

# VOICE



January—March 2011

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

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**6** Letter from the President \*

**7** Corporate Profile \*

**8** Continuing Education \*

**11** New with the *Bureau* \*

**13** On The Hill \*

**14** Iowa Dept of Transportation \*

**16** NAEMT Corner Profile \*

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



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# VOICE



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8515 Douglas Avenue, Suite 27B \* Urbandale, IA 50322

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## IEMSA

### Board Meetings

January 26, 2011

WDM Marriott 6:00—8:00 pm

February 17, 2011

Altoona Fire Dept 1:00—3:00 pm

March 17, 2011

WDM EMS Station 19 1:00—3:00 pm

April 21, 2011

WDM EMS Station 19 1:00—3:00 pm

May 9, 2011

Gateway Hotel, Ames IA 1:00—3:00 pm

June 16, 2011

WDM EMS Station 19 1:00—3:00 pm

July 2011

No Meeting

August 18, 2011

WDM EMS Station 19 1:00—3:00 pm

September 15, 2011

WDM EMS Station 19 1:00—3:00 pm

October 20, 2011

WDM EMS Station 19 1:00—3:00 pm

November 10, 2011

Annual Meeting 6:30—8:00 pm

December 15, 2011

WDM EMS Station 19 1:00—3:00 pm

2011

# IEMSA

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# A Message from the President

**Jerry Ewers, Fire Chief**  
IEMSA President  
Board of Directors

**“Members, members, members”**

For me, it is a great pleasure and honor to address all EMS Providers, Affiliate Members, and our gracious Corporate Sponsors as I begin my responsibilities as President of IEMSA. We would not be in existence today without the support and following of our members, sponsors, dedicated board members, and our highly attended annual conference. But before I begin my term as President I wanted to personally give thanks and praise for the last few predecessors that I have watched and worked with, including John Hill, Jeff Dumermuth, and Jeff Messerole for their strong leadership and wise vision which successfully led the organization to where it is today. With a history of twenty-four years, IEMSA has set up solid roots, achieved a mature level of influence across the state, and has truly become a Voice for EMS in Iowa. So, on behalf of the entire Board of Directors we would like to thank all of you for your continued support and commitment to YOUR organization - IEMSA.

As I was reflecting on what my words might be for the article, I realized that I have a new appreciation for anyone who volunteers; whether it's to volunteer to serve on a board, ambulance service, fire department, or for anything else that helps people or our communities. My experience prior to becoming a board member was in the military, fire service, and ambulance service, all of which were compensated positions. But, now I know that is not the norm in Iowa. According to the IDPH Bureau of EMS, fifty-five percent of services are staffed by uncompensated providers and twelve percent are staffed by mixed compensation providers. Only thirty-three percent of services are staffed by compensated providers. For this reason IEMSA supports a system to reward volunteerism in public safety, which is in the form of an Iowa income tax credit.

Did you know that IEMSA represents its members on task forces, advisory groups and boards at the local, regional, state, and national levels? Did you know that IEMSA, as well as our lobbyist, initiates and supports EMS legislation that positively affects each of us and our services? Did you know that IEMSA's annual conference is the largest in the state and one of the largest EMS conferences in the Midwest? Did you know that as a member you receive a subscription to the IEMSA Newsletter “The Voice,” weekly electronic issues of E-News, discounts on IEMSA merchandise, discounts and special rates on insurance programs, a FREE \$10,000 accidental or line of duty death/dismemberment insurance policy, discounted registration to the annual conference, leadership conference, billing conference, and access to the members only section on IEMSA's webpage?

Have you ever asked yourself how you can help grow our organization? How about getting involved and help us spread the word. You may never know how sharing your thoughts, experiences, writing an article, giving a presentation, or just lending an ear may create a force of change. As American Express says, “Membership has its privileges.” Numbers speak volumes when trying to make changes that affect our profession. Membership in IEMSA is an investment in yourself, and if you make the most of it, will provide an amazing return. IEMSA currently has approximately 2,900 individual members, but there are 12,267 certified providers in the state. You can help us by spreading the word and asking your co-workers and services to join this great organization. I challenge not only the Board of Directors, but I also challenge all of you to spread the word about IEMSA and to increase our membership. Just imagine if you recruited just one member to join, or one service to join as an affiliate member, and then another person did the same, and so on. After all, that's why people join: to give back, to learn, to grow, to network, to add value to others and to the organization. Where else can you find knowledge, affiliation, professionalism, camaraderie, and fun for such a reasonable investment? An individual active membership is only \$30.00 a year.

I want to share just one little quote that I thought fits this topic.

*“Coming together is a beginning. Keeping together is progress. Working together is success.” Henry Ford*

I believe that together we can be a stronger voice for EMS issues that are important to each and every one of us, our communities, and our profession. We can achieve this through membership, membership, membership. Let's increase the visibility of our great organization and our amazing membership. Help us to help you.

I personally welcome your input and guidance during my time in this role. Please tell us what we are doing well and what we can improve upon. Again, this is YOUR organization. Thank you for the opportunity to lead IEMSA as we continue our journey together and thank you for all you do for your communities across this great state.

Please check out IEMSA's website for upcoming programs, conferences, and events for 2011.

# CORPORATE PROFILE | IOWA HEALTH - DES MOINES

The staff and physicians of Iowa Health - Des Moines are committed to high-quality, compassionate healthcare for our patients. Whether it's providing some of the finest cardiovascular care or cancer treatment in the country to creating a hospital just for kids and their families or working to keep central Iowa residents healthy through preventative healthcare and health education



programs, we're working every day to improve the quality and convenience of healthcare services in central Iowa. Iowa Health - Des Moines is comprised of: Iowa Methodist Medical Center, Iowa Lutheran Hospital, Blank Children's Hospital and Methodist West Hospital, John Stoddard Cancer Center and Physicians and Clinics. Working together, we are committed to "improving the health of our communities through healing, caring and teaching." Proof of this ongoing commitment is demonstrated through the many awards and recognitions for outstanding care that Iowa Health - Des Moines has received over the past few years:

- Designated as a Bariatric Center of Excellence
- Iowa Better Business Bureau's Integrity Award

- National Innovation Award for outstanding contribution to medical education
  - Blue Distinction Centers<sup>SM</sup> for Complex and Rare Cancers
  - Three Star Rating for Total Joint Replacement Care (highest possible rating)
  - Consumer Choice Award as a Top U.S. Hospital
- Medal of Honor recipient from the US Health and Human Services for Outstanding Organ Donation

Several major projects have been recently initiated that will dramatically raise the quality of care and help to provide truly the best outcomes for patients and their families.

One such advancement is available to cancer patients at the John Stoddard Center. It is the World Class TrueBeam STx. This type of radiation technology allows patients in central Iowa to have access to a level of care previously offered by only a handful of the world's most prestigious institutions.

Equally as exciting and unique is the commitment to build a new Pediatric Development Center at Blank Children's Hospital, where a multi-disciplinary team of specialists can help children with special needs reach their full potential.

In late 2009, Iowa Health Transport Services added a new EC 145 helicopter and specialty pediatric/neonatal ground transport ambulance to the

fleet. All the transport specialty teams are top notch and staffed with nurse and paramedic experts in the field of adult, pediatric and neonatal emer-



gency transport. The hospitals of Iowa Health - Des Moines are committed to getting the right care to patients and getting patients to the right care. We feature transportation services unmatched by any other hospital system in Iowa.

Iowa Health Des Moines Transport services include:

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# HYPOTHERMIA

Even though hypothermia can occur at any time of the year, during the winter EMS will have more calls involving hypothermia. The normal range of body temperature is 97-99° F. The body loses heat in 5 different ways: radiation, conduction, evaporation, respiration, and convection. Our bodies radiate heat naturally, and when we are in a warm environment – or covered with clothing – the loss is minimal. When we are in a cold environment, and have exposed body areas, the heat loss can be monumental. Conduction occurs when there is direct contact with a cold surface. Heat is lost from the skin to the cold surface, thus reducing the temperature of the body part in contact with that surface. Evaporation occurs when the skin is wet, either with sweat or another wet substance, such as rain, snow, or water from another source. As the wetness evaporates, heat is lost into the air. When there is wind or other air movement over the skin, heat loss also occurs, which is called convection. Convection, combined with evaporation, speeds up the process of heat loss. You have likely witnessed heat loss by respiration when you have gone outside into a cold environment and you “see your breath” as you exhale.

People who are most susceptible to cold emergencies are the very young, and the elderly. Babies and children have a proportionately larger body surface area than adults, and lose more heat through the skin than adults do, plus they have less ability to shiver. Elderly patients have less ability to regulate their body temperature, making them easier

targets for the cold. People with health problems such as diabetes or other conditions that can cause interference with the autonomic nervous system (which regulates temperature) are at higher risk. Some medications also interfere with thermoregulation, and include diuretics, beta-blockers, antihistamines, and antipsychotic drugs. Four other factors include the length of exposure, the intensity of exposure, the presence of humidity and wind, and whether or not the person is accustomed to the temperatures he or she has been exposed to.



Cold environments do not have to be what we consider extremely cold to cause hypothermia. Elderly people who live on fixed incomes and keep their thermostats set at very low temperatures can become victims of hypothermia in their own homes. Most hypothermic patients, however, have been exposed to a cold outdoor environment without proper protection from the elements. Adding more than one type of exposure, such as cold air and cold water, or any time a patient is wet and in a cold environment, heat loss will be more rapid.

Signs and symptoms of hypother-

mia change as the patient becomes colder. Temperature cannot be measured with a standard thermometer, as the readings do not go low enough. A hypothermia thermometer or a tympanic or other type of thermometer that reads low temperatures should be used.

As body temperature begins to drop, shivering will begin at about 96° F, and once temperature drops below 95° F, shivering will become uncontrollable and will cause the patient to have difficulty speaking. This will continue to a temperature of 91° F. Pulse and respirations may be increased, and skin will be red.

Moderate hypothermia, from 90° F down to 86° F shivering will decrease and the muscles will become rigid, causing a lack of coordination and possible uncontrollable jerking movements. Mental status will begin to change and the patient will have dulled judgment and understanding, and may be oriented only to his or her present surroundings. Pulse and respirations will become rapid, as in shock. Skin will be pale.

Severe hypothermia sets in at 85° F. From that point, down to 81° F, the

patient will experience a significant change in mental status, becoming irrational, stuporous, and completely disoriented. Muscle rigidity worsens, and pulse and respirations slow. Skin is likely cyanotic at and beyond this stage.

At and below 80° the patient will lose consciousness and become unresponsive – first to voice, then to pain. Reflexes will not function and the pulse and respirations will continue to slow until cardiac arrest occurs.

Treatment for hypothermia will depend on how cold the patient is.



For mild hypothermia, where the patient's level of consciousness is normal, the patient can be warmed actively with heat packs to the armpits, groin, and neck. Warming should be concentrated on the trunk prior to warming the extremities. Warm fluids (non-alcoholic and decaffeinated) by mouth may be given if the patient is not nauseated. Wet clothing should be removed and replaced with dry, warm clothing and/or blankets. Warmed, humidified oxygen should be given. One way of warming oxygen is to place heat packs or hot towels around the oxygen tubing, and/or using warmed sterile water for humidification. Advanced EMS Providers may give IV fluid, preferably warmed fluid.

For patients with moderate or severe hypothermia, treatment should be passive instead of active. Remove wet clothing and replace with warm and dry clothes and/or blankets. Increase the temperature of the back of the ambulance during transport. Administer warmed, humidified oxygen. Advanced providers may gain IV access (administer only warmed IV fluids), and paramedics should monitor the patient's cardiac rhythm, referring to the ACLS guidelines for hypothermia if a dysrhythmia is present. Basic providers should provide CPR and no more than three defibrillatory shocks if there is no pulse. Do not allow the patient to exert himself and handle the patient carefully.

In addition to passive re-warming, the patient should be evaluated for breathing and carotid pulse for a full minute. If any pulse is found, CPR should *not* be started, and the patient should be handled very gently to avoid irritating the heart's electrical system. Ventricular fibrillation is a common dysrhythmia in hypothermia. Warmed, humidified oxygen should be administered. Active warming is reserved for the emergency room where the core of the body can be warmed via warmed blood, IV solutions, gastric lavage, and other more advanced procedures.

Re-warming the core first will prevent potentially fatal complications that can occur with active peripheral warming. If the extremities are warmed first, vasodilation of the blood vessels can occur, which results in both a failure in

the circulatory system, and a dumping of acids into the core of the body. This can result in ventricular fibrillation, metabolic acidosis, multiple organ-system failure, and other complications.

Even though we associate hypothermia only with cold environments, we should be concerned with our patient's body temperature on every call. While induced hypothermia is becoming standard treatment in post-resuscitation of cardiac arrest care, most patients still

be routine to keep the patient covered and warm. A simple question – “Are you warm enough?” asked to your patient, or feeling the patient's skin, will tell you if you need to add more blankets.

Patients in the emergency department must be monitored for maintenance of an adequate temperature (>96.8°). Many procedures result in the patient being uncovered, some drugs tend to lower body temperature, and in general, hospital emergency departments sometimes tend to have a cooler room temperature than other areas of the hospital. Be alert to your patient's need for warmth. Warmed blankets are usually welcomed by patients feeling the chill of the E.D.

Patients with burns are the most susceptible to developing hypothermia, as well as patients with bleeding or spinal injuries. Shock lessens the body's ability for thermoregulation. Patients with diabetes, generalized infections, drug overdoses or poisonings, or who have ingested alcohol are also more susceptible to the cold. Blood loss can cause a build-up of acid in the tissues, and hypothermia can increase this effect. Many EMS departments and hospital E.D.s utilize warmed IV fluids all year round, which except in cases of hyperthermia, are appropriate for almost any patient. Isotonic solutions such as 0.9% Sodium Chloride or Ringers Lactate should be used for infusion.

In summary, all patients should be observed for temperature. The EMT should be aware of the signs and symptoms of the different stages of hypothermia when an actual temperature is not available. Mild hypothermia can be treated actively, but all other hypothermic patients should be treated passively until the patient reaches the emergency room. Some patients – young, old, chronically ill, injured, and others – are more susceptible to the cold. Throughout the patient's treatment, be diligent in keeping the patient covered to prevent heat loss.

(Supporting references on file)

## **Objectives:**

**At the end of this course, the participant will be able to:**

- **Identify 5 ways the body loses heat.**
- **Discuss factors that make a person more susceptible to the cold**
- **Identify different stages of hypothermia and signs / symptoms associated with each**
- **Discuss appropriate treatment for the different stages of hypothermia**
- **Discuss the importance of preserving body heat in the trauma patient**

need to be kept warm. Trauma patients are highly susceptible to the loss of body heat, even in warmer seasons, and studies have shown that trauma patients who are kept warm have a more positive outcome than trauma patients who arrive in the E.R. with cooler body temperatures. Even if the EMT doesn't have a thermometer to check the patient's temperature, it should

**By:  
Jan Beach-Sickels**

# Hypothermia QUIZ | IEMSA CONTINUING EDUCATION

- A patient is considered to be hypothermic if his or her temperature is below:
  - 99° F
  - 98° F
  - 97° F
  - 96° F
- Of the following, which would patient would be the LEAST susceptible to hypothermia?
  - A two year old child with no chronic health problems
  - A 40 year old with diabetes
  - A 50 year old man with no chronic health problems
  - A 79 year old female with high blood pressure
- When actively warming a patient, heat packs should be placed:
  - On the neck, armpits, and groin
  - On the neck, abdomen and behind the knees
  - Around the upper and lower extremities
  - On the legs and under the arms
- Which of the following patients should be actively warmed?
  - A patient with rigid muscles, disorientation, and slow pulse
  - A patient with shivering and normal level of consciousness
  - A patient with no pulse and no respirations
  - A patient who has a pulse but is not responsive
- In the early stages of hypothermia, pulse and respirations increase, and in later stages of hypothermia, pulse and respirations will slow.
  - True
  - False
- A patient exposed to cold air and cold water loses heat more rapidly than someone exposed only to cold air.
  - True
  - False
- Trauma patients should be kept hypothermic for the best outcome.
  - True
  - False
- Your patient is a 60 year-old woman who fell outdoors in an air temperature of 30° F and was on the ground for several hours before a neighbor noticed her and called 911. The patient is unresponsive, cyanotic, with a carotid pulse of 2/minute and no discernable respirations. Your treatment should include:
  - CPR with warmed oxygen to the BVM, and transport
  - Remove wet clothes, place heat packs in appropriate places, and transport
  - Warm, humidified oxygen by non-rebreather mask, and rapid transport
  - Gentle handling, warmed oxygen by BVM, and rapid transport
- Your patient is a five-year-old girl who fell through the ice in a pond and was submerged for 15 minutes prior to being rescued. She is not breathing and has no pulse. Your treatment should include:
  - CPR with warmed oxygen to the BVM, and transport
  - Remove wet clothes, place heat packs in appropriate places, and transport
  - Warm, humidified oxygen by non-rebreather mask, and rapid transport
  - Gentle handling, warmed oxygen by BVM, and rapid transport
- Your patient is a 17 year-old male involved in a one-car accident in the winter and was not found for several hours. He has no apparent external bleeding or other signs of injury, temperature is 92° F and he has a pulse of 100 with respirations of 28. Skin is pale and cold, and he is responsive to voice with confused answers to questions. Which of the following statements about this patient is TRUE?
  - The patient could have internal injuries
  - Hypothermia could mask injuries that have occurred
  - The patient will most likely be shivering
  - All of the above statements are true.



## IEMSA CONTINUING EDUCATION Answer Form

(Please print legibly)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

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EMS Level \_\_\_\_\_

Check which box is the correct answer				
1	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
2	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
3	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
4	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
5	A <input type="checkbox"/>	B <input type="checkbox"/>		
6	A <input type="checkbox"/>	B <input type="checkbox"/>		
7	A <input type="checkbox"/>	B <input type="checkbox"/>		
8	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
9	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>
10	A <input type="checkbox"/>	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>

*IEMSA members completing this informal continuing education activity should complete all questions 1 through 10, and achieve at least an 80% score in order to receive the 1 hour (1CEH) of optional continuing education.*  
**Deadline: May 1, 2011**

**Mail completed form via mail, email or fax to:**

**IEMSA  
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Urbandale, IA 50322**

**administration@iemsa.net Fax: 515.225.9080**



# What's New with the Bureau

## Transition Link Active!

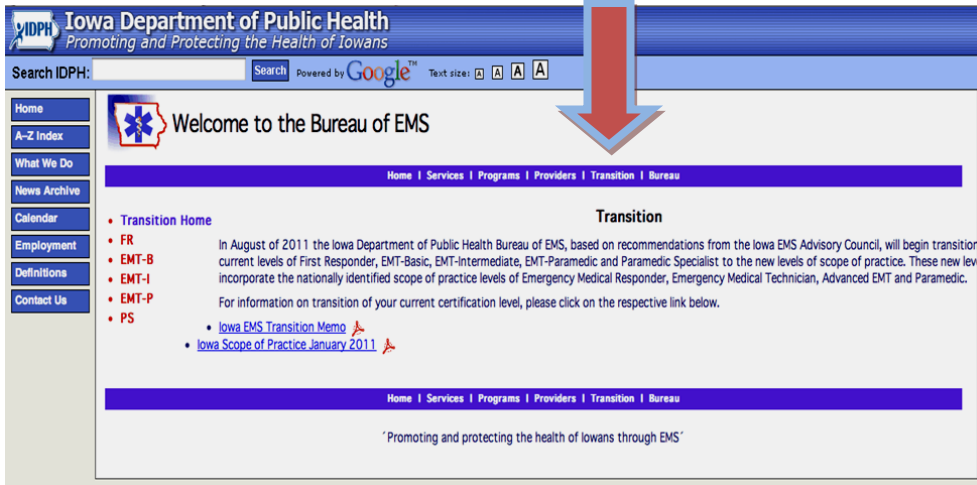
Visit [www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems) and select the Transition link for details regarding how each level of provider will transition to the Emergency Medi-

als, Adult and Pediatric Care and include Iowa's Scope of Practice as an Appendix A. New protocols have been added specifically for airway management, cardiac arrest, nausea & vomit-

also require EMS training programs that provide Paramedic courses to be nationally accredited by December 31, 2013

## Chapter 641—132 "Emergency Medical Service—Service Program Authorization" IAC and Chapter 641—136 "Trauma Registry" IAC.

The rules in Chapter 132 describe the standards for authorization of EMS service programs. The rules in Chapter 136 describe the trauma registry procedures and policies. The proposed amendment requires the electronic submission of ambulance report data. The effective date is May 11, 2011.



cal Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) or Paramedic. The new 2011 Scope of Practice is conveniently located on each page. The scope of practice document has been separated into Basic (FR-79, FR-G, FR-96, EMR, EMT-A, EMT-D, EMT-B, and EMT) and Advanced (EMT-I, AEMT, Iowa EMT-P, Paramedic Specialist, and Paramedic) levels. The new scope will be effective on August 1, 2011 when the transition officially begins.

## Revised Protocols Posted January 2011

The 2011 Iowa Adult and Pediatric Protocols have been posted at [www.idph.state.ia.us/ems](http://www.idph.state.ia.us/ems) > Services > Protocols. As always, EMS services will need to seek Medical Director approval, document staff training and place the protocols in the service vehicles for easy access by providers. Send a copy of the physician approved Protocols Authorization pages and any changes to your field coordinator.

These protocols serve as Iowa's minimum standard and provide you with a streamlined, concise, easy-to-edit document. The protocols are divided into Basic and Advanced lev-

ing and pain control. Dr. Darrel Forslund and the Quality Assurance, Standards and Protocols (QASP) subcommittee members provided a great product for the Iowa EMS Advisory Council to approve and recommend as the standard. And special thanks to my colleague, Evelyn Wolfe, Bureau Field Staff, for tirelessly seeking comment and editing the document.

EMS service leaders and providers have been busy reviewing the document and providing suggestions for improvements. The comments have been overwhelmingly positive regarding the new format. QASP welcomes comments and is committed to ongoing review of the protocols to ensure the most current evidence-based EMS is provided to Iowans and visitors.

## ADMINISTRATIVE RULE CHANGES

The Iowa EMS Advisory Council has recommended the bureau proceed with the following rule changes. There was one comment received at the February 18, 2011 public hearing supporting the changes to IAC 641—131.

**Chapter 641—131 "Emergency Medical Services Provider Education/Training/Certification"** These rules adopt the new scope of practice and the transition process. The rules

## AND FINALLY...GREAT NEWS!

In mid-December 2010, Janet Houtz, BSN, M.P.H., M.H.A., started with the bureau as the Trauma Coordinator. Janet is eager to learn the system and meet the leaders in Iowa's Trauma System.

It is with a heavy heart we bid farewell to Craig Keough, NE Coordinator and EMS Bureau Chief Kirk Schmitt. Craig retired at the end of 2010 after 12 years of serving Iowans with the Bureau. Craig is well known for his sharp intellect, superior work-ethic and calm presentation style. He co-lead the EMS System Standards project and stepped up to lead the bureau and trauma system when needed. His listening skills and thoughtful commentary will be missed. Enjoy your well-deserved retirement Craig!

In early March, Chief Schmitt will move back to sunny California. In five short years, Kirk built a consistent regulatory process, introduced EMS System Standards, and guided us through many code and rule improvements. He challenged us all to make data-driven decisions and made more data than ever available to the staff, partners and researchers. He leaves the state knowing that all services will submit data electronically.

Kirk was quick to challenge the status quo and his no-nonsense, cut-to-the-chase, style made an impression. His dedication and commitment to safe, quality EMS will surely be missed. We wish him well in his new endeavors.



# On The Hill

The legislative season has already been active. Michael Triplett has been working hard for us at the State House in making sure the Voice Of EMS has been heard. I am inserting Mike's comments on the legislation thus far.

A three-person House subcommittee voted unanimously this week in support of a bill that would give volunteer EMS providers an income tax credit. HF 119 will now go to the House Ways and Means committee for further debate. Rep. Brian Moore (R-Zwingle) will be the floor manager of the bill. Other members of the subcommittee were Reps. Dave Jacoby (D-Coralville) and Ross Paustian (R-Walcott). If either of these three is your representative, please take a moment to thank them for their support of volunteerism in public safety. More importantly, please take some time this weekend to contact your state representative and urge them to talk with House leadership about getting this important bill up for a vote and over to the Senate.

In other bills of interest, a House subcommittee was scheduled to meet Thursday on a bill that would eliminate the requirement that every high school graduate complete a CPR course. IEMSA strongly opposes this

bill, which is supported by the Iowa Association of School Boards and other administrator groups. We will keep you updated on this bill if any other action is taken.

There has been no movement yet on either of the bills that would require townships to provide EMS to their citizens. HF 9 is in the House Ways and Means committee, which makes it immune from any funnel deadline. SF 98, which is in the Senate Local Government committee, is going through a redraft that will address the township levies. After the redraft, the bill will also become a Ways and Means committee bill, which will keep it eligible for the entire session. So a couple of things in summary the tax credit is still alive in committee, bill for funding EMS is in committee and is being rewritten and reviewed by the Iowa League of Cities, IEMSA, and the Iowa State Association of Counties. This may not pass this year but it is certainly in the starting processes. My last comments are about the CPR in schools issue. IEMSA believes in CPR being taught to students before they graduate. We also know that if schools have to pay for "certification cards" and someone to teach CPR this does cost money. That being said we also have commented that to take the certification out is fine

they just need to be taught the basics of CPR and AED. This could be part of a PE class Health Education Class or whatever. This should not be a financial burden for them. As always we certainly want your input into these issues and encourage you to call, email myself or the office and call your legislators about these items with the bill numbers. EMS in Iowa and across the country is at a crossroads in the thinking and EMS finally being an Essential Service.



BY:  
**MICHAEL TRIPLETT**

## No Worries

### TriTech EMS Solutions Online

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# All Tangled Up:



## How to Extricate a Vehicle from a High-Tension Cable Median Barrier



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### High-tension cable median barrier systems are saving lives

High-tension cable barrier systems are a fairly new safety feature being added to select stretches of Iowa highways where there is a higher occurrence of median crossover crashes. The barriers are designed to reduce median crossover crashes by keeping errant vehicles on their own side of the road.

When vehicles have become entangled in the cables, emergency service providers have asked: **What do we do if there are life-threatening injuries and we can't get to the victims because of the cables. Can the cables be safely cut to save lives?**

The answer is "yes," but cutting the cables should be a last resort. There are other options for extrication that allow the cables to remain intact and continue to save other lives. When high-tension cable barriers are cut, thousands of feet of barrier could be placed out of service until repairs can be made.

### Barrier system elements

High-tension cable barrier systems used in Iowa have either three or four cables. Each cable is held in constant tension in the range of 3,000 to 8,000 pounds, depending on ambient temperature and seasonal changes.

Although several different high-tension cable barrier types exist, they all use the same cable that consists of 3/4-inch-diameter galvanized steel cable with 3x7 (21 wires) construction.

Depending on the type of system, the cables may be attached to the weak steel posts using special locking hook bolts or



threaded through the posts. The barrier is installed using concrete footings in which metal tubes are cast to form sockets for the posts. After impact, any damaged posts can be removed from the sockets and replaced with new posts.

Turnbuckles are used to achieve the appropriate tension in the system. Turnbuckles are generally installed every 1,000 feet or at lesser distances (as little as 200 feet), if required.

### Keep the cables intact and release tension

If a vehicle becomes entangled in the cable, the first instinct of emergency responders is to cut the cable to gain better access to the victims. However, there are better options and cutting the cables should be a last resort using extreme caution and proper procedures. **The alternatives to cutting the cable are listed here in order of preference.**

**Option 1:** If satisfactory extrication time exists, Iowa DOT maintenance personnel are trained to safely add slack to cable by taking out posts and loosening turnbuckles. To seek Iowa DOT assistance during an emergency, contact the Iowa DOT's Operations Support Center at 515-233-7900 any time of the day.

**Option 2:** Move the cables back to their original positions by releasing the tension of the cables. This can be accomplished by driving, pushing or pulling the vehicle back in the opposite manner that it entered the cable system.

**Option 3:** Lift the cables out of and/or off the posts for approximately 100 feet upstream and downstream of the vehicle. A span of approximately 100 feet without any posts will allow the cables to lie on the ground.

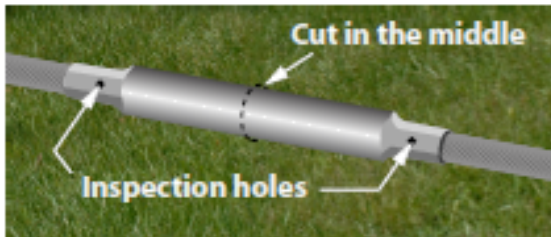
**Option 4:** Remove the posts from their sockets for approximately 100 feet upstream and downstream of the vehicle. If the cables are under extreme tension, use extra caution and secure the post with a chain or restraining device during removal.



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**Option 5:** Tension in the cables can also be released at the nearest upstream and downstream turnbuckles or at one of the cable end anchors, whichever is closest. Use hand tools to loosen the turnbuckle until the end of each threaded terminal reaches the inspection hole. **Warning: The threaded terminals should always remain visible in the inspection holes. Unscrewing the turnbuckle or cable anchor end beyond this point can be unsafe. The cables could release rapidly as the threads strip out of the connection.**

**Option 6:** The final option, which is still preferred to cutting the cable, is cutting the turnbuckle. It is much easier and less costly



to replace a turnbuckle than it is to install a cable splice or to replace a section of cable. Before

cutting a turnbuckle, remove the adjacent posts in the vicinity of the turnbuckle, if possible. Loosen the turnbuckle until the end of each threaded terminal reaches the inspection hole. Always cut in the middle of the turnbuckle. **Cut only the minimum number of turnbuckles necessary. Safety warning: Although the cable should move only a short distance in each direction after the turnbuckle is cut, everyone except the person making the cut should stand a safe distance clear of the cable. High-tension cables are under thousands of pounds of tension, and a vehicle trapped in the system creates even higher tension forces. Therefore, cutting a turnbuckle has the potential to cause injury.**

### **Cut the cables as a last resort**

Although it can be done, cutting cables under tension should be done with caution and only as a last resort where a life-threatening situation exists, time is critical and other alternatives for loosening the cables are not feasible. Cutting cables will require a cable splice or complete cable section replacement, which is time consuming and costly. It also disables a section of the system.

If it is necessary to cut the cable, cut only the minimum number of cables necessary. Make the cut midway between two undamaged posts where the cables are parallel and not being subjected to multiple forces, located several hundred feet from the vehicle.

The cable should be securely taped with duct tape on each side near where the cable will be cut to prevent unraveling. Make the cut standing perpendicular to the system, arms in front. Use either an abrasive blade cutoff saw or hydraulic cutters. Use gloves and safety goggles, and cut very carefully. Pay particular attention when there are only a few strands remaining during the final stage of cutting.

**Safety warning: Although the cable should move only a short distance in each direction, everyone except the person making the cut should stand a safe distance clear of the cable. High-tension cables are under thousands of pounds of tension, and a vehicle trapped in the system creates even higher tension forces. Therefore, cutting a cable has the potential to cause injury.**

### **Need crash scene extrication assistance?**

Iowa DOT maintenance personnel can provide guidance and on-site help at a crash scene 24 hours a day, seven days a week. During an emergency, contact the Iowa DOT's Operations Support Center at 515-233-7900 or Iowa State Patrol through their dispatch center.

Emergency responders may also call this number to report a damaged or cut cable system following a crash.

### **More information about high-tension cable barriers**

For additional details, visit: [www.iowadot.gov/mediacable.htm](http://www.iowadot.gov/mediacable.htm); or view several cable-cutting demonstration videos using different cutting tools at: [www.minnesotafireservice.com/whatsnew\\_high\\_tension\\_cables.html](http://www.minnesotafireservice.com/whatsnew_high_tension_cables.html)

To learn more about the location and safety benefits of high-tension cable barriers in Iowa, contact the Iowa DOT's Office of Traffic and Safety at 515-239-1557. To learn about the design of these barriers, contact the Office of Design at 515-239-1783.

Federal and state laws prohibit employment and/or public accommodation discrimination on the basis of age, color, creed, disability, gender identity, national origin, pregnancy, race, religion, sex, sexual orientation or veterans' status. If you believe you have been discriminated against, please contact the Iowa Civil Rights Commission at 800-457-4416 or Iowa Department of Transportation's affirmative action officer. If you need accommodations because of a disability to access the Iowa Department of Transportation's services, contact the agency's affirmative action officer at 800-262-0003.





Hello! On behalf of the National Association of EMTs (NAEMT), I'd like to thank President Ewers and the IEMSA board of directors for providing a spot in the Voice to keep you informed of NAEMT activities representing EMTs and Paramedics federally and how those actions affect EMS practitioners at the state and local levels

I serve on the NAEMT Advocacy Committee and in the past year we have worked hard on getting key legislation passed at the federal level that will definitely affect EMS locally. NAEMT, working with AAA and Advocates for EMS has lobbied for permanent Medicare reimbursement relief and the Public Safety Officers Benefits Act to include non-governmental EMS practitioners and volunteers. The PSOB bill has recently been successfully passed by the Senate!

The first annual EMS on the Hill Day was held on May 3-4, 2010. This first event exceeded our expectations with 120 practitioners from 40 states and Puerto Rico and 160 congressional visits conducted. It was an amazing sight and feeling to see all those EMS folks in uniform on Capitol Hill. EMS on the Hill Day 2011 will take place on May 3-4 in Washington, D.C. NAEMT awards \$1200.00 grants to one EMS practitioner in each of the four NAEMT regions each year. You can get more information and register to attend EMS on the Hill by going to the NAEMT [www.naemt.org](http://www.naemt.org) and clicking on the link for EMS on the Hill Day. We hope to double or triple our numbers each year.

I look forward to writing about all the exciting things happening for EMS at the federal level over the next year. If you

have any questions, comments or concerns or would like to be more actively involved in the NAEMT organization please contact me at [jksadden@gmail.com](mailto:jksadden@gmail.com).

Best Regards!

Jules Scadden, PS  
NAEMT-  
Director-at-large



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