IEMSA

July – September 2008

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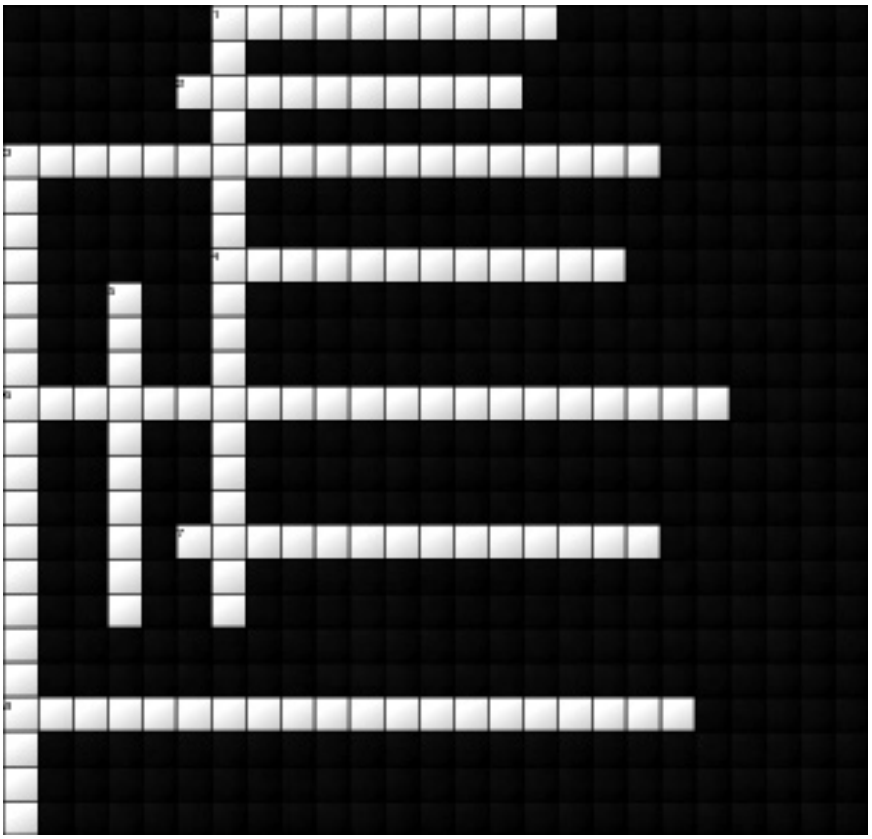
# IEMSA CROSSWORD PUZZLE *Challenge*



**ACROSS**

**1** The disease state that results from the presence of microorganisms or their toxic products in the bloodstream.
**2** The presence of bacteria in the blood, whether or not a disease process is present.
**3** A form of incomplete spinal cord injury in which some of the signals from the brain to the body are not received; results in weak or absent motor function, which is more pronounced in the upper extremities than the lower extremities.
**4** Simultaneous use of many medications.
**6** Fractures that involve flexion, with a distraction component (energy being dispersed in two opposite directions) that causes a fracture through the entire vertebral body and bony arch; typically results from an ejection or occurs in those wearing only a lap belt without a shoulder harness.
**7** Compression fractures of the vertebrae that typically result from a higher energy mechanism such as a motor vehicle crash or fall from substantial height.
**8** A spinal injury that has a high risk of permanent neurologic deficit or structural deformity.

**DOWN**

**1** A sinal injury that has a low risk of leading to permanent neurologic deficit or structural deformity.
**3** Stable spinal cord injuries in which often only the anterior third of the vertebra is collapsed. This type of fracture often results from minimal trauma, from simply bending over, rising from a chair, or sitting down forcefully.
**5** The depression on the lateral pelvis where its three component bones join, in which the femoral head fits snugly.

*Crossword puzzle solutions printed on page 21. 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

- **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:

**October 17, 2008**
Application submission deadline to apply for an IEMSA Educational Scholarship. Visit www.iemsa.net for complete details.

**November 13 – 15, 2008**
Annual Conference & Trade Show
Des Moines, Iowa

**January 29, 2009**
EMS Day on the Hill and Leadership Conference
Des Moines, Iowa

**March 15 – 22 , 2009**
Iowa EMS Cruise
Departs from Miami, Florida
Visit www.iemsa.net/cruise for details

# A *Message* from the President

**John Hill, EMT-PS**
IEMSA President
Board of Directors

I would like to begin by first saying it is both humbling and an honor to be addressing the Emergency Medical Services men and women across the state of Iowa.

As I attempted to gather my thoughts to write this article, I found myself reflecting on the unbelievable devastation this state has endured over the past two months. Two words kept coming to mind: Sacrifice and Heroism. Iowa's First Responders deserve our thanks and recognition for the countless sacrifices and acts of heroism they preformed. The men and women of Iowa's EMS, Fire and Law Enforcement who answered the call for help during the recent devastation created by the flooding and multiple tornadoes throughout the state showed tremendous heroism. I don't believe anyone would argue that over the course of the last couple months Iowans have had many opportunities to see multiple heroes. Included in these heroes are the many responders who lost their own homes and belongings, yet still responded to others' calls for help on an ongoing basis, putting their own needs aside.

What is heroism? Webster's dictionary defines a hero as a "mythological or legendary figure often of divine descent endowed with great strength or ability." I would define a hero as someone who in a pure moment, has their education, ideals, and mental preparation come together and prompt them to knowingly respond to the needs of others without any consideration of personal benefit or needs. The commitment of Iowa's First Responders and countless others who are currently rebuilding the infrastructure of many of these devastated communities exemplifies the values of the people I would call heroes.

We learn again and again from our men and women in EMS how much it means to get a simple thank you from others for the work that all of you do in times of tragedy. Even though it's part of your life's pattern to respond to emergencies, there are only a few that share the depth, passion, and diversity as those who are Iowa's First Responders.

There is no end to the good things you do for each other every day. Your stories about good Samaritans and Heroes warm our hearts and restore our faith in humankind. If someone has done something nice for you, do something nice for someone else.

On behalf of the Iowa EMS Board of Directors we would like to say thank you to all of Iowa's First Responders, to those of you who responded to the recent tragedies, and to those of you who continued to serve and protect your own communities. You are what makes Iowa a safe place to live and raise our families.

God bless and stay safe! ■



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# *Maximizing* the Relationship with Your Medical Director

**Azeemuddin Ahmed, MD, FACEP**
IEMSA Medical Director

As an active medical director with my air ambulance program, I am often asked how to foster and maintain a solid working relationship with EMS providers in an environment where there is always too much to do and not enough time. I feel that every EMS service deserves an enthusiastic, engaged and knowledgeable medical director, and it is a goal that we should all strive toward. Using my unique perspective of having been an EMS provider and a current EMS medical director, I have developed a quick list of tips for building a great professional relationship.

## Medical Director Selection

The reality is that EMS services are often "assigned" a medical director. However, if your service has the opportunity to select your medical director, then choose one that has a demonstrated interest in EMS either during residency training, previous professional experiences or by sheer enthusiasm. These people are out there, so ask the prospective candidate regarding their experience and enthusiasm for EMS. If you have a problematic medical director, then you should explore opportunities to replace him or her. An inadequate medical director can really harm an EMS service.

## Medical Director Duties

Ask your medical director to ride along on a scheduled basis, review charts on a scheduled basis, review protocols on a scheduled basis, and attend training on a scheduled basis. The key word is scheduled because if left up to "as needed" scheduling, then the involvement of the medical director deteriorates. It does not have to be a very rigorous schedule, but by having some type of schedule, this will make it more like a job and less of a hobby.

## Medical Director Education

Just like any other job, being a medical director requires some formal training. Make sure that they have attended the Bureau of EMS medical director workshop as well as any medical director events offered through IEMSA or other professional organizations. Encourage your medical director to network with other medical directors in your area and across the state. There are plenty of resources out there!

## EMS Service Provider Interactions

Treat your medical director as part of the team. I hear from other medical directors that they sometimes feel excluded from the EMS service they oversee because they are not "EMTs or paramedics" and don't feel part of the club. Make sure you include your medical director in social events, public relations events, etc. Give them a uniform to wear. Nothing makes me feel like a part of the team like putting on a flight suit and going on a transport with my crews. It's the little things that can make the difference.

## EMS Service Professionalism

Show your medical director that you mean business when it comes to EMS. By showing enthusiasm, dedication, and the desire to learn and improve, this demonstrates a high level of professionalism that everyone responds to. Your medical director will recognize your service's desire to take it to the next level, and will hopefully respond. If he does not respond, then you must work through your chain of command to deliver the message. How you behave oftentimes influences the behavior of your medical director. For better or for worse.

Strong relationships between EMS services and their medical directors are not born overnight. They are nurtured through mutual respect, enthusiasm, and the desire to provide the best medical care possible. As I stated before, every service deserves an excellent medical director and hope is never lost.

I am happy to speak with your medical director or service director if they have any questions or concerns. I may not have all of the answers, but I am willing to provide any information, advice or references that may prove to be helpful. Please e-mail me at azeemuddin-ahmed@uowa.edu.

Until next time, please be safe and thank you for your service to your community and to the world of EMS. ■

# Welcome New IEMSA Members

**APRIL – JUNE, 2008**

**AFFILIATES:**
Virginia Township Fire and Rescue

**CORPORATE:**
Iowa Donor Network
Philips Healthcare

**INDIVIDUALS:**
Anthony Ward
Bryon Helt
Cheryl Larson
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Debra Meyer
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Eric Griffin
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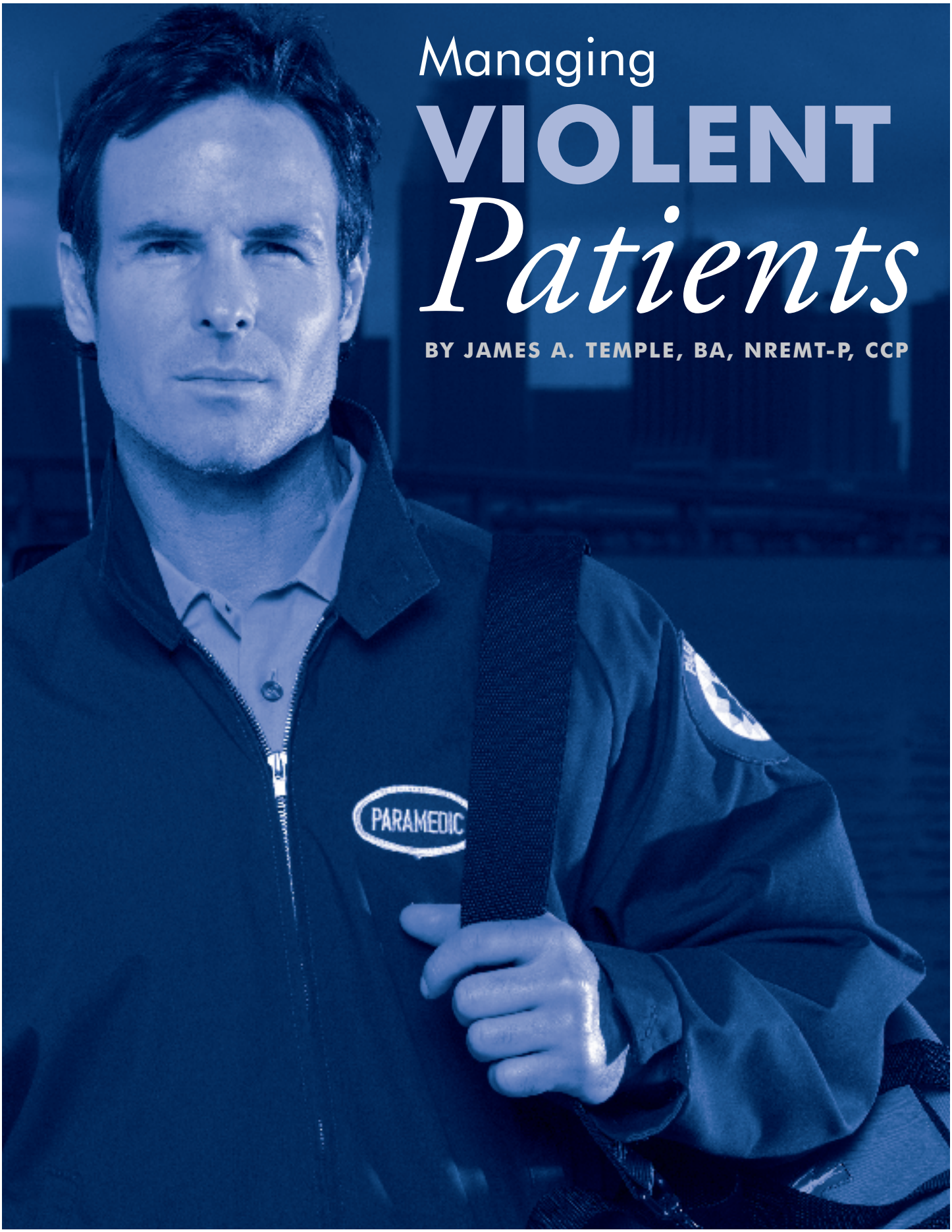
Jim Hegarty
Kyle Howard
Lori Ward
Nathan Rusinack
Peggy West
Sonny Alvarez
Susan Coates
Thomas Schmidt
Traci Hegarty
Trent Loneman

**STUDENTS:**
Brooke Johnston
Chris Roberts
Chris Sampson
Christina Schmidt
Darwin Ritchie
James Mclaughlin
Jeff Heide
Jessica Baker
Kelly Rapier
Kristi Hansen
Kristina Tomford
Michael Moriarty
Nick Snyder
Pamela Sokolowski
Robert Copenhauer
Seanna Mayer
Stacy Ross
Ty Davison
Zack Husz

**TRAINING:**
Eastern Iowa Community College

# Managing VIOLENT *Patients*

BY JAMES A. TEMPLE, BA, NREMT-P, CCP



Anyone who has ever gone to an EMS conference, CE class, or meeting at the office will be able to personally relate to this situation. Over on the table next to the coffee and juice is a fresh, unopened box of donuts. Jackpot! You slink over there, navigate the tamper-tape, and open the box of fried goodness. We all have our favorites, and being a creature of habit, you choose your standby – the filled chocolate frosted. You take a man-sized first bite and immediately spew it out all over the floor! This one was filled with vanilla pudding, not white frosting, and you hate vanilla pudding. How could you have made such a mistake? It looked so familiar, you were so certain. You have eaten boat loads of these gems without ever fast-tracking them to the floor! Did you become complacent and lazy in your assessment of the donut? Do all chocolate frosted white frosting filled donuts look the same? From the drool on your chin, the answer must be that they certainly do not.

Sometimes we need to pay closer attention to the subtle details and clues our patients are showing. This is probably never so true as when it comes to dealing with violent or behaviorally challenged individuals. After all, no matter where you went to school, you were taught that your safety is the most important aspect of any emergency response. What follows here is a discussion about violent or potentially violent patients, signs of impending violence, conditions or attitudes that can precipitate violence, management of violent patients and situations, scene safety, and current practices for proper patient restraint. The format is question and answer, not unlike you might hear between a green as grass newbie and a grizzled veteran, with key points and tips in italics.

## What factors increase the chances of experiencing a violent patient encounter?

As you know from your experience on the streets, violence can erupt almost anywhere and at anytime. On occasion, there are absolutely no warning signs and you are in the middle of an ugly situation. More likely, however, there were signs and warnings that you could have noticed and taken evasive action. We will discuss some of the factors that lead to violence. These causes of violence can be broken down into the following categories:

**Patient's Medical Processes** – Diagnosed medical conditions that cause altered mental status and poor decision-making may include hypoglycemia, hypoxia (which can have many causes, even our restraint method), seizures, CVA or head trauma, and acute psychosis. You will notice the absence of drug ingestion in this category. It has such an effect on mental status that it has grown into its own category.

**Drug Ingestion** – cocaine, methamphetamine, alcohol, hallucinogenics, opiates, you name it. The illicit drug scene is in constant flux, with new variations on old drugs, combinations of drugs, new designer drugs. Unless you keep up with the literature and keep your ear to the streets, you may not be aware of the next big thing everyone's doing. Understand, when speaking of chemical restraint, it is important to know what the patient has ingested for the sake of possible drug interactions and the need to choose a different chemical restraint drug.

**Personal issues** – Many patients who end up resorting to violence simply have lost the ability to cope, so they do what comes easiest: they act out physically. Although it is easy to blame our patients for the violent behavior, do not forget about your attitudes, speech, and non-verbals. The way you stand, hold your hands, make eye contact or not, and tone of voice just may be the last straw. If your patient picks up on these and thinks you don't really want to be there or care about their crisis, violence may be in your future. Communications are only 7% what you say, 38% how you say it, and a whopping 55% non-verbal! A list of some non-verbal clues can be found in figure 1-1.

**NON-VERBAL COMMUNICATION** Figure 1-1

| Non-Verbal Clue | Perceived Meaning |
|---|---|
| Glancing sideways | Suspicion |
| Rubbing the neck | Frustration |
| Hands in pocket | Insecurity |
| Clenched Fist | Defensiveness / impending aggression |
| Open hands | Openness |
| Smiling | Confidence |
| Upper body leaning forward | Cooperation |
| Stroking the chin | Evaluation |
| Rolling the eyes | Apathy |

## What is the best way to approach the violent patient?

Obviously, if you know prior to patient contact that there is scene safety issue, stay away! Law enforcement will secure the scene and let you know when it is time to go to work. In some systems, some personnel have dual function (police / EMS). Unless you are trained and equipped for handling scene safety issues, let the professionals take care of it.

Once the scene is safe, approach the patient slowly and with open eyes, ears, and mind. Respect their personal space and keep a minimum two arms-lengths away if not more. Stand bladed, or at a 90 degree angle to the patient with your palms up, and smile. Place your weight on your back leg, so in the event you have to turn and retreat, you are prepared. Always make sure you can see the patient's hands! If they are in their pockets, kindly ask them to show you their hands. Don't get caught "napping" and have a weapon smuggled into the back of your truck! Speak slowly and calmly, trying not to make any sudden movements. Don't forget about the non-verbals you are using. Make sure you are near to and have a clear exit path. If someone or something blocks your egress route, reposition yourself for a quick, clear getaway. The primary care-giver has obvious responsibilities, as should their partner. "I got your back" should be heard routinely on your service. If not engaged directly in patient care, the partner should constantly scan the scene for hazards, such as weapons or persons coming to check out the action. A large gathering can happen quickly, so be sure all are watching.

*If the situation deteriorates and you need to retreat, a code word or phrase may be used to alert all to the danger you see. One method is to call your partner by the wrong name. If you have worked together with any regularity, all should recognize what is meant, and react accordingly. Another method is to ask a partner to go out and get the "green" bag, knowing full well you carry no such bag. Again, this requires communication prior to the incident, but can be invaluable when faced with an erupting situation.*

If the patient is verbally abusive, use calm words and voice, acknowledge their concerns, answer their questions, and assure them that you are really there to help. Use empathetic statements such as "I can understand that you may be upset" or "I can understand how that may make you feel sad." Try not to validate their feelings, but rather put yourself in their shoes and try to understand where they are coming from. Don't take the insults personally, although it may be difficult. If you become angry, you lose your ability to think clearly and make good decisions, which may lead to rash and inappropriate patient care.

## What are some signs of impending violence?

Violence can erupt at any time, so if you can predict or sense when it is coming your way, the healthier you will remain. You will notice that of the signs listed, more than a few can be associated with the "flight or fight" response. If you can learn to recognize the physiological indicators of impending violence, you will stay that ever important step ahead. Signs of impending violence may include anger, agitation, chanting, clenched fists, profanity, flushed face, flared nares, darting eye movements, dilated pupils, pointing, pacing, or loud outbursts.

*Make sure you or any of your crew avoid the above behaviors! What message does that send to your patient? They may think the violence is impending toward them and plan a preemptive strike!*

## When should I use restraints?

Restraints should be used in situations where there is imminent danger to you, your crew, or the patient. If the patient's behavior is such that injury may occur to anyone involved, the use of restraints may be warranted. Just keep in mind local protocols regarding physical restraint. Medical control may have to be advised and actually give the order. Be familiar with your local procedure. You may wish to use restraints in any of the following situations: To protect patients from themselves (extubation, etc.); to protect crew, staff, and bystanders; to allow assessment and appropriate treatment (uncooperative patients); to protect disoriented patients from external dangers (falls, etc.).

*All patients who are candidates for restraint should have a blood glucose check prior to restraint!*

## What are the dangers of using restraints?

The most serious risk of restraining patients is sudden death. Research currently identifies six factors that contribute to poor outcomes from restraint: excited delirium, drug overdose, comorbid medical conditions, recent extreme exertion, fighting against the restraints, and inappropriate restraints.

**Excited Delirium** – A severe disturbance in the level of consciousness over a short period of time, manifested by mental and physiological arousal, agitation, hostility, and heightened sympathetic stimulation. It has been shown that patients who are already worked up and fight against restraint increase their risk for arrhythmias, respiratory distress, and MIs. The massive release of catecholamines over an extended period of time coupled with substance abuse and any preexisting medical conditions can lead to death while in restraint.

**Inappropriate Restraints** – EMS personnel are by nature very resourceful and able to think on their feet. There are many ways to effectively restrain someone. However, we need to be smart and do it safely. The days of sandwiching folks between long boards are over, as are the days of hog-tying people. Although effective, hog-tying, or any restraint method which places people prone, should not be employed. Another common method is to hobble, or somehow bind the feet or legs together to limit extremity movement. Again, a person who cannot get off of their belly may end up with respiratory compromise. Once prone, respiratory effort can easily be impaired, especially in those with a large pendulous abdomen. Remember the fact that they are or have recently been fighting with you and increasing their oxygen demand, and now they are in a position that can compromise their oxygen supply chain. This is called positional asphyxia, and is currently a popular cause for legal action against emergency responders.

*Never place a restrained person in the prone position. Place them supine or in a lateral position. Also, never leave a restrained person unattended.*

**TABLE 1-2**

| Drug | Initial dose | Onset | Peak Effect | Duration |
|---|---|---|---|---|
| Haldol (Haloperidol) | 2-5 mg IM | 10-30 min | 30-45 min | 12-38 hrs |
| Inapsine (Droperidol) | 2.5-5 mg IV / IM | 3-10 min | 30 min | 2-4 hrs |
| Valium (Diazepam) | 2-5 mg IV / IM | <2 min | 3-4 min | 15-60 min |
| Ativan (Lorazepam) | 1-3 mg IV / IM | 1-5 min IV<br>15-30 min IM | 15-20 min IV<br>30-60 min IM | 6-24 hrs |
| Versed (Midazolam) | 1-3 mg IV / IM | 1-5 min IV<br>15-20 min IM | 5-30 min IV<br>15-30 min IM | 2-6 hrs |

** Haldol 5 mg and Ativan 2 mg = B52 or Halivan, commonly used for sedation and control*

## How can I use physical restraint and not endanger myself or the patient?

You can think of the restraint process in three steps: verbal, physical, and chemical. Each situation requires careful consideration as to what is the best method for the patient. You may physically restrain a patient who struggles

mightily against the restraints who puts themselves at risk medically. That patient may just be a candidate for chemical sedation.

If verbal de-escalation does not effectively control the patient, physical restraint is next. Simply put, there is strength in numbers. Use your available resources. Usually five persons can manage physical restraint. There are cases of super human strength, usually drug-induced, where eight to nine persons aren't enough to adequately restrain someone. When faced with the need to use physical restraint, remember the following:

Use only the minimum amount of force necessary to control the patient. Do not become angry or agitated. Again, that can blur your decision-making capabilities.

Tell the patient they are going to be placed in restraints because they are threatening responders with violence. Letting them know what behaviors are not acceptable (setting limits) gives them choices and may be the key to avoiding a physical confrontation.

Direct responders to cover and control large joints. Holding a foot for example is less effective than controlling the knee. Care should be taken when grasping clothing, given the possibility for weapons or drug paraphernalia such as needles in pockets. As always, gloves should be worn by all persons engaged in physical restraint. Some patients may want to spit, so wear appropriate eye protection and maybe even a face-shield. The old trick of placing an oxygen mask on the patient is functional, just be sure to turn the oxygen on!

*Any patient who you would consider a behavioral risk should be "patted-down" prior to getting in your ambulance. The back of the truck is a difficult place to manage a patient with a knife or other weapon.*

There are commercial devices available for "soft" restraint, or you can use the old standby roller gauze to restrain each extremity. For those who use the hard restraints (handcuffs per police) or four-point leathers, always be sure to have a key to quickly remove or adjust them. Your local protocol may require the police to actually ride in the ambulance with you, as EMS may not be trained in handcuff operations. On occasion, you will find a patient handcuffed to the ambulance cot. Consult local procedures, but beware: If you are in an accident or in a situation requiring rapid evacuation, Law Enforcement better be in the back with key in hand. Again, safety is the first priority! The focus of soft restraint is to reduce the ability of the patient to kick or swing at you. Remember, placing the patient prone is not an option!

If you cannot control the patient physically or you are concerned for their safety while in the physical restraint, chemical restraint is the next option. Many drugs can be used for this purpose. Many are commonly found in your drug box. When you graduate to chemical restraint, the risks increase as should your attention level. You need to be on the lookout for possible drug interactions, and not just with prescription drugs! Table 1-2 lists some common drugs used for chemical restraint.

The two families of drugs most popularly used for restraint are Butyrphenones (Haldol, Inapsine) and Benzodiazipines (Ativan and Valium). All of these drugs can be given IV or IM, which is a definite bonus given that the violent patient rarely will hold still long enough to allow IV access. Current and promising research is also looking at the efficacy of Geodon (ziprasidone), Respiridal (respiridone), and Zyprexa (olanzepine) in the acute chemical restraint situation. Given the resourcefulness of EMS providers, new combinations and ideas will certainly evolve. So again, keep current on trends and literature.

Potential side effects of using these meds include hypotension, possible EPS reactions (dystonia), and respiratory depression or arrest, which in the big picture is quite manageable.

If your service uses paralytics for RSI procedures, remember you cannot paralyze without also sedating! Paralytics are great for restraint, but must be accompanied by a sedative.

## What are the potential dangers of chemical restraint?

The most serious dangers of chemical restraint reside in cardiovascular side effects. Patients may experience PVCs, ventricular arrhythmias such as Torsades de Pointes, or bradycardia. These symptoms are made even more possible by the presence of other ingested substances (drugs or alcohol). It makes sense then to say each patient who has been chemically restrained needs to have a cardiac monitor applied. Haldol and Inapsine present special challenges in regard to side effects. Extrapyramidal symptoms may consist of dystonic reactions, motor restlessness, and Parkinsonian signs. Treatment for these symptoms is Benadryl (diphenhydramine) 25-50 mg IV/IM/PO and even Cogentin (benztropine) 1-2 mg IM/PO. Pregnant patients should not receive Haldol and Inapsine, as it has been shown to have potential detrimental effects on the fetus, as it crosses the placenta.

Be careful when giving Haldol or Inapsine to the patient with a history of seizures or exposure to cocaine, amphetamine, and tricyclic antidepressants, as it may further lower the seizure threshold, complicating management.

*In the patient with acute cocaine ingestion who needs to be restrained, Benzodiazepines are the drug of choice (Ativan, Valium).*

## How do I manage the patient who has been controlled with a TASER?

Law enforcement is continually developing new non-lethal means of controlling violent and uncooperative subjects. The TASER is a gun that shoots two metal "prongs" and then delivers an electric charge intended to incapacitate briefly and allow control. The TASER is a high voltage, low wattage device. The voltage may be around 50,000 volts, but the amperage is minimal but still able to briefly incapacitate. The two prongs may penetrate up to 2 inches of material, making actual skin contact unnecessary. These prongs have fish-hook like barbs on them, making them difficult to remove, even for responders. The best method has been to pull the skin around the prong taught, and pull up to remove. This process can be somewhat painful, so beware of the potential patient reaction. In the event that the prong cannot be easily removed or is in a conspicuous place, such as near a large vessel, allow the Emergency Department to remove the prong.

The electric current from the TASER is not enough to cause Vfib. The cardiac Vfib

threshold is 10 to 50 joules, while the current from the TASER ranges from 0.37 to 1.2 joules. While incapacitating, the current is well below that needed to induce Vfib.

Although painful and effective, most treatable injuries from TASERS involve the fall once the patient has been "hooked-up." Remember to treat appropriately and use spinal precautions, which as a bonus is another form of restraint!

*At all times, you are responsible for the medical condition of the violent patient! If restraint has been used, you must ensure proper ABC management, and must insist upon transport to the ED for those patients who qualify!*

Managing violent patients takes some quick, resourceful thinking. If you are concerned about your ability to escape a violent situation, you may consider taking a self-defense course. There are folks out there who offer EMS self-defense courses that build self-confidence, sharpen the mind, and are seriously fun! Remember, the best way to manage a violent situation is to preempt it altogether with some careful assessment of the scene and patient. On occasion, as many of us can attest, things go south with a quickness. Most of us are no worse for wear, with a scratch, lac, or a rap upside the beak. Know when you should restrain and how you should restrain. After all, the goal of every responder is to go home after each call. Stay safe and live to eat another filled chocolate-frosted! ■

### References

*eMedicine: Clinical Safety in Neurology; James R Brasic, MD, 3/07*

*eMedicine: Restraints; H Neil Wigder, MD; 3/07*

*Stratton SJ, Rogers C, Brockett K, Gruzinski G. Factors Associated with Sudden Death of Individuals Requiring Restraint for Excited Delirium. Am J of Emerg Med 2001, 19: 187-191*

*National Association of EMS Physicians (NAEMSP) Paper: Patient Restraint for EMS Systems. Prehospital Emergency Care 2002;6(3); 340-345*

*Yildiz A, Sachs GS, Turgay A. Pharmacological Management of Agitation in Emergency Settings. Emerg Med J. 2003; 20:339-346*

*Whitehead S. After Shock: A Rational Response to Taser Strikes. JEMS 30(5)*

*www.ncchc.org Savage, SS. After the Zap: Taser injuries and How to Treat Them. CorrectCare summer 2005.*

*Wolfetory.com: Mucosal Atomizer Device*

*Jamie currently serves as the EMS Coordinator for Eastern Iowa Community College District in Davenport, IA, occasionally taking the opportunity to enjoy life as a street medic with MEDIC EMS, where he has been running calls for 16 years. He is a graduate of Dordt College in Sioux Center, IA with a Bachelors degree in Biology. He holds instructor status in ACLS, PALS, BLS, PHTLS, TBI, and PEPP, as well as having served as a primary educator for the last 15 years. He serves as the coordinator for the Quad Cities CISM Team as well as a contributing author for EMS texts. He has been a presenter at numerous conferences with an engaging style that is casual, informative, and down right fun! Away from EMS, he enjoys his three children, music, and has an incurable addiction to the game of golf.*

## 1st Annual **IEMSA** *EMS Team Competition* to be Held

**BY LORI REEVES**

The Iowa EMS Association is pleased to announce the first annual IEMSA EMS Team Competition to be held in conjunction with the annual IEMSA Conference in November. The purpose of the event is to create a fun, challenging and educational experience for prehospital providers that tests their ability to be prepared for the spectrum of challenges that they may encounter in the field. More importantly, it's the goal of the competition to motivate EMS personnel to provide the highest level of professionalism and patient care possible.

During the preliminary competition to be held on Thursday, November 13, 2008, BLS and ALS teams will compete in scenario-based competitions. The two BLS and two ALS teams receiving the highest point scores during the preliminary competition will advance to the team finals to be held Friday, November 14 immediately following the completion of the day's conference sessions. Final competitions will be scenario-based and will be open for viewing by all conference attendees. The winning ALS team will be eligible to receive a $1,500 scholarship to represent Iowa and IEMSA and attend a national level EMS team competition.

Competition rules and regulations are posted on the IEMSA website. Team applications will become available on the website on approximately August 20, 2008. All team applications must be submitted to the IEMSA office no later than September 20, 2008. Completed applications will be accepted on a first come, first served basis to fill the eight BLS team slots and twelve ALS team slots.

Please see the IEMSA web site for more information or contact Lori Reeves at lreeves@iemsa.net. ■

### MEMBERSHIP ANNOUNCEMENT

**Please Update Your Email Address**

Since email addresses are so easy to establish and change, we know it's likely that yours could be out of date with IEMSA's database. Please send any email address updates to administration@iemsa.net to ensure that you are receiving IEMSA eNews, as well as other notices regarding special events or calls to action.

### NEWS TO SHARE

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

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

## 10 QUESTION POST-ARTICLE Quiz

**1) Overdosing on heroin will have which of the following effects?**
**A)** Hypoglycemia
**B)** Hyperventilation
**C)** Dilated pupils
**D)** Respiratory Depression

**2) Your suicidal patient is sitting quietly constantly rubbing his neck. This non-verbal communication may indicate an attitude of which of the following?**
**A)** Cooperation
**B)** Suspicion
**C)** Apathy
**D)** Frustration

**3) While treating an assault victim, a large crowd gathers around you and begins shouting and threatening. Your best course of action would be:**
**A)** Ignore them as you know your partner has your back
**B)** With or without the patient, leave the danger zone
**C)** Call and wait for law enforcement
**D)** Confront them and order them to disperse

**4) Which of the following is an example of an empathetic statement?**
**A)** You have no idea what you're talking about
**B)** You should be angry, what they did was wrong
**C)** I know how you feel
**D)** I can imagine this must be difficult for you

**5) When transporting a patient who is in police custody and handcuffed, you should instruct law enforcement to do which of the following?**
**A)** Give you your very own handcuff key
**B)** Follow behind in the squad car
**C)** Meet you at the emergency department
**D)** Ride with the patient in your ambulance

**6) Which of the following would be the best choice when attempting to control or restrain a patient who has been snorting cocaine?**
**A)** Narcotics
**B)** Benzodiazepines
**C)** Tricyclics
**D)** Sympathomimetics

**7) Now that you have successfully chemically restrained your patient, you should:**
**A)** Place them prone for transport
**B)** Monitor vital signs every 3 to 5 minutes
**C)** Leave the patient unattended
**D)** Complete your report

**8) You are called to assist law enforcement with a patient who fell while being tased. You evaluate the patient who complains of a headache and abrasions to the forehead. Who is responsible for the medical welfare of the patient?**
**A)** EMS
**B)** Law Enforcement
**C)** Fire Department
**D)** Social services

**9) EMS has chemically and successfully retrained a patient using Haldol. The patient is now exhibiting some tremors and other Parkinsonian signs and symptoms. Which of the following correctly describes this condition, which can be treated with Benadryl?**
**A)** Ectopic
**B)** Anaphylactic
**C)** Dystonic
**D)** Asthmatic

**10) Paralytic meds are useful for restraint, but must absolutely be accompanied by:**
**A)** Tricyclics
**B)** Sedation
**C)** Hyperventilation
**D)** Fluid Bolus

# IEMSA
## CONTINUING EDUCATION
## *answer form*

**CLIP AND RETURN**

(Please print legibly.)

Name _____

Address _____

City _____

State _____ ZIP _____ – _____

Daytime
Phone Number _____/_____–_____

E-mail _____

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. ☐ |

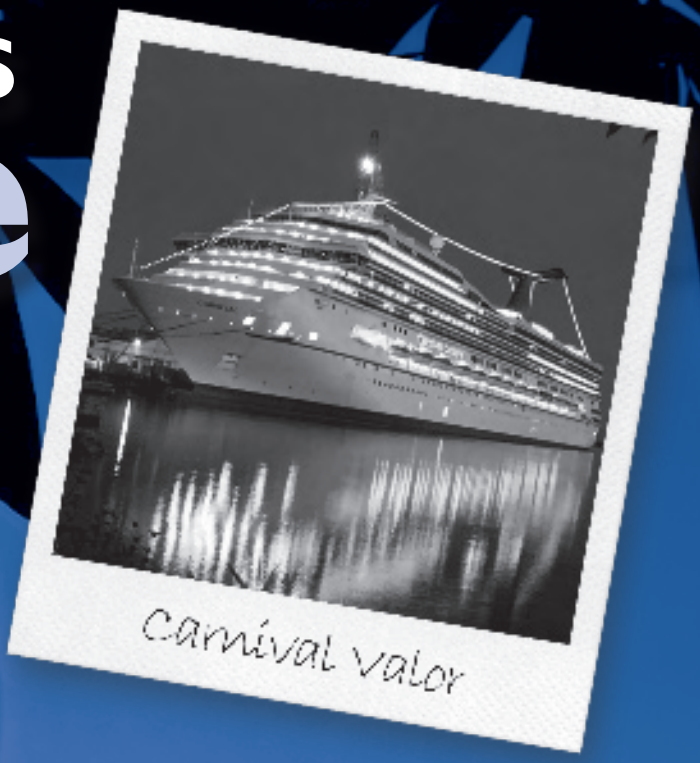
*IEMSA Members completing this informal continuing education activity should complete all questions, one through ten, and achieve at least an 80% score in order to receive the one hour **(1 CEH)** of optional continuing education through Indian Hills Community College in Ottumwa, Provider #15.*

***For those who have access to email, please email the above information along with your answers to:*** administration@iemsa.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
**SEPTEMBER 30, 2008**

# The First Iowa EMS Cruise




## March 15 - 22, 2009

Make plans today to attend the first Iowa EMS Cruise presented by the Iowa EMS Association. The amazing Carnival Valor will host hundreds of your fellow EMS providers on an unforgettable tour of four spectacular Caribbean islands. Be there as we set sail from Miami, Florida March 15 - 22, 2009. With rates as low as $380 per person, this is one cruise you can't afford to miss! Visit www.iemsa.net today for more information and to book your cruise.

Rates are per guest, double occupancy and cruise only. Restrictions Apply. Government fees and taxes are additional. Multiple air options available from many cities.


## Call today for more information!

# 1-800-793-6820

# Sail Away with IEMSA

DON HUNJADI, EMT-I

The very first Iowa EMS Cruise is off and running, or perhaps smooth sailing is the metaphor that's most appropriate. The reaction to this brand new Iowa EMS Association event has been nothing less than fantastic. There are already more than 250 people booked to take part in this history-making cruise.

Are you one of them? If you are, you are in for the time of your life, or at the very least one of the best vacations that you've ever taken. If you are not yet one of the lucky passengers who have signed up, there is still plenty of time for you to get on board.

To begin with, you won't find a better vacation value anywhere. Beyond the fact that the buying power of our group has provided lower cruise rates than standard, for less than $100 a day you'll enjoy a modern, spacious cabin. All of your meals, including the grand four course dinners offered every night, are included. Then there are the fabulous Las Vegas style shows, comedy acts, magicians, and more. A full casino along with a variety of bars and lounges give you plenty to do. How much would it cost to rent a hotel, go out to a fancy restaurant and take in a show? $300 dollars? Perhaps more? With your Iowa EMS Cruise, you pay for nothing other than your drinks. The rest is all up to you. With cabin rates starting as low as $380, this is one of the best and least expensive seven day cruises you'll find.

In addition to all of the regular offerings, everyone will also be treated to several group cocktail parties – held only for EMS Cruisers. We'll take a group photo and even provide it for sale at a discounted price.

A casual EMS get-together is also planned during the week. Imagine how much fun you'll have getting away from next year's winter along with 300 of your new friends.

For those EMS providers who have family and friends who would like to go along, that is no problem! They are welcome to sign up along with you as part of the Iowa EMS Cruise. They too will be offered all of the extras and treated like part of the group. If you or your spouse are worried that this will end up being non-stop EMS talk, that is not the case. We've talked with other EMS and fire groups who have taken a cruise to find out that shop talk rarely occurs. There is simply too much else to do. Of course, you can get your emergency adrenalin fix at one of the group gatherings – if you'd like to.

A view from above the spectacular American Lobby

## SAIL AWAY WITH IEMSA PORTS OF CALL

| | |
|---|---|
| Sunday | Miami |
| Monday | Day at Sea |
| Tuesday | Grand Cayman |
| Wednesday | Roatan Island |
| Thursday | Belize |
| Friday | Cozumel |
| Saturday | Day at Sea |
| Sunday | Miami |

The Iowa EMS Cruise is one of those things that you just don't want to miss being a part of and that you will kick yourself for years to come if you let it pass by. Don't let that happen. You can hold your spot for only $25 per person. Final payments are not due until December. Once you are signed up, you'll receive a copy of the EMS Cruiser's Newsletter, published only for those taking part in the EMS Cruise. We'll provide you with tips, information on the ports of call, flight information and much more. It will help to build the excitement until next March rolls around.

So, what are you waiting for? Simply head to www.iemsa.net/cruise and check out the EMS Cruise pages. From there you can either request more information through the mail or if you're ready, you can join all of the others by completing your booking.

Don't miss this unique opportunity to be part of the very first ever Iowa EMS Cruise, sailing March 15-22, 2009 from Miami. Get on board today! ■


# *In Her Own Words:* a glimpse of PARKERSBURG

TAMMY FLESHNER

*The following was submitted by Merrill Meese, PS Regional Coordinator for the Iowa Bureau of EMS. The letter, which was first published in the NC Region Newsletter, was written by Tammy Fleshner of Parkersburg Ambulance.*

Dear Friends in EMS,

When Merrill asked me to write something for the newsletter, I started thinking about everything that has happened this past month and decided that I didn't have enough time or energy to write all of that down at this time. So, instead you're just going to get a summary of all of the emotions that I have felt in the same time period.

**Fear** I've never been so afraid as I drove into town at approximately 5:00 p.m. on May 25, 2008, not knowing what I was responding to!

**Frustration and Helplessness** I can't get to the Station. There are trees and power lines down everywhere! There's a gas leak – I can't breathe! I need to get to the Station and get my tools so I can help!

**Relief** I see some of my crew members and they are okay. Jeremiah, Jan, Todd, Neal, Chris, Deb, Ryan…

**Duty** I don't have time to think about this. We need to get organized! MCI Kit out, vests out, triage areas set up. Everyone has their job! We need to stay focused!

**Gratitude** Help is showing up from everywhere. Services from 75 miles away are here to help. Patients are being transported out of here as fast as possible.

**More Gratitude** They are staging all of the EMS Services at the High School parking lot. The road is finally clear enough to drive there. The parking lot is full of EMS services, waiting and willing to help! I've never seen so many rigs in one area at one time! Knowing that you are here to help gives us the strength to keep going! Thank you all!

**Disbelief** Door to door Search & Rescue has begun. There have to be more patients out there, but will they still be alive?

**Faith** God was watching over us tonight. We lost four precious souls, and lots of material things, but with this destruction, we could have lost so much more!

**Automatic Pilot** I don't know if you call this an emotion, but it's what got me through day after day after day. We manned a first aid station for 10 days, 12 hours per day, with volunteer EMS and nurses from all over the State responding. We went from treating to preventing. We confiscated every gator and golf cart we could find, and put teams on them with water, Gatorade, bananas, peanuts, sun screen, and of course, first aid supplies! We had three different rigs with stokes to transport patients back to the clinic for treatment, and IVs for dehydration, lacerations, puncture wounds, etc. We would triage those who came to the first aid station, cleanse wounds, bandage, etc., and then send them into the clinic for tetanus shots or sutures, or whatever we couldn't handle. I can't thank those who helped enough. Some days were crazy busy, other days cool and very slow, but you were there for me, and you did whatever I asked! You even helped me dismantle the trailer and move all of the supplies into our old building. I owe all of you big!

It may take me awhile to repay you, but someday I will!

**Fear Again** We had EMS Transport Service Coverage for the first two weeks. FEMA wanted ALS services available at all times, and they were staged at Incident Command. On June 6, 2008 at 7:00 p.m., the Parkersburg Ambulance Service started covering again through the night. This was very scary for us, but we knew it was an important step in getting back to normal.

**Confidence** Daytime coverage was still a problem, however, and we requested help through the IMAC system for daytime coverage through June 20, 2008. Things seemed to go pretty well with this. The covering services actually had nice quiet days, and were probably bored out of their minds, but we were happy to see the lack of injuries, etc. My husband actually got used to the 5:30 a.m. phone calls from the services that were coming into town. I tried to meet all of you personally and thank you for helping us out. If I missed any of you, I apologize! Again, I want to thank all of you! You came from all over the State to help us out! If you ever need anything, just give us a call, and Parkersburg will be there to help you!

**Confusion and Disbelief** Why are we getting all this rain? It can't flood, can it? The City of Parkersburg was isolated – you couldn't go north, or east, or west. You could go south, but... And what about our neighbors and friends?

**Helplessness Again** We need to go help our neighboring communities – they all came to help us. But we can't get there! New Hartford is evacuating. We can send one of our rigs over as long as we have coverage left in town with the other rig. My husband and I can go in from the north with our truck. We hauled 10 loads of people out of town through the water in the back of our truck. Don would drive in from the north, turn around at the school and back down to the Kwik Star, and then the boats would come up to us and people would step from the boats to the truck. Many of these people were friends from Parkersburg who were staying with family in New Hartford since their home was destroyed. And now they are flooded out again! Each day of the flooding, I would try to contact my EMS friends in their respective communities and try to do whatever I could from the outside – get supplies to them, send help through our Public Health office, whatever. It just didn't seem to be enough!

**Guilt** When my husband asks me why I've taken on so much of this extra work, I tell him it's because I feel guilty. I have a home – it wasn't destroyed by the tornado or by the floods. My home is just fine, but my heart is broken and I need to do this for my friends and my community! He doesn't ask me any more – he just knows it's going to keep on happening!

**Normalcy** I've been told over and over that in order to heal, we need to get back to normal. With the floods, some of our covering services were unable to come, and so the Parkersburg Ambulance got back to normal coverage a little sooner than planned! We had four crews that rotated coverage before the tornado, each with at least three EMTs and a driver. Now we have two crews rotating,

*Continued on page 16*

# What's *New* with the *Bureau*

ANITA J. BAILEY, PS

## Emergency Driving Training

At the April 09, 2008 Iowa EMS Advisory Council meeting there was unanimous approval to have the Bureau of EMS draft changes to the Iowa Administrative Code 641—132.8(1) c.(2) that requires training in emergency driving techniques. The proposed improvements require that EMS services have a driving policy and document each driver's training that includes a review of Iowa's laws regarding emergency vehicle operations, hands-on (behind the wheel) training and review of the EMS service policy. The policy for operation of department and personal vehicles includes the frequency and content of driver's training requirements, emergency and non-emergency response, speed permitted, intersection requirements, and crash notification. The rule changes could be effective by early 2009.

## 2008 Protocol Updates

The Iowa Department of Public Health Adult and Pediatric EMS Protocols are the minimum standard for all authorized services. Annual updates can be found on the Protocols page, which is located in the Services section at www.idph.state.ia.us/ems. Protocol revision is an ongoing process that represents the effort to supply Iowa's EMS providers with the most current medical standards for patient care. The process begins every October at the Quality Assurance, Standards and Protocols (QASP) subcommittee of the Iowa EMS Advisory Council where they review submissions from services, training programs, physicians and EMS providers. QASP makes recommendations for improvements based on current evidence, practical application and implementation costs. The proposed 2008 revisions include minor changes to Appendix K and the Apparent Death protocol and clarification of the Altered Mental Status and Cardiac protocols. Services are encouraged to have their physician medical director review and approve the updates ASAP. Be sure to mail a copy of the physician approval page to your regional coordinator.

**BEST PRACTICE**

Many EMS services use the annual protocol update as an opportunity to meet other minimum standards as well. In addition to the protocol review, they discuss the scope of practice and provide a medications training. Combining those trainings can meet the requirements for IAC Chapter 132.8(3) b, c, and 132.8(4)c. Efficient and effective!

## National Scope of Practice Document

By the time you read this, the Quality Assurance, Standards and Protocols (QASP) subcommittee of the Iowa EMS Advisory Council will have reviewed the public comments on the Iowa implementation of the National Scope of Practice Model. Over 100 comments were submitted between April 16 and June 25. It is clear that the Iowa EMS community is passionate about the transition and devoted to serving Iowans. Visit www.idph.state.ia.us/ems to read the public comments.

## SPI Hosts CAAS Onsite

On June 5 and 6, the CAAS consultants combed through volumes of records at SPI in Sioux City to verify the information submitted was accurate and in common practice at the agency. CAAS team leader Barry Mogil, a retired EMT, dispatcher, and EMS administrator from Pinnelas County Florida, visited the communications center and interviewed the billing center and field supervisors. Barry said, "SPI does about the same number of dispatches annually as our company in Florida does in one month. Yet, I see the same well-organized approach to tasks." Dr. Charles Cady, Assistant Professor for the Department of EM at Froedtert Hospital in Milwaukee, WI and Medical Director for the Kenosha, Wisconsin FD interviewed Quality Manager, Jeff Anderson and medical director, Dr. Gary Carlton. Shannon W. Stephens, NREMT-P, Clinical Research Coordinator for the Department of EM at the University of Alabama, examined fiscal data and interviewed the office manager and training officer, John Jorgensen. The entire team inspected ambulances, equipment, protocols and interviewed staff.

"This is the fun part," said Jim Haden, CAAS coordinator for SPI. "This is where we see how well we have done. We dove into these standards over a year ago. We have been working very, very hard to make improvements to meet these ideals. We found we needed to improve our documentation of activities and processes. The hard part will be waiting until October to see if we will be officially accredited."

All the reviewers spent time with SPI Operations Manager, Terry Stecker. "The company has made a significant financial commitment to this process, including assigning and in some cases adding staff to make sure we can accomplish and maintain these standards in quality and education. This has been a real education for all of us. We have involved the entire company in this effort. I am proud of them all," said Terry.

641—132.7 (147A) Service program—authorization and renewal procedures, inspections and transfer or assignment of certificates of authorization.
132.7(1) i. Service programs that acquire and maintain current status with a nationally recognized EMS service program accreditation entity that meets or exceeds Iowa requirements may be exempted from the service application inspection process. A copy of the state service application and accreditation inspection must be filed with the department for approval.

CAAS reviewer Stephens said, "We are happy to see that the Bureau of EMS recognizes CAAS accreditation as exceeding the state minimums. To have that acknowledgement in Iowa law and have staff present for the visit is clear evidence of the State of Iowa's commitment to excellence in EMS."

Providing they are accredited, SPI joins an elite group of 114 ambulance services in the US and Canada and only two others in Iowa. Medic EMS in Davenport and West Des Moines EMS proudly display the CAAS seal on their ambulances.

## And finally...

Our hearts go out to all Iowans who are suffering due to the wrath of Mother Nature. Even with all the destruction it is easy to see that we live on the sweetest spot on the planet. The EMS and Public Health immediate response to assist those in need was nothing short of overwhelming. As the recovery phase drags on we urge you to continue your efforts to help. This is gonna be a long one. ■

# 2008 Star of *Life* AWARD RECIPIENTS

## BRIAN J. JACOBSEN, NREMT-P

**L to R:** Brian Jacobsen and Brian Arnold with U.S. Senator Grassley

When I was young, I sat and watched Johnny and Roy save citizens of L. A. County in the TV show "Emergency" on Saturday evening right before bath time. That show was the inspiration for me to become a paramedic. The year was 1972 and in no way did I expect that 36 years later I would be in Washington, D.C. to receive the prestigious "Star of Life Award," a 20-plus year paramedic and the coordinator of a fire-based EMS service that responded to over 8,000 EMS requests for service in 2007.

Washington, D.C. was a very fitting location for the 2008 "Star of Life" award ceremony and conference, sponsored by the American Ambulance Association. From all corners of America, and the world for that matter, 108 deserving individuals gathered to honor each other as exceptional EMS personnel. What was incredibly humbling about the whole event is that for every person who was honored, there were many more personnel back in our home towns answering calls for service, who were just as deserving as the 108 "Stars" who were present.

I was sponsored by IEMSA as the "Career Provider of the Year." Nominated by my employer, Davenport Fire Department, for my work within the EMS community, I traveled to D.C. knowing that I would be rubbing shoulders with some great EMS providers. Each one of the award recipients had a unique story to be told, one of heroism, excellence or unselfish giving to the community they served.

Along with being honored by the industry that we devoted our careers to, a rare opportunity was given to carry important messages to our nation's lawmakers. The American Ambulance Association arranged for meetings with elected officials from our area to discuss the importance of Medicare Ambulance Relief. Medicare average payment per transport is 8% below the average cost per transport. This figure and the 6% from the GAO report does not include the Medicare share of uncompensated care or bad debt on Medicare beneficiary co-pays and deductibles, and assumes no margins for providers to finance capital improvements in technology, communications systems, equipment and facilities, and further assumes no reserve capital for responding to a natural disaster or terrorist attack. The dollar amount also did not include the 50% increase in the cost of diesel fuel that all services have encountered.

The other message carried to elected officials was the importance of extending the public safety death benefit to include EMS providers from all ranks of service, not just the public sector.

Both of these messages were well received by the Iowa Senators that I had the privilege to meet with, Senators Chuck Grassley and Tom Harkin.

I sincerely appreciated the experience provided by the Iowa EMS Association. ■

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*Continued from page 14*

each with four or five EMTs and a driver. We opted to do this so that each crew has a little padding, with summer schedules in full swing. We have temporarily lost many of our crew members due to their homes being destroyed, and they are living away from Parkersburg. Two of our crew members have other major responsibilities with the recovery effort, and we are not asking them to respond at this time. Another member is now the acting crew chief, and I'm his assistant. We ask for input from the others, and then make the best decisions we can. Everyone has stepped up!

**Stressed Again** We've had a couple of rough stretches, including last weekend. Five calls in 24 hours – a new record for our Service. These calls included three cardiacs, a motorcycle (without a helmet) versus deer, and a double brain aneurysm. Not only were these calls stressful to our crew members, it also personally affects one of our members – she's the mother of the brain aneurysm patient. We're also looking at crew members leaving on vacations (which we all need to do!), so our daytime coverage is again critical. Thanks to our Paramedic Guardian Angels at Sartori, we will be doing a dual-paging system for the days that we are short, and will act as First Responders only. We thank Sartori for everything they have done for us this past month. We couldn't have done it without them!

**Hopeful** Although I still hope to wake up from this bad dream, and want to see Parkersburg as I did on May 24, I do continue to see progress! There are homes going up. The lumberyard is rebuilt and open for business. Kwik Star has the new footings poured for the foundation, etc. There are still piles of debris everywhere, but hopefully they will be gone within a month or so. Plans are being made with the school to rearrange classrooms, etc. The football players are lifting their weights in a newly remodeled barn just on the outskirts of town. We will get stronger! We will rebuild! We will survive!

**Sincere Gratitude** How can I ever say thank you to all of you? I received so many emails and phone calls! Every time I turned around I saw a familiar face!

To Merrill, Thomas and Lou – you are my guardian angels!

Whether you were here for EMS, fire, law enforcement or just because, thank you!

And now, as I sign off, I ask that you all continue to pray for our recovery. We need your support and prayers now more than ever, as each day gets a little longer and a little harder in this very long rebuilding process!

Sincerely yours,
Tammy Fleshner
Parkersburg Ambulance Service ■

# Spotlight on Training

KRISTI BROCKWAY

Northeast Iowa Community College in Calmar is located in the scenic Upper Iowa River valley about 10 miles south of Decorah on Hwy 150 South. NICC has served thousands of people who are interested in joining the Emergency Services or Fire Fighting fields. NICC is responsible for EMS courses in the Allamakee, Winneshiek, Clayton, Fayette, and Chickasaw counties under the Medical Direction of Dr. David Schwartz from Veterans Memorial Hospital in Waukon. We invite you to explore the opportunities that await you as we offer exciting emergency courses to enhance your employment and improve your well-being. Over 40% of all Northeast Iowa Community College graduates are nurses, police officers, EMT's, firefighters, and other vital community personnel.

Kristi Brockway, Northeast Iowa Community College Emergency Services Program Manager states, "The college strives for success for all EMS students, provides an EMS educational environment that values excellence and innovation, strives to establish lasting EMS partnerships that benefit students, and we engage in ongoing planning and assessment to respond to advancing technology in the healthcare field." Northeast Iowa Community College in Calmar offers courses such as initial First Responder, EMT-Basic, and EMT-Intermediate, top of the line continuing education sessions that meet the needs for all providers, an EMS conference, and instructor training. Located in rural Northeast Iowa, the college brings classes to area EMS or Fire Departments. Most EMS personnel in the area are volunteer first responders and EMT-Basics who have received their training from Northeast Iowa Community College. With three hospital-based Paramedic Services in the area, the local community is well served for any emergency.

If you are interested in registering for a course or want to inquire about our EMS programming, please call Kristi Brockway at 1-800-728-2256 ext 225, or email her at brockwak@nicc.edu. Come and explore what NICC has to offer. ■

NORTHEAST IOWA COMMUNITY COLLEGE

## 2008 IEMSA Award Nomination Form

**INDIVIDUAL:** ☐ Volunteer ☐ Career

**SERVICE:** ☐ Volunteer ☐ Career

**INSTRUCTOR:** ☐ Full Time ☐ Part Time

**FRIEND OF EMS:** ☐

**HALL OF FAME:** ☐

**Nominee's Name:** _____

Address: _____

City/State/Zip: _____

Phone: _____

Certification Level & Number: _____

**Nominator's Name:** _____

Day Telephone: _____

Evening Telephone: _____

Mail Nomination Form and Letter of Recognition/Nomination to

**IEMSA Awards**
2600 Vine Street, Suite 400
West Des Moines, IA 50265

Or Fax to 515-225-9080

**Deadline: September 19, 2008**

## Board Seat Nomination Form

Return to the IEMSA office by NOON on September 17, 2008

☐ Regional Representative Nomination ☐ At-large Nomination

**Nominee's Name** _____

Company/Service _____

Address _____

City/State/Zip _____

Phone Number _____

**Brief biography of nominee describing EMS involvement**
(50 words or less – use a separate sheet of paper if necessary)

_____

_____

**Nominator's Name** _____

Phone Number _____

Mail to: **IEMSA – Board Seat Nomination**
2600 Vine Street, Suite 400
West Des Moines, IA 50265
Fax: 515-225-9080 / e-mail: administration@iemsa.net

# 2008 IEMSA *Award* Nominations

Do you work with a person who exemplifies what a professional emergency medical services provider should be? Are you proud of the accomplishments made by your ambulance service? Did an EMS instructor have an extraordinary ability to shape your career through his or her teaching? Do you know of someone in your community who supports EMS activities in a meaningful way? If so, now is your chance to recognize these outstanding EMS providers by nominating them for an annual IEMSA award! Read on for a description of each award, which is given at the annual IEMSA Conference and Trade show annually in November.

**Individual** The nominee must be currently certified by the State of Iowa, have strong and consistent clinical skills at his/her certification level, and have made an outstanding contribution to the EMS system either within or outside of his/her squad or service. Award recipients MUST be (or become) an active Iowa EMS Association member. Two awards in the Individual category will be presented – volunteer and career.

**Service** The nominee must be currently certified by the State of Iowa, have made outstanding contribution(s) in the last year to public relations, information and education (PI&E), maintain a positive and outstanding relationship with the community it services and take visible and meaningful steps to assure the professionalism of its personnel and the quality of patient care. Two awards in the service category will be presented – volunteer and career.

**Friend of EMS** Any individual who has made outstanding contribution(s), which enhance the quality of EMS at the local, regional or state level.

**Hall of Fame** Any individual who has made outstanding contributions to EMS during longevity in the field (10+ years). This individual may be someone to recognize posthumously. This will be an ongoing plaque displayed in the Association Office.

**Instructor** Any individual who instructs and/or coordinates on a full-time or part-time basis; has dedication to EMS through instruction, number of years in EMS and/or number of years instructing EMS. Two awards in the Instructor category will be presented – full time and part time.

Winners of these prestigious awards will be announced on the eve of the first day of the conference, just after the annual Board of Directors' meeting. Each award winner will receive a plaque to commemorate their achievements and will be recognized in The Voice. Winners of the Hall of Fame award will have their name engraved on a permanent plaque that is displayed at the IEMSA office (when it is not being displayed at the IEMSA booth). Winners of the Individual of the Year awards will be sent to the AAA Stars of Life program in Washington, D.C.

In order to nominate a person or service for one of these awards, you must **1)** complete the Award Nomination Form, **2)** include a letter of recognition/nomination and **3)** submit your nominations to the IEMSA office any time between now and September 19, 2008.

Don't miss this opportunity to recognize excellence in EMS! ■

## BOARD NOMINATIONS *Requested*

It is time to consider your At-Large and Regional representatives to the IEMSA Board of Directors. The regional representatives elected will serve two-year terms beginning in January, 2009. Those board members, whose terms expire in December, 2008 are as follows: Thomas Craighton, NC region, Rick Morgan, NE region, Terry Stecker, NW region, Jon Peterson, SC region, Tom Summitt, SE region, Bill Fish, SW region, Jan Beach-Sickels, SW region, Dan Glandon At-Large.

### Nomination Process Requirements & Guidelines

The nominee must be an active member of IEMSA. Nominations can be submitted by using the format provided (*see page 18*). Nominations must be received in the IEMSA office by **September 17, 2008 at noon.**

Upon receipt at the IEMSA office, the nominations will be checked to ensure compliance with the nomination process. The nominee's membership status within the association will also be verified.

Successful nominations will comprise the final ballot, which will be made available on the IEMSA web site (Members Only Section) on October 1, 2008. Voting will cease on October 31, 2008. Detailed instructions will be provided on the ballot. Should you require a paper ballot, please contact the IEMSA office by calling Angie at 515-225-8079.

We urge all members with an interest in becoming involved with their professional organization to consider nomination. Please complete and return the At-Large/Regional Nomination Form by September 17, 2008.

*Your involvement truly makes a difference!* ■

## HONORING OUR OWN *2008*

TOM SUMMITT, COMMITTEE CHAIRMAN

Please join us for Honoring Our Own 2008, a moving service honoring volunteer and career EMS/Fire personnel from Iowa who are no longer with us.

If you know of someone who has died within the last 10 years and was part of our "family," please plan to include them in this year's presentation. Please indicate whether or not the death was in the line of duty. Please remember, it does not have to be line of duty death to be featured on this presentation. Any service wishing to be featured in the Honoring Our Own video can also email Tom to discuss the details. Please mail a photo and this information to Tom Summitt, Honoring Our Own, 1718 Timberline Drive, Muscatine, Iowa 52761. You may also scan and email the photo to: tcsummitt@machlink.com. Please note "Honor Our Own" in subject line. If you have any questions, please contact Tom at 1-563-506-0103.

If you have never seen our presentation at the Iowa EMS Conference, please plan to attend the next one at the 2008 Annual Conference. It is a beautiful remembrance of a precious life that once served Iowa EMS.

*Please note that due to a computer crash anyone who has already submitted information to Tom Summitt will need to send the information again.* ■

## JUST AROUND THE *Corner*

JEFF DUMERMUTH, CONFERENCE CHAIR

With summertime in full bloom, it's hard to imagine that the annual IEMSA conference and trade show is just around the corner. Too soon, the long, hot summer days will turn into the cool fall. We hope that many of you will make the trip back to Des Moines for what promises to be another great opportunity to get some high quality pre-hospital education, network with other EMTs and Paramedics, and have some well deserved fun.

We have a great line up of speakers this year, bringing back Baxter Larmon at your request. We also are excited to have John Politis back to Central Iowa for his dynamic lectures. Several other national and regional speakers have also been contracted for the event: Dr. Keith Wesley – WI, Brian Donaldson – NE, and Melissa Sally-Mueller – FL.

Six pre-conference sessions are bound to offer something for everyone. We will bring back our popular CCP track, Management track, Physician Track, Education Track, a 12-Lead course, and an Iowa Stroke Task Force Train-the-Trainer Course. In addition, Central Iowa Service Directors will present a Volunteer/Paid On Call Management track.

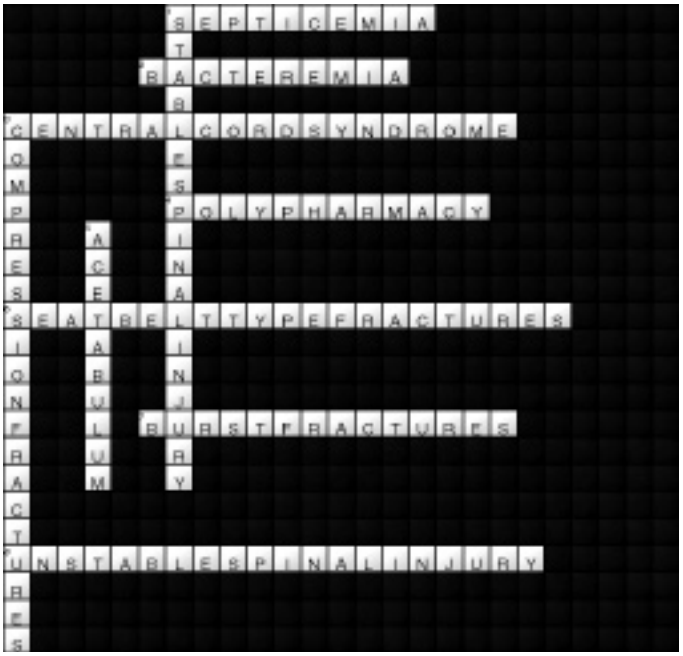
Again this year, we will offer our participants the option of whether they purchase their meals or not with their conference registration. Food is by far the largest expense for this conference and by doing this we reduced costs by $10,000 dollars last year. Several other enhancements have been made for this year, so review your registration brochure very closely.

Rooms fill up quickly at our host hotels; consider making your registration today.

The entertainment committee is working hard to assure you have a good time while in Des Moines. Watch for the details of our EMS Parties both Thursday and Friday evening.

Enjoy the rest of summer and we look forward to seeing you very soon. ■

## CROSSWORD SOLUTIONS




# Corporate Profile

## ALLMED

Founded in 1986 by Larry Dahl in Russellville Missouri, AllMed® has grown steadily over the past 22 years. Since then, AllMed has evolved from a one-room operation to become a major national distributor of EMS and rescue equipment, uniforms, and supplies.

At AllMed, you'll find a staff comprised of several trained Paramedics, EMTs, Firefighters, and Public Service professionals. They pride themselves on an educated, knowledgeable customer care and sales team that can provide the highest levels of customer service.

In July of 2008 AllMed opened a brand new, state of the art distribution center in Jefferson City, Missouri. This new facility enables them to operate even more efficiently, giving customers more accurate and faster shipments.

AllMed has always encouraged the development of strong statewide and local associations. They do a wonderful job representing the interests of the EMS and Fire organizations throughout their given states and they feel honored to be a partner in this effort.

For more information, please feel free to visit their website, www.AllMed.net or give them a call at 1-888-633-6908. They will be more than willing to answer any questions you may have about products and services available to you. ■

AllMed®

**You can provide an extension of care to families when a life is lost at the scene of an accident or a death at a home.**

**Referring scene deaths to Iowa Donor Network is easy and fast.**

**Your referral gives us the opportunity to honor the decedent's wishes via the Iowa Donor Registry or the opportunity to provide the family with donation options.**

**Help us save and enhance the lives of Iowans needing transplants.**

**Referrals calls are exempt under HIPPA and allowed by Iowa's UAGA law.**

**Call 1-800-831-4131 for referrals.**

IOWA DONOR NETWORK

## CALLING FOR EMTS IN ACTION

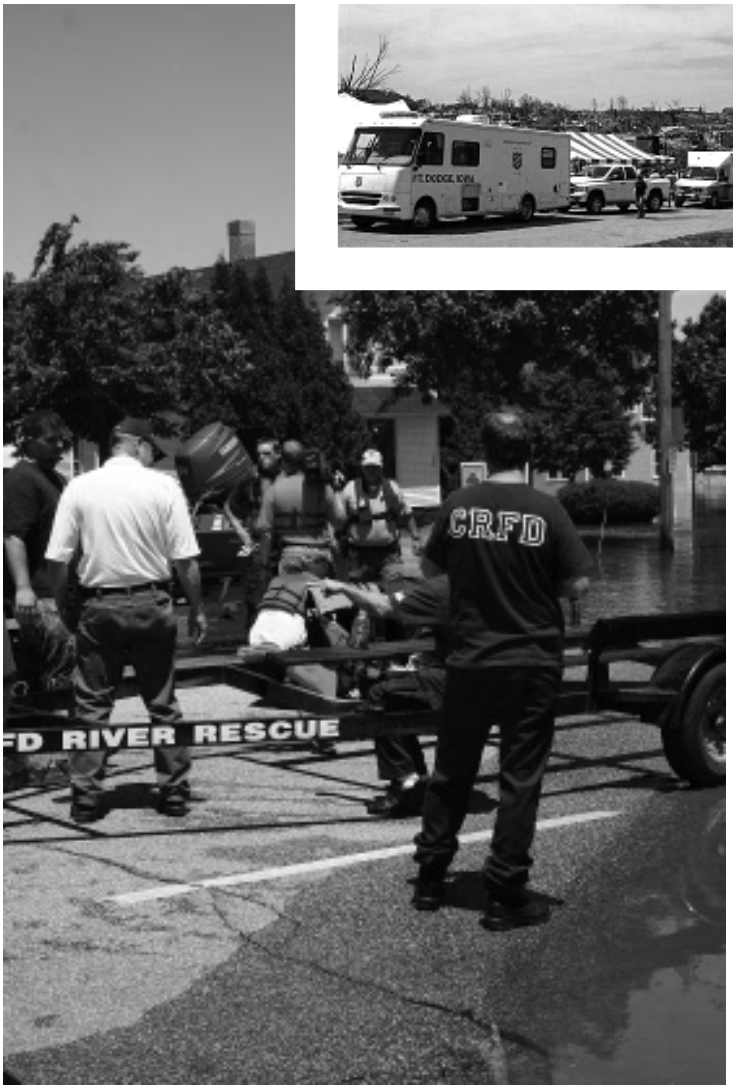
Please email your EMT action photos to **communications@iemsa.net.**

**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@iemsa.net regarding your interest in this project.

# EMS Providers In Action

## GIVING THEIR ALL...






# Affiliate Profile

## ALGONA AMBULANCE SERVICE

Prior to the Algona City Council adopting a resolution to establish an ambulance service on July 12, 1967, the community was served by one of the local funeral homes. When a call would come in where a transport was needed, one of the local black cars would hurry to the scene with whoever was available.

Algona Mayor William Finn was named administrator of the new service, and Kossuth County agreed to pay $400 a month to help with the maintenance cost. According to the Algona Kossuth County Advance, the city agreed to purchase, maintain and operate the ambulance for Algona and for other communities in Kossuth County that might need the service. A purchasing committee was entrusted with the duty to purchase an emergency vehicle and equipment with a $5,000 limit.

The initial volunteer service headed up by Finn consisted of 12 men who had at least 20 hours of first aid training. To avoid any conflicts, the ambulance personnel would be independent of the fire and police department.

What a difference more than 40 years have made. Currently, the Algona Emergency Medial Service is a combination volunteer service with two full-time paramedics, one specializing in critical care and the other a paramedic specialist.

Volunteers include a nurse exempt, five PRN paramedics, seven EMT-Is, 16 EMT-Bs and 17 drivers. While a provisional paramedic service, the crew strives to have at least one paramedic available at all times.

Another change over 40 years has been the type of training needed to volunteer for the service. In 1979, the city reimbursed nine volunteers for the cost of an Emergency Medical Technician class. Currently, all volunteers are CPR certified while the ones working directly with patients need to be at least an EMT-B. The overall result has been better patient assessment and care.

Originally, the service was homeless and held its meetings at city hall while the ambulances were stored in a secured lot next to the police station. In 1981 the council allotted $4,400 to build a garage. In 1985, the ambulance service had taken control of the old Algona fire station. The building, however, needed a new roof, heating system and new garage doors. These problems plagued the service until 1995 when a new, four-bay EMS facility with offices, a TV and lounge area, two sleep rooms for volunteers on call and a large conference room was constructed in collaboration with Kossuth Regional Health Center.

From the humble start as a hearse, the Algona ambulance has seen numerous equipment changes. The service currently uses four LifeLine ambulances with its newest one purchased in 2008.

In September 1986, as part of a University of Iowa study, the service purchased an Automated External Defibrillator, and each member of the crew received eight hours of training to be certified in its use. Within the first month, the AED was used to make a positive difference in someone's life.

Now the service uses the Zoll E series biphasic defibrillators and is one of the first rural services in northern Iowa to use the Zoll AutoPulse, an automatic cardiopulmonary resuscitation machine that makes CPR during the long runs from a rural community in Kossuth County to the hospital a safer, more effective procedure.

The two AutoPulse machines used by the Algona Ambulance Service were not paid for out of its operating budget. Instead, the community raised $23,000 in less than two years to pay for the equipment.

"That's how supportive our community is," explained current Algona Ambulance Director Russ Piehl, a critical care paramedic. "We could not provide the service we do without the support of our volunteers, their employers, their families and the residents of Kossuth County."

The service became an affiliate member of the Iowa Emergency Medical Services Association in 2003. In 1996, the service had 581 calls. In the 12 months proceeding June 2008, the service responded to 866 calls. The average time from the first page to being en route to the patient is 4.3 minutes.

It's not just emergency calls for the service. The ambulance volunteers assist with the Kossuth County Fair, A.B.A.T.E. Freedom Rally, Farm Safety Camp, teaching first aid and CPR classes to the community and providing infant car seat inspections. Additionally, the service has either participated in or helped with several disaster drills to prepare local volunteers for multi-stage events, including a packed school bus accident and a gas leak/gunman situation at a local ball park. Recently, several of the service's volunteers responded to a call for assistance by the Parkersburg ambulance service after a tornado destroyed more than half of the town in a category EF5 tornado on Sunday, May 25.

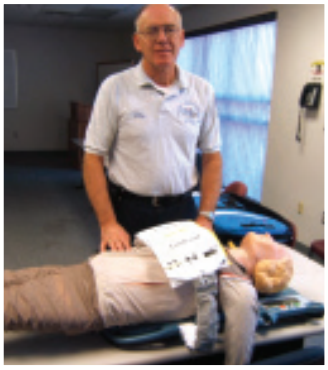
As the smaller communities in Kossuth County struggle with the fact that many of the residents are aging while the younger residents needed to run the local ambulance service also need to look for work out of

# In *Action*

## ALGONA AMBULANCE SERVICE

town, the Algona Ambulance Service strives to fulfill its mission to provide the highest level of care, compassion, concern and education for the community of Algona and all of Kossuth County. Its goal is to be able to provide the most up-to-date, advanced treatments for its patients, as well as to continue to grow as a service for the betterment of Algona and Kossuth County.

As a result, the Algona Ambulance Service has found itself increasingly assisting with coverage in LuVerne, Burt and Wesley, a coverage area of 286 square miles, while the service also provides Advanced Life Support tiered response for all of Kossuth County's 980 square miles. ■



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