IEMSA

July – September, 2010

# VOICE

A VOICE FOR POSITIVE CHANGE IN IOWA EMS


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Iowa Emergency Medical Services Association

# Join IEMSA Today!

**Membership**
Individual Active Membership

■ One Year Renewal **$30.00**

A resident of the State of Iowa and/or an individual who is currently associated in providing emergency medical care within the State of Iowa who pays annual dues is eligible to become an Active Member of the Association. Only Active Members may be elected to the Board of Directors.

*Become an IEMSA member today and take advantage of the discounted conference pricing!*

## IEMSA Individual Membership Application Form

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City*, State, Zip

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Daytime Phone* Fax

_____
Email (very important to keep you updated)

_____
Certification Level (i.e. EMT-P, RN, etc.)

_____
Certification # / RN#

_____
Certification Expiration Date*

**required information to establish an IEMSA membership*

**Please Check All That Apply**
☐ Volunteer ☐ Career ☐ Both ☐ Other
☐ Full-Time ☐ Part-Time ☐ Urban ☐ Rural

**Method of Payment**
Payment must accompany this application form. Make checks payable to IEMSA and mail with this form to:
IEMSA
8515 Douglas Avenue, Ste. 27B
Urbandale, IA 50322
or Fax to 515-225-9080

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Authorized Signature

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VOICE

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**IOWA EMERGENCY MEDICAL SERVICES ASSOCIATION**
8515 Douglas Ave., Ste. 27B • Urbandale, IA 50322

# 2010 IEMSA Conference HIGHLIGHTS

**By JEFF DUMERMUTH, CONFERENCE CHAIRMAN**

The Iowa Emergency Medical Services Association Conference and Trade show is scheduled for November 11-13 back at the Des Moines Convention Center. This year's conference is sure to bring not only high quality education but excellent opportunities to network with EMS providers throughout Iowa.

The exhibit hall is filling up fast and will provide our attendees with opportunities to see, hands on, the newest equipment available for the delivery of pre-hospital emergency care. Entertainment events will give us the opportunity to wind down after a full day of education — with no responsibility for responding to pagers!

This year, our conference will feature five national speakers. Making his first visit to IEMSA, David Gurchiek is currently the Paramedic Program Director at Montana State University as well as an EMS author and educator. Returning after previous engagements and great reviews are Bill Justice, a Firefighter/Paramedic from Oklahoma City; Chief Bruce Evans from the North Las Vegas Fire Department; Chief Jon Politis from the Town of Colonie, New York EMS Department; and Lisa Hollett, R.N. Acute Care, Critical Care Surgery and Education Program Manager at Penn State Milton S. Hershey Medical Center in Pennsylvania. These speakers will mix with many of your local and regional favorites to fill three exciting days of education.

The Des Moines Marriott and the Savery Hotel continue to be our featured conference hotels and get booked up quickly. Call soon to make your reservations.

Look for the conference brochure to be out in just a few weeks, and continually monitor www.iemsa.net for up-to-date information. ■

## 2010 IEMSA MEETINGS

**2010 Board Meetings:**
The IEMSA Board of Directors will meet either in person or via teleconference on the following dates from 1:00-3:00 p.m. unless otherwise noted.*

- **August 19**
  Teleconference
- **September 16**
  West Des Moines
  EMS Station 19
- **October 21**
  West Des Moines
  EMS Station 19
- **November 11***
  *Annual Meeting*
  Polk County Convention Center
- **December 16**
  Teleconference

**Additional Important Dates:**

**November 11 – 13 , 2010**
IEMSA 21st Annual
Conference & Trade Show
Polk County Convention Center
Des Moines, IA

**Meeting time to be announced*

## 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.

# A Message from the President

JOHN
**HILL**
EMT-PS,
IEMSA President


## Changing of the Guard

Once upon a time, a group of eager EMS providers discussed what they thought the organization of The Iowa EMS Association should look like and how it should function. Seems like yesterday, but there were lots of miles and lots of discussion that has happened. The result was an organization that has become a voice that represents EMS in Iowa, whether you are a member or not. We used to worry about making it to the 1,500 member mark, and here we are thinking of whether or not we will make 2,500 some day down the road.

So what do we need to do to keep this organization moving forward? Of course, my first comment is active membership. We also have two areas in which the membership needs to sit up and pay attention. One is leadership mentoring and the other is quality education. We need providers to realize that they, too, can be leaders even though they have no experience and are not quite sure what it takes. The best way to do that is quality leadership training and a good mentoring program. That is how most of the leaders of today did it. I must admit, I was both excited and scared to death when I learned I would be taking over the IEMSA presidential position. Many thoughts ran through my head such as would I make everyone mad at the things I tried to do, would I not do enough or be too bossy? Well, I hope that the past four years speak for themselves and that I have made you think a lot and maybe even laugh a little at some of the things I have done, especially when I have made some controversial statements and/or decisions. Certainly, I have been blessed to work with a very gifted, talented and dedicated board. No one expected me to know how to do everything in the beginning, and I certainly had no idea of the ride I was about to endure. I must say, however, I have had great support from other leaders, past and present, as well as scrutiny from others. Not only has this been one of the greatest experiences of my life, but also one of the most educational.

> "As I come to the end of my last term as president, I have **nothing but praise** for the EMS providers of this great State."

As I come to the end of my last term as president, I have nothing but praise for the EMS providers of this great State. People often say volunteerism is dying. Obviously they haven't looked at EMS providers in Iowa. Whether you are into EMS full-time or as a volunteer is irrelevant. We all have the same mission in sight. Iowa has experienced many changes over the years — some good and some not so good, but that is what has made Iowa EMS a leader in providing quality care. We have the opportunity to try things, collect data and move more toward evidence-based quality care. Has everything we have attempted to do been successful? No, probably not, but at least we have been fortunate enough to be able to try new things. I encourage all of you to remember that EMS in Iowa five to ten years from now will only be as good as we make it. We are the ones providing input into decisions being made about EMS. These things don't happen by themselves, so being active in local and state EMS associations is how we shape our own future. Please keep the momentum going.

I look forward to working with whomever the new IEMSA president will be. I will treasure my experience and lessons learned as the president of IEMSA for many years to come. I want to thank the Board for the opportunity to work with such dedicated individuals. I also want to thank the membership for your support of IEMSA.

Please stay safe, and I hope to see you all at our annual conference in November. ■

# Welcome *New* IEMSA Members!

MAY **2010** — JUNE **2010**

**AFFILIATES:** Clearfield Rescue

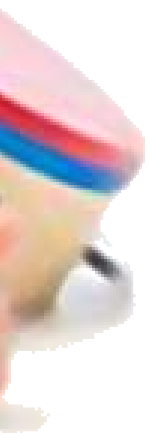
**INDIVIDUALS:**
Becky Barner
Michael Brennan
Kathy Connelly
Judi Darling
James Fahrer
Char Franklin
Karen Galema
Neil Galema
Lia Grogan
Janet Hess
Stephanie Hill
Brooke Lenze
Melissa Mayers
Wendy Morris
Michael Potts
Gina Van Brocklin
Andrew Wagner
Carl Walleser
Ricky Welsh
Terisa Winters - Steiber

**STUDENTS:**
Cecily Ambroson
Sarah Barrett
Cortney Bax
Katy Bown
Jordan Brauns
Noah Brown
Mike Buchholz
Paula Buchholz
Christina Butrum
Jamie Clultate
Jenny Drake
Melissa Eiklenborg
Bradley Fobian
Natalie Ginty
Madeline Godar
Travis Goedken
Mike Heller
Austin Hershberger
Cortney Jensen
Miller Kelsey
Kimberly Marlette
Kelsey Miller
Brown Noah
Kathleen Oneill
Joshua Pappas
Andrew Pettine
Brett Pierson
Clem Primer
Freemont Ron
Chelsea Schroeder
Leon Schwerdtfeger
Mitchell Smith
Jeff Stirling
Julie Thornton
Ben Timmer
Alicia Villareal
Tanner Wallen
Carrie White
Eric Wilson
Jake Yahn

# SHAKE, RATTLE & ROLL

## Fever & Seizures in Children

By **JEFF MESSEROLE | EMT-P | PALS REGIONAL FACULTY**



This article is dedicated to my son, Jordan. His seizures helped me better understand an affliction as old as medicine itself, and yet still in about six out of 10 seizures the cause is unknown. Having responded to my own home for a 911 call for a child having a seizure, I can tell you there is nothing more frightening than finding your child unresponsive, frothing at the mouth while convulsing and not knowing why it is occurring, or what exactly should be done to resolve it. For this reason, we will answer some of the most common questions concerning the causes, the assessment of, and the treatment for seizures in children.

## What is the cause of a seizure?

A child's brain contains billions of nerve cells (neurons). They communicate with each other through electrical charges that fire on and off in a random fashion. When some or all of these neurons begin to fire together, a wave of electrical energy travels through the brain. This massive uncontrolled discharge (MUD) of neurons causes the seizure. Several factors determine the type and seriousness of the seizure and include whether the discharge is limited to a small portion of the brain or both hemispheres, as well as length and frequency of the MUD. Fortunately, most seizures are short lived and often are over by the time the EMS provider arrives. Most simple, one-time seizures do not require medical intervention, but repeated seizures without rest, known as status epilepticus, are a true life and death emergency. Seizures can be a sign of something more serious. Further assessment beyond the seizure is required to find a treatable cause. Whatever the cause, the treatment for the more serious types of seizures is similar. During this MUD of neurons, it should be noted that the brain's use of both oxygen and sugar increases and can lead to hypoxia and hypoglycemia.

Seizures can occur any time the brain is injured, irritated or deprived of nutrients. The causes can be divided up into those that occur in the head, those that occur outside the head and those with no known cause, also known as Idiopathic. (*See Table 1 for common causes of seizures.*)

## How prevalent are seizures in children?

Seizures are a common childhood neurological disorder. Approximately four to 10 percent of children have a seizure for no known reason and without recurrence. Each year, about 150,000 children and adolescents have their first seizure, and 25% of them are found to have epilepsy, 25% are found to have a treatable cause, and 50% remain unknown or idiopathic.

## Are there different types of seizures?

A seizure occurring for the first time is just that — a seizure and a sign of something more serious. A child having one or two seizures early in life is not considered an Epileptic. Seizures can be Partial. Partial seizures begin with a focal onset, meaning those neurons discharging are limited to only one part of the brain. Partial seizures can further be divided into Simple and Complex. Seizures can also be Generalized, meaning that all the neurons of both hemispheres of the brain are involved and can further be divided into categories describing the outward appearance of the seizure. Those categories include Absence, Tonic/Clonic, Atonic, or Myoclonic.

## What is status epilepticus?

While several definitions of status epilepticus exist, the following are considered acceptable in defining this life or death emergency. A seizure lasting more than 30 minutes, or a series of seizures lasting more than 30 minutes without regaining consciousness between the seizures, are considered status epilepticus. Some experts would advocate shorter time frames. Status epilepticus carries a 30% mortality rate, and the longer the seizure activity persists, the more likely the development of serious life threats like hypoxia, hypoglycemic, as well as a host of other metabolic problems associated with all the violent, excessive muscle activity. Aspiration, bodily injury, or cardiac arrest can also occur with status epilepticus, making it a true life or death emergency. Status epilepticus requires aggressive airway management and the administration of anti-seizure medications at higher than normal doses to stop the seizure activity.

## What are the signs and symptoms of a Seizure?

Diagnosing a type of seizure is difficult and requires a close observation and description of the muscle activity during the seizure. If the seizure activity has ceased before your arrival, the signs and symptoms may be subtle and include things like incontinence of urine and/or feces, tongue biting, a state of embarrassment, panic or fear, or a postictal state of consciousness where the child would rather rest or sleep than stay awake to answer questions.

Partial seizures may cause periods of automatic, repetitive behavior and altered consciousness. The behaviors may be like wringing of the hands, buttoning and unbuttoning a shirt multiple times, and are often not remembered.

Simple partial seizures begin in one part of one hemisphere and do not affect the level of consciousness. The simple partial seizure may consist of any task the brain is capable of doing, such as the jerking of just one extremity or hand or finger, abnormal sensation of one part of the body, flushing of the skin, nausea, an intense fear, hallucinations or a feeling of deja-vu.

Complex partial seizures begin in one part of one hemisphere and do affect the level of consciousness. There usually is an aura followed by confusion, or an intense fear or laughter, or hallucinations, or a feeling of deja-vu, which is accompanied by lip smacking, fumbling, wringing of the hands or fluttering of the eyes, or unconsciously walking or running. The aura preceding a seizure is thought to represent an initial symptom produced by seizure activity and is often described as a foul odor or taste. Complex partial seizures last several minutes and are accompanied by a postictal state and the child appears awake during the seizure. They are often mistaken for a psychotic event because of the bizarre behavior exhibited during the seizure.

Both simple and complex partial seizures may spread and involve both hemispheres resulting in a generalized tonic-clonic seizure.

General seizures involve both hemispheres of the brain and may cause a loss of consciousness. They are categorized by the type of muscle movements involved and include Absence, Tonic, Tonic/Clonic, Myoclonic, and Atonic. With limited space, we will focus on the Generalized, Tonic/Clonic seizures as they are the reason for the 911 call, and if allowed to continue, can lead to a serious life threat.

**Table 1 COMMON CAUSES OF SEIZURES**

| Causes | Examples |
|---|---|
| Intrinsic Central Nervous System Disorders | Brain tumors, lesions, cysts, CVA, head injury |
| Infections / Infectious Diseases | Meningitis, encephalitis, otitus media, |
| Extrinsic / Metabolic Disorders | Hypoxia, hypercapnea, hypoglycemia, hyperglycemia, liver or renal failure, electrolyte imbalances, failure to take seizure medication, fever |

A generalized Tonic/Clonic or "grand mal" seizure describes the type of muscle activity seen with this type of seizure. Tonic refers to continuous stiffening of the extremities and Clonic refers to the rhythmic jerking of the muscles. Tonic/Clonic seizures are among some of the most frightening and dramatic seizures to witness. The child has an immediate loss of consciousness, may produce a loud cry, fall to the ground and begin this initial stiffening of the muscles followed by the violent rhythmic jerking of the muscles. Tongue biting is common during this phase of the seizure and blood may be seen coming from the mouth. Facial muscles are drawn and fixed to one side, secretions cannot be swallowed, and drooling may be excessive. Tonic/Clonic seizures affect all muscles to include those of respiration. During the stiffening and violent rhythmic jerking of muscles, the child will not be breathing adequately and, depending on the length of the seizure, may become severely hypoxic, hypercapniac, hypoglycemic, as well as a host of other metabolic problems associated with all the violent, excessive, muscle activity. The muscle contractions may be so violent that the child is incontinent of urine and feces, or fractures a long bone. These seizures usually last from three to five minutes, but can last as long as 30 minutes. There is a postictal state following the seizure activity where the child will want to sleep and is difficult to keep awake. During this phase, the child must rest and replenish the stores of energy consumed by the seizure. There is usually no memory of the seizure.

## What role does a fever play in seizures?

Seizures caused by fever are termed febrile, from the Latin word febris, which means fever. Febrile seizures are very common and occur in 3 to 5 percent of all children. One in 25 children will have a febrile seizure before age six, and more than one-third of these children will have additional febrile seizures before they outgrow them. They are rare in children less than six months old and usually are not seen in children older than six years of age. They usually occur within 24 hours of onset of fever. It is not certain whether it is how fast the temperature rises or how high the temperature must get before a child has a febrile seizure. Typical febrile seizures cause Tonic/Clonic motor activity lasting one or two minutes with rapid return of consciousness. Febrile seizures usually occur only once during any given illness. Repeated febrile seizures during the course of an illness point to a more serious illness like encephalitis, an abscess or meningitis, and signs for those illnesses should be sought.

"**One in 25 children** will have a **febrile seizure** before age six, and **more than one-third** of these children will have **additional febrile seizures** before they outgrow them."

Children with febrile seizures have only a 0.9% chance of developing epilepsy. Febrile seizures can be classified as simple, complex, and atypical, and are caused by an infection in children who are otherwise neurologically normal. They are commonly associated with viral infections and vary in length and presentation. Although they can be frightening for parents, the majority of febrile seizures are harmless. During a seizure, there is a small chance that the child may be injured by falling or may choke from food or saliva in the mouth, but generally they are not life-threatening. Instead, the febrile seizure is a sign of something more serious. There is no evidence that febrile seizures cause brain damage. Large studies have found that children with febrile seizures perform as well on intellectual tests as their siblings who don't have seizures. Most children recover completely from even prolonged febrile seizures. Febrile seizures tend to run in families. In a child with febrile seizure, the risk of febrile seizure is 10% for the siblings and almost 50% for the siblings if a parent had febrile seizures, as well. Although clear evidence exists for a genetic basis of febrile seizures, it remains unclear how it is passed on genetically. (*Table 2 lists the risk factors for developing febrile seizures.*)

## Assessment for a seizure includes?

A SAMPLE history — a thorough explanation of what the seizure activity looked like and how long it lasted — is necessary to determine the type of seizure.

**S** – Signs and symptoms include looking for the evidence of seizure activity if the seizure has stopped prior to your arrival. Is there tongue biting? Is the child incontinent of urine or feces? Is the child in a postictal state or is there some other etiology for their unresponsiveness? Head and spine injury may be present if the child fell, and manual c-spine immobilization should be attempted.

**A** – Is the patient allergic to any medications, foods, animals or plants? An allergic reaction may be the cause of the seizure and, as a paramedic, you may give medications should the seizure reoccur.

**M** – Do they take medications for seizures and have they taken them? A common cause for a seizure is noncompliance with medications. Taking the medications often makes them feel no different. Forgetting to take them or a rapid withdrawal will lead to seizures. (*Common antiseizure medications are listed in Table 3.*)

### Table 2 RISK FACTORS FOR DEVELOPING FEBRILE SEIZURES

| |
|---|
| Family history of febrile seizures |
| High temperature |
| Parental report of developmental delay |
| Neonatal discharge at an age greater than 28 days (suggesting perinatal illness requiring hospitalization) |
| Daycare attendance |
| Presence of 2 of these risk factors increases the probability of a first febrile seizure to about 30%. |
| Maternal alcohol intake and smoking during pregnancy has a 2-fold increased risk. |

| Table 3 COMMON ANTI-SEIZURE MEDICATIONS |
|---|
| Phenytoin (Dilantin) |
| Phenobarbital |
| Ethosuximide (Zarontin |
| Carbamazepine (Tegretol) |
| Valporic Acid (Depakote or Depekene) |
| Clonazepam (Clonopin) |
| Clorazepate (Traxene) |
| Felbamate (Felbatol) |
| Fosphenytion (Cerebryx) |
| Gabapentin (Neurontin) |

**P** – Pertinent past medical history to include a history of seizures, epilepsy, febrile seizures, diabetes or recent head injury are important to note and will assist you in establishing a history of seizures or a condition capable of causing a seizure.

**L** – Last oral intake may clue you in to the likelihood of a full stomach and the potential for vomiting. It may also lead you to check a blood sugar in the patient with diabetes.

**E** – Determining what events led up to the seizure activity is important. Did the child complain of an aura? Younger children may not be able to communicate the presence of an aura and may just suddenly run up to the parent or caretaker prior to their onset of seizure activity. Did the seizure start or affect one part of the body more than the others? The establishment of an aura and the seizure affecting only one part of the body defines a seizure with a focal onset as seen with complex partial seizures. A generalized seizure affects the entire brain at its onset and usually begins with no aura. Did the child experience a recent head injury, or is the child diabetic and has taken insulin but has not eaten or has been more active than normal? Has the child been exposed to a toxic substance and is the scene safe? Often times the child is confused or does not remember the seizure, so family members or bystanders may need to be asked these important questions.

A rapid head to toe look for injuries that may have occurred if the patient fell to the ground, experienced violent muscle jerking or tongue biting, is essential following the termination of the seizure activity.

Pulse oximetry should be measured to determine the presence of hypoxia. Generalized Tonic/Clonic seizure patients do not breathe normally during their seizure and, depending on how long the seizure lasts, they may become hypoxic and hypercapniac. Pulse oximetry is of little value and highly inaccurate if obtained during an actual seizure. Pulse oximetry should be reserved for after the seizure activity has stopped.

A blood sugar should be obtained in all patients with an altered mental state. Assuming that the confusion is a postictal state may lead to the hypoglycemia going undiagnosed and untreated.

### What is the treatment for a Seizure?

While most seizures require no special treatment other than close observation, those that alter the level of consciousness or cause severe muscle jerking may need advance level care. The goal of seizure treatment is to stop any active seizure activity, support the ABCs, determine a possible treatable cause, lower the body temperature and assure hypoglycemia does not exist. Treatment for seizures should begin like the treatment of all patients — with the ABCs.

**A** – Secretions are heavy and swallowing during a Tonic/Clonic seizure may not occur, putting the child at risk of chocking and aspiration. Vomiting may also occur if the child has a full stomach after the seizure activity has stopped. EMS providers need to remain alert for the need to suction and place the patient on their side to assist in drainage of secretions. Children in a postictal state may have trouble maintaining their airways. Items should not be placed in the mouth to prevent tongue biting as they may cause teeth to be broken off or cause an airway obstruction. A nasopharyngeal airway is most appropriate to assist keeping the airway open.

**B** – Breathing is inadequate for the duration of a Tonic/Clonic seizure, and administering supplemental oxygen is of immediate concern if hypoxia exists. Assess the rate of breathing as during the postictal state; the child's respirations may be shallow and positive pressure ventilation may be required initially until the postictal state resolves. The need to intubate the child is rare and would be based on respiratory arrest from multiple doses of antiseizure medications or status epilepticus.

**C** – Check the child's pulse as seizures do occur prior to cardiac arrest of a hypoxic or hypovolemic nature. IV access may be difficult during the Tonic/Clonic phase of the seizure, but should be attempted as soon as the activity stops. Arms should not be held down as fractures may occur from the violent muscle jerking.

**Table 4 BENZODIAZEPINES USED TO TREAT SEIZURES**

| Drug | Advantages | Disadvantages | Dose |
|---|---|---|---|
| Diazepam *(Valium)* | ■ Rapid IV onset<br>■ May be given rectally<br>■ Widely available<br>■ Inexpensive | ■ Short duration of about 20 minutes 0.2 mg/kg IM<br>■ Apnea common when given IV<br>■ Irritating to veins | ■ 0.1-0.3 mg/kg IV/IO<br>■ 0.2 – 0.6 mg/kg rectally |
| Lorazepam *(Ativan)* | ■ Rapid IV onset<br>■ Duration of 4 – 6 hours | Requires refrigeration | 0.1 mg/kg IV/IO (not to exceed a single 4 mg dose) |
| Midazolam *(Versed)* | ■ May be given IV, IM, Intranasal<br>■ Rapid onset of action | Short duration of about one hour | ■ 0.1 mg/kg IV/IO<br>■ 0.2 mg/kg IM<br>■ 0.2 – 0.3 mg/kg Intranasal<br>■ (Maximum single dose of 4 mg any route) |

A blood sugar should be checked following cessation of seizure activity. Hypoglycemia may be the cause of the seizure, or the excessive muscle and brain activity during a Tonic/Clonic seizure can expend a tremendous amount of sugar, making the child hypoglycemic. If hypoglycemia is found, an administration of D25 would be appropriate based on the child's weight. D25 can be prepared by mixing D50 1:1 with sterile water or it may be premixed. It can be given at a dose of 0.5 – 1 g/kg IV/IO.

Should the child have a fever, rectal administration of Acetaminophen will reduce the fever. Reducing the fever decreases the seizure threshold in children with Epilepsy and should be a priority.

Should the child seize in your presence or continue to seize, antiseizure medication administration would be appropriate. Benzodiazepines are the first-line drugs of choice and should be administered by IV, and include Diazepam (Valium), Lorazepam (Ativan), or Medazolam (Versed). (*Table 4 outlines the particular properties of each medication.*) Diazepam may be given rectally if IV access is unobtainable by inserting the barrel of the syringe into the rectum about 3 cm and instill the medication. Remove the syringe and hold the cheeks together allowing for the absorption of the Diazepam. Rectal Diazepam may take longer to reach a therapeutic level but will last longer because of continued absorption. DIASTAT® AcuDial™ (diazepam rectal gel) is a gel formulation of diazepam that can be administered rectally, as well. Keep in mind that the use of benzodiazepines may cause hypotension and respiratory depression. Respiratory arrest has been demonstrated with multiple doses of benzodiazepines. Be prepared to assist ventilations should that occur.

Should the child develop respiratory arrest, aggressive airway management is required to prevent cardiopulmonary arrest. The need to intubate children is a highly debated and hot topic in medical circles. Intubating children because you can is not the proper attitude one should have when considering the need for airway management in children. The bottom line would depend on your competency. If you are competent and comfortable intubating children, and they meet these recommended guidelines, then intubation would be appropriate:

- Respiratory arrest after administering anticonvulsants in a child who did not respond to several minutes of bag mask ventilation
- A concern for a rise in intracranial pressure after the seizure activity has stopped as demonstrated by posturing, blown pupil, or recognizable breathing pattern
- Status epilepticus not stopped by benzodiazepines
- Hemodynamic compromise

Successful treatment of seizures is based on supportive care. EMS providers should be able to recognize a seizure has occurred, look for a treatable cause and initiate general treatment for all seizures to include protection of the patient; supporting their ABCs; ensuring adequate oxygenation and supplying oxygen when indicated; determine the presence of hypoglycemia and administer dextrose to correct it; determine the presence of a fever and control body temperature; and, if necessary, administer anticonvulsant medication. ■

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*4. Ralston, M.; Hazinski, M., Pediatric Advanced Life Support Provider Manual, 2006 American Heart Association, Dallas, TX*

*5. Caroline, N; Pollak, A.: Nancy Caroline's Emergency Care in the Street, 6th Edition, Pediatric Medical Emergencies 41: 41.40-41.43; 2008. Jones and Bartlett, Sudbury, Massachusetts*


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- www.emedicinehealth.com/seizures_in_children/article_em.htm
- www.nlm.nih.gov/medlineplus/seizures.html
- www.epilepsyfoundation.org
- www.ninds.nih.gov/disorders/febrile_seizures/detail_febrile_seizures.htm


*Jeff Messerole is an EMT-P who serves as PALS Regional Faculty and Clinical Instructor for Spencer Hospital in Spencer, IA. Messerole was recently recognized by Iowa EMS Bureau Chief Kirk Schmitt for serving three terms as EMSAC's first non-physician chair.*

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

**CLIP AND RETURN**

(Please print legibly.)

Name _____

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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. ☐ | | | |
| 4. | A. ☐ | B. ☐ | C. ☐ | D. ☐ | |
| 5. | A. ☐ | B. ☐ | C. ☐ | D. ☐ | |
| 6. | A. ☐ | B. ☐ | C. ☐ | D. ☐ | E. ☐ |
| 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.*

***Please email the above information along with your answers to:*** administration@iemsa.net.

***If you do not have email access, please mail this completed test to:***
Ginny Richardson-Driggers
IEMSA
8515 Douglas Ave., Ste. 27B
Urbandale, IA 50322

The deadline to submit this post test is
**OCTOBER 31, 2010**

## 10 QUESTION POST-ARTICLE Quiz

**1) Common causes of seizures in children include which of the following?**
- **A)** Hypoglycemia
- **B)** Hypoxia
- **C)** Fever
- **D)** All the above

**2) What percentage of seizures are idiopathic?**
**A)** 25% **B)** 50% **C)** 70% **D)** 10%

**3) Seizures are often a sign of something more serious, and a thorough SAMPLE history may help you find that cause.**
**A)** True **B)** False

**4) A seizure lasting more than 30 minutes, or a series of seizures lasting more than 30 minutes without regaining consciousness between the seizures is called:**
- **A)** Grand Mal Seizure
- **B)** Epilpsia
- **C)** Status Epilepticus
- **D)** Petit Mal

**5) Seizures that begin in one part of one hemisphere and do affect the level of consciousness, often preceded by an aura, followed by confusion, or an intense fear or laughter, or hallucinations, or a feeling of deja-vu, which is accompanied by lip smacking, fumbling, wringing of the hands or fluttering of the eyes, or unconsciously walking or running is called:**
- **A)** Simple Partial
- **B)** Complex Partial
- **C)** Grand Mal
- **D)** Petit Mal

**6) Common anti-seizure medications taken by the patient include which of the following:**
- **A)** Phenytoin (Dilantin)
- **B)** Carbamazepine (Tegretol)
- **C)** Valporic Acid (Depakote)
- **D)** Clonazepam (Clonopin)
- **E)** All the above

**7) The EMS Provider's primary goal of seizure treatment is to:**
- **A)** Determine the cause of the seizure
- **B)** Stop the seizure activity
- **C)** Administer high flow oxygen
- **D)** Protect the patient from injury

**8) The first line drugs of choice for the treatment of active seizures include:**
- **A)** Diazepam
- **B)** Lorazepam
- **C)** Midazolam
- **D)** All the above

**9) Should the child be hypoglycemic the dose of D25 would be:**
- **A)** 0.5 – 1 g/kg IV/IO
- **B)** 1 – 2 g/kg IV/IO
- **C)** 0.5 – 1 mg/kg IV/IO
- **D)** 1 – 2 mg/kg IV/IO

**10) The IV/IO dose of Diazepam for children is:**
- **A)** 0.1 mg/kg
- **B)** 0.2 – 0.6 mg/kg
- **C)** 0.1-0.3 mg/kg
- **D)** 2 – 5 mg

# 2010 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? Do you know a dispatcher who seems to always go above and beyond? 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 each year 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.

Clive Fire — 2006 Career Service of the Year

## 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.

## Dispatcher

The nominee must be currently active as a dispatcher in a primary or secondary PSAP (public safety answering point) and have made outstanding contributions as a member of the public safety team.

## 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 plus years). This individual may be someone to recognize posthumously.

## 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, DC.

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

3) Submit your nominations to the IEMSA office any time between now and October 1, 2010.

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

## 2010 IEMSA Award Nomination Form

**INDIVIDUAL EMS PROVIDER:**
☐ Volunteer
☐ Career

**EMS SERVICE:**
☐ Volunteer
☐ Career

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

☐ **DISPATCHER**
☐ **FRIEND OF EMS**
☐ **HALL OF FAME**

**NOMINEE INFORMATION**

**Nominee's Name:**

Address:

City/State/Zip:

Home Phone:

Work Phone:

Cell Phone:

Certification Level & Number:

**NOMINATOR INFORMATION**

**Nominator's Name:**

Home Phone:

Work Phone:

Cell Phone:

Mail Nomination Form and Letter of Recognition/Nomination to:

**IEMSA Awards**
8515 Douglas Avenue, Ste. 27B
Urbandale, IA 50322

Or Fax to 515-225-9080

**Deadline: October 1, 2010**

## Board Seat Nomination Form

Return to the IEMSA office by NOON on September 24, 2010

☐ **REGIONAL REPRESENTATIVE NOMINATION**
☐ **AT-LARGE NOMINATION**

**NOMINEE INFORMATION**

**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 INFORMATION**

**Nominator's Name**

Phone Number

Mail to:

**IEMSA Board Seat Nomination**
8515 Douglas Avenue, Ste. 27B
Urbandale, IA 50322

Or Fax to 515-225-9080
e-mail: administration@iemsa.net

# BOARD NOMINATIONS REQUESTED

It is time to consider serving on the IEMSA Board of Directors as an At-Large or Regional representative. Representatives who are elected will serve two-year terms beginning in January 2011. Board members whose terms expire in December 2010 are as follows:

- Thomas Craighton - NC Region
- David Johnson - NC Region
- Rick Morgan - NE Region
- Terry Stecker - NW Region
- Jeff Dumermuth - SC Region
- Jon Petersen - SC Region
- Thomas Summitt - SE Region
- Bill Fish - SW Region
- Jan Beach-Sickels - SW Region
- Dan Glandon - At Large

### Nomination Process Requirements & Guidelines

The nominee must be a member of IEMSA whose dues are current. Nominations can be submitted by using the form provided on the left side of this page. Nominations must be received in the IEMSA office by September 24, 2010 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 be verified.

Successful nominations will comprise the final ballot, which will be made available electronically in the Members Only section of the IEMSA web site on October 1, 2010. Voting will cease on October 31, 2010. Detailed instructions will be provided on the ballot. Should you require a paper ballot, please contact the IEMSA office by calling Ginny at 515-225-8079.

We urge all members with an interest in becoming involved with their professional organization to consider serving. Interested members may nominate themselves. Remember to complete the nomination form and submit it to the IEMSA office by September 24. Your involvement truly makes a difference. ■

# HONORING OUR OWN *2010*

Please join us for Honoring Our Own 2010, a moving service paying honor and respect to those 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 during IEMSA's Annual Conference. To do so, you can mail two photos (good quality pictures are a must) to Tom Summitt, Honoring Our Own, 1718 Timberline Drive, Muscatine, Iowa 52761. You can also scan and email the photos to tcsummitt@machlink.com. Please note "Honor Our Own" in subject line and indicate whether or not the death was in the line of duty (it does not have to be a line-of-duty death to be featured in this presentation). Any Service wishing to be featured in the Honoring Our Own video can also contact Tom to discuss the details.

If you have never seen our presentation at the Iowa EMS Conference, please plan to attend the next one at the 2010 Annual Conference. It is a beautiful remembrance of precious life that once served Iowa EMS.

If you have any questions, please contact Tom Summitt at 1-563-506-0103. ■

*Corporate Profile*

# WHEATON FRANCISCAN HEALTHCARE

BY ANGELA BUSKOHL

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

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

Sartori Paramedic Service of Sartori Memorial Hospital was established in 1982 as an EMT Basic Service for the City of Cedar Falls. Within a couple of years, the service became one of the first services in Black Hawk County to become an advanced level service.

In 1997, Wheaton Franciscan Healthcare established ownership of Sartori Memorial Hospital to include the Sartori Paramedic Service. Sartori Paramedic Service continues to provide 911 Ambulance Coverage for the City of Cedar Falls.

Mercy-Oelwein Ambulance Service of Mercy Hospital in Oelwein, Iowa was originally based out of the Oelwein Fire Department. The fire department-based service was staffed with full-time firemen and volunteer EMTs. In 2005, Wheaton Franciscan Healthcare obtained ownership of the service when a request to consider the purchase of the service was received by the City of Oelwein. The Service is now hospital-based from Mercy Hospital in Oelwein.

The ambulance services of Wheaton Franciscan Healthcare-Iowa are at the Paramedic Specialist Level with CCT endorsement.

Covenant Ambulance, staffing three ambulances 24/7, responds to approximately 4,000 requests per year for emergencies, mutual aid, critical care transfers, neonatal transfers and all other types of ALS and BLS requests in Black Hawk and surrounding counties.

Sartori Paramedics, staffing two ambulances 24/7, responds to approximately 3,500 requests per year and provides 911 service for Cedar Falls, as well as requests for mutual aid from surrounding communities.

Mercy-Oelwein Service, staffing one ambulance 24/7, responds to approximately 1,200 requests per year and provides 911 coverage and transport for the cities of Oelwein, Hazelton, Stanley, Aurora and Maynard.

Community Event Coverage — The Wheaton Franciscan Healthcare Ambulance Services maintain a positive public image by providing support to the communities of Waterloo, Cedar Falls and Oelwein. Some of the events they provide ambulance coverage for include, but are not limited to, the following: University of Northern Iowa Dome events — Football, Basketball, Wrestling, Music Concerts, etc.; Sturgis Falls Celebration, My Waterloo Days Celebration, Bike Trail Events, Marathon Races, Rodeos, Go-Cart Races, etc.

Education — The Wheaton Franciscan Healthcare Ambulance Services provide continuing education classes for EMS providers at no cost in the months of January, February and March every year. Throughout the year, many of the Wheaton Franciscan Ambulance Service Paramedics fulfill training requests for rural community ambulance services, as well.

The Wheaton Franciscan Healthcare Ambulance Services are committed to living out the healing ministry of the Judeo-Christian tradition by providing exceptional and compassionate health care services that promote the dignity and well being of the people we serve. ■



*Affiliate Profile*

# LOUISA COUNTY AMBULANCE

BY TOM SUMMITT

Louisa County Ambulance covers approximately 245 square miles, consisting of the western and northern halves of Louisa County and two and one-half townships in Muscatine County. Overall, coverage is provided for nearly 8,200 area residents. Mrs. Linda Verink is the President/Service Director, and Mr. Sean Salazar is the Operations Assistant

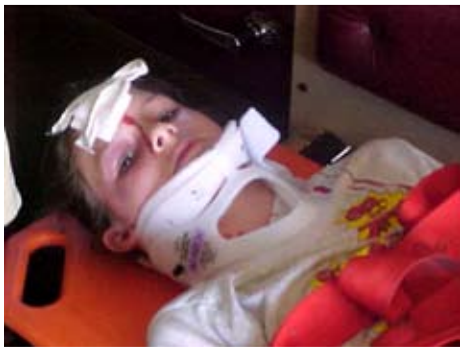
In 1988, when the local Stacey Lewis Funeral Home decided to cease providing ambulance service, what is now called Louisa County Ambulance was formed by a private ambulance company from Iowa City. At that time, the owner provided two Type II van ambulances to operate in Louisa district, with one ambulance in Columbus Junction and the other in Letts. A group called CARE (Columbus Area Responders and EMTs) was formed with 12 EMT-As and supplied the manpower to run the ambulances. Then, in February 1990, the CARE group decided to take over the services from the Iowa City group and started the Louisa County Responders Ambulance. They subsequently purchased two used Type III ambulances.

In the summer of 1991, the service staff became certified as EMT-Ds and purchased two Phillips defibrillators. Later that year, the first EMT-Is were also added to the service. Louisa County Ambulance became a conditional Paramedic service in the summer of 1993 when six EMTs passed their paramedic course.

Louisa County Ambulance Service is a non-profit organization, consisting of 45 volunteers. The current roster now includes 20 EMT-Bs, four EMT-Is, three EMT-Ps, four Paramedic Specialists, two RN Exceptions and 12 CPR certified drivers. We also currently have one student enrolled in the Basic class and three EMT-Bs taking the Paramedic Specialist class.

Currently, we provide ambulance coverage in the Iowa cities of Columbus Junction, Columbus City, Conesville, Letts and Grandview. We have three Type III ambulances; two are primary response units on call 24 hours a day, seven days a week and one is a back-up ambulance. One primary ambulance and the backup ambulance are located in Columbus Junction, and the other primary ambulance is located in Letts. In 2009, we responded to 520 calls. Our biggest obstacle is that no hospitals are located in our county. Therefore, most of our time is spent transporting to hospitals in other counties.

Louisa County Ambulance continually faces a large variety of potentially dangerous challenges that can jeopardize the personal safety of our volunteers and equipment. Within our territory, we have a food processing plant, a 750 MW power plant, a gas plant, a rock and sand quarry and a fertilizer plant. We also border the Mississippi River, and the Cedar and Iowa rivers run down the middle of our territory. With US Highway 61 and State Highway 92 running through our territory, along with the IC & E railway, all function as routes for hazardous materials. We also have two school systems with 2,000 students and a 60-bed nursing facility. As a result, we have had many motor vehicle crashes, train crashes, industrial accidents, drownings, sporting and recreational accidents over the years.




Our training is done in-house, bringing qualified teaching staff from nearby colleges in Burlington, Iowa City and Muscatine. We also work closely with the fire departments in our primary response area doing mock and disaster drills. We have also participated in disaster drills with our neighboring counties.

As a demonstration of our commitment to the communities that we serve, we stand by at many events, such as youth league and high school sporting events, local stock car races, demo derby, walk and run marathons, as well as the 4th of July parade, county fair and Columbus Day. We also offer CPR classes to the public.

In celebration of National EMS Week, we displayed our rigs and gave tours to preschool and elementary school students, giving out coloring books and crayons to each child present. We also held a coloring contest for our second grade students, awarding a $50 savings bond donated by our Community National Bank for first place. The second and third place winners received bicycle helmets.

In recognition of all of our volunteers for National EMS Week, we held a family picnic for them and their family members, acknowledging that it is not just about the EMS providers — it is also about the support given by each family member involved!

We, as volunteers, are all so very proud of the outstanding service we provide to our communities. ■



Training Profile

# DMACC

BY T.J. CARROLL

The Des Moines Area Community College EMS education program was formed in the early 1990's in response to a perceived need in the community for EMS education opportunities. DMACC offers both entry level EMS certifications as well as continuing education opportunities for EMS professionals. The DMACC EMS education program serves the residents of Polk, Story, Boone, Carroll, Dallas, Jasper, Marion, Warren, Madison, Guthrie, Adair and Audubon counties. In the last 15 years, DMACC has enrolled just under 2,000 students in the various EMS certification courses.

DMACC is authorized to provide EMS education for all levels. These levels include First Responder, EMT-B, EMT-I (85), EMT-I (99) and Paramedic Specialist. These courses are primarily offered at our Ankeny facility with outreach courses provided several times a year to area fire and EMS agencies. In the last year, DMACC has had the opportunity to educate 150 EMT-B students on the Ankeny campus and in the outreach settings. DMACC EMT-B graduates had the highest pass rate for the NREMT certification exam in the State of Iowa for 2009.

In addition, DMACC provides a wide range of continuing education opportunities for EMS providers. These opportunities range from classes sponsored or hosted at area departments to a regional EMS conference offered once a year in conjunction with the Central Iowa EMS Service Directors.

DMACC is also pleased to report that our EMS Education Program has moved into a new facility on the Ankeny campus. In January 2009, the Health Sciences Building opened at a cost of $14 million with 58,000 square feet of classroom and clinical training space. As a result, the EMS education program received its first permanent home and dedicated classroom space. We now occupy classrooms that allow the instructional staff the opportunity to teach students in a traditional classroom setting and then augment that experience by bringing them to the EMS skills lab. This allows the students the opportunity to hone their skills in the back of an ambulance.

DMACC is very pleased to report that we will be offering our first Paramedic Specialist class in the fall of 2010. This will be a daytime course offering with students meeting Monday through Friday from 8:00 AM until 4:30 PM. This course will be offered once a year starting in August, and will also be offered for 46 hours of college credit. Students will focus their attention on completing the requirements for the PS certification with a voluntary option to obtain an associate's degree after their first year of study. By the end of their first year, a student should have the option to test for certification with the NREMT. If a student elects to continue their educational experience past the PS certification, the associate degree offers them three tracks to select from: public administration, fire science, or a clinical emphasis.

With the public administration track, a student will be exposed to a broad sampling of various management concepts. This will give the student a flavor of what management is about as well as exposure to various theories of management. This education will make the student more marketable for leadership and management positions within an organization.

With the fire science track, a student will be educated in the areas of building construction, fire behavior and suppression, as well as fire ground operations. This will give the student additional marketability and mobility if they are looking to pursue a career with a fire service.

With the clinical emphasis track, a student will focus on various courses such as anatomy, physiology, chemistry and physics that will prepare them for obtaining additional advanced health care degrees. Should a student choose to pursue a degree as a physician's assistant or registered nurse, this series of courses will serve them well as a foundation.

The DMACC EMS education program is beginning the process of earning CAAHEP accreditation which will be completed within the next two years. ■

# What's New with the Bureau

ANITA J.
**BAILEY**
PS

**R to L:** Bureau Chief Kirk Schmitt presenting Jeff Messerole a certificate in appreciation of Jeff's service to Iowa's EMS community.

## New Officers for EMSAC

Dr. Carlos Falcon has been elected to serve as the Chair for the Iowa EMS Advisory Council. Dr. Falcon represents the Iowa Chapter of the American Academy of Emergency Physicians. Outgoing Chairperson Jeff Messerole, PS represents the Iowa EMS Association and served three terms as the first non-physician to chair EMSAC. Janis Adams, RN, CCRN, PS, represents the Iowa Nurses' Association, and she will serve as the Vice Chair replacing Dr. Darrel Forslund representing the Iowa Academy of Family Physicians.

## Transition to the National Scope of Practice Model

by Joe Ferrell, MS, PS

It has now been 10 years since the *EMS Agenda for the Future: A Systems Approach* identified the need for a National Scope of Practice Model. The National Scope of Practice Model serves as a base for the development of EMS education, certification and practice. Iowa has been involved in every stage of the Model's development, from the origins of the concept through development of the final product that was released in 2007.

While it seems like we have been talking about implementation for a very long time, we actually have some dates set to begin. At the July 2010 Iowa EMS Advisory Council (EMSAC) meeting, the council approved implementation dates for the new education standards. The council also approved transition periods. While some details are still being worked on, the timelines will allow the final developments to proceed.

EMS Training Programs will begin offering courses at the Emergency Medical Responder, Emergency Medical Technician, Advanced EMT and Paramedic levels starting August 1, 2011. After July 31, 2011, the present training levels of First Responder, EMT-Basic, EMT-Intermediate, EMT-Paramedic and Paramedic Specialist will no longer be offered.

Three of the current certifications will transition by documenting continuing education in specific topic areas. A provider currently certified as a First Responder, EMT-B, or Paramedic Specialist will complete the transition during the regular renewal cycle. A provider who has not previously received education in the transition topics will be able to complete all the requirements within the normal continuing education requirements.

First Responders who renew in odd-numbered years will have until September 30, 2013 to complete the transition requirements. Those renewing in even-numbered years will have until September 30, 2014. EMT-B and Paramedic Specialist providers who renew in even-numbered years will have until March 31, 2014 to complete the transition requirements. EMT-B and Paramedic Specialist providers who renew in odd-numbered years have until March 31, 2015. These dates give all providers a minimum of one full certification period to complete the requirements.

EMT-Intermediate providers wishing to transition to the Advanced EMT level will have until March 31, 2016 to complete the requirements. These providers will need to complete specific education topics, verify skill competency through a local EMS training program and complete the National Registry of EMT Advanced EMT computer-based examination. The Bureau of EMS has attained funding to pay for the first test attempt of EMT-Intermediates completing the transition. EMT-Intermediates who do not complete the transition by March 31, 2016 will receive certification at the EMT level.

EMT-Paramedic providers wishing to transition to the Paramedic level will have until March 31, 2018 to complete the requirements. These providers will need to complete specific education topics and complete the National Registry of EMT Paramedic computer-based examination. The Bureau of EMS has attained funding to pay for the first test attempt of EMT-Paramedics completing the transition. EMT-Paramedics who do not complete the transition by March 31, 2018 will receive certification at the Advanced EMT level.

A substantial amount of thanks goes out to the providers, training programs, EMSAC members and legislatures who have worked on this transition. This is a huge step not only for the State of Iowa, but also for the entire nation. While we are getting closer to implementation, there is still a lot of work to do. This fall, the Bureau will provide draft Administrative Code to the Advisory Council, along with final drafts of the transition requirements. After the October EMSAC meeting, this information will be distributed to the EMS community. ■

Members of the QASP subcommittee of EMSAC. **Front L-R:** Chris Perrin, Cindy Small, Jeff Kurth; **Middle L-R:** Dr. Falcon, Dr. Forslund, Dan Gubbins, Kerrie Hull; **Back L-R:** Jim Steffen, Jeff Anderson, Dave Staner, Angela Buskohl, Dan Paulsen

# Medical Director's Report

DARRELL **FORSLUND, MD**
PS, IEMSA MEDICAL DIRECTOR

The Iowa EMS Advisory Council met on July 14, 2010. After much discussion, it was finally decided to adopt the new National Scope of Practice model as is without any modification. One of the biggest concerns was airway management and loss of the use of Combitubes at the FR/EMR level. Since supra-glottic airways have been defined as "oral" airways, and oral airways can be used by the EMR level, this major concern was felt to have an adequate solution. The QASP subcommittee will monitor issues related to the changes in the scope of practice and the impact on EMS in Iowa. QASP/EMSAC are willing to advocate for needed future changes in the scope of practice through the National Scope of Practice system. The system for ongoing governance of the National Scope of Practice is being developed at this time.

"After much discussion, it was finally decided to **adopt the new National Scope of Practice model** as is without any modification."

Also, the IDPH Bureau of EMS presented a plan to transition the current provider levels to the new provider levels. The plan was approved by EMSAC. The main point I want share with you is that the training and education will be rolled into the regular continuing education. The time and money spent to transition would have been spent anyway for continuing education. Also, depending on the level, the transition will be occurring over the next three to six years. Eventually, detailed information on this will be sent concerning these plans.

The Bureau of EMS and EMSAC realize these changes won't be made without some difficulty. As much as possible, attempts have been made to soften the impact by allowing plenty of time to transition levels and minimize the economic and time costs. ■