VOICE

January—March 2012

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION

MEDIC EMS—Career EMS Service of the Year

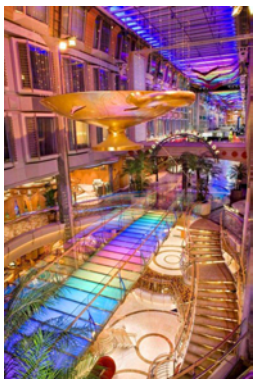
www.IEMSA.net

IEMSA | A VOICE FOR POSITIVE CHANGE IN IOWA EMS

VOICE

Vol. 2012-01, January—March 2012

The Voice Newsletter is published quarterly by:
IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION
8515 Douglas Avenue, Suite 27B ✱ Urbandale, IA 50322



To those going on the EMS Cruise March 4 -11, have a safe, wonderful, fun trip! We look forward to your pictures and stories.

2012 IEMSA Board Meetings

Unless otherwise noted, meetings will be held from 1-3 p.m. at West Des Moines EMS, Station #19

February—no meeting

March 15

April 19

May 2 (6-8 p.m., Stoney Creek Inn, Sioux City)

June 21

July—no meeting

August 16

September 20

October 18

November 8 (6:30-8 p.m.,Community Choice Credit Union Convention Center, Des Moines)

December 20

All members are welcome and encouraged to attend.

IEMSA's Annual

EMS Billing and Management Conference

With Doug Wolfberg

of Page,Wolfberg & Wirth, LLC

(Watch our website for more details and topics)

NAAC National Academy of Ambulance Coding CEU Approved

Thurs., May 3, 2012

Sioux City, IA

8 a.m.—5 p.m.

Stoney Creek Inn

800-659-2220 or 712-234-1100

300 3rd St., Sioux City, IA 51101

When booking your room ask for the IEMSA rate of $79. After 4/2/12 regular rates apply.

Sponsored by LifeQuest Billing and Collection Services

LIFEQUEST Services

2012

IEMSA

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Jerry Ewers, Brad Buck, Brandon Smith

Education
Kristi Brockway, Brian Rechkemmer

Medical Director
Dr. Forslund

Lobbyist
Michael Triplett

UPCOMING 2012 EVENTS

Please save these dates on your calendars

- IEMSA SC Iowa EMS Saturday March 3, Des Moines. See pages 20-21.
- EMS Cruise March 4-11, Western Caribbean
- Ambulance Billing & Management Conference May 3, Sioux City. Sponsored by LifeQuest. See page 3.
- EMS Memorial Ceremony May 19, West Des Moines.
- Leadership Academy Details to be announced
- 23rd Annual Conference & Tradeshow November 8-10, Des Moines - Community Choice Credit Union Conference Center, Des Moines.. Annual Meeting and Awards Presentation Nov. 8. Honoring Our Own Ceremony Nov. 10.

A Message from the President

Jerry Ewers, Fire Chief
IEMSA President
Board of Directors

Team Building, Change, & Survival

What does team building mean? Vince Lombardi once said team building is "Individual commitment to a group effort - that is what makes a team work, a company work, a society work, a civilization work." As for me, team building in my organization back home and team building in the IEMSA organization is pretty similar. Building trust and having open dialogue through communication is the key to building a successful team. Sometimes this doesn't occur overnight or in a first year as President of an organization. As with any team, group, board, organization, or culture you will have some form of conflict, changing dynamics, or resistance to change. But, this is not all bad. You may call it growing pains or just overcoming the organizational comfort zone.

I can promise you that the Board of Directors of IEMSA is building a strong, successful, and dedicated team that is working diligently to be the "Voice" for EMS for both you and your organization at the state and national level. I would like to personally thank the Board Members who are volunteering their time to help this organization move forward and for all their hard work they do putting together the programs offered throughout the year in Iowa, such as the regional EMS Saturdays, EMS Day on the Hill, Leadership Conference, EMS Memorial, Ambulance Billing and Management Conference, Leadership Academy, and the Annual Conference. This is truly progress and success. As for President of IEMSA, I look forward to working with all the different teams involved in EMS in Iowa in 2012. Teamwork is truly essential for IEMSA, just as it is essential in providing safe and efficient care for those we serve.

" I believe the idea or intent to successfully overcome any tragedy, close call, or event, is to learn from the past so you don't repeat it in the future."

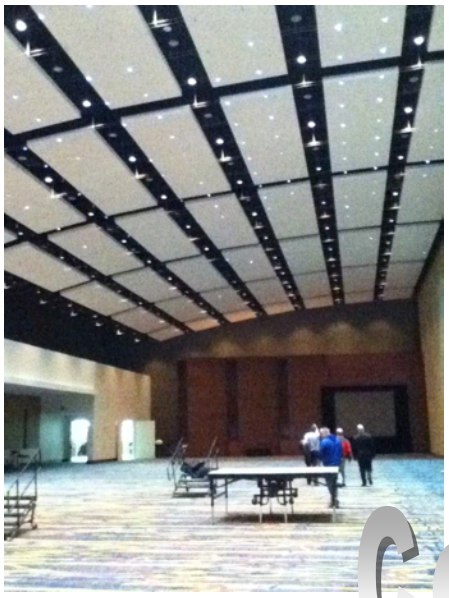
In writing as I change from paragraph to paragraph, or topic to topic, I wanted to transition my thoughts into changing the dynamics of what we do every day to pass along and share our close calls or lessons learned. As for what may be viewed as survival, I'd like to address and end this letter with what we may call lessons learned, close calls, or safety and survival. The reason I bring this up is because we (Muscatine Fire Department) had a close call at a structure fire last month where a fire fighter had to be rescued from an industrial facility while fighting a fire and was hospitalized with minor burns and inhalation injuries. This really had the potential to have a different outcome.

I believe the idea or intent to successfully overcome any tragedy, close call, or event, is to learn from the past so you don't repeat it in the future. Whether it means implementing change, creating new departmental policies, or sharing past practices, or close calls, hopefully we can prevent these incidents from occurring or repeating them over and over. I think it's important for all of us to share our experiences and close calls with your partners, staff, organizations, and neighboring departments. As for me personally, I can say in my career I've had plenty of close calls on fire calls, motor vehicle crash scenes, and even domestic violence and suicidal patient EMS calls. But, over the years I've also always tried to share my experiences during conversations with peers, during EMS continuing education classes I've either taught or participated in, and when ever precepting EMS students and training probationary employees. By sharing your close calls or lessons learned over the years with peers and new employees hopefully we can prevent or reduce the incidence of both future injuries and deaths. If we can change or reduce just one incident from occurring then this article was worth writing. So, please share your close calls or lessons learned so we can all stay safe and hopefully the next generation doesn't have to encounter the same close calls we encountered.

Please stay safe and I look forward to seeing you at the IEMSA sponsored events throughout the year. As always, if you have any questions about the organization please don't hesitate to send me an e-mail or call me in person. Also, please tell us what we are doing well and what we can improve upon. Again, this is YOUR organization. Take care and God Bless.

Thanks.

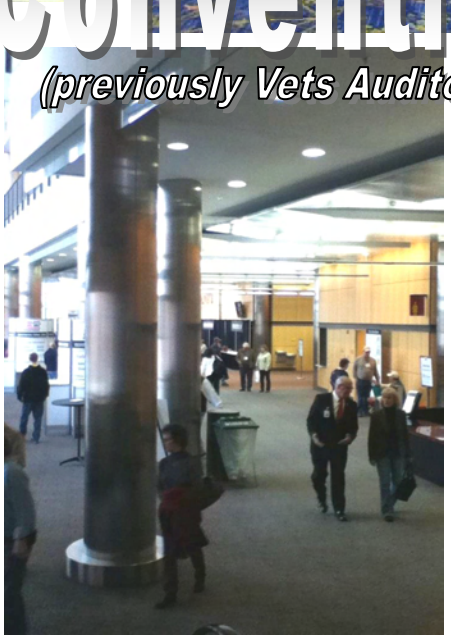
Gerald P Ewers

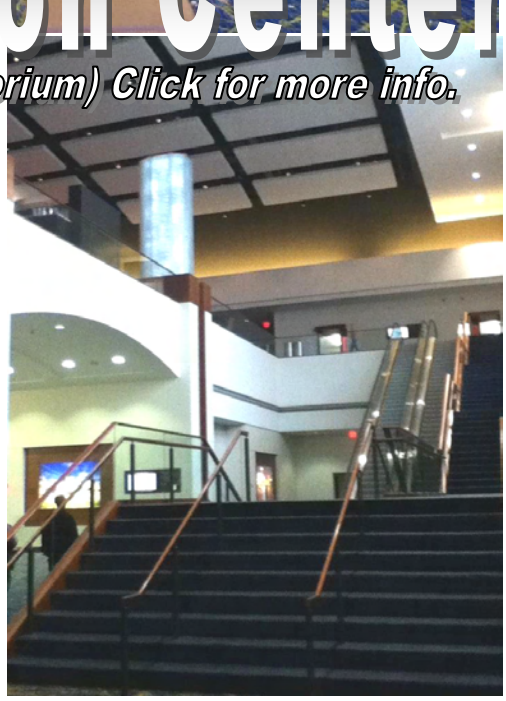


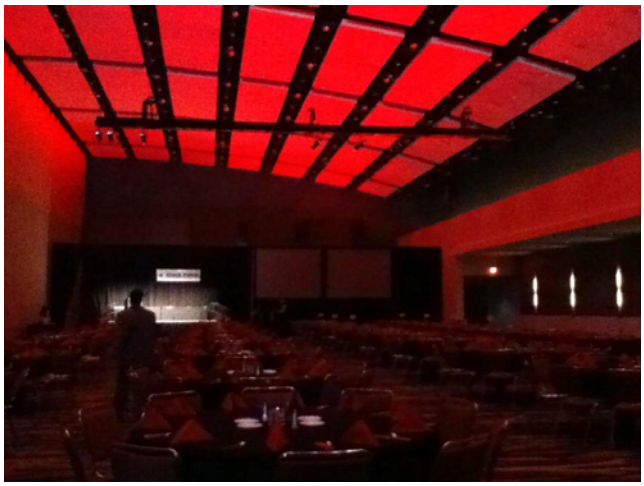
Community Choice Credit Union Convention Center

(previously Vets Auditorium) Click for more info.

In January, the IEMSA Board Members had the opportunity to tour the remodeled Veteran's Auditorium, location of the 2012 Annual Conference and Tradeshow. The lay-out, modern design, and spacious rooms, and being able to hold all events in one location will definitely be an advantage for IEMSA's conference attendees. The Convention Center is on the downtown Des Moines Skywalk system, and the vendor hall is almost twice the size as the area in the Plex we were accustomed to, allowing for more vendors, and more ambulance and helicopter spaces. Start planning now to attend this year's conference Nov. 8-10.







Iowa EMS Protocols: 2012 Update

Dr. Forslund, Iowa EMS Medical Director

The updates to the 2012 protocols will be published at the end of January 2012. Last year we had major updates to the protocols with a complete change of the format and the addition of pediatric protocols. It was a challenging project. We achieved our goal of changing the format but not in making the protocols as clean and consistent from protocol to protocol as we wanted them to be. I would like to give you an overview of the ongoing approach of the EMSAC/QASP protocol committee.

A protocol is a standing order from the EMS medical director to the EMS provider. It should provide clear and concise guidance on how to approach the condition it was written to treat. It is a struggle to balance being clear and concise with wanting to put more information than needed in the protocol.

Education items were removed from the protocols to focus on treatment. This approach was taken because it is felt initial training should provide the skills necessary to perform specific tasks and interventions The protocol tells you when to perform skills tasks and interventions We also removed indicators as to who could perform a skill or intervention. The provider needs to know and follow their scope of practice.

"A protocol is a standing order from the EMS medical director to the EMS provider."

Evidence based recommendations are used to develop the protocols when they are available. Unfortunately, there are not evidence based recommendations for every treatment or intervention that EMS providers perform. When evidence based recommendations are not available we use best practice/consensus to guide treatment.

We monitor new and changing treatments in the field of EMS and will develop new protocols as needed. Again, we are aware of your initial training and do not believe all functions of EMS providers need a specific protocol.

For this year's updates we have mainly worked on editing the protocols to improve the grammar and consistency between the protocols. This is better, but it is something we will continue to refine every year. The burn protocol was edited by removing the Parkland formula for fluid resuscitation from the chemical and electrical burn sections. There is no evidence that the Parkland formula is useful for these. We also emphasized the need to limit on-scene time for time critical injuries.

What's on the agenda for next year? First of all we, are considering expanding the cardiac problem protocols. In the past the Iowa EMS Protocols have not provided direction for specific cardiac rhythm problems. This is because it was felt AHA/ACLS guidelines could be followed and we wouldn't have to worry about our protocols outdating. For completeness it is felt, by some, they should be included. We will also be looking at post-resuscitation care including therapeutic hypothermia. Other items will likely come up as well through the year. There are no perfect protocol sets. Just look online at the many "designs" they have. Our goal is facilitating solid medical care while keeping the format simple.

"Our goal is facilitating solid medical care while keeping the format simple."

David Seastrom RN, BSN
Trauma Injury Prevention,
Outreach & Education Coordinator
Children's Mercy Hospitals
& Clinics,Kansas City, MO

Sports Related Concussion – A Wolf in Sheep's Clothing

It's Friday night, and you are working the high school football game standby for your local EMS agency. It's one of the most important games of the season against their rival high school. During the third quarter of the game, the quarterback gets sacked by a linebacker and the crowd goes wild. As the loud roar starts to simmer, you notice the quarterback is getting up a bit slowly. He makes it to his feet and stumbles to the sideline. You notice he's moving a little slower than normal, but makes it on his own. After sitting out a few plays, you are asked by an assistant coach to check out the player. You assess him as you would anyone suspected of sustaining a head injury. He is alert and oriented, reports no loss of consciousness but states he is feeling dazed. His pupils are PERRLA, and he is moving all extremities. You believe he sustained a concussion and tell the coaches he should probably sit out the rest of the night. He pleads to return to the game, but the coaching staff agrees it is best he sit out.

The next day the athlete reports the presence of a headache, which he has had since the game. He is then taken by his parents to their family physician. The family physician assesses him and agrees that he has probably sustained a concussion. The doctor informs the family that he should not play for another seven days, and if his symptoms get any worse to return to his office. The young man, although not very happy, agrees to go along with the physicians recommendations.

This type of scenario plays itself out time and time again in youth sports. Concussions aren't a problem that is isolated to football, but occur frequently in cheerleading, soccer, basketball, and wrestling. The Centers for Disease Control and Prevention estimate that approximately 1.7 million traumatic brain injuries occur annually, with a total direct and indirect medical cost estimated at $12 billion in 2000. Many healthcare providers describe concussions as mild because they are not usually immediately life threatening, even though their effects can be lasting and serious in nature.

So what is a concussion? For the purposes of this article, we will use the definition provided by the Center for Disease Control and Prevention's published physician tool kit. A mild traumatic brain injury (mTBI) or concussion is defined as *a complex pathophysiologic process affecting the brain, induced by traumatic biomechanical forces secondary to direct or indirect forces to the head. Disturbances of brain function is related to neurometabolic dysfunction, rather than structural injury, and is typically associated with normal structural neuroimaging findings (ie, CT scan, MRI). MTBI may or may not involve a loss of consciousness (LOC). Mild traumatic brain injury results in a constellation of physical, cognitive, emotional, and sleep-related symptoms. Duration of symptoms are variable and may last for as short as several minutes and last as long as several days, weeks, months, or even longer in some cases.*

A mild concussion has also simply been described, by some, as a transient loss of contact. Most of us have heard the terms "getting your bell rung" and "seeing stars." Though classic concussions can be accompanied by a loss of consciousness, most are not. Concussions can be caused by any significant blunt force trauma to the head, such as a fall, a vehicle crash, or being struck in the head. Concussions do not include injuries where there is bleeding under the skull or into the brain tissue itself. Another type of brain injury is present if bleeding is visible on a CT scan. There may be an associated cognitive deficit with those types of injuries as well.

Several reactions occur at the cellular level when a person sustains a blow or jolt to the head. Initially, the concussive wave travels through the brain, injuring the axons and neurons in its path. It's this disruption of the axons and neurons that produces the loss of contact, and at times, the loss of consciousness. As this happens, there is a neurometabolic crisis occurring in the brain resulting in many chemical changes, migrations and fluctuations involving calcium, potassium, glucose, and cerebral blood flow. Together these reactions create the crisis and the "perfect storm" within the cranium. This perfect storm also makes the already injured brain much more vulnerable to secondary injury.

Saunders and Harbaugh referred to it as "the secondary-impact syndrome of catastrophic head injury" in 1984. This condition occurs when a person suffers a second blow to the head before complete recovery, and symptoms from a previous concussion have subsided. It is a condition in which the brain swells rapidly and catastrophically. This deadly second blow may occur minutes, days, or weeks after the initial concussion and can occur even with the mildest of concussions. This second insult is believed to, at times, be remarkably minor. The cause of secondary-impact syndrome remains uncertain, but is thought to occur due to the brain's loss of ability to autoregulate its blood flow. This loss of autoregulation leads to vascular engorgement within the cranium. This in turn leads to a catastrophic and most often fatal cerebral edema. Most commonly the pressure leads to herniation either of the medial surface (uncal herniation) of the temporal lobe or lobes below the tentorium of the cerebellar tonsils through the foramen magnum. Factors that make this disease process complicated to care for include its rapid onset and progression. Surgical intervention is usually of little use.

"Secondary-impact syndrome is thought to be more severe than repetitive concussive head injuries in both the short and long term."

Secondary-impact syndrome significantly differs from repetitive concussive head injury syndrome. Repetitive concussive head injuries are usually suffered over a period of time and lead to a slow decline in cognitive function. Secondary-impact syndrome is thought to be more severe than repetitive concussive head injuries in both the short and long term. There is still controversy surrounding these topics as emerging research is still forth-coming.

So, how do we recognize a concussion?

Lack of appropriate recognition and diagnosis of injury presents one of the greatest barriers to providing the correct care to an individual who has sustained a mTBI. Without identification of the injury, it is more difficult to implement a personalized treatment program. No two TBIs are the same and should not be treated as if they are. Recognition is the first critical step to the appropriate identification and treatment of these individuals. Recognizing mTBIs can be difficult as their symptoms mimic other medical conditions such as PTSD and headache syndromes. Another complicating factor is that the onset of symptoms can be days to weeks after the initial injury. A standardized systematic assessment of the injury must be preformed to allow proper management

and to reduce mortality.

When talking about concussions related to sports, there are two important components to watch for. First, we must identify a forceful blow or bump to the head resulting in rapid movement. We should not solely rely on a loss of consciousness to diagnose a concussion because 90 percent of them occur without it. The second component is a change in the athlete's behavior, thinking, or physical functioning. Some of the most frequent symptoms associated with concussion include headache, feeling slowed down, difficulty concentrating, and dizziness. Refer to the Centers for Disease Control and Prevention's website for a more comprehensive list of signs and symptoms of concussions (www.cdc.gov/concussion). Any athlete who experiences any signs or symptoms of a concussion should be immediately removed from play/practice and not return until they have been evaluated and cleared by a healthcare provider.

For a catastrophic condition, such as secondary-impact syndrome, that carries a 50 percent mortality rate and a nearly 100 percent morbidity rate, we must make prevention a top priority. We do know that care for the patient who has sustained a concussion is, in large part, recognition and prevention of re-injury. Players who have sustained a concussion or are suspected of sustaining a concussion should never be allowed back into the game or practice. Ideally, this person should avoid all contact and collision sports and activities until all cerebral symptoms have subsided and then preferably for another week after.

Following guidelines for patients with concussions is required. The Acute Concussion Evaluation (ACE) form, that is part of the CDC's "Heads Up: Brain Injury in Your Practice" kit is one such guideline. The ACE was developed as an initial method of identifying a mTBI, but is not a comprehensive evaluation tool. So one would ask when does a child need to be referred to a specialist? The CDC recommends referral to a specialist if symptom reduction is not evident within three to five days post injury, or sooner if the type or severity of symptoms are of concern. A second evaluation tool supported by the 3rd International Conference on Concussion is the Sports Concussion Assessment Tool 2 (SCAT2). This tool can be used on individuals 10 years of age or older, and includes the Maddock's questions for sideline concussion assessment. Both of these assessment tools are of great value and should be used according to recommendations.

Another form of evaluation for injury prevention includes neuropsychological testing. These tests involve performance of specific cognitive tests that can assist with confirming self-reported symptoms and tracking recovery. Cognitive recovery commonly follows clinical symptom resolution, suggesting that assessment of cognitive functioning should be an important component of any return to play guideline.

We also must employ, what possibly could be our biggest asset, and that is education. Our education among coaches, players, parents, and healthcare providers should be consistent and widespread. The importance and dangers of participating with concussions must be explained to the parents as well as the athletes. For if they fail to accurately report symptoms, then we may not be able to provide them the best possible care. There are documented cases at the National Center for Catastrophic Sport Injury Research that display athletes who did not report their symptoms for fear they would not be allow to compete. Some of them tragically played with postconcussional symptoms and developed secondary-impact syndrome.

Prevention of re-injury is also of paramount importance. Prevention includes the passage of legislation across the nation to protect America's athletes. In May 2009, the Lystedt Law was passed in Washington state following the death of Zackery Lystedt. Zackery died in 2006 from a brain injury after returning to his middle school football game in which he had sustained a concussion. There are roughly 30 states in the US that have now enacted return to play legislation and 13 more that have introduced it. Kansas and Missouri recently

passed similar legislation that supports the three main components of prevention. Those are 1) Athletes, parents, and coaches must be educated about concussions; 2) If an athlete sustains or is suspected of sustaining a concussion or head injury, he/she must be immediately removed from practice/game; 3) A healthcare provider must clear the athlete before he/she is allowed to return to play. This legislation is a good start, but we as healthcare providers must actively support the education of not only ourselves, but also the coaches, parents, and athletes.

> ***"...we as healthcare providers must actively support the education of not only ourselves, but also the coaches, parents, and athletes"***

The graduated return to play protocol that was developed at the 3rd International Conference on Concussion in Sports is also a guide for healthcare providers. This protocol allows the athlete to return to play in a stepwise progression. The athlete would begin this protocol after he/she is asymptomatic at rest. There are six levels in which the athlete will move through, each taking approximately 24 hours. If the athlete remains asymptomatic at each step, then in 24 hours he/she can graduate to the next level. Although, if he/she develops any post-concussive symptoms, the patient should drop back to the previous asymptomatic level and try to progress again after a further 24-hour period of rest has passed. More information about this can be found at: http://sportconcussions.com/html/Zurich%20Statement.pdf

So, a month after that important rival football game, you are back on the rig at the football field when you hear a tapping on the window. You look over to see the quarterback standing at your door. As you step out of the unit, he sticks his hand out and thanks you for all that you did for him. He goes on to tell you that he's been out of sports for a month, but should be returning in the next week or so. You exchange some conversation and wish him well. He goes running off back to the sideline to join his teammates, you step back into your "office" and just smile…

I hope this article has spurred you to think about the past, present, and future care of the patient with a sports related concussion and your role in their prevention, treatment, and recovery.

To obtain 1 CEH for completion of the class "Concussion—A wolf in sheep's clothing," complete the quiz and registration on the next page and return to the address listed by April 1, 2012.

QUIZ | IEMSA CONTINUING EDUCATION

1. **True**/False – Approximately 1.7 million traumatic brain injuries occur annually in the United States
2. True/False – Many healthcare providers consider concussions mild because they are usually not immediately life threatening.
3. True/False – Most concussions are accompanied by a loss of consciousness.
4. True/False – Concussions, as diffuse brain injuries, do not show blood on a CT scan and there is no bleeding under the skull.
5. True/False – As a concussion occurs there are several neurometabolic crisis occurring in the brain including chemical changes.
6. True/False - Secondary Impact Syndrome is a mild condition, usually with no long lasting effects.
7. True/False – A major factor in recognition of concussions is that they do not mimic other medical conditions.
8. True/False – Symptoms associated with concussions include headaches, feeling slowed down, difficulty concentrating and dizziness.
9. True/False – Athletes suspected of sustaining a concussion during a sporting event should be left in the game until it's conclusion and the seek medical attention.
10. True/False - The Centers for Disease Control & Prevention have developed the "Heads Up: Brain Injury in Your Practice" toolkit to assist healthcare workers while caring for patients with mild traumatic brain injuries.

IEMSA
CONTINUING EDUCATION
Answer Form

(Please print legibly)

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

IEMSA Member Number _____

EMS Level _____

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: April 1, 2012

Mail completed form via mail, email or fax to:
IEMSA
8515 Douglas Ave., Suite 27B
Urbandale, IA 50322
administration@iemsa.net Fax: 515.225.9080

Check which box is the correct answer					
1	T ☐	F ☐	6	T ☐	F ☐
2	T ☐	F ☐	7	T ☐	F ☐
3	T ☐	F ☐	8	T ☐	F ☐
4	T ☐	F ☐	9	T ☐	F ☐
5	T ☐	F ☐	10	T ☐	F ☐

Legislative Update

EMS day and the Hill was a "SUCCESS". Thank you to the nearly 40 providers who were at the capitol to talk with your legislators and show support of IEMSA on the Hill. We made contact with approximately 25 legislators and were able to discuss issues in funding and reimbursement. Conversations were started on Iowa Care and getting money appropriated for some payment in that system. We also have legislation introduced to make tax credit for the volunteer provider. Senator Hancock and Senator Danielson have introduced several pieces of legislation that we will be following over the next several months.

Mike Triplett our IEMSA Lobbyist works closely on these issues and you can keep track of this legislation as it moves forward by going to https://www.legis.iowa.gov/Legislation/BillTracking/billTrackingTools.aspx. Here you can create a specific list of bills you want to follow. We also send this information out in the eNews each week so you can follow. This is an interesting time, as the legislators know EMS is important and they are trying to find the ways to get it in legislation so it has to be addressed when other items come out that could affect us.

Our legislative priorities for IEMSA stay the same: Iowa Cares Program reimbursement, Volunteer tax credit and Essential Service of EMS whether that comes to Townships or Counties.

The Leadership Conference on Thursday was also a success. We had 46 providers registered and attend and discussed topics of transition, training, Leadership quality, Etics in EMS and Quality Improvement and moving EMS into evidence based practice. John Hill, Joe Ferrell and Kim Price did a great job and I personally want to thank them for their time to this day.

The 2013 EMS Day on the Hill and Leadership Conference will be January 31, 2013. Plan to attend and be informed and help make a difference in EMS in Iowa.

What's New at the Bureau?

Bureau of EMS News
January 23, 2012

Anita J. Bailey
BUREAU of EMS

SYSTEM STANDARDS

The System Standards FAQ document and brochure are posted at the Bureau of EMS Website www.idph.state.ia.us/ems select **Programs** and then **System Standards.** You will also find the monthly meeting records there. Committee members are eager to present the System Standards at conferences, county and local meetings. The program can be scheduled by contacting Evelyn Wolfe, SE Regional EMS Field Coordinator by phone at: (319) 624-9085 or by email at: evelyn.wolfe@idph.iowa.gov

ELECTRONIC DATA SUBMISSION

On May 11, 2011 the Iowa Administrative Code changed to require electronic submission of the required patient data for every patient transported. The Bureau no longer accepts paper patient care reports.

The department contracts with Med Media, Inc. for our data warehouse. We offer WebCUR, a web-based data entry tool at no cost to services. For login and password information contact Med Media at 717-657-8200. You can also visit their website at www.med-media.com and select Products to EMS to WebCur: Data Warehouse. Please set up your account and ensure July – September 2011 transports are entered by January 1, 2012 and October – December 2011 are due by April 1, 2012. Contact your Regional EMS Coordinator if you have questions regarding data submission compliance.

PROTOCOLS

The Quality Assurance Standards and Protocols (QASP) committee continues to work to develop consistent language and formatting throughout the protocols. The 2012 protocol revisions will get a final review by the physicians on EMSAC prior to posting at www.idph.state.ia.us/ems select **Services** and then **Protocols**. Following physician review and approval, be sure to document staff training. Send any protocol changes to your Regional EMS Coordinator.

SAMPLE MEASURABLE OUTCOME

100% of EMS providers on the roster are annually trained to the revised Iowa EMS Protocols within 45 days of physician approval or by April 15.

QUALITY ASSURANCE, STANDARDS, and PROTOCOLS (QASP)

At the January 11, 2012 QASP meeting, Jim Steffen, Henry County Health System in Mount Pleasant, presented information on the National EMS Information System (NEMSIS) Data Cube. The cube is an on-line analytical processing tool that allows public access to the EMS data submitted by 33 states and territories. Iowa has been submitting data to NEMSIS since 2008. Four more states are expected to begin data submission in 2012. Jim demonstrated how to access the system and was able to drill down to show how many nine year-old boys were injured in bicycle crashes on Christmas Day in 2010. Visit www.nemsis.org for more information. Jim's demonstration stimulated much discussion regarding the value of comparative data for EMS services and systems. Clear, measurable outcomes can improve the quality of care for patients and provide consistent feedback for staff. Quality initiatives will be a new agenda item at the April 11, 2012 QASP meeting. Stay tuned…

…AND FINALLY

*Katrina Altenhofen received the **Lifetime Achievement Award** at the Injury Prevention Conference in September. Katrina is well known for her work in Child Passenger Safety & Injury Prevention. We are honored to have her as part of our team! Katrina (center) is pictured above with Iowa Department of Public Health Director, Dr. Miller-Meeks (left) and Deputy Director, Gerd Clabaugh (right).*

If you're not getting the weekly eNews, send an email to: administration@iemsa.net

CORPORATE PROFILE - Alexis Fire Equipment Company

109 East Broadway, Alexis, IL 61412 www.alexisfire.com 800-322-2284

Gene Morris built his first two trucks while employed at Ashland Oil Company. After six years with Ashland, he decided to use the experience he gained to begin his own business. in 1945, Gene opened a small welding and fabrication shop in his hometown of Alexis, Illinois. He noticed the fire engines he repaired in his shop were poorly built and knew he could build a higher quality truck. In 1947, Alexis Fire Equipment Company was born. The original facility employed four men and could accommodate only three to four units at a time. Gene discovered a market opportunity in rural Illinois and Iowa for his product. With dedication, pure hard work, and extensive training, Alexis Fire Equipment grew rapidly to a sophisticated business that now spans over 55,000 square feet and employs over 75 skilled engineers, craftsmen, and mechanics.

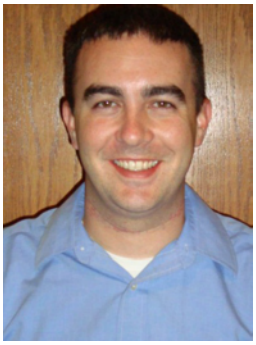
As one of the only remaining family-owned fire equipment manufacturers in the Midwest, Alexis continues to instill the tradition of product excellence, acute customer care, and superior service. Family dedication is the foundation for the successful operation of Alexis Fire Equipment. Jeff Morris, son of Gene Morris, started working at Alexis while attending college. Upon graduation he became chief engineer. Jeff, now president of the company, has a great deal of gratitude to his father. "I'm managing the company now, but the credit goes to Dad for building this business."

Over the past few years, Alexis has pushed and expanded its product line to include not only uniquely custom-built aerials, rescues and pumpers, but also custom-crafted law enforcement vehicles, fire/rescue Aggressor Watercrafts, and now introducing the new ambulance series. And for those who are not interested in custom-built vehicles, Alexis has done most of the work for you with their exclusive line of Specialty Vehicles featuring the Response 1, Vision Series, and the new Engine 1 series - designs based on decades of experience building fire trucks and truly understanding the needs of firemen and rescue workers.

The company that began with Gene and his family has grown into a multilevel corporation with an ever-expanding staff of dedicated employees and skilled craftsmen. Since Alexis Fire Equipment opened their doors in 1947, pride has prevailed in both the positive attitude of employees and the quality of their workmanship. Even with the company's significant growth over the years, Alexis Fire continues to provide their customers with a personal, family atmosphere - to which the Morris family and Alexis employees are devoted.

Spotlight on Training

North Iowa Community College
Mason City, Iowa



North Iowa Area Community College, located in Mason City, is a progressive, comprehensive learning institution positioned to serve as the major cultural, educational, and economic development force for the North Iowa region. NIACC began in 1918 as Mason City Junior College (the first public two-year college in Iowa) and became North Iowa Area Community College in 1966.

NIACC offers many programs of study along with numerous continuing education classes. Currently offered is EMR, EMT, AEMT and many non-credit EMS courses. A Paramedic program is being developed with hopes to offer this course in the near future.

Adam Wedmore has recently been hired as EMS Program Manager. Adam was previously employed by the Mason City Fire Department, Mercy Air Life and Snell's Ambulance Service. He currently is a Nationally Registered Paramedic, Paramedic Specialist with Critical Care endorsement and both BLS and ACLS Instructor along with many more certifications. He is the service director for Rockwell-Swaledale EMS, a Captain on the Rockwell Fire Department, Assistant Chief of the Swaledale Fire Department and a council member for the City of Rockwell. Adam received his EMS training from the EMSLRC and is completing his BA in fire science administration at Waldorf College. In his free time Adam enjoys playing with his three year old son Owen and spending time with his wife Kristen.

Adam Wedmore
EMS Program Manager
North Iowa Area Community College
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Mason City, IA 50401
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Fax: 641.422.4112

Affiliate Spotlight—Muscatine Fire Department *by Tom Summitt*

After a series of destructive downtown fires with overwhelmed hastily assembled bucket brigades, the city of Muscatine issued a charter on January 7, 1875 to create its first volunteer fire company, the Champion Hose Company. The Rescue Hose Company and the Excelsior Hose Company in 1876, the Relief Hook and Ladder Company in 1877, and the Relief Hose Company in 1880 followed this unit. In addition to these five city companies, there were also four private fire brigades: Huttig Hose, Hershey Hose, Kaiser Hose and Roach & Musser Hose. These nine units combined to give the city nearly three hundred volunteer firemen. With hand drawn hosecarts and plenty of spirit, they provided fire protection for Muscatine until the second decade of the twentieth century.

In 1913, after a terrible fire that destroyed two lumberyards and a bridge, one of Muscatine's leading citizens, P.M. Musser, purchased a new American LaFrance fire engine for the city to help with future fires. Two men were hired to drive and maintain the vehicle. Fred Bilkey and J.P. Maurath were paid $62.50 a month to do these jobs, and their arrival signaled the inevitable demise of the volunteers. In 1915 a second pair of men were hired to give needed relief to the original two, and the changeover became complete in December of that year when an ordinance was passed to create a department consisting entirely of paid members. It was also agreed that the volunteers would be disbanded. In January of 1916 the paid firemen began manning stations on Sycamore, Cherry and Hershey Streets. The city purchased two more fire engines so that each station would have one. The original members were as follows: Chief J.J. Brown, Assistant Chief Fred Bilkey, Mechanic J.P. Maurath, and firemen John Leysen, Harry Freeman, Lee Schenkel, Charles Vetter, Herman Raethz, Charles Lemkau, Ed Priester, Charles Opelt, James Wise, and Louis Faulhaber. Chief Brown had previously served as chief of the volunteers during the last three years of their existence.

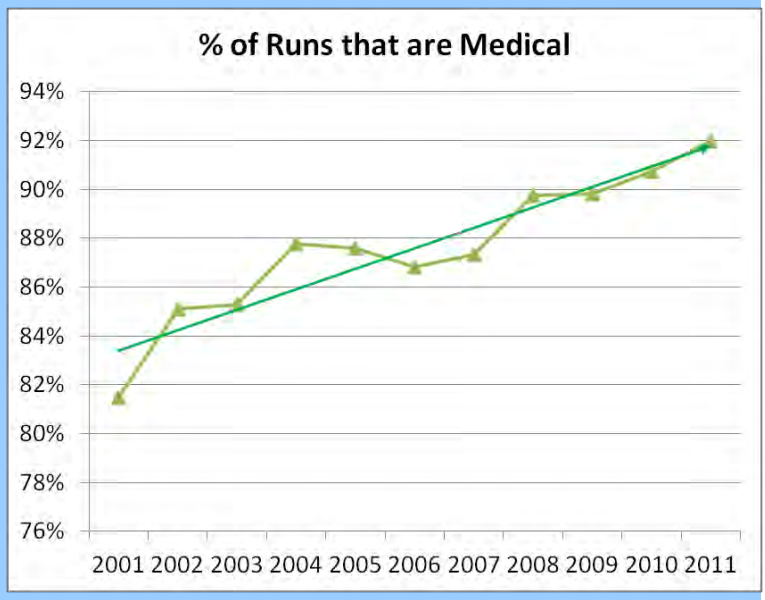
In 1926 the department expanded from one platoon to two allowing members to have every other day off. In 1965 a third platoon was formed which reduced a fireman's workweek to fifty-six hours. In the eighty-two years since the department went professional, eight men have served as chief: J.J. Brown 1916-1941, Harold Bierman 1941-1947, Paul Meerdink 1947-1954, Alex Bender 1954-1975, Paul Ziegenhorn 1975-1984, James Pumfrey 1985-1991, Steve Dalbey 1991-2009, and Jerry Ewers 2009 - present. Today's department consists of thirty-six firefighters who provide not only fire protection, but

also emergency medical services, building inspections, public education, a hazardous materials response team, and a confined space rescue team. We've come a long way from bucket brigades and hand drawn hose carts!

> *"We've come a long way from bucket brigades and hand drawn hose carts!"*

The Muscatine Fire Department is a 36 paid member department consisting of 3 shifts, Ambulance Billing Manager, and the Fire Chief. We also have a part-time secretary. The fire department also employs 4 part time ambulance attendants. The Muscatine Fire Department serves approximately 145 square miles for ambulance service and tiers with ambulance services in surrounding Iowa and Illinois counties. We also provide fire services to the entire City of Muscatine and its citizens as well as HAZMAT for Muscatine, Louisa, Washington, and Henry counties.

In 2011 we responded to 3,916 calls. 91.9% were medical calls. The fire department invests numerous hours each year in EMS training, fire training, HAZMAT training, high angle rope rescue training, and confined space training as well as other types of training from outside instructors brought into the department. We also do routine Fire Inspections in Muscatine.



The Muscatine Fire Department has provided an extremely well run ambulance since transport services were added to the fire department in July of 2000. The service, thanks to the street medics, consistently provides a high quality of EMS care for the sick and injured. In addition to the 911 service provided, the Fire Department provides interfacility transports and provides transports to hospitals out of the Muscatine area. Ambulance operations continue to grow as a part of the Department, and the call volume continues to grow as well. Over the years we have been able to maintain an outstanding service. This is evidenced not only by the consistent excellent responses times, but more so by the positive comments from our community. It is not uncommon for management to hear positive statements about our service and/or thank you cards from those we have served!

Our ambulance service also provides Critical Care Transport, with 12 Paramedic Specialists with the Critical Care Paramedic endorsements. In 2002, the Muscatine Fire Department was also named Iowa Emergency Medical Services Association EMS service of the year. On top of that in 2002 Assistant Chief Jerry Ewers was named paramedic of the year by the IEMSA marking the first time in IEMSA history that 2 awards were given to the same service in the same year. In 2006 Darren Brooke was named paramedic of the year by IEMSA and in 2009 Andy Summitt also received the paramedic of the year award marking the department's 4th award since 2002. Tom Summitt, a member of the Department since 1999 was also a recipient of paramedic of the year in 1997. The Muscatine Fire Department continues to upgrade it's training for EMS to provide better quality services to our public including refreshers in advanced cardiac life support, pediatric advanced life support, neonatal resuscitation, prehospital trauma life support, and advanced medical life support.

IEMSA

IOWA EMERGENCY MEDICAL SERVICES

A voice for positive change in Iowa EMS

1st Annual Education Day

March 3rd , 2012 8:00 am-12:00 pm

Virginia Thompson Conference Center
Iowa Methodist Medical Center
1200 Pleasant St. Des Moines, IA 50309
For Directions visit: http://www.iowahealth.org/maps-directions-parking-iowa-methodist.aspx

TENTATIVE SCHEDULE*

This rapid-fire energetic course will satisfy all EMT B transitional topics and participants will be awarded the required 4.0 CEHs to meet their transitional certification needs.

Tracy Shaw RN, MS, CEN, CCRN, CNRN
Sickel Cell Crisis ~ Blast injuries ~ Tracheostomy care/dysfunction
Neuro Assessment & Sensory Deficit

Lisa Baumhover, RN - Geriatric Clinical Nurse Specialist
Agitated delirium ~ Alzheimer's Dementia
Technology Dependency

Teresa LaMasters, MD, FACS Bariatric Surgeon
Bariatrics & EMS health related concerns

Paula Kae Willilams, RN, BSN, CHPN - Clinical Educator
Mercy Hospice
Hospice & homecare issues related to EMS

Sarah Seehase, Mercy Des Moines
Pediatric Assessment Triangle ~ Developmental Disability

Abby Freese – Central Iowa Shelter and Services
Homelessness & Poverty & the related health concerns for EMS Providers

*Speakers and topics are subject to change; all changes will maintain the integrity of the course objectives.
Use the registration form on the opposite page to register.

SOUTH CENTRAL REGION

IEMSA

A voice for positive change in Iowa EMS

1st Annual Education Day

March 3rd, 2012 8:00 am to 12:00 pm

Virginia Thompson Conference Center
Iowa Methodist Medical Center
1200 Pleasant St. Des Moines, IA 50309

REGISTRATION FORM

☐ IEMSA Member - $20
Membership #_____

☐ Non Member - $50
(Includes $ 30 Membership)

Service Name: _____

Attendee's Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Credit Card # _____ - _____ - _____ - _____ Exp Date: ___/____

3 Digit Sec Code: _____

Name on Card: _____

Billing City: _____ State: _____ Zip: _____

Conference Fees must accompany ALL registrations
No refunds will be made after February 24, 2012 on cancellations.

Please copy and complete this registration form for each individual attending.
Fax completed form to: 515.225.9080 or
Mail it to: IEMSA, 8515 Douglas Ave., Suite 27B, Urbandale, IA 50322

NOTE:
By registering as a non-member at this conference, you will receive a 1-year membership to IEMSA. Many benefits are included with this membership such as:

$10,000 Accidental Death & Dismemberment Policy, discounts on IEMSA Conference registration and merchandise, VOICE newsletter, Weekly E-News, and more.

(Formal CEH's have been applied for)
Walk-Ins are welcome the day of the Conference

Memberships

Are you getting the most from your Individual, Affiliate, or Corporate Membership? If you haven't looked at your benefits lately, go to the IEMSA website Membership page for details.

Stop by our Booth

IEMSA will have a booth at the conferences in Sioux City and Cedar Rapids in March. Please stop by and say hi, ask questions, offer suggestions. Lend us your voice so that we can be your voice for positive change.

Board Member Visits

Your IEMSA Board representative would like to visit your county or department meetings. Please contact your rep with dates and times.

Awards Nominations

No need to wait until fall to nominate someone for one of the IEMSA Awards. Nominate a deserving person any time of the year. You can download the nomination form from our website Honorees page. Annual Awards categories are:

- Full Time Instructor of the Year
- Part Time Instructor of the Year
- Dispatcher of the Year
- Friend of EMS
- Volunteer Individual EMS Provider
- Career Individual EMS Provider
- Volunteer EMS Service
- Career Service
- Hall of Fame

Awards are presented after the Annual Meeting of IEMSA on Thursday night of the Conference and Trade Show.

EMS Memorial

The annual EMS Memorial Ceremony will be held May 19 in West Des Moines. More details will be announced soon. If you know of EMS Providers who should be recognized on the memorial, please contact IEMSA. You can download the application form from the Honorees page on our website.

The Iowa EMS Memorial is located at 8055 Mills Civic Pkwy, Public Safety Bldg. #19 in West Des Moines. MAP

IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION
8515 Douglas Avenue, Suite 27B
Urbandale, IA 50322