, overall decreasing the patient's time to treatment, as well as cardiac morbidity and mortality.



Iowa's first Child Passenger Safety Seat Fit Station

In 1999, a new MEDIC EMS method of operation called the "Alternative Delivery Model" or "ADM" began its existence in a newly constructed Scott County facility located in Eldridge. This model pairs seasoned paramedics in quarters with an EMS Provider from the community, offering a cost effective solution to the delivery of advanced life support services in low-volume operations. With a mission to reduce childhood death and disability, we created the first permanent Child Passenger Safety Seat Fit station in the state of Iowa at this station, which has shown a measurable, positive impact on child safety. To sustain this operation, MEDIC EMS partners with Eastern Iowa Community College to provide EMT-Basic programs at no cost to its community partners, and just began its fifth class at the Eldridge facility, educating nearly 100 EMT-Basics since 1999.

In 2000, MEDIC EMS began a non-emergent transfer operation at Mercy Medical Center in Clinton, Iowa. With a fulltime staff of six personnel, this operation responds to approximately 1,200 calls annually, and offers emergency tier services for surrounding volunteer ambulance services.

In 2001, MEDIC EMS began another ADM operation in LeClaire, Iowa, after receiving a donation of two modular ambulances from LeClaire Volunteer Ambulance. In 2005, the LeClaire station began its mission to reduce death and disability from heart disease by initiating Community CPR classes on a monthly basis.

In 2002, total call volume exceeded 20,000 at 20,123 calls, handled with a fleet of 16 ambulances, five shuttles and two command cars. In 2003, MEDIC EMS began a joint venture with Advanced Medical Transport in Peoria, Illinois, to provide emergency and non-emergency ambulance service to the Mercer County, Illinois region.

In 2006, MEDIC EMS was approved to provide Critical Care Ambulance Transportation by the State of Iowa, utilizing specially trained personnel and three custom-designed Critical Care Ambulances. New LifePak 12 monitors with capnography were purchased, and we made a commitment with the University of Iowa and the National Institute of Health to participate in the Resuscitation Outcomes Consortium, or "ROC" study, which required a significant investment in personnel education. Also, as one of four PSAPs in Scott County, MEDIC EMS participated in a Consolidated Dispatch Study, making a decision to co-locate our current center in the Scott Emergency Communications Center in 2010.

In 2007, MEDIC EMS celebrated its 25th Anniversary with a staff of 150 talented employees, reaching a record number of dispatches at 23,724. MEDIC EMS is proud to have Dr. Richard Vermeer, the first employee of our company, still on staff as our Medical Director. With his knowledge, expertise, vision, and medical oversight, he has helped to guide our service to the highest level of excellence in emergency medical care.

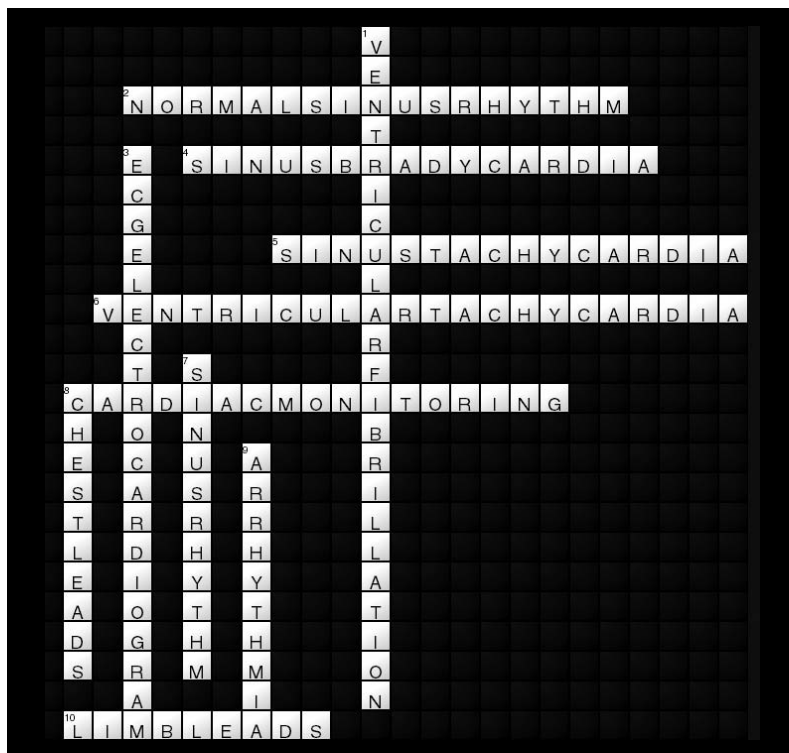
Facing challenges of increased costs of operation and educational needs with respect to shrinking reimbursement, we are highly committed and energized to partner with our valued First Responders, the Davenport, Bettendorf, and County Fire



MEDIC EMS would like to thank Dr. Vermeer for his leadership and support over the last 25 years

Departments, as well as Genesis Medical Center, Trinity at Terrace Park, and the Scott County Health Department to provide a premier system delivery of emergency medical services in Scott County today and in the future. ■

CROSSWORD SOLUTIONS





Corporate Profile

WHEATON FRANCISCAN HEALTHCARE AMBULANCE SERVICES

The Wheaton Franciscan Healthcare Ambulance Service is comprised of three services that were at one time separate entities. Each has an interesting history of its own: Covenant Medical Center Ambulance, Sartori Paramedic Service and Mercy-Oelwein Ambulance.

Covenant Medical Center Ambulance-Waterloo, Iowa was established in 1983, originally called the Northern Iowa Emergency Transport, also known as NIET. The service later became Schoitz Paramedic Service and finally Covenant Paramedic Service when the Schoitz and St. Francis Hospitals of Waterloo joined to become Covenant Medical Center under the ownership of Wheaton Franciscan Healthcare.

Sartori Paramedic Service of Sartori Memorial Hospital was established in 1982 as an EMT Basic Service for the City of Cedar Falls. Within a couple of years the service became one of the first services in Black Hawk County to be designated as an advanced level service. In 1997, Wheaton Franciscan Healthcare – Iowa established ownership of the Sartori Paramedic Service through a long term agreement with the City of Cedar Falls to operate Sartori Memorial Hospital. Sartori Paramedic Service continues to provide 911 ambulance coverage for the City.

Mercy-Oelwein Ambulance Service of Mercy Hospital in Oelwein, Iowa was originally based out of the Oelwein Fire Department. The Fire Department-based service was staffed with fulltime firemen and volunteer EMTs. In 2005, Covenant Medical Center obtained ownership of the service when a request to consider the purchase of the service was received by the City

of Oelwein. The Service is now hospital-based out of Mercy Hospital in Oelwein.

These three services of Wheaton Franciscan Healthcare – Iowa are designated at the Paramedic Specialist Level with CCT endorsement. Covenant Ambulance staffs three Ambulances 24/7, responds to requests for emergencies, mutual aids, critical care transfers, neonatal transfers and all other types of ALS and BLS requests in Black Hawk and surrounding counties. Sartori Paramedics staff two ambulances 24/7, providing 911 service for Cedar Falls as well as requests for mutual aid from surrounding communities.

Mercy-Oelwein Service staffs one full time unit and one on call unit 24/7, providing 911 coverage and transport for the cities and rural areas of Oelwein, Hazelton, Stanley, Aurora, and Maynard.

The Wheaton Franciscan Healthcare Ambulance Services are committed to living out the healing ministry of the Judeo-Christian tradition by providing exceptional and compassionate health care services that promote the dignity and well being of the people we serve. In addition to providing excellent care for our patients, The Wheaton Franciscan Healthcare Ambulance Services maintain a positive public image by providing support to the communities of Waterloo, Cedar Falls and Oelwein. The services provide ambulance coverage for many community events including: University of Northern Iowa Dome events, sports, music concerts, area High School sporting events, Sturgis Falls Celebration, My Waterloo Days Celebration, bike trail events, marathon races, rodeos and numerous other events.

The Sartori Paramedic Service, in a collaborative effort with Covenant and Mercy Ambulance Services, provides continuing education classes for EMS Providers at no cost in the months of January, February and March of every year. Throughout the year many of the Wheaton Franciscan Ambulance Service Paramedics fulfill training requests for outlying community ambulance services, as well.

Wheaton Franciscan Healthcare (WFH) is a faith-based 511-bed, not-for-profit, comprehensive medical/surgical health care provider offering acute levels of medical care at Covenant Medical Center, Waterloo; Sartori Memorial Hospital, Cedar Falls; and Mercy Hospital, Oelwein. In addition, WFH includes Covenant Clinic (138 primary and sub specialty physicians), Covenant Foundation and Sartori Health Care Foundation. Areas of excellence include cardiology, orthopedics, neurosurgery, maternity and NICU, cancer treatment, and minimally invasive and Bariatric surgery. WFH invests in the communities we serve and is committed to living out the healing ministry by providing exceptional and compassionate health care service that promotes the dignity and well being of the people we serve. ■

Covenant Ambulance Service
5,000 requests per year

Sartori Paramedics Service
3,500 requests per year

Mercy-Oelwein Ambulance
1,400 requests per year

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IOWA HEALTH
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