IEMSA

October – December 2006

VOICE

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

Iowa Emergency Medical Services Association

Congratulations to two of Iowa's own

Just like our motto at Life Line Emergency Vehicles
The next generation... will follow our lead.

Mr. Jerry Johnston, NREMT-P
Director Henry County Health Center, Mount Pleasant, Iowa

On Sept. 29, Jerry was handed the gavel as the new president of NAEMT. This is not only a great honor for Jerry, but for all of us in Iowa. NAEMT gives all first responders, EMTs, and paramedics a VOICE in Washington D.C., and throughout the United States. Now the president of NAEMT is from Iowa.

Congratulations, Jerry. Your hard work and commitment is commendable. We wish you the best.

Mr. Jeff Dumermuth, EMT-P
EMS Chief of West Des Moines EMS

On Sept. 29, Jeff received the William Klingensmith EMS Administrator of the Year award from NAEMT. This national award recognizes an EMS administrator who has made a significant contribution to the EMS community. Jeff Dumermuth is that administrator.

Jeff has been the Chief of West Des Moines EMS since 1990 and has served IEMSA as president the last four years. He also continues to serve the Mae Davis Free Clinic in West Des Moines and has received the Governor's Volunteer Achievement Award twice. We congratulate Jeff Dumermuth on this great honor.

Both of these men help to represent true Iowa values and continue to lead EMS into the future. All of us in Iowa shall remain proud of the EMS system we have in each of our communities. The commitment **all EMS providers** make to the people they serve shall never go unnoticed. We wish all of you a safe holiday season. ***Thank you!***

Life Line EMERGENCY VEHICLES

(800) 922-7477 www.lifelineambulance.com

NAEMT NAMES IEMSA PRESIDENT JEFFERY DUMERMUTH
William Klingensmith Administrator of the Year

Excerpts from the 9/30 NAEMT Press Release

The National Association of Emergency Medical Technicians (NAEMT) has named Jeffery D. Dumermuth, EMT-PS, EMS Chief of West Des Moines EMS, as its 2006 William Klingensmith EMS Administrator of the Year. This award recognizes an EMS administrator who has made a significant contribution to the EMS community and demonstrates exceptional leadership within the profession and outstanding commitment to prehospital medical care. He received the award at the NAEMT Annual Awards Dinner in Las Vegas on September 29, 2006.

Dumermuth has served as EMS chief of West Des Moines EMS since 1990. In addition to his EMS work, Dumermuth is an active volunteer at the Mae Davis Free Clinic in West Des Moines. He also serves on the NAEMT Board of Governors as well as the president of the Iowa EMS Association. He has been involved in EMS since 1983.

Dumermuth received the Paramedic of the Year award from the Central Iowa chapter of ASIS International in May 2006, and he was honored for the second time with a Governor's Volunteer Achievement Award in July 2006 for his work with the Free Clinics of Iowa.

IEMSA is thankful for Dumermuth's leadership, which has led the Association into a new era of progress and professionalism. The IEMSA Board of Directors and Staff would like to wish its president, Jeffery Dumermuth, heartfelt congratulations for this well-deserved national honor. ■

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2006 IEMSA MEETINGS

Board Meetings:
The IEMSA Board of Directors will meet on the following dates in 2007. Each meeting (with the exception of the Annual meeting) will be held at the Raccoon River Nature Lodge, 2500 Grand Avenue, West Des Moines. All meetings, with the exception of the Annual meeting, will be held at 1:00p.m.

2007

- January 18
- February 15
- March 15
- April 19
- May 17
- June 21
- July... **No Meeting**
- August 16
- September 20
- October 18
- November 8... **Annual Meeting**
- December 20

Additional Important Dates:

Annual Conference & Trade Show
November 8 – 10, 2007
Des Moines, Iowa

Membership Announcements

ONLINE FORUM
Visit www.iemsa.net, enter the Members Only Section and start using IEMSA's newest communication tool, the Online Forum. At the Online Forum you can read and contribute to statewide discussions on anything and everything EMS related. Share your ideas and post questions to all of IEMSA's membership and leadership.

MEMBERS ONLY SECTION
New features continue to be added to the Members Only Section, including access to member benefits like the Online Forum, a publications archive, as well as event registration, various ballots, By-Law changes, Resource CDs and more. Check back often to make the most of your member benefits at www.iemsa.net.

IEMSA MERCHANDISE
Browse through IEMSA's stylish and useful logo'd merchandise and conveniently shop online with the handy new shopping cart. IEMSA now accepts Discover Card in addition to Visa, MasterCard and American Express. Get started at the IEMSA Merchandise page at www.iemsa.net.

INDIVIDUAL MEMBERSHIP RENEWALS
You can renew your membership online with your credit card! Visit the Membership Information page at www.iemsa.net and click on the "Renew or Establish a Membership Now" link.

MEMBERSHIP DATABASE
Occasionally, we make our membership list available to carefully screened companies and organizations whose products and organizations may interest you, as well as board candidates who wish to solicit your vote. Many members find these mailings valuable. However, if you do not wish to receive these mailings (via postal service or e-mail), just send a note saying "do not release my name for mailings" to the IEMSA office via fax (515-225-9080), e-mail (administration@iemsa.net), or regular mail (2600 Vine St., Ste. 400, West Des Moines, IA 50265). In order to ensure the correct adjustment to our database, please include your name, address and membership number.

Keeping the *Momentum*

Jeffery D. Dumermuth
IEMSA President
Board of Directors

How exciting to see so many of you at our annual conference in Des Moines. Once again we set an attendance record, and if you were present, you participated in the largest gathering of EMS providers in Iowa history! Congratulations to the Conference Committee and several subcommittees on a job well-done. We look forward to seeing everyone next year.

This will be the last article I write as your President and I do so with great pride on the accomplishments that I have been able to lead your Board of Directors through over the past four years. We have made substantial improvements in your Association by adding numerous programs (benchmarking, leadership, billing), we have increased our contracted staff from one member to three including the addition this year of a Communications Specialist, we have implemented an Affiliate Membership for our ambulance services with numerous benefits (reference CD, discounts to management topics, etc.) and more than 100 ambulance services are participating. We have implemented a volunteer Medical Director for guidance to our Association. We have also made a very conscious attempt to make sure that we provide as many tangible benefits to our individuals as possible. In fact, we have increased our individual membership 58 percent in the last four years.

Stepping up the image and professionalism of IEMSA was also one of my main priorities. I would hope you agree that we have made significant accomplishments in the professionalism of our board, the look and content of our newsletter, and the upgrade of our website including our new Members Only Section.

Great things are happening in Iowa EMS. Your Association is being noticed. While in the past EMS was often overlooked, we are now at the table as the third piece of the Public Safety Triangle. We also have been invited to participate in homeland security planning, pandemic planning and many other public health and safety issues.

Your next President will have the challenge of keeping the momentum of our Association. We have many important challenges coming in the next couple of years including our alignment with the new National Scope of Practice, funding issues, and securing stable income sources to maintain our Association without raising the dues for our individual members. I am confident that either of the candidates have the abilities to meet these challenges.

So as I leave my office, let me start by thanking my family for their understanding and the time that they have allowed me. To my employer and more specifically my crews who have absorbed many special "projects" over the past four years, thanks for doing the outstanding job you always do. To the Board of Directors current and past, thank you for your support and encouragement. None of the accomplishments I've listed were done by me alone, but rather by us as we build this great organization. To Colleen, Abby and Dr. Russi, thank you for your commitment. Finally, I would be remiss if I didn't recognize our Office Administrator Karen Kreider, my partner in this adventure. Without you on my team, the organization wouldn't be nearly as successful. ■

THE ADVANTAGES TO THE ADOPTION OF THE

National Scope of Practice

Christopher S. Russi, DO
IEMSA Medical Director
Dept. of Emergency Medicine
University of Iowa

In addition to my duties with IEMSA, I also have the distinct privilege to sit on the EMS Advisory Council (EMSAC) for the Bureau of EMS. This council is a collection of disciplines and specialties across healthcare that is charged with, as its name implies, "advising" the Bureau of EMS on current issues facing prehospital care in Iowa. At the most recent meeting (October 2006) the council entertained an issue that evokes fear, concern, hope and excitement from all corners of our state. Before we discuss the national scope adoption, I am compelled to compliment the men and women who took time to attend the meeting and allow their voices to be heard. I have served on the council since January and this great showing allowed for one of the liveliest discussions. Following the meeting, the council members highlighted our pride in Iowa's prehospital providers coming to share their concerns and beliefs. Kudos.

The state of Iowa has not made decisions on this issue. Speaking on behalf of the state, the Bureau of EMS and the Iowa Department of Public Health are merely exploring what this national scope means and how it would change EMS in Iowa, if adopted. At this time I have only been privy to the national scope of practice model, however the educational component is still being developed and will be reviewed critically by the Bureau when it is available in 2007. The Bureau has no agenda to take away certifications, but does have an agenda in line with its mission to keep Iowans safe and our providers at the forefront of prehospital care in the country. We provide exceptional care for Iowans; it is critical that we continue moving toward the future.

I received a myriad of emails and letters prior to the EMSAC meeting on this issue. The driving motivator, in my opinion, for the communication was concern for the removal of skills and the cost necessary to enroll and complete a bridge course; valid concerns given that the vast majority of Iowa's EMS providers hold a volunteer position. I can respect the concern that in order to advance to the national paramedic level, costs accrue from tuition, fees and time away from primary vocation. However, there appears to be little recognition that adopting national standards and training would keep Iowa held in its high status as well as provide a conduit for future personal and system development.

Other considerations to the national adoption need to be given merit. An honest look at how the change will affect the demographic you serve is important, but consider also what the adoption would allow for our providers and state for the future. I encourage everyone in an EMS system (providers and medical directors) to look at the Iowa and national scopes of practice, compare the proposed and current skills, and weigh how the adoption would affect your community. What makes this particularly challenging is a lack of data. In order to provide any guidance or position on how the adoption would affect a community, the Bureau of EMS needs data. Until consistent data is provided, systems require an independent, honest look at their respective service demographics and an exploration of community needs (i.e., number of cardiac arrests, number or trauma cases, total number of emergent and non-emergent transports, etc.) Using that information, you will get a better understanding of the skills necessary in your community to determine if the national model will suffice or if your system personnel will need to complete a bridge course.

Reciprocity

EMS providers are currently not considered equals from state to state. An Iowa provider may not be considered to have or be allowed to use his or her skills in another state following a move. By having a national scope of practice and education curriculum, a clear understanding would develop so providers who share the same title can share the same skills between states.

Funding for Research and System Development

In order for Iowa to hold its position as one of the premier states for prehospital care, we have to be competitive for federally allocated funding from such agencies as the Centers for Disease Control (CDC), Health and Human Services (HHS) and Homeland Security. In my opinion, if other states adopt the national scope of practice and Iowa chooses to provide its own certification levels (as it currently does), I am concerned a message may be sent that results in a less competitive position for funding. These monies are critical for system development, equipment and personnel.

My goal for this short opinion piece is to not interject, force or promote my views on this topic. I am compelled to provide other considerations for discussion as we all look at the national scope and education model for potential adoption. I look forward to further discussion and encourage the debate to be centered on what is best for patient care and Iowans. ■

What's Up Doc?

"In Wisconsin I believe EMT-Bs can use the new CPAP technology for CHF patients, etc. I feel Iowa should adopt this also, or consider it for the Basic level. Transport times can be long and patients would benefit."

Posted 11/12/2006 by forum user LEMS

"On a personal level, I completely agree. CPAP (continuous positive airway pressure) as well as Bi-PAP (Variable Inspiratory and Expiratory Positive Airway Pressure) are fantastic tools to stave an intubation in patients with acute CHF and COPD exacerbations. The state of Iowa currently has a pilot trial ongoing, and that data is being collected to look at the feasibility of adding it to the scope. Much more to come on this topic..." – **Dr. Russi**

What's Up Doc? features selected questions and comments from IEMSA's Online Forum. Access the Forum through the Members Only Section at www.iemsa.net.

2006 Annual

BRUCE THO

Melinda Brittain, Volunteer Individual of the Year

Darren Brookes, Career Individual of the Year

Blairstown EMS, Volunteer Service of the Year

Clive Fire Department, Career Service of the Year

MELINDA (MINDY) BRITTAIN

Volunteer Individual of the Year

Mindy Brittain started as a volunteer in EMS in 1994 and has worked her way from the basic level to her current certification level of Paramedic. She provides professional, compassionate care while creating a safe and secure environment, making her patients and crew comfortable both physically and emotionally.

Mindy volunteers her time and talents serving on numerous boards and committees that promote her community and county while balancing her roles as a wife and mother of two very active teenagers.

In 2003, Mindy assumed the duties as the part-time director for Blairstown EMS. Through her recruiting skills, personality and compassion for the profession, a number of volunteers from around the area have requested to be on the squad and under her tutelage.

Mindy's people skills and professionalism have played a significant part in bringing the Benton County EMS system to a level of emergency preparedness we can all be proud of.

DARREN BROOKES

Career Individual of the Year

Darren Brookes has been a paramedic for the Muscatine Fire Department since January 2000. When the Muscatine Fire Department started a transport ambulance service in July 2000, Darren's experience as a member of a volunteer ambulance assisted in the transition of firefighter/paramedics and in helping them to adjust to the added responsibilities of the ambulance. Darren also teaches basic classes and CPR to many industrial workers and community members in the area.

Darren projects a professional, caring, sincere attitude in all aspects of his service, including patient care, documentation, and working relationships with doctors, nurses, firefighters, EMTs, and staff. His jovial attitude as well as personality helps those around him feel more comfortable. Darren personifies the positive representation of EMS through his professional courtesy and honorable character.

BLAIRSTOWN EMS

Volunteer Service of the Year

Blairstown EMS has been busy this past year providing outreach programs to their communities and developing a strong team to provide the best care to all in need.

Over this past year they have initiated a Public Access Defibrillation program through donations and grant funding and placed an AED in their Community Center. They have hosted their first Blood drive, provided CPR and AED training for area community schools as well as renewing CPR for their Fire department. They have worked to enhance injury prevention through helping the local Girl Scouts earn badges in safety and first aid and presented a program to their senior citizens explaining how the ambulance service operates, required skills, how 911 dispatching works and answering many Medicare related questions.

The Blairstown Service was given a large facility. The crew, through a large donation by a local business, was able to remodel and upgrade the building, making it possible for the ambulance service to move from the Fire Department to their own building where they can hold EMS classes, continuing education classes and provide a "home" in which to stay for the members who come to volunteer their time and energy from out of town.

Blairstown EMS believes strongly in their mission, which they practice daily: "To respond to each call in a timely, safe and professional way exemplifying the best possible emergency care for each patient they serve." As volunteers, they are committed to helping patients and often their families during an emergency with the best possible care and compassion they can provide.

CLIVE FIRE DEPARTMENT

Career Service of the Year

Clive Fire Department has displayed a dedication to the growth and success of its EMS program through several new and innovative changes. In addition to providing frequent ALS assistance to neighboring communities Clive was able to utilize its considerable and talented pool of paid on call staff to provide in-house, 24-hour a day service beginning September 1,

Award Winners

MAS, AWARDS COMMITTEE CHAIRMAN

2006. The proactive safety committee made up of employee volunteers and the EMS operation has undergone positive changes in the spirit of safety that have all been employee driven.

The Clive Fire Department has been proud to serve as a host site for the IEMSA AED distribution, Bureau of EMS staff meetings and led the metro area in pandemic planning. They partner with neighboring communities to govern WestCom (the dispatch agency for Clive, Urbandale and West Des Moines), serving on the QA Committee and the Operations and Management Committee to assure that the citizens in Clive are receiving the best possible care before and after the ambulance arrives.

The Clive Fire Department fosters an environment in which EMTs and Paramedics can thrive and grow. It is predicated on excellence in patient care and looking out for the best interests of the patients and employees.

JIM STEFFEN
Part-Time Instructor of the Year

Jim Steffen is a full-time Paramedic Specialist at Henry County Health Center in Mt. Pleasant and serves as an EMS Instructor for Southeastern Community College in Burlington.

As an instructor, Jim puts in countless hours before, during and after class to make sure his students receive the best education possible. During their clinical and field experiences, Jim always keeps in mind the required skills that are needed by students, making sure the hospital knows a student is in-house and needs to perform these skills.

An example of Jim's dedication to his students came during an ambulance call to an unresponsive patient who required intubation. Jim handed the student the intubation tube and laryngoscope, saying "Go for it!" In a small rural area, the opportunity for such a skill does not often arise, and for a full-time person who needs to maintain his skills to give a student "the tube" shows an outstanding dedication to his student's success.

Jim has voluntarily traveled many miles to hold review sessions to ensure his students are prepared for testing. Jim Steffen is a person who truly exemplifies a committed instructor and we join his students in thanking him for his dedication!

GEORGE VANNATTA
Full-Time Instructor of the Year

George Vannatta has devoted approximately 37 years to EMS in many forms. George began as a combat medic, was a member of the first Paramedic class in Iowa, and has worked as a street medic throughout his career.

The greatest influence he has had on EMS is in his role as an EMS instructor. He is dedicated to ensuring every student is not only a ready, willing and able medic, but that each of them is fully capable of running the streets as a competent member of the EMS profession. He has a vested interest in every student he instructs, not only academically but also on a personal level.

Recently, due to some unforeseen issues and health concerns, George was unable to continue teaching a portion of one of his classes. He continued to encourage the students, and his motto: "Failure is *not* an option" became that class's mantra and guiding force.

Throughout George's 37 years in EMS, he has constantly passed on his caring, compassionate knowledge to make EMS and the individual providers the best they can be.

ABATE OF IOWA
Friends of EMS

A Brotherhood Aimed Toward Education (ABATE) represents more than 7,700 motorcycle enthusiasts. ABATE of Iowa has been the sole sponsor of the EMS continuing education program "Two Wheel Trauma," providing the program, refreshments and free continuing education hours to more than 3,500 certified EMS Providers since 1987. Additionally, ABATE provides the "Share the Road" instruction for the course, a 30-minute presentation teaching all ages and experience levels to see, respect and understand the motorcyclist's needs and rights on Iowa roads. ABATE successfully introduced the legislation that requires "Share the Road" education in every drivers education course in Iowa.

ABATE also sponsored the Accident Scene Management course on numerous

Jim Steffen, Part-Time Instructor of the Year

George Vannatta, Full-Time Instructor of the Year

ABATE of Iowa, Friends of EMS

Herman Dirksen, Hall of Fame

John Heller, Hall of Fame

Ray Jones, Hall of Fame

Emergency Medical Services Learning Resources Center, IEMSA Annual Conference Award

occasions, which is a three-hour basic first aid course that trains bikers and riders how to manage the first few minutes of a two-wheel crash event.

ABATE is firmly committed to motorcycle safety and crash prevention through education. ABATE is truly a friend of EMS through sharing their passion with the EMS community by sponsoring prevention, first aid and EMS continuing education programs.

HERMAN DIRKSEN
Hall of Fame

Herman Dirksen, EMT-B and firefighter, joined the Rock Valley Fire Department in 1961, started a First Responder unit in 1971, and helped to organize and start the ambulance service in 1972. He has served on many committees over his 30-plus years on the squad, always showing compassion, concern, love and the desire to care for and help others throughout those years. He has been a mentor to all who joined the squad or who later became instructors desiring to teach the skills to other providers.

Herman retired from the Rock Valley Fire Department in April 2001 after 40 years and later in 2003 from the ambulance service due to health concerns. To Herman, it was his family and his faith that came first. However, when the call came, he was always ready to respond.

The EMTs Herman has worked with thank him for his passion for EMS and for all he has done for our community and for us.

Herman Dirksen passed away on June 16, 2003. Herman was survived by his wife Mildred, children Harlan, Joe, Lynette and Myra, as well as 10 grandchildren and four great grandchildren.

JOHN HELLER
Hall of Fame

John Heller will tell you "he can't remember for sure if it was when he was 19 or 22" when you ask him when he began his career as a caring, capable emergency responder. Regardless, he has been an active member of the Dunlap Fire & Rescue Squad since 1961.

John owned a local business but responded as much as possible to all calls, especially the ones originating at his store located along Hwy 30. Many times travelers needing aid would stop and John would summon help, caring for them until the ambulance arrived.

He has been active in educating the public by participating in community safety training, Fire Prevention Week presentations at the local schools and preschool including "fun" fire truck rides, giving additional school presentations as well as helping with pancake breakfasts and soup suppers.

John Heller's experience, good example and calm, caring ways toward department members helped retain valuable personnel over his nearly five decades in EMS. He has been an asset to the Dunlap Fire & Rescue Department and to the community as a whole.

RAY JONES
Hall of Fame

Ray Jones has been a distinguished member of the Iowa EMS community for more than 30 years. He has played an integral part in shaping how EMS was developed and evolved, always pushing to make Iowa a top model of how EMS can work throughout the country.

Ray spent many years as the Iowa Bureau of EMS Regional Coordinator for Southeast Iowa. Throughout his career, Ray has always been a strong advocate for EMS, serving on numerous boards and committees throughout his region and at the state level. Ray is further distinguished as holding the certification number 01 as the first registered member of the Iowa EMS Association.

Ray was appointed as Chief of the Bureau of EMS a couple of years after the turn of the century (21st – not 20th – as Ray is quick to point out) and continued to fight for the funding needed for training, equipment and system development that would enable the volunteers to do what they have volunteered to do. That mission was to provide emergency care to the sick and injured of their communities. Ray retired in January 2006.

Ray's significant contributions to EMS – not only to the region where he lives but to the entire State of Iowa – has demonstrated a lifetime of enthusiasm and dedication to EMS that is truly priceless.

EMERGENCY MEDICAL SERVICES LEARNING RESOURCES CENTER
IEMSA Annual Conference Award

The Emergency Medical Services Learning Resources Center (EMSLRC) was established in 1978 to develop and conduct comprehensive statewide educational programs in emergency medicine for physicians, physician assistants, nurses, EMTs and paramedics. Through the EMSLRC, specialists in emergency and critical care education provide a variety of EMS-related programs locally for University of Iowa staff and on an outreach basis throughout Iowa and the nation.

Approximately half of the more than 100 courses conducted each year by the EMSLRC are taught in communities outside the Iowa City area. Since its initiation, the Center has provided EMS programs for more than 70,000 physicians, physician assistants, nurses, EMTs and paramedics as well as community citizens in 16 different states and two foreign countries. More than 7,500 participants attend EMSLRC courses each year.

The Center offers a broad spectrum of emergency medical training through its in-house and outreach programs. It serves as the primary emergency medicine training department for the University and provides a base for innovative research to improve emergency care. As a national leader, the EMSLRC is committed to progress, building on the traditional missions of education, creating innovations in emergency medicine and to the delivery of state-of-the-art emergency medicine programs, adapting their organization to succeed in a changing environment, and working collaboratively as partners with the people, the communities and the organizations they serve.

Because the EMS Learning Resources Center believes IEMSA is a worthwhile organization and strongly supports their endeavors, EMSLRC staff members have given time away from their jobs to take on various IEMSA responsibilities – including two executive committee positions. The EMSLRC has also provided audiovisual equipment for the annual conference for more than 10 years at a substantial expense to them free of charge to IEMSA. ■

Jerry Johnston Begins Term as *NAEMT President*

Since beginning his career in EMS in 1975, Jerry Johnston has distinguished himself as an advocate and leader for the EMS community on numerous levels both locally and nationally.

Jerry's leadership has been instrumental in the growth, development and promotion of not only the services he manages – Henry County Health Center and Superior Ambulance – but also IEMSA and NAEMT.

His strong leadership within the NAEMT Organization will continue the fight to provide a voice for all EMS providers on the difficult issues EMS faces today and as we look to the future of our profession.

The Iowa EMS Association's Board of Directors is proud of the accomplishments Jerry's leadership has provided to this organization in the past and thanks him for the service he has given to IEMSA and EMS overall. We are confident that his leadership as NAEMT President will continue to serve the EMS community for years to come.

Congratulations Jerry! ■

Death by *Hyperventilation*

Continuing Education: The New AHA Ventilation Recommendations

BY LORI REEVES, EMT-P

As listed in the EMT Code of Ethics, the fundamental responsibilities of the Emergency Medical Technician are to conserve life, alleviate suffering, promote health, and do no harm. Yet, likely on a daily basis, EMTs and paramedics are doing harm – harm through unintentional hyperventilation. We have all been taught since our first airway classes that oxygen is good for patients. And if a little is good, then more must be better, right? Wrong. If hyperventilation only accomplishes the delivery of additional oxygen to the patient, then hyperventilating a patient would appear to be advantageous. The problem, however, is that hyperventilating a patient affects more than oxygen levels. There are two other results that must also be considered: carbon dioxide levels and intrathoracic pressure. As it relates to these two situations, more is not better.

First, let's examine the simpler of the two – carbon dioxide levels. While hyperventilation may increase oxygen supply in the blood, it cannot do so without correspondingly affecting carbon dioxide levels. Normal partial pressure of carbon dioxide dissolved in arterial blood (or PaCO2) should be 40 mmHg ± 5 (35 - 45mmHg). Hyperventilation, of course, decreases CO2 levels (hypocarbia). What may not be as well known is that decreasing the CO2 level is suspected to cause constriction of cerebral vessels. While a small decrease in CO2 levels (to 25-30 mmg Hg) resulting in mild vessel constriction may be desirable in patients with increased intracranial pressure, excessive hyperventilation causes CO2 levels to decrease too far and effectively constricts cerebral vessels to the point that blood flow to the brain is diminished and cerebral hypoxia can occur in spite of elevated oxygen levels.

Second, let's look more closely at how hyperventilation can affect intrathoracic pressure, beginning with an examination of the physiology of respiration. As cells metabolize glucose to produce energy, they also produce the byproduct carbon dioxide. As levels of carbon dioxide increase in the cells and become more concentrated than in the blood stream, the carbon dioxide diffuses into the capillaries. As the carbon dioxide moves into the blood, these increasing levels are detected by chemoreceptors located in the aorta, carotids and near the medulla oblongata. These chemoreceptors primarily monitor changes in pH and PaCO2 levels. As more carbon dioxide builds up in the blood, the PaCO2 levels rise and pH falls as the carbon dioxide in the blood converts into acid.

OBJECTIVES:

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

1. Review the physiology of the respiratory cycle.
2. Recall new AHA standards for ventilation of patients.
3. Examine the action of the intrathoracic (thoraco-abdominal) pump.
4. Evaluate current research on hyperventilation of patients.
5. Be an advocate for reducing unwarranted patient hyperventilation.
6. Complete the post-test with a minimum score of 80%.

ABOUT THE AUTHOR:

Lori Reeves is the Program Director for Emergency Medical and Fire Education at Indian Hills Community College in Ottumwa. She also maintains a position as staff paramedic with ORMICS at Ottumwa Regional Health Center.

When the acidity and PaCO2 reach sufficient levels, the chemoreceptors send a message to the brain indicating the levels are getting too high. The brain's response is to send a message back to the body to initiate a breath, which will remove the CO2 from the blood and lower the acidity. The brain accomplishes this by sending an electrical impulse to the muscles of the respiratory system, thereby stimulating them to contract. The diaphragm flattens, the intercostals pull the ribs up and out, and the space within the thoracic cavity increases. The suction cup adherence between the pleural lining of the thoracic cavity and visceral pleura of the lungs pulls the lung tissue outward with the thoracic cage. As this space is expanded, a negative pressure is created within the lungs. The negative pressure literally pulls air into the thoracic cavity through the only opening into the area – the trachea.

Stretch receptors in the lung tissue determine when the lung tissue has been stretched sufficiently and send a message to the brain to stop the process. The recoil of the respiratory muscles, ribs and natural elasticity of the lung tissue return the thoracic space to its original size during exhalation. As these tissues push in just like a balloon that has been blown up and released, the thoracic cavity fills with a positive pressure and the air in the lungs is pushed out through the trachea. Air that was pulled into the lungs during inspiration replenishes oxygen supplies in the alveoli. Air that has been pushed out of the lungs during exhalation has removed excess carbon dioxide. As soon as carbon dioxide levels build up again, the body will be stimulated to initiate another breath.

When we naturally inhale, the negative pressure created in the thoracic cavity not only pulls air into the thoracic cavity but also has the potential to pull blood into the vena cavas from the peripheral tissues, thus promoting blood flow to the heart. When we exhale, a negative push pressure is created. This helps to push the blood forward to

the heart as the valves in the venous system will not allow it to flow back. With each breath we take, this intrathoracic pump (also referred to as the thoracoabdominal pump) assists in returning blood to the heart and, in turn, helps create adequate preload for cardiac filling and, therefore, adequate blood volume for cardiac output and blood pressure.

Simple enough, right? We naturally inhale by creating a negative "pull" pressure in the lungs and exhale by creating a positive "push" pressure in the lungs. Correspondingly this "pull" and "push" also helps pull blood into the thorax and push it toward the heart. Now let's look at how that changes when we ventilate a patient.

When we ventilate a patient via a bag valve mask (BVM) or other device, we push air into the lungs with positive pressure. This puts positive pressure in the thorax during inhalation rather than the normal negative pressure. This eliminates the "pull" that helps pull blood from the body in toward the heart. We already know that exhalation also creates a positive pressure in the lungs. This means there is now positive pressure in the lungs during both inhalation and exhalation. With this constant positive pressure present, blood meets resistance when trying to flow into the thorax during both these times. Most blood flow then occurs when blood passively flows into the thorax during the time between breaths when pressure in the chest is neutral. When we hyperventilate a patient, we dramatically increase the amount of time that positive pressure is present in the lungs and we shorten or nearly eliminate the time between respirations when there is neutral pressure and blood flow can still occur. This can significantly reduce preload, which in turn means reduced cardiac output and blood pressure.

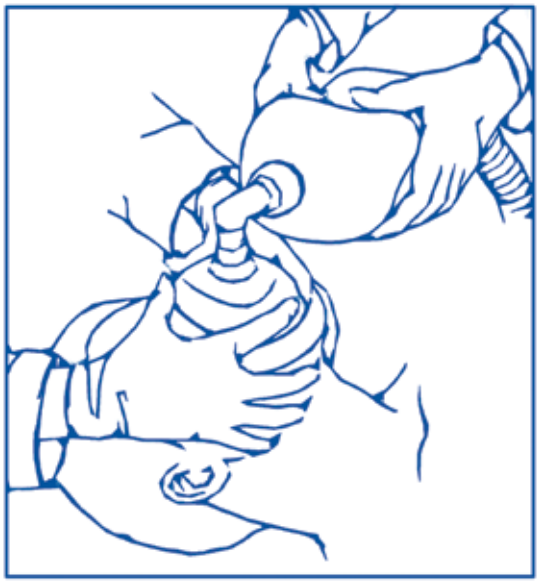
The American Heart Association has released new recommendations for ventilation rates for patients. According to the AHA, for patients with inadequate breathing with a pulse, ventilations should be delivered 10 to 12 times per minute or once every five to six seconds. For the patient without a pulse, compressions and ventilations should be delivered at a ratio of 30:2 until placement of an advanced airway. At that time, compressions are delivered continuously while ventilations should be delivered at only eight to 10 times per minute, or once every six to eight seconds.

> "It is believed that in the 'heat of the moment' EMS providers unintentionally allow [ventilation] rates to increase as adrenaline affects their actions."

Seems easy enough right? Just slow down and don't hyperventilate. But is that as easy as it seems? In the heat of the moment, many EMTs ventilate at a rate much faster than they believe they are ventilating. In a study completed in Milwaukee, Wisconsin (Aufderheide, et al 2004), researchers studied how many times paramedics ventilated patients with an advanced airway in place in a cardiac arrest situation. The study showed that on average the paramedics delivered 37 ± 4 breaths per minute. That's almost four times the recommended rate of eight to 10 breaths per minute. After two months of retraining the paramedics to ventilate at correct rates, they were again evaluated and still had an average ventilation rate of 22 ± 3 breaths per minute – over twice the recommended rate. Why were the rates still high after retraining? It is believed that in the "heat of the moment" EMS providers unintentionally allow rates to increase as adrenaline affects their actions.

These same researchers went on to evaluate the risks of hyperventilation on pigs in induced cardiac arrest. In the study the pigs were ventilated at 12, 20 or 30 breaths per minute. The study showed that increased ventilation rates were associated with significantly higher intrathoracic pressures and significantly lower coronary vessel perfusion pressures (the blood pressure in the coronary vessels of the heart). In the pigs ventilated at 12 breaths per minute, six of seven were successfully resuscitated from V-fib. Only one of seven pigs ventilated at 30 breaths per minute was successfully resuscitated from V-fib. This corresponds to an 86% survival rate in normal ventilation (12 breaths per minute) versus a 14% survival rate for pigs hyperventilated (30 breaths per minute). Hyperventilation does do harm.

To effectively make the changes needed, be very conscious of the rate you ventilate a patient. Count one number per second: "Squeeze - two - three - four - five - six - squeeze - two - three - four - five - six - squeeze..." Think about it, practice it, and commit to doing it. If you are not the person ventilating, make note of how fast the person ventilating is delivering breaths. If they are doing a good job, tell them so and reinforce their behavior with positive feedback. If they are ventilating too fast, be an advocate for the patient and remind them to slow down or take over. Remember: Conserve life, alleviate suffering, promote health and do no harm. ■



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10 QUESTION POST-ARTICLE Quiz

1) During natural inhalation, _____ pressure is created in the thorax.
A) Positive **B)** Negative **C)** Neutral

2) During ventilation with a bag valve mask (BVM), _____ pressure is created in the thorax.
A) Positive **B)** Negative **C)** Neutral

3) Hyperventilation causes:
A) Increased intrathoracic pressures and hypocarbia
B) Increased intrathoracic pressures and hypercarbia
C) Decreased intrathoracic pressures and hypercarbia
D) Decreased intrathoracic pressures and hypocarbia

4) Apatient without a pulse with an advanced airway in place should be ventilated at a rate of:
A) 20 times per minute (once every three seconds)
B) 12 times per minute (once every five seconds)
C) 10-12 times per minute (once every five to six seconds)
D) 8-10 times per minute (once every six to eight seconds)

5) A patient with a pulse but inadequate breathing or apnea should be ventilated at a rate of:
A) 20 times per minute (once every three seconds)
B) 12 times per minute (once every five seconds)
C) 10-12 times per minute (once every five to six seconds)
D) 8-10 times per minute (once every six to eight seconds)

6) The intrathoracic pump (or thoracoabdominal pump) effectively works to:
A) Pull air into the lungs during inhalation
B) Push air out of the thorax during exhalation
C) Pull blood into the thorax from the body and push it toward the heart
D) Recoil respiratory muscles, ribs and lung tissue to allow for exhalation

7) Chemoreceptors are triggered to initiate a respiration when:
A) Blood CO2 levels rise and pH drops (becomes more acidic)
B) Blood CO2 levels drop and pH rises (becomes less acidic)
C) Blood CO2 levels rise and pH rises (becomes less acidic)
D) Blood oxygen levels fall and pH drops (becomes more acidic)

8) Hyperventilation induced hypocarbia with PaCo2 levels below 20 mm Hg can result in:
A) Increased intrathoracic pressure
B) Decreased intrathoracic pressure
C) Excessive cerebral vasoconstriction
D) Decreased cardiac output

9) In the Aufderheide study, paramedics were found to be ventilating patients:
A) At correct rates
B) Too slowly
C) At rates up to four times normal

10) Increased intrathoracic pressure:
A) Assists venous return to the heart
B) Opposes venous blood flow to the heart
C) Has no effect on venous blood flow to the heart

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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.	
10.	A.	B.	C.	

IEMSA Members completing this informal continuing education activity should complete all questions, one through ten, and achieve at least an 80% score in order to receive the one hour of continuing education through The Southwestern Community College in Creston, Provider #14.

For those who have access to email, please email the above information along with your answers to: blazek@swcc.cc.ia.us.

Otherwise, mail this completed test to:
Cheryl Blazek
Southwestern Community College
1501 Townline Road
Creston, IA 50801

The deadline to submit this post test is **FEBRUARY 15, 2007**

INTERNATIONAL ROUNDTABLE ON COMMUNITY PARAMEDICINE

This *Ain't* Your Daddy's EMS

ANITA J. BAILEY, PS

The Second Annual International Roundtable on Community Paramedicine and Rural Healthcare Delivery convened July 24 through 27, 2006. More than 50 participants from a dozen U.S. states, Australia, England, and Canada met at Mayo in Rochester, Minnesota. Many other international experts joined via video satellite uplink.

Following addresses by dignitaries from the U.S. Surgeon General's Office, NHTSA, DHHS, and the Minnesota Department of Health, the agenda proceeded to a past, present, future and best-practices format.

Conference host Gary Wingrove from Gold Cross/Mayo Medical Transport noted the worldwide similarities in rural EMS. There is a growing demand for comprehensive primary healthcare coverage, and staffing shortages continue to plague most EMS systems. Even in areas where all EMS is career, it is difficult to recruit and retain staff.

It was interesting to note that some of the best practices presented were commonplace here in Iowa. Allowing paramedics to function within hospitals to support nursing staff (Minnesota) and distance learning via teleconferencing systems for CEH (Washington, Oregon, Idaho, Montana and Alaska) were touted. People were quite interested when I shared the very successful use of the ICN system by the EMS Learning Resource Center in Iowa City to train paramedics in rural Iowa.

The following three recurring themes flooded most discussions and focused on the need to improve the system by better utilization of resources:

1. Technology will continue to evolve and we must budget to invest in infrastructure to support telemedicine for assessment, treatment and education in rural areas.

2. "Treat-and-release" or "treat-and-refer" EMS was touted as a cutting edge solution to reduce fiscal woes and decrease emergency room overcrowding.

3. The need for an EMS provider with skills somewhere between a paramedic and ARNP or PA seems quite necessary in many of the more remote areas.

In Nova Scotia and Alaska, paramedics are trained to fill the gaps created by the reality of remoteness. Suturing, chronic wound care, well-baby check-ups, and monitoring of chronic problems like diabetes and CHF are routinely provided. In Queensland, Australia remote paramedics will earn certificates, diplomas and Master's degrees to learn how to take and interpret x-rays, suturing, vaccinations, minor surgeries and many health promotion activities.

Jerry Overton from Richmond Ambulance Authority and contributing author provided an overview of the "big three" visionary documents. A look at the Institute of Medicine's "The Future of Emergency Care in the United States Health System," England's "Taking Healthcare to the Patient," and "The Future of EMS in Canada" reinforced the similarities and complexities surrounding EMS challenges. The burden of uncompensated care, personnel shortages and fragmented care are pervasive in all three countries.

Interesting projects to watch include two very innovative endeavors in the U.S. First, the Idaho Bureau of EMS is embarking on the "Bigger than Idaho Project." Their goal is to improve regionalized access to preventive, primary and tertiary healthcare services for rural Idaho residents. Over the next couple of years they will use federal Flex Grant funds to do a gap analysis, including needs assessment, catalogue of infrastructure, and identification of models of excellence. Nick Nudell, NREMT-P and Regional Specialist for the Idaho Bureau of EMS, will lead the movement to inspire collaboration and cooperation to consolidate EMS into the rural healthcare system in Idaho. Yes kids, regionalization is back!

Second, Joseph D. Hansen, Executive Director of the Critical Illness and Trauma Foundation and director of Sweet Grass County Ambulance in Big Timber, Montana, will lead a research project intended to improve outcomes. They hypothesize that elderly diabetes and CHF patients who are regularly monitored at home by EMS personnel will result in fewer ED visits and hospitalizations. This results in better utilization of healthcare resources, lower costs, and improves the quality of life for patients. EMS providers in very small communities will visit patients following hospital discharge. EMS will do home visits a couple times per week checking vital signs, dietary and medicine compliance, providing patient education as necessary.

The ongoing debate between expanded scope and expanded role kept creeping into the discussions. It makes one wonder if the U.S. missed the boat by deleting the Advanced Practice Paramedic from the National Scope of Practice. We continue to try to put EMS in a box, creating a few levels based on skills. On one hand, the consistency is good. On the other hand, it seems to be less practical to ensure patient care needs are met efficiently and effectively.

The 3rd Annual International Roundtable will be held in Queensland, Australia sometime next summer. Prior to that meeting, this energized group will teleconference seven times to discuss "hot topics," including international data sets, existing research, funding for future research, development of cost benefit/analysis templates, and the creation of an international curriculum catalogue.

The future of EMS will be hard to predict. The one constant will be change. ■

DON'T THROW THE BABY OUT WITH THE BATHWATER

IN DEFENSE OF... *Prehospital Endotracheal Intubation*

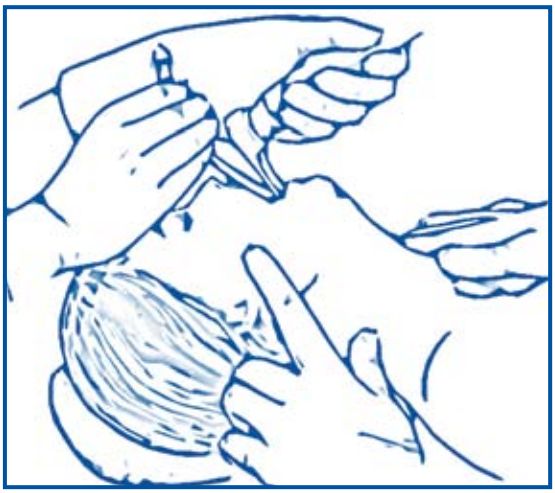
MICHAEL McLAUGHLIN, MAT NREMT-P
KIRKWOOD COMMUNITY COLLEGE, CEDAR RAPIDS, IA

Prehospital endotracheal intubation today is at a crossroads. With the publication of the *Emergency Medical Services Agenda for the Future* and its recommendation that prehospital patient care be grounded in research and evidence-based medicine (Dawson 1996), the practice of endotracheal intubation has come under increased scrutiny. Recent studies, including the San Diego RSI Trial (Davis, Ochs et al. 2003) and Dr. Henry Wang's work at the University of Pittsburgh (Wang 2005) (Wang 2002), have called into question the benefit of and even the need for prehospital endotracheal intubation.

The debate over prehospital endotracheal intubation is not a new one. In a 1983 article on prehospital intubation of the trauma patient, Robert Di Lorenzo, M.D. wrote: "In the final analysis, until an effective alternative to endotracheal intubation can be developed and field tested, the risk of prolonged hypoxia, intracranial hypertension, and aspiration far outweighs the risk of inducing spinal cord injury." (Di Lorenzo 1989). In 2000, Gausche and Lewis published their findings from a prospective, randomized study that showed no increase in survival or improved patient outcomes when they compared patients who were intubated with an endotracheal tube and patients who received only bag mask ventilations in the prehospital setting (Gausche, Lewis et al. 2000).

In its 2005 supplement to the journal Circulation, the American Heart Association cited studies that suggest there is an incidence of between 6% and 14% unrecognized tube misplacement or displacement in endotracheal intubations (Jones, Murphy et al. 2003). It is because of this and other findings that in its 2005 guidelines the American Heart Association reaffirms its recommendation that, "to reduce the risk of unrecognized tube misplacement or displacement providers should use clinical assessment plus a device such as an exhaled CO2 detector, [and that] providers should confirm the placement of any advanced airway immediately after insertion, in the transport vehicle, and whenever the patient is moved" (Hazinski 2005).

Despite the doom and gloom about prehospital intubation in some recent professional journals and other publications, there are evidence-based research studies that suggest that prehospital intubation is not only an essential paramedic-level skill but also one where the benefits still outweigh the risks. The ability to generalize useful conclusions from the Gausche study has been questioned due to the fact that it was limited to pediatric intubation in a large urban setting with short transport times to the hospital. A study published in Academic Emergency Medicine concluded that, "There appears to be added benefit to intubation over non-invasive airway maneuvers in correcting hypoxia" (Davis, Fisher et al. 2005). In contrast to the San Diego RSI Trial, a recent analysis of rapid sequence intubation in the prehospital setting suggests that the practice of intubation with neuromuscular blocking agents actually improves outcomes for patients with traumatic brain injuries (Bulger, Copass et al. 2005).



Historically, EMS has been a profession that has taken its cues from in-hospital emergency medicine. Often we adopt practices and use equipment because it has proven successful in the hospital setting or we have had anecdotal success in the prehospital arena. As a first line airway management system, the passing of an endotracheal tube through a patient's visualized vocal cords remains the gold standard in advanced airway management. Before prehospital providers relegate or – even worse – eliminate this weapon in our airway management arsenal, I would suggest that we explore a less drastic solution.

The American Heart Association correctly identifies misplaced and displaced endotracheal tubes as an issue of critical importance (Hazinski, Chameides et al. 2005). Their solution is primary confirmation, secondary confirmation, and then repeated re-confirmation of correct tube placement (Hazinski, Chameides et al. 2005). Before we conclude that paramedics are not skilled at intubating patients, let us make an attempt to aggressively educate all EMS providers in the critical importance of protecting the endotracheal tube and attempt to habituate in them the practice of frequently re-checking tube placement. This is not just an advanced provider skill. I have had first responders suggest to me that we place a C-collar on our intubated patients. I have had EMT-Bs remind me to check lung sounds after we have moved an intubated patient onto the cot.

In order to be skilled at endotracheal intubation, the paramedic needs to perform the skill frequently enough to maintain his or her psychomotor and cognitive skill sets. As an educator, I believe in correcting deficiencies and gaps in proficiency with analysis, education, and, when needed, remediation. The advances in advanced patient medical simulators and the evolution of medical simulation (both as a technology and a philosophy) may one day minimize the emphasis on live patient intubations as the yardstick with which to measure paramedic proficiency in endotracheal intubation. The verisimilitude of these simulators and the ability for the creation and re-creation of typical

and atypical airway management scenarios suggest a future where all paramedics have the tools and resources to maintain their advanced airway management skills.

Advanced airway management has benefitted from some very exciting technological advances in recent years. The gum elastic bougie, the lighted stylette, and the development of 'plug-and-play' prehospital end-tidal CO2 monitoring technology allow prehospital providers access to treatment and diagnostic equipment that was once the sole purview of the in-hospital provider. When preparing to manage the airway of any patient, the prehospital provider must have a Plan B and a Plan C should endotracheal intubation fail and a secondary or bridge airway strategy is needed. However, before turning our backs on endotracheal intubation and hitching our wagons to the latest airway management star, I would urge caution and deliberation. Before we undertake a complete 'ETT-ectomy' from our scope of practice and from our skill set, let us first try to solve the problem with education and by working to change attitudes and correct behaviors. ■

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The Scoop on Scope

The Old Battle: Skills, Knowledge, Titles

Rosemary Adam

"Iowa is going to remove the Iowa Paramedic level?" you ask.

That's the rumor. That rumor and some well-placed emails packed the house at the last Scope of Practice Subcommittee meeting on October 18. With the exception of one person, all of the communication about the issue was professional and the questions at the meeting were befitting of a State Advisory meeting. Thank you!

Now that I have your attention – let's try and answer some questions so you know what's going on.

The Scope of Practice Subcommittee was assigned the task of advising the Bureau of EMS through the Iowa EMS Advisory Committee on matters related to EMS boundaries of practice for this State. The subcommittee is made up of EMS providers of all levels, representing rural, urban, volunteer and paid with additional members from Nursing and the Physician community.

Over the past year, this group has been discussing the National Scope of Practice model and how that four-level EMS system will fit into Iowa's five-level process. Please refer to: www.NAEMSE.org. This site includes the National Scope of Practice document.

From this document, the National Association of EMS Educators is in the process of writing the four different curricula that match these EMS levels: Emergency Medical Responder, EMT, Advanced EMT and Paramedic. The first drafts of the education standards are not due to be released until the Spring of 2007. The anticipated implementation will not occur until 2010.

There is no purposeful intent to eliminate the Iowa Paramedic. Iowa's plan will include a time line for implementation and transition to make sure all current EMS levels from the 1999 rollout will fit into the 2010 changes. As an example of the patience in the transition process, Iowa still has 26 EMT-As (vs. EMT-Bs) from that 10-year process.

Since 1999, the battle has been raging that the Iowa Paramedic is nearly the same as the Paramedic Specialist because there are very few differences in the skill sets. What about the difference in knowledge? There are very few skill differences between the Licensed Practical Nurse (LPN) and the Registered Nurse (RN), but the difference in educational preparation is fairly large.

What if Iowa does (again) refuse to follow the National Standard Curricula as written and approved by the federal agencies? Issues include credentialing by other health care entities, national standards, national testing, recruiting, legal issues, federal grants, and professionalism. EMS needs a universal scope of practice just like Physician Assistants, nurses and nurse practitioners, and physicians.

The Institute of Medicine was tasked with studying emergency medicine in the U.S. and they reported a huge problem in EMS with fragmentation of levels in care. If you were to compare us to Canada, for instance, their entire country has about three levels. That system allows for very easy understanding by the entire healthcare community and the public. The U.S. has about 31 different levels in EMS. That report may be viewed at: www.iom.edu.

Be cautious when considering this new scope of practice model and how it should fit into Iowa's EMS system. Be careful of titles and thinking about your professional scope based just on skills.

Remain involved and aware. The Scope of Practice and Advisory meetings are held the 2nd Wednesday, quarterly. You may go to the Bureau of EMS website to find locations and dates. The next meeting will be held on Wednesday, January 10 with the Scope meeting in the morning and Advisory after lunch.

It's a little too early to protest something that has not been decided. The Advisory group and the Scope of Practice members are healthcare stakeholders with a firm knowledge of who is providing EMS in Iowa and the needs of the entire State. ■

What's *New* with the *Bureau*

ANITA J. BAILEY, PS

We extend a special thanks to our partners on the IEMSA board for inviting us to routinely submit to this vital publication. Quarterly, we intend to provide a brief overview of a couple current issues from the Bureau of EMS.

EMS System Standards

EMS System Development has a new face. The Bureau has developed and supported many initiatives since the mid-90s, but there was never enough funding to support all the proposals. Lack of leadership training, inconsistent funding mechanisms, and failure to embrace proposals led to varied implementation across the state. A handful of counties have benefitted greatly from these programs. Others were not as successful. A few system "best practice" models have evolved, but the majority of counties struggle to implement system development concepts. A primary goal of this EMS System Standards initiative is to reduce this fragmentation and provide an inclusive system to assure patient and provider needs are met.

The Bureau of EMS currently regulates standards for providers, service programs and training programs. A standard defines common performance expectations, structure, and processes to ensure minimum activities are carried out for every patient. Standards have been developed "sub-systems" for pediatrics, trauma, injury prevention, and data collection. In order pull this all together, minimum standards for EMS Systems are the next step in the evolution of EMS in Iowa. This answers the question, "What should every Iowan expect from EMS?"

The Bureau will convene a group of partners to develop a draft document to present to the Iowa EMS Advisory Council in late 2007. The group will review eight possible areas to define minimum EMS System Standards:

1. System Administration
2. Staffing and Training
3. Communications
4. Response and Transportation
5. Facilities and Critical Care
6. Data Collection and System Evaluation
7. Public Information and Education
8. Disaster Medical Response and Planning

Pilot evaluations will be conducted to determine measurability of benchmarks, ease of implementation and associated costs. Local systems will define how large of an area they wish to include. There are some areas that will benefit greatly from collaborating across county lines.

If you wish to be a part of this exciting project, please contact project leaders, Larry Cruchelow at lcruchel@idph.state.ia.us or Craig Keough at ckeough@idph.state.ia.us.

National EMS Scope of Practice Model (NSPM)

The Scope of Practice is a description of what any certified EMS provider legally can or cannot do within a state. It intends to delineate the minimum knowledge and skills necessary for providers to function safely and effectively at each level. Combined with certification, education and credentialing, the scope helps develop a competent workforce. Iowa currently defines 11 levels of EMS provider. Nationally, more than 40 levels are defined. This fragmentation leads to confusion among the public and providers and makes reciprocity difficult.

The NSPM defines four levels of providers. It is suggested that states adopt the standards as written, but acknowledges that some specialty certifications may evolve to accommodate local needs and subtle differences in practice environment. States that deviate from the NSPM must develop their own infrastructure that includes educational content (curriculums and lesson plans), support materials (texts and AVs), and certification examinations. Yikes!

The NSPM document defines the following four levels:

Emergency Medical Responder (EMR)

The EMR will initiate immediate lifesaving care to critical patients while awaiting additional EMS response. The interventions at the EMR level will be simple, non-invasive interventions with minimal equipment, based on assessment findings.

Emergency Medical Technician (EMT)

The EMT will provide basic emergency care and transportation for critical and emergency patients. The EMT will perform basic, non-invasive interventions and is the minimum staffing for transport.

Advanced Emergency Medical Technician (AEMT)

The AEMT will provide basic and high-benefit, lower risk advanced emergency medical care and transportation for critical and emergency patients.

Paramedic

The paramedic is an allied health professional who provides advanced emergency care for critical and emergent patients. The paramedic performs basic and advanced interventions based on advanced assessment and the formulation of field impressions, linking the scene to the healthcare system.

Following considerable input and discussion, the Iowa EMS Advisory Council (EMSAC) has voted to embrace the premise of the National Scope of Practice and accept the proposed four-level system. EMSAC acknowledges that the process will be challenging and somewhat painful. Time frames, bridge courses and costs associated with the transition will need thoughtful consideration. Impact on current recruitment and retention strategies will be deliberated as well. First draft curriculums are scheduled to be released early in 2007. Getting a look at those documents will help classify skills and provide information to stimulate more discussion.

EMSAC Chair Jeff Messerole and Bureau Chief Kirk Schmitt urge everyone to stay informed and involved with the process. Make your wishes known by attending the quarterly meetings, through your representative on EMSAC, or directly to Bureau of EMS staff.

The National EMS Scope of Practice Model document is available at www.idph.state.ia.us/ems. These are exciting times for EMS! ■

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AUGUST – OCTOBER, 2006

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Legislative Report

RIC JONES, IEMSA PUBLIC POLICY CHAIR

2006 Update

We have been busy preparing our talking points and strategies and seeking partnerships for a successful legislative session. In recent weeks, we appeared before the Legislative Interim Committee on Emergency Services twice. The early October presentation highlighted challenges to greatness in EMS. The committee is focusing their attention on urging collaboration where appropriate. I look for strong direction from the Legislature to share resources wherever and whenever possible. The immediate focus is on the regional training centers for the Fire Service. There is great interest in assuring that they will have programming and facilities for all emergency responders.

We made a strong case that EMS is the third leg of the public safety triangle and that fire and law enforcement alone do not complete the puzzle. We made a case for additional funding for the EMS Bureau and EMS training. We discussed ways to improve recruitment and retention of the volunteer and career work force. We discussed arcane district lines and possible collaborative solutions. It appears that another meeting is certain. So far there are far more questions than answers. Even if nothing results directly from the interim committee's work, a great deal of information found interested ears. Because of this, our advocacy should be a little easier this year.

We shared agendas with member groups of the Iowa Fire and Emergency Response Council at their Ames meeting on November 2. We have much in common and will be able to build on our strengths to create some synergies with the other public safety groups.

Speaking of public safety, we have been invited to make a presentation to the joint public safety committee in December about IEMSA's possible inclusion in that group. The committee is made up of many of the main paid players in Iowa public safety, including the Iowa Professional Fire Fighters, Iowa State Troopers' Association, Iowa State Troopers Supervisors' Association, Iowa State Policemen's Association, Iowa Chiefs of Police, The Iowa Sheriff's Association, and others. Their focus is also about synergy. They host a dinner for lawmakers before every session and present the groups' agendas en masse. They have been very effective in advancing legislation. It is my hope that we can convince them to invite us to join their group.

We expanded our professional team this year as well. We have re-enlisted the very capable and well-credentialed Cal Hultman as our lead lobbyist. Cal's associate, Mike Triplett, is another recent addition to the team. They will begin immediately seeking lawmakers to sponsor bills on our behalf. They will provide us with weekly reports during the session. Look for these reports in IEMSA's weekly E-News. Please understand, though, that there will be weeks when the report is that nothing happened. Remember, no report is not necessarily a bad report.

2007 Legislative Agenda

We anticipate a faster pace in the Iowa Legislature in 2007 than was demonstrated in 2006. As I write, the caucuses are meeting and choosing their leaders for the session. The Democrats hold a firm majority in both houses and hold the governorship. Contradistinct to the situation in the previously deadlocked Senate, it is my belief that legislation will happen comparatively rapidly this year.

IEMSA's Board of Directors unanimously adopted the following as the 2007 Legislative Agenda at the annual meeting on November 9 in Des Moines.

The Iowa Emergency Medical Services Association will work for the following public policy measures:

1. Provide for equity of pensions for public employees in EMS. Currently firefighters and law enforcement officers under the Iowa Public Employment Retirement System (IPERS) receive a higher retirement benefit earned with fewer years of service than EMS providers.

2. Protection of any and all current language on scope of practice and area of practice for EMS providers.

3. Provide a permanent funding stream for the provision of emergency medical services for all Iowans. This includes fully funding the Bureau of EMS, including the restoration of a full-time physician medical director and an AED Coordinator, as well as providing money for training and equipment for individual EMS services in the State.

4. Provide a system to reward volunteerism in public safety. This might take the form of an Iowa income tax credit or the ability to earn a pension for volunteer service in EMS, Fire or Law Enforcement.

5. Provide support for other initiatives and organizations working to improve the health and safety of Iowans.

6. Require that counties shall make provision for, by whatever means necessary, emergency medical services treatment and transport for all within the county.

7. Require complete criminal background checks on all EMS providers and students or allow the EMS Bureau and EMS Service Directors access to any and all criminal records of any EMS student or provider.

8. Provide liability protection for volunteer physician medical directors.

9. Provide tuition rebates for EMS Provider certification training for persons who become active EMS volunteers.

10. Allow EMS service directors to sign off on eligibility for EMS license plates.

11. Support the Bureau of EMS's four agenda items: Requiring counties to provide EMS, establishing a patient transport fee, requiring electronic data submission, and requiring criminal background checks on all EMS providers.

We believe that job number one for every elected official is to keep Iowans safe and healthy in their homes, at work, at leisure and in transit. This includes fully funded, well-trained, and dedicated law enforcement, fire and Emergency Medical Services resources throughout the state.

2007 Iowa EMS Day on The Hill

Iowa's annual EMS Day on the Hill is schedule for Thursday, February 1 at 7:00 a.m. in the Capitol Rotunda. Please plan to join us. Enjoy coffee, juice and donuts and meet with your lawmakers to help them understand Iowa EMS's needs. It's fun and has resulted in a great deal of success.

We are hearing that there may be some discontent about our area of practice from another group of healthcare providers. The introduction of legislation to further limit where EMS providers can practice is not inconceivable. We stand ready to resist any such measure, should one be raised. We are currently gathering information on this issue and hope to disarm it before it wins any legislative attention.

How Can I Help?

It could not be truer that all politics are local. Direct contact with your lawmakers to share the 2007 Legislative Agenda along with illustrations of how these legislative changes improve your local EMS system are the most effective tools we have. Identify your senators and representatives and contact them through the General Assembly's website: www.legis.state.ia.us.

If there are other issues that need addressing in addition to those on the 2007 agenda, please communicate those to us. The Board of Directors can approve additions to the legislative agenda. If you've got a no-brainer suggestion, we can organize a consensus via e-mail for immediate approval.

Don't be shy and dismiss your ability to change your world. You can. Sometimes, all it takes is a conversation. ■

2006 Board of Directors Election Winners

NORTHWEST REGION

Terry Stecker *(New)*
Terry is a Paramedic Specialist employed with Siouxland Paramedics as the Director of Operations in Sioux City. Terry has been involved in EMS since 1982 as a volunteer on the Pierson Ambulance and Fire Department. He is very active on the Woodbury County and Plymouth County EMS Boards and is also a member of the Sioux Lakes EMS Board, WITCC EMS Advisory Committee, Tri State Disaster Committee and several other regional committees.

NORTH CENTRAL REGION

David Johnson *(Returning)*
Mr. Johnson is the Captain and EMS Director for Mason City Fire Department. Dave holds a B.A. in Fire Department Administration as well as the following certifications: EMS-PS and BLS/ACLS Instructor. He is a 1985 EMT-P Graduate from the University of Iowa Hospitals and Clinics EMSLRC. Dave has been serving as an NC Region Representative on the IEMSA Board of Directors in the seat that was vacated by Tammy Snow.

Thomas Craighton *(New)*
Mr. Craighton has been in EMS since 1982. He is currently the EMS Manager/Coordinator at Franklin General Hospital, where he also serves as their Respiratory Care Manager/Coordinator. Thomas holds certifications as a Paramedic Specialist, Critical Care Paramedic, Respiratory Therapist and Firefighter II. Thomas has been a member of IEMSA since 1988 and served on the board between 1994 and 2000. He is also an instructor at NIACC, a Flight Paramedic for Air Life North and a volunteer for the Coulter Volunteer Fire Department.

NORTHEAST REGION

Rick Morgan *(New)*
Rick has been a member of IEMSA and involved in healthcare for over 25 years. He began his EMS career as a volunteer EMT-A. Rick became a Paramedic in 1980 and was an original ORMIC graduate. He is currently employed as a PS, CCP at Mercy Medical Center in Cedar Rapids in ICU. He is also active as an ACLS and BLS Instructor/Regional Faculty. Rick adds his Respiratory Therapy experience and talented teaching abilities to his extensive EMS background in three regions of Iowa. According to Rosemary Adam in her nomination letter for Rick, "when an organization like IEMSA calls for experienced EMS providers with the ability to get the job done, we call on Rick Morgan."

SOUTHWEST REGION

Jan Beach-Sickels *(New)*
Jan has been involved in EMS since 1986, serving as a volunteer since then with Lenox Ambulance Service, where she is presently Director. She worked as a Paramedic Specialist for seven years in a hospital-based ambulance service, and two and a half years for Fraser Medical Services where she is a PRN employee. Jan is an EMSI and teaches FR through PS classes for Southwestern Community College in Creston, as well as continuing education, BLS, and ACLS. She also serves as System Development Coordinator for Union County EMS Association.

Bill Fish *(Returning)*
Bill is currently a Critical Care Paramedic and Director of Carroll County Ambulance Service. He started his EMS career as a volunteer firefighter in Red Oak in 1982, later becoming a full-time member of the department. There he became a first responder, EMT-A, and later attained the EMT-I certification. Bill attended the U of I EMSLRC paramedic program in 1991. In 1992 Bill was recruited to Davis County Hospital when the local private ambulance service was transferred there. In 1994 he became Director for the county-wide EMS system. Bill and his wife Deb have two very active girls, Beth and Katelyn. Bill's hobbies include Christmas Lights displays, camping, walking and gardening.

SOUTH CENTRAL REGION

Jon Petersen *(New)*
Jon is a Lieutenant at West Des Moines Emergency Medical Services. Having been in EMS since 1989, Jon has worked in such diverse environments as Las Vegas, rural Iowa EMS and flight medicine. Jon is married and has one son, Austin (13). Away from EMS Jon enjoys outdoor activities such as fishing, hunting and golf.

SOUTHEAST REGION

Tom Summit *(Returning)*
Tom has been involved in EMS for 28 years. He is employed by the Muscatine Fire Dept. as EMS Liaison/Ambulance Operations, and is a Paramedic-Specialist/Critical Care Paramedic and Firefighter II. Tom is also a certified ERT and Iowa EMS Instructor, and serves as deputy Medical Examiner for the Muscatine County Sheriffs Dept. Tom is the President of the Muscatine County EMS Association and immediate Past President of the Southeast Iowa EMS Council. Tom has also served on the Muscatine EMS committee and is a Past President and board member of the Muscatine-Louisa American Red Cross, and Great River Days board of director. Tom's sons, Andy and Jason are both involved in EMS. Another son, Matt, is deceased.

AT LARGE – Dan Glandon *(New)*
Dan has been involved in EMS since 1980. He is retired from the U.S. Coast Guard where he began in EMS. He is currently a Base Paramedic Supervisor at Air Evac Lifeteam, Adjunct Faculty at Indian Hills Community College, and part-time Paramedic at Davis County Hospital. He also owns Continuing Education Solutions. Dan and his wife Suzan live in Hayesville and have four children.

AFFILIATE PROFILE: Clive Fire Department

The Clive Fire Department prides itself on many things, but the biggest point of pride for the CFD is its people. More than 85 responders work together to provide fire and EMS services year-round in Clive. Sharing one station with the West Des Moines Fire Department and staffing another with in-house 24/7 staffing, the CFD utilizes a mix of full-time employees augmented by part-time staff to serve a population of 15,000 citizens. In the spirit of cooperation, the Clive Fire Department partners with Urbandale Fire Department, West Des Moines Fire Department and West Des Moines EMS to govern WestCom, a tri-city public safety dispatch center.

Established in 1962, the City of Clive and the Clive Fire Department has seen exponential growth and a corresponding increase in demand for public safety services. The Clive Fire Department operates two ALS ambulances and one ALS rapid response vehicle and often provides frequent ALS mutual aid to neighboring communities. In 2005, The Clive Fire Department responded to 1,672 calls for service in and around Clive, and in 2006 the Iowa EMS Association named the CFD as the Iowa Career EMS Service of the Year.

The Clive Fire Department spearheaded implementation of public access defibrillation in the city and has placed nine AEDs in service to the community so far. Fire Chief Rick Roe has built a culture within the department that values each individual and utilizes them in concert with their talents. Under Medical Director Joe Karre, the Clive Fire Department was among the first EMS services in Iowa to implement intranasal delivery of medications and continues to lead the way in the development of cutting edge protocols, education, and quality improvement initiatives. Under the leadership of Chief Roe, Assistant Chief Brad Madsen and the other officers, everyone at the Clive Fire Department takes pride in their commitment to excellence in EMS and fire fighting. ■

AFFILIATE PROFILE: Blairstown EMS

Blairstown EMS was awarded the Volunteer Service of the Year Award from IEMSA at the 2006 Annual Conference and Trade Show in Des Moines. They dedicate their award to Dr. William Moothart who passed away suddenly. "His expertise as a wonderful physician, his positive attitude, support of our crew, and warm smile will be missed so much! Our crew would not be what is today if it had not been for his leadership as our Medical Director."

In History

Like so many services in rural Iowa, the details of the establishment of Blairstown EMS are a bit murky. It all began with people volunteering to take a Desoto from the funeral home to take people to the hospital quickly. The first volunteers may have started in the late 1930s or early 1940s. Eventually the city bought a station wagon that served as the first "city-funded ambulance," and 1970 was about the time that Blairstown gained their first trained EMTs.

Once the city had an ambulance it was housed in one bay of the fire department. At the end of 2004, Blairstown began to use one of the city buildings and started remodeling it into an ambulance garage. A large donation from a local business made it all possible. What had been a large storage shed at one time was transformed into an office, a meeting room with kitchen and laundry, a bedroom, a supply room, and an ambulance bay. The business that made the large donation for our building and an additional AED wishes to remain anonymous… but we thank them with all our hearts! We were able to host our first EMT-B class in the meeting room and have a bedroom for those who stay overnight for a shift.

Today

Blairstown averages about 170 calls per year with a record high of 191. Blairstown EMS is currently Paramedic Conditional and has been at the paramedic level since 2000. The crew is comprised of 25 members (24 volunteer and one part-time/paid director). Six of the volunteers commit to serve from out of town.

Blairstown's coverage area includes Blairstown, Norway, Van Horne, Watkins and a large rural area in southern Benton County. Blairstown also works with the First Responder services of Norway, Van Horne, Newhall and, on occasion, Keystone.

Blairstown EMS has been a member of IEMSA since 2003. The service has this to say about their membership: "IEMSA is our voice in EMS – from representing us in lawmaking issues to obtaining group rates for supplies. The annual conference CEHs are always great, too. We appreciate all the time and energy they have for all of us working in EMS!"

Service

Blairstown EMS can be proud of a long list of community service involvement with local projects and organizations, including:

- PAD Program – AED placed in Blairstown Community Center
- Teach CPR, AED and 1st aid skills
- Help with HOSA (Health Occupation Students of America) and health class at Benton Community High School
- Local blood drives
- Medic/first aid badges for Boyscouts and Girlscouts
- 4-H Club
- Annual soup luncheon
- First aid coverage at many special events throughout the year

Blairstown's Mission

"Our goal is to respond to each call we receive in a timely, safe and professional way that exemplifies the best possible emergency care for each patient we serve. More often than not, our patients are our friends and neighbors. This is sometimes more difficult for us, but the patient is always glad to see a familiar face after calling 911. Whether the patient is a neighbor or someone passing through, we as volunteers are committed to helping patients and often their families during their emergency with the best possible care and compassion we can provide." ■

REDESIGNING PUBLIC HEALTH in *Iowa*

CRAIG KEOUGH, PS

This initiative, which is a collaborative effort between local and state public health, was launched in the summer of 2004 in response to the challenges facing the public health system in Iowa. A work group of local and state public health professionals was commissioned in the summer of 2004 to assess public health service delivery and to make recommendations for redesigning public health in Iowa.

The Work Group decided to establish local public health standards as an initial step. More than 100 local and state public health professionals and public health partners were invited to serve on committees to draft local public health standards. Committee members included representatives from local public health agencies, local boards of health, EMS, boards of supervisors, state legislature, academic institutions, the State Board of Health and the Iowa Department of Public Health.

Since October 2005, nine Local Public Health Standards Development Committees have met monthly to draft standards. Committee members used resources from federal agencies, national organizations, and other states in addition to their own expertise and input from colleagues and stakeholders. Guiding principles used by the committees in developing the standards were:

- What should every Iowan reasonably expect from local and state public health
- Use clear, concise language that is easily understood by both public health professionals and laypersons outside of public health
- Identify criteria to meet the standards that are measurable
- Incorporate the principles of the public health core functions (Assessment, Policy Development, Assurance) and 10 essential services (Monitor Health, Diagnose and Investigate, Inform/ Educate/Empower, Mobilize Community Partnerships, Develop Policies, Enforce Laws, Link to Provide Care/Assure Competent Workforce, Evaluate, Do Research)

Representatives of EMS are participating on the Work Group and Local Public Health Standards Development Committees. These representatives have worked on the standards for Community Assessment and Planning (identify priorities and build a health improvement plan); Prevent Injuries (provide leadership in involving community stakeholders in efforts to prevent intentional and unintentional injuries); Prepare for, Respond to, and Recover from Public Health Emergencies (maintain and update the Public Health Emergency Response Plan).

The Work Group for Redesigning Public Health in Iowa accepted comments and suggestions about the Iowa Local Public Health Standards from all interested parties from March 28, 2006 through May 11, 2006. To view comments on the standards go to http://www.idph.state.ia.us/rphi/default.asp.

Local Public Health Standards Development Committees will meet now through March 2007 to review stakeholder comments and make recommendations for potential changes based on submitted comments. The workgroups will also develop a county self-assessment tool and several demonstration projects may be conducted to provide additional data on the measurability of the criteria and costs. The results of the field-testing will assist the Work Group in determining implementation strategies, which will include legislative changes and funding requests.

How does this impact local EMS? This initiative will strengthen the link between the county EMS association and the local public health agency. Local public health will need our help to complete assessments. EMS experts will need to provide input to assist with planning for disaster response, mass immunization, disease surveillance and Strategic National Stockpile local distribution. Additionally, this is the same process the department will utilize to implement EMS System Standards. Now is a good time to get to know your local public health board members and nursing staff. ■

Highlights of Membership Benefits

NAEMT Membership Discount
Members of IEMSA receive a 25% savings on individual membership dues. Call (800) 34-NAEMT to learn more.

Group Purchasing
Affiliate Members – Don't forget to check out the discounts available through IEMSA's Group Purchasing program. Visit the Group Purchasing Page at www.iemsa.net to get connected with Alliance Medical, Inc. and Tri-Anim Health Services, Inc.

AAA Insurance Products
Now available to IEMSA membership at the Association discount rate. Contact Melissa Frievalt at (800) 236-1300, x2418.

AFLAC Insurance Products
Now available to IEMSA membership at the Association discount rate. Contact Marvin A.Wittrock, District Sales Manager, at (515) 432-0578.

IEMSA E-News
IEMSA Members receive a limited number of free and discounted submissions to IEMSA's weekly E-News publication. Read the E-News Submission Policy at the publications page of IEMSA's website for more information, or contact Abby Russi at communications@iemsa.net.

Classifieds Online
Members may post equipment and employment advertisements on IEMSA's website. Send ads to communications@iemsa.net. Please specify that the ad is for the website.

2006 Annual Conference and Tradeshow *Recap*

BY ABBY L. RUSSI, IEMSA COMMUNICATIONS SPECIALIST

This is where you might expect to read "another year, another conference." Coming from this conference rookie, you'll hear nothing remotely close. I've heard IEMSA's annual conference described as the premier annual EMS event in the state of Iowa. After seeing it with my own eyes, I'll likely be the source quoted for lavishing kudos on these extraordinary efforts and events in the coming year.

Record Setting Growth

At least 1,225 people are on record as having attended events at IEMSA's 2006 Annual Conference and Trade Show that took place November 8 through 11 in Des Moines, Iowa. This is a 10% increase in attendance over last year's record setting attendance. As a result of this growth, conference events overflowed from The Plex and Downtown Marriot and into the Renaissance Savory Hotel. It seems Iowa is running out of venues large enough to host Iowa EMS's largest contingent.

As conference attendance increases, so does its programming. This year, participants had more choices than ever in the way of breakout session topics and speakers. 2006 Annual Conference-goers were a privileged audience of national and local speakers, the likes of which are seldom gathered under one roof. From pre-conference hands-on workshops to a celebrity keynote address from Randolph Mantooth – *Emergency's* Johnny Gage – it will be tough to top the 2006 lineup.

Technology to the Rescue

The volume of people and events could not have been managed as smoothly as they were had it not been for the wise foresight of board and staff members to adopt various new technologies into IEMSA's arsenal of resources. In addition to electronic registration, members this year took advantage of an electronic ballot for the Board of Director's election. Barcode scanning for continuing education hours saved conference attendees and workers much valuable time. Some coned certificates were dispersed on-site! A mid-conference E-News (one of IEMSA's newest communication tools) was even published, with up-to-the-minute news and information. Last but not least, session evaluations were digitally scanned for consistent and virtually instantaneous feedback. These innovations freed up time for IEMSA's board and staff to remain focused on more pressing needs and even to benefit from some of the conference events as fellow EMS providers.

Unforgettable

While technology was integral in the success of the 2006 Conference and Trade Show, it was the people who stole the show. A Veterans Day memorial service was carried out on Saturday morning that paid tribute to the fallen EMS providers of Iowa. The service, known as "Honoring Our Own," hosted the family members and loved ones of those it respectfully and affectionately recognized with a traditional honor guard and bagpiper, a touching slide show, a symbolic Table of Honor, a stoic final ringing of the bell for each name read, and speeches and readings from ceremony leaders and participants. It was difficult to find a dry eye in the room.

Randolph Mantooth gives keynote address at the 2006 Annual Conference and Tradeshow.

Another fond gathering was the annual awards ceremony that took place on Friday over lunch. Individuals, Services, Instructors, Hall-of-Famers and Friends of EMS were all recognized in both career and volunteer categories. Randolph Mantooth graciously presented the awards to the winners, thrilling the recipients with unique photos ops that I encourage you to enjoy in the Annual Awards coverage.

IEMSA leaders President Jeffery Dumermuth and Past-President Jerry Johnston were recognized throughout the events for their stellar leadership on a state and national level. A congratulatory reception was held on Thursday evening for Jerry Johnston's recent accomplishment of being named President of the National Association of Emergency Medical Technicians (NAEMT). In addition, Jeffery Dumermuth thanked Jerry Johnston for his contributions to the field of EMS at the Annual Meeting on Thursday night. The tables were turned when Jeff Dumermuth's recent NAEMT Award, The William Klingensmith EMS Administrator of the Year, was highlighted at the annual meeting. Iowa EMS can only benefit from the quality of the leadership that was made so evident from these honors.

Other Iowa EMS figures who enjoyed well-deserved moments in the spotlight were newly elected board members and scholarship winners who were each announced at the annual meeting on Thursday night. Look for full coverage of the board election results and scholarship winners in this and the next edition of *The Voice*.

A Collective Effort

While most conferences of this scale and magnitude are likely planned and managed by full-time professional event planners, IEMSA's 2006 Annual Conference and Trade Show is accomplished as a result of an astonishing collaboration of volunteer time and talents. The moment I came on board with IEMSA last Spring, I was exposed to the year-round efforts that culminate in this first-rate occasion. A heartfelt thank you from the IEMSA Board of Directors and staff goes out to the conference planning committee and subcommittee members, speakers, student volunteers, IEMSA member volunteers, corporate sponsors, exhibitors, volunteer photographers, facility staff and many, many more.

Until next year, mark your calendars for another great event November 8 through 10, 2007! ■

Military, fire, and EMS representatives stand guard over the table of honor.

Randolph Mantooth signs autographs for Annual Conference and Tradeshow attendees.

Annual Conference and Tradeshow attendees enjoy a walk around the spacious expo hall.

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