Approved March 6, 1991
Date

MINUTES OF THE SENATE COMMITTEE ON LOCAL GOVERNMENT.

The meeting was called to order by Sen. Don Montgomery at
Chairperson

9:00 a.m./p.m. on March 5, 1991 in room 531-N of the Capitol.

All members were present except:

Sen. Gaines

Committee staff present:

Emalene Correll, Legislative Research
Theresa Kiernan, Revisor of Statutes
Mike Heim, Legislative Research
Shirley Higgins, Committee Secretary

Conferees appearing before the committee:

Bob McDaneld, Board of Emergency Medical Services
Larry Couchman, Riley County Emergency Medical Service
Jerree Forbes, EMS Program, Hutchinson Community College
Dr. Lester Richardson
Randy D. Easter, McPherson Emergency Medical Service
Fred Thorp, Kansas City, Kansas, Fire Department
R. E. "Tuck" Duncan, Medevac Medical Services

SB 271 - Concerning emergency medical services.

SB 273 - Concerning health care providers; relating to peer review.

Bob McDaneld, Board of Emergency Medical Services, testified in support of SB 271 with suggested amendments as shown on a balloon which he had prepared. (Attachment 1.)

The Chairman asked Mr. McDaneld for his stand on SB 273. Mr. McDaneld stated that this bill makes a simple but important change. It creates a brand new area. It makes ambulance attendents and first responders accountable to peer review programs. He feels they should have the same protection to develop qualaity insurance programs as other health care providers have.

Larry Couchman, Riley County Emergency Medical Service, testified in support of SB 271 and also included letters of support from Memorial Hospital in Manhattan and from Manhattan Family Physicians. (Attachment 2).

Jerree Forbes, Hutchinson Community College, followed with further testimony in support of SB 271. (Attachment 3).

Dr. Lester Richardson testified in support of both SB 271 and SB 273. (Atttachments 4 and 5). Dr. Richardson suggested the deletion shown in Mr. McDaneld's balloon on page 4, line 1, "during an emergency", be left in the bill. The Chairman asked Dr. Richardson if he was in agreement with the other recommendations in the bill. Dr. Richardson was in agreement with them.

Randy D. Easter, McPherson Emergency Medical Service, gave testimony in support of SB 271. (Attachment 6).

Fred Thorp, Kansas City, Kansas Fire Department, followed in support of SB 271. (Attachment 7).

R. E. "Tuck" Duncan with Medevac Medical Services, Inc., appeared in support of SB 271. (Attachment 8). Mr. Duncan noted tht it would be helpful if the committee could see a copy of the Attorney General's opinion to which he referred in his testimony.

With regard to SB 273, Mr. Duncan said he is in support of it. However, he feels that the report after the peer review should be destroyed so that the records are not discoverable.

Also distributed were two letters of support for SB 271 from persons not able to appear. (Attachments 9 and 10).

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON LOCAL GOVERNMENT,

room 531-N, Statehouse, at 9:00 a.m. ~~p.m.~~ on March 5, 1991.

Lt. Bill Jacobs, Kansas Highway Patrol, stood in support of SB 271.

The Chairman asked two representatives of the Kansas State Nurses Association if they support the bill. They replied that they have no problem supporting it with regard to the transfer of persons, but they do have difficulty with allowing emergengy personnel to treat persons in medical care facilities.

The minutes of March 4 were approved with a correction on page 2 in the motion made by Sen. Frahm where "that it be placed on the Consent Calender" was deleted as it was not part of the motion.

The meeting was adjourned at 9:58 a.m.

Date: 3-5-91

GUEST REGISTER

SENATE

LOCAL GOVERNMENT

NAME	ORGANIZATION	ADDRESS
R.E. "Tuck" Duncan III	Medevac	Topeka
Thomas L. Little	Medevac	411 S. Jackson
JERREE FORBES	Hutchinson Community College	815 N. Walnut Hutchinson
Larry Cochran	Riley County EMS - Memorial Hospital	2011 Claflin, Manhattan
RANDY EASTER	Memorial Hospital / McPherson EMS	1000 Hospital Dr. McPherson KS.
Ed FLETCHALL	Hutchinson Hosp / Reno Co. EMS	1701 East 23rd Hutchinson, KS 67502
Joe FURJANIC	KCA	TOPEKA
Lester C Richardson, DO	Emergency Physician Advisor to Johnson Co. Med Act	Shawnee Mission Med Ctr Sm, KS 66201
MICHAEL PRESS	Johnson County MED-ACT	10901 LOWELL #135 O.P. KS. 66209
Don White	Ks Board of EMS	109 S.W. 6th Topeka
Tom Pollan	KEMTA, KAEMSA, AJA Sedgwick County EMS	538 N Main, Wichita 67203
Chip Wheeler	Ks Medical Society	Topeka
Jerry Sloan	KMS	Topeka
Connie Kahe	KSNA	Topeka, Ks
Joyce Doemel	Ks Dept Health & Env	Topeka KS
Sherrin Nuckolls	AG's Office	Topeka
Lt. BILL JACOBS	KS HIGHWAY PATROL	TOPEKA
Mark W. Stafford	KS Attorney General	Topeka
Gloria Meyer	KSNA	Atchison, Ks.
Kathy Miller Hall	SJMC	Wichita
Pat. Johnson	Board of Nursing	Topeka
Terri Roberts	KSNA	Topeka

Date: 3-5-91

GUEST REGISTER

SENATE

LOCAL GOVERNMENT

NAME	ORGANIZATION	ADDRESS
Diane Gilyard	Asst. Atty. General	Judicial Center
Jon Cannon	Ark City Firefighters	115 So. D St. Ark City, KS 67005
FRED THORP	KCKFD/EMS	815 N 6th KCK 66101
Bob McDonald	Board of Edu	
Shawan Stegman	WSU - Grad. Nursing Prog.	3917 N Athenian
Joan Thome	WSU - Grad Nsg Prog	19000 W 55th St So. Viola KS
Sue Rotz	WSU - Grad Nsg Student	8019 Lakepoint Way Wichita
Jan Kahler	WSU - Grad. Nsg. student	2900 Wabaunsee Dr. Wichita 67204
Frances Marshall	WSU - Journalism	1806 [illegible]

State of Kansas
BOARD OF EMERGENCY MEDICAL SERVICES

109 S.W. 6TH STREET, TOPEKA, KS 66603-3805
(913) 296-7296 *Administration*
(913) 296-7403 *Education & Training*
(913) 296-7299 *Examination & Certification*
(913) 296-7408 *Planning & Regulation*

Bob McDaneld
Administrator

Joan Finney
Governor

DATE: March 5, 1991

TO: Senate Local Government Committee

FROM: Bob McDaneld

SUBJECT: Testimony on SB 271 and SB 273

The Board of Emergency Medical Services voted at its February 1, 1991, meeting to request that the Senate Local Government Committee introduce legislation which make a number of changes to the current emergency medical services statutes. SB 271 is that legislation. SB 273 adds ambulance attendants to the definition of health care providers in the peer review/quality assurance statutes.

As committee members may recall, most EMS legislation has been introduced by the Local Government Committee since an interim local government committee studied emergency medical services and developed the concept of an independent agency in 1987. In addition, Sen. Don Montgomery has served as a member of the Board since its creation in 1988.

Because of the very limited timeframe to develop legislation and have that legislation introduced as a committee bill, the State Board of Nursing and the Kansas State Nurses Association were not consulted prior to filing the bill. Both agencies had a number of concerns about new language in SB 271. I met with Pat Johnson of the State Board of Nursing and Terri Roberts of the Kansas State Nurses Association to see if compromise language could be developed to address their concerns. We have jointly provided a balloon copy of SB 271 which includes the following:

Amend K.S.A. 65-6112 and related statutes to delete the "crash injury management technician" level of certification from authorized levels of attendant certification. A new section permits currently certified crash injury management technicians to apply for certification as a first responder or emergency medical technician as prescribed in rules and regulations adopted by the board.

Almost all crash injury management technicians are members of the Kansas Highway Patrol. The KHP is now training its troopers as first responders instead of crash injury management technicians and will be supporting this bill.

(Continued on next page.)

Senate L.G.
3-5-91
Attachment 1

Amend K.S.A. 65-6112 to clarify the definition of "emergency medical service" to ensure that ambulance attendants may legally provide non-emergency medical care in the pre-hospital phase of patient care and transportation.

Amend K.S.A. 65-6120 to permit emergency medical technicians-intermediate to provide intra-venous therapy without first establishing direct voice contact with a physician when approved by the local component medical society in written protocols.

Amend K.S.A. 65-6129 to permit the board to regulate instructor-coordinators in the same way as the board regulates other levels of personnel. This would include establishing fees for certification and certification renewal, creating a certification examination, and mandating continuing education requirements.

Amend K.S.A. 65-6129 to permit regaining an attendant's or instructor-coordinator's certificate within two years of its expiration without taking an examination.

Amend K.S.A. 65-6145 to permit a person enrolled in an initial course of training program or continuing education approved by the board to perform the activities authorized for that level of certification when the person is being supervised by a qualified instructor, as defined in the bill.

The Board of Emergency Medical Services believes these changes are necessary for Kansas emergency medical services to continue providing training programs and pre-hospital care. I request your support of SB 271, with the changes proposed by the board, the Kansas State Board of Nursing, and the Kansas State Nurses Association.

The Board of Emergency Medical Services also supports passage of SB 273. This bill amends K.S.A. 65-4915 to include ambulance attendants and first responders in the definition of "health care provider" in the peer review/quality assurance statutes.

This change would permit ambulance services to develop peer review/quality assurance programs with the knowledge that records of those programs could not be subpoenaed. The board believes it is essential that Kansas ambulance services have the tools with which to develop good quality assurance programs. SB 273 provides one of the necessary tools for this important task.

I have enclosed a memorandum which describes each level of attendant certification to assist committee members with terminology used in emergency medical services. I would be happy to provide you with additional information if you want to call me at 296-7296.

RM/st
enc.

State of Kansas
BOARD OF EMERGENCY MEDICAL SERVICES

109 S.W. 6TH STREET, TOPEKA, KS 66603-3805
(913) 296-7296 *Administration*
(913) 296-7403 *Education & Training*
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Bob McDaneld
Administrator

Joan Finney
Governor

TYPES OF EMERGENCY MEDICAL SERVICES CERTIFICATION

FIRST RESPONDER (FR) There are 532 certified first responders. They complete a 45 hour training program and pass a written and practical examination. They have statutory authorization to provide basic first aid and stabilization. These individuals work for law enforcement, rescue squads, and fire services.

CRASH INJURY MANAGEMENT TECHNICIAN (CIMT) There are 420 certified crash injury management technicians. They complete a 72 hour training program and pass a written and practical examination. They have statutory authorization to provide basic first aid and stabilization. This training program was replaced at the national level by the first responder. Almost all of those certified as CIMT are KHP troops. The KHP has changed its training program to first responder and will be supporting Board of EMS legislation to remove CIMT as a level of certification.

EMERGENCY MEDICAL TECHNICIAN (EMT) There are 5607 certified emergency medical technicians. They complete a 120 hour training program and pass a written and practical examination. They have statutory authorization to provide basic first aid, insert oropharyngeal airways, apply medical anti-shock trousers, stabilize injuries, and extricate patients. These individuals work for the 190 ambulance services which provide basic life support. Many of them are volunteers. A number of fire departments also train their firefighters as EMTs.

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE (EMT-I) There are 224 certified emergency medical technicians-intermediate. A person certified as an EMT may take an additional 40 hour training program in intra-venous therapy and pass a written and practical examination. They have statutory authorization to provide all the activities of an EMT, and in addition, provide intra-venous therapy. Most EMTs-I work for volunteer services, although some work as the second attendant on a service which provides advanced life support.

EMERGENCY MEDICAL TECHNICIAN-DEFIBRILLATOR (EMT-D) There are 75 certified emergency medical technicians-defibrillator. A person certified as an EMT may take an addition 27 hour training program in manual defibrillation and pass a written and practical examination. They have statutory authorization to provide all the activities of an EMT, and in addition, provide defibrillation and cardiac monitoring of heart attack victims. Most EMTs-D work for volunteer services.

(Continued on next page.)

MOBILE INTENSIVE CARE TECHNICIAN (MICT) There are 658 certified mobile intensive care technicians. This is the Kansas term for paramedic. These attendants provide advanced life support, including intravenous therapy, drug intervention, and manual defibrillation. This level of certification requires a minimum of 1200 hours of training. Most MICTs work for the 19 ambulance services which provide advanced life support. These services are mostly in larger cities (e.g. Wichita, Kansas City, Topeka.)

INSTRUCTOR-COORDINATOR (IC) There are 174 certified instructor-coordinators. These are the individuals authorized to teach training programs for first responders and attendants. All instructor-coordinators have to be first certified as an attendant (EMT, EMT-I, EMT-D, or MICT) and then complete a 90 hour training program. Most instructor-coordinators work full-time in another job and provide training as a part-time job. Many instructor-coordinators are also service directors or work for an ambulance service.

AUTOMATED EXTERNAL DEFIBRILLATOR (AED) This is not a level of certified personnel, but attendants and first responders who complete a four to six hour training program are certified to provide cardiac defibrillation using an automated defibrillator. There are 891 first responders and attendants certified to use an automated external defibrillator.

rm/st
certlist
3/5/91

March 5, 1991
Recommended Changes to S,B, 271
agreed upon by Representatives of:

Emergency Medical Services Board (EMS)
Kansas State Board of Nursing (KSBN)
Kansas State Nurses' Association (KSNA)

1-5

Session of 1991

SENATE BILL No. 271

By Committee on Local Government

2-21

AN ACT concerning emergency medical services; amending K.S.A. 1990 Supp. 65-6112, 65-6119, 65-6120, 65-6121, 65-6122, 65-6123 and 65-6129 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1990 Supp. 65-6112 is hereby amended to read as follows: 65-6112. As used in this act: (a) "Administrator" means the administrator of the emergency medical services board.

(b) "Ambulance" means any privately or publicly owned motor vehicle, airplane or helicopter designed, constructed, prepared and equipped for use in transporting and providing emergency care for individuals who are ill or injured.

(c) "Ambulance service" means any organization operated for the purpose of transporting sick or injured persons to or from a place where medical care is furnished, whether or not such persons may be in need of emergency or medical care in transit.

(d) "Attendant" means a ~~crash injury management technician,~~ an emergency medical technician, an emergency medical technician-intermediate, an emergency medical technician-defibrillator or a mobile intensive care technician whose primary function is ministering to the needs of persons requiring emergency medical services.

(e) "Board" means the emergency medical services board established pursuant to K.S.A. ~~1989~~ *1990* Supp. 65-6102, and amendments thereto.

~~(f) "Crash injury management technician" means any person who has successfully completed a course of training, approved by the board, in preliminary emergency medical care and who holds a valid crash injury management technician certificate under this act.~~

~~(g)~~ *(f)* "Emergency medical service" means ~~a service which provides for~~ the effective and coordinated delivery of such ~~emergency~~ care as may be required by an emergency, including services provided by first responders and transportation of individuals by ~~ground or air~~ ambulance and the performance of authorized emergency care by a person licensed to practice medicine and surgery, a licensed professional nurse, a registered physician's assistant, a ~~crash injury~~

, care services,

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EMS, KSBN, KSNA

~~management technician,~~ ~~an emergency medical technician,~~ emergency medical technician-intermediate, emergency medical technician-defibrillator or a mobile intensive care technician.) Do not delete

~~(h)~~ *(g)* "Emergency medical technician" means any person who has successfully completed a course of training, approved by the board, in preliminary emergency medical care and who holds a valid emergency medical technician certificate under this act.

~~(i)~~ *(h)* "Emergency medical technician-defibrillator" means any person, currently certified as an emergency medical technician or emergency medical technician-intermediate, who has successfully completed a training program in cardiac defibrillation approved by the board and who holds a valid emergency medical technician-defibrillator certificate under this act.

~~(j)~~ *(i)* "Emergency medical technician-intermediate" means any person, currently certified as an emergency medical technician or emergency medical technician-defibrillator, who, has successfully completed a course of training approved by the board which includes training in veni-puncture for blood sampling and administration of intravenous fluids and advanced patient assessment and who holds a valid emergency medical technician-intermediate certificate under this act.

~~(k)~~ *(j)* "First responder" means a person who has successfully completed a course of training in preliminary emergency care, who holds a valid first responder certificate under this act and who provides services to individuals in need of emergency medical care that assist in stabilization or improvement of such individual's condition until personnel with a higher level of training arrive at the scene and assume responsibility for the individual.

~~(l)~~ *(k)* "Instructor-coordinator" means any person who has successfully completed a course of training, approved by the board, to instruct attendants and first responders, and who holds a valid instructor-coordinator certificate under this act.

~~(m)~~ *(l)* "Local component medical society" means a county medical society or a multicounty medical society.

~~(n)~~ *(m)* "Medical adviser" means a person licensed to practice medicine and surgery.

~~(o)~~ *(n)* "Mobile intensive care technician" means any person who has successfully completed a course of training, approved by the board, in emergency medical care, and who holds a valid mobile intensive care technician certificate under this act.

~~(p)~~ *(o)* "Municipality" means any city, county, township, fire district or ambulance service district.

~~(q)~~ *(p)* "Operator" means a person or municipality who has a

permit to operate an ambulance service in the state of Kansas.

~~(r)~~ *(q)* "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.

(r) "qualified instructor" means a person licensed to practice medicine and surgery, a registered professional nurse, an instructor-coordinator or a mobile intensive care technician,

Sec. 2. K.S.A. 1990 Supp. 65-6119 is hereby amended to read as follows: 65-6119. Notwithstanding any other provision of law, mobile intensive care technicians may perform any of the following:

(a) ~~Render reseue, first-aid and resuscitation serviees~~ *May perform all the authorized activities of an emergency medical technician as described in K.S.A. 1990 Supp. 65-6121, and amendments thereto.*

~~(b) During training at a medical care facility and while caring for patients in a medical care facility administer parenteral medications, under the direct supervision of a person licensed to practice medicine and surgery or a registered professional nurse qualified instructor, perform those activities authorized by this section and K.S.A. 1990 Supp. 65-6121, and amendments thereto.~~

(c) Perform cardiopulmonary resuscitation and defibrillation in a pulseless, nonbreathing patient.

(d) When voice contact or a telemetered electrocardiogram is monitored by a person licensed to practice medicine and surgery or a registered professional nurse where authorized by a person licensed to practice medicine and surgery, and direct communication is maintained, and upon order of such person or such nurse do any of the following:

(1) Perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions.

(2) Perform gastric suction by intubation.

(3) Perform endotracheal intubation.

(4) Administer parenteral injections of any of the following classes of drugs:

(A) Antiarrhythmic agents.

(B) Vagolytic agents.

(C) Chronotropic agents.

(D) Analgesic agents.

(E) Alkalinizing agents.

(F) Vasopressor agents.

(5) Administer such other medications or procedures as may be deemed necessary by such an ordering person.

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EMS, KSBN and KSNA

, except that, in a medical care facility, a qualified instructor, means a registered professional nurse or a person licensed to practice medicine and surgery.

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Recommended changes to SB 271
agreed upon by Representatives of;
EMS, KSBN and KSNA

Do not delete

(e) Perform~~, during an emergency,~~ those activities specified in subsection (d) before contacting the person licensed to practice medicine and surgery or authorized registered professional nurse when specifically authorized to perform such activities by written protocols approved by the local component medical society.

Sec. 3. K.S.A. 1990 Supp. 65-6120 is hereby amended to read as follows: 65-6120. Notwithstanding any other provision of law to the contrary, an emergency medical technician-intermediate:

(a) May perform any of the activities described by K.S.A. ~~1988~~ *1990* Supp. 65-6121, *and amendments thereto,* which an emergency medical technician may perform;

~~*(b) during training and while under the direct supervision of a qualified instructor, perform those activities authorized by this section and K.S.A. 65-6121, and amendments thereto;*~~

~~(b)~~ *(c)* when approved by the local component medical society and where voice contact by radio or telephone is monitored by a person licensed to practice medicine and surgery or a registered professional nurse, where authorized by a person licensed to practice medicine and surgery, and direct communication is maintained, upon order of such person or such nurse may perform veni-puncture for the purpose of blood sampling collection and initiation and maintenance of intravenous infusion of saline solutions, dextrose and water solutions or ringers lactate IV solutions; or

~~(c) when under the direct supervision of a mobile intensive care technician who is functioning under the provisions of subsection (c) of K.S.A. 1988 Supp. 65-6119 may perform the functions authorized under subsection (b) of this section~~ *(d) perform, during an emergency, those activities specified in subsection (c) before contacting the person licensed to practice medicine and surgery or authorized registered professional nurse when specifically authorized to perform such activities by written protocols approved by the local component medical society.*

Sec. 4. K.S.A. 1990 Supp. 65-6121 is hereby amended to read as follows: 65-6121. Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following:

(a) Patient assessment and vital signs;

(b) airway maintenance to include use of:

(1) Oropharyngeal and nasopharyngeal airways;

(2) esophageal obturator airways with or without gastric suction device; and

(3) oxygen demand valves.

(c) Oxygen therapy;

(d) oropharyngeal suctioning;
(e) cardiopulmonary resuscitation procedures;
(f) control accessible bleeding;
(g) application of pneumatic anti-shock garment;
(h) management of outpatient medical emergencies;
(i) extrication of patients and lifting and moving techniques;
(j) management of musculoskeletal and soft tissue injuries to include dressing and bandaging wounds or the splinting of fractures, dislocations, sprains or strains;
(k) use of backboards to immobilize the spine;
(l) administer syrup of ipecac, activated charcoal and glucose; ~~or~~
(m) monitor peripheral intravenous line delivering intravenous fluids during interfacility transport with the following restrictions:
(1) The physician approves the transfer by an emergency medical technician;
(2) no medications or nutrients have been added to the intravenous fluids; and
(3) the emergency medical technician may monitor, maintain and shut off the flow of intravenous fluid.~~; or~~

~~*(n) during training, under the direct supervision of a qualified instructor, perform those activities authorized by this section*~~.

Sec. 5. K.S.A. 1990 Supp. 65-6122 is hereby amended to read as follows: 65-6122. ~~Notwithstanding any other provision of law to the contrary, a crash injury management technician may perform any of the following:~~

~~(a) Initial scene management;~~
~~(b) patient assessment and vital signs;~~
~~(c) airway maintenance to include:~~
~~(1) Oropharyngeal airways;~~
~~(2) oropharyngeal suctioning; or~~
~~(3) use of bag valve mask.~~
~~(d) Oxygen therapy;~~
~~(e) provide cardiopulmonary resuscitation procedures;~~
~~(f) control accessible bleeding;~~
~~(g) application of pneumatic anti-shock trousers;~~
~~(h) management of outpatient medical emergencies;~~
~~(i) extrication of patients and lifting and moving techniques;~~
~~(j) management of musculoskeletal and soft tissue injuries to include dressing and bandaging wounds and the splinting of fractures, dislocations, sprains or strains; or~~
~~(k) use of backboards to immobilize the spine.~~ *Any person who is certified as a crash injury management technician on the effective date of this act may apply for certification as a first re-*

sponder or emergency medical technician as prescribed by rules and regulations adopted by the board.

Sec. 6. K.S.A. 1990 Supp. 65-6123 is hereby amended to read as follows: 65-6123. Notwithstanding any other provision of law to the contrary, an emergency medical technician-defibrillator:

(a) May perform any of the activities described by K.S.A. ~~1988~~ *1990* Supp. 65-6121, *and amendments thereto,* which an emergency medical technician may perform;

(b) when approved by the local component medical society and where voice contact by radio or telephone is monitored by a person licensed to practice medicine and surgery or a registered professional nurse, where authorized by a person licensed to practice medicine and surgery, and direct communication is maintained, upon order of such person or such nurse, may perform electrocardiographic monitoring and defibrillation; ~~or~~

(c) perform, during an emergency, those activities specified in subsection (b) before contacting the person licensed to practice medicine and surgery or authorized registered professional nurse when specifically authorized to perform such activities by written protocols approved by the local component medical society~~.~~*;* ~~or~~

~~*(d) during training, under the direct supervision of a qualified instructor, perform those activities authorized by this section and K.S.A. 1990 Supp. 65-6121, and amendments thereto.*~~

Sec. 7. K.S.A. 1990 Supp. 65-6129 is hereby amended to read as follows: 65-6129. (a) Application for an attendant's *or instructor coordinator's* certificate shall be made to the emergency medical services board upon forms provided by the administrator. The board may grant an attendant's *or instructor coordinator's* certificate to an applicant who: (1) Has made application within one year after successfully completing the appropriate course of instruction for the classification of attendant's *or instructor coordinator's* certificate for which application has been made; (2) has passed an examination prescribed by the board; and (3) has paid a fee for the classification of attendant's *or instructor coordinator's* certificate for which application has been made as prescribed by rule and regulation of the board.

(b) An attendant applying for ~~a crash injury management technician's~~ *an instructor coordinator's* certificate shall have successfully completed a course of training, approved by the board, in ~~preliminary emergency medical care~~ *instructing and coordinating attendant training programs*. An attendant applying for an emergency medical technician's certificate shall have successfully completed a course of training, approved by the board, in preliminary emergency

medical care. An attendant applying for a mobile intensive care technician's certificate shall have successfully completed a course of training, approved by the board, which shall include, but not be limited to, didactic and clinical experience in a cardiac care unit and in an emergency vehicle unit. An attendant applying for an emergency medical technician-intermediate certificate shall have been certified as an emergency medical technician and, after certification as an emergency medical technician, shall have successfully completed a course of training, approved by the board, which shall include training in veni-puncture for blood sampling and administration of intravenous fluids and advanced patient assessment. An attendant applying for an emergency medical technician-defibrillator certificate shall have been certified as an emergency medical technician and, after certification as an emergency medical technician, shall have completed a training program approved by the emergency medical services board. Any program of instruction or training offered by the armed forces of the United States or in a jurisdiction other than Kansas, which program is at least equivalent to the program approved by the board for the class of attendant's certificate applied for, shall be granted reciprocity by the board for purposes of satisfying the requirements of subsection (a)(1) of this section.

(c) An attendant's *or instructor coordinator's* certificate shall be valid through December 31 of the year following the date of its initial issuance and may be renewed thereafter for a period of one year for each renewal for a fee as prescribed by rule and regulation of the board upon presentation of satisfactory proof that the attendant has successfully completed continuing education in emergency medical care as provided in this subsection. Attendants shall complete not less than eight hours of continuing education as prescribed and approved by the emergency medical services board for each full calendar year that has elapsed since the certification or the last renewal thereof. If a certificate is not renewed within 30 days after its expiration such certificate shall be void.

(d) The emergency medical services board may issue a temporary certificate to any person who has not qualified for an attendant's certificate under subsection (a) when:

(1) The operator for whom such person serves as an attendant requests a temporary certificate for that person; and

(2) such person meets or exceeds minimum training prescribed by the board by rules and regulations.

A temporary certificate shall be effective for one year from the date of its issuance or until the person has qualified as an attendant under subsection (a), whichever comes first. A temporary certificate

March 5, 1991
Recommended Changes to S.B. 271
agreed upon by Representatives of:
EMS, KSBN, KSNA

1-12

shall not be renewed and shall be valid only while an attendant works for the operator requesting the temporary certificate.

(e) At least once each month all fees received pursuant to the provisions of this section shall be remitted to the state treasurer. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury to the credit of the state general fund.

(f) If, within two years of the date of expiration of an attendant's *or instructor coordinator's* certificate, such person applies for renewal of the certificate, the board may grant a certificate to such applicant without such applicant completing a course of instruction specified in subsection (b) if the applicant has ~~passed an examination prescribed by the board~~ *completed continuing education requirements* and has paid a fee prescribed by rule and regulation of the board.

~~Sec. 8.~~ 9 K.S.A. 1990 Supp. 65-6112, 65-6119, 65-6120, 65-6121, 65-6122, 65-6123 ~~and~~ 65-6129 are hereby repealed.

~~Sec. 9.~~ 10 This act shall take effect and be in force from and after its publication in the statute book.

~~Sec. 8.~~ insert New Section 8. (see next page)

Reorder

ADD: 61-6145

Reorder

NEW Sec. 8. KSNA 1990 Supp 65-6145 is hereby amended to read as follows:

65-6145. Same: limitations of act. Nothing in this act shall be construed: (a) To preclude any municipality from licensing or otherwise regulating first responders operating within its jurisdiction, but any licensing requirements or regulations imposed by a municipality shall be in addition to and not in lieu of the provisions of this act and the rules and regulations adopted pursuant to this act;

(b) to preclude any person certified as an attendant from providing emergency medical services to persons requiring such services; or

(c) to preclude any individual who is not a certified first responder from providing assistance during an emergency so long as such individual does not represent oneself to be a certified first responder.

History: L. 1988, ch. 261, § 45; April 14

Source or prior law:
65-4345.

NEW (d)

(d) to preclude the provision of authorized activities by students enrolled in an initial course of training or continuing education approved by the board when supervised by a qualified instructor.

RILEY COUNTY
EMERGENCY MEDICAL SERVICE
913·539·3535
2011 CLAFLIN ROAD
MANHATTAN, KS 66502

March 4, 1991

Senator Don Montgomery and Committee Members
Committee on Local Government

Reference: Senate Bill 271

Dear Committee Members,

I would like to take this opportunity to thank you for allowing me to testify before this committee. My name is Larry Couchman. I am a Registered Nurse, a Mobile Intensive Care Technician, a member of the executive committee of the Kansas Association of EMS Administrators, and Director of the Riley County Emergency Medical Service, a Type I (Paramedic level) ambulance service in the state. I also work as an RN at Memorial Hospital in Manhattan. I am here today to speak as a proponent for Senate Bill 271.

As you are aware, Senate Bill 271 amends several sections of the statutes governing state EMS. I support this bill as it is progressive in nature, and it will clear up some of the questions raised by the Attorney General's opinion # 90-134 dated December 13th, 1990. In this opinion the A.G. has ruled that MICT's may perform only during an emergency, and define an emergency as "an unforseen combination of circumstances which calls for immediate action". A good percentage of patients that an MICT may come in contact with would not meet this strict criteria of an "emergency". Another accepted definition of an emergency situation by the public is defined as, "any patient who seeks prehospital care from an ambulance service or seeks care in an Emergency Department". As one can see these definitions are not similar and may lead to confusion in regards to what services are available.

As the Director of an Advanced Life Support Emergency Medical Service, I feel there are several areas in the statute that need to be addressed:

1. The statutes governing the authorized activities of an MICT should allow the MICT to perform their skills in both the emergent and non-emergent setting. This will allow MICT's to continue to care for patients being transferred to a primary care hospital, or transferring patients from the initial care facility to a tertiary care facility. MICT's are required to care for patients who are being administered a variety of medications during non-emergent inter-facility transfers. With the A.G. opinion as it is, the ability for MICT's to continue to provide ALS during inter-facility transfers is questionable.

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2. During the 1200 to 2000 hrs of training the MICT must complete prior to their licensure, one-third of this time is spent in the clinical setting under the supervision of a qualified instructor. This clinical experience has proven to be a critical link in the transition of the MICT student from the classroom setting to the field internship setting. With the potential limits of an MICT only working in the "emergency setting", the training program would be in jeopardy.

3. If the current language is not cleared up and it is determined that the MICT may not function outside of an emergent setting, I foresee a major problem developing regarding the transfer of patients between facilities. A registered nurse would be required in the back of an ambulance during non-emergent patient transfers requiring medications or monitoring enroute to the receiving facility. Hospital Administrators are having a difficult time in providing RN coverage for their inpatients, let alone staffing an RN in the back of an ambulance so a patient can be transferred to another facility. This would not only be an inefficient use of health care resources, but would result in a potential increase in the patient's health care costs.

4. Per current statutes, the MICT has the responsibility to provide prehospital and inter-facility patient care in an emergent setting without question. Thus, should there be a question if the MICT is capable of performing the same type of care in a non-emergent setting? Besides the prehospital care setting, the MICT has many skills that could be offered in an acute care setting in the hospital during emergency situations under the appropriate supervision and guidance, which should not be overlooked.

In summary, I support this bill as it is written or would support any amendments to the bill as long as it addresses the above points.

I have enclosed two other written testimonies. The first is from Dr. Jim Regan, Associate Administrator of Memorial Hospital, and second is from Dr. Douglas Hinkin, Medical Director for Riley County EMS. Both of these testimonies are in support of Senate Bill 271.

Thank you for your consideration.

Sincerely,

Larry Couchman RN, MICT
Director, Riley County EMS

MEMORIAL HOSPITAL

Yesterday's values, Tomorrow's technology

March 4, 1991

Senator Don Montgomery
& Committee Members
Committee On Local Government

Re: Senate Bill #271

Dear Senator Montgomery:

This letter is in support of Senate Bill #271 dealing with the authorized activities of a Mobile Intensive Care Technician (MICT). As you know, the Attorney General issued an opinion, #90-134, on December 13, 1990, that brought into question the activities MICTs are authorized to perform in a non-emergency situation. Because of this we strongly encourage and support the passage of Senate bill #271.

One of the primary functions of an emergency medical service, after that of rendering emergency care, is the transfer of patients between facilities. These would include hospitals, nursing homes and other healthcare facilities. Many times the patients that are being transferred are on I.V. medications or are utilizing an intensive medical support system. In the past these patients have been monitored by qualified MICTs during these transfers. If we were to have to provide registered nurses to ride with the ambulances it would put a hardship on our already scarce R.N. resources. In addition, this would increase the cost of transfers and the overall costs of health-care in these situations. One of the purposes of Sentate Bill #271 is to clarify our concern about the ability of MICTs to care for patients in a transfer situation.

Memorial Hospital has been involved in the training of MICTs through the provision of a clinical setting for some time. During this time, we have observed the training that MICTs receive and feel confident that a well trained MICT is capable of giving care to patients in a non-emergent setting. As a matter of fact, MICTs who are trained to perform in an emergency setting are performing the same skills that would be required in a non-emergent setting but they are doing it in a situation that requires considerable knowledge, insight and composure. It is a logical conclusion that if MICTs can function effectively in a crisis situation they are more than capable of effectively performing those same skills in a non-crisis situation.

1105 Sunset/P.O. Box 1208 • Manhattan, Kansas 66502 • 913-776-3300 • FAX 913-776-6947

Again, we suport passage of Senate Bill #271, and feel that it will be important to the cost containment and efficient functioning of the health-care system in the State of Kansas. If you would like any additional information or clarification on the above points, please contact me.

Sincerely,

James H. Reagan, Jr., Ph.D.
Associate Administrator/CFO

JHR/sdg

MANHATTAN FAMILY PHYSICIANS

Steven J. Mosier, M.D. Michael L. Mosier, M.D. Kevin K. Wall, M.D. Douglas P. Hinkin, M.D.

March 4, 1991

Senator Don Montgomery & Committee Members
Committee on Local Government
Kansas Senate
Kansas State House
Topeka, KS 66604

Re: Senate Bill 271

Dear Senators:

I am writing as the Medical Director for the Riley County Ambulance Service in support of amending KSA 65-6112 and 65-6119 as outlined in SB 271. These sections deal with definitions that specifically authorize activities of the mobile intensive care technician (MICT/Paramedic).

Because of the Attorney General's Opinion #90-134, 12/13/90, questions the authorized skills of the MICT and concludes that those skills should only be used in an emergent setting, I feel that the clarifications made in SB 271 should be implemented. Emergency Medical Service, especially at the paramedic level, is called on to provide emergent prehospital care in emergent and nonemergent intrafacility transfer. This is especially found in rural areas where transfer to major medical centers is necessary for treatment of acute conditions, primarily cardiac. SB 271 provides language that will allow the paramedic to provide care in a nonemergent setting such as a transfer from a local community hospital to a major medical center. I feel the MICT/Paramedic is capable of caring for a patient from the point of pickup until he is turned over at the major medical facility.

If this language is not cleared up, one could assume that the MICT would have no statutory authority to care for patients being transferred between facilities in a nonemergent situation. This would require the hospital to provide a registered nurse to accompany all patients. This would not only be an inefficient use of health care resources but would place an increased staffing burden on both the hospital and hospital administrators and would result in increasing the patient's health care cost.

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SB 271 does clarify the language needed to allow the MICT/Paramedic to provide these services in nonemergent conditions and I strongly encourage that it be approved by your committee. Please don't hesitate to contact me if you have any further questions or thoughts on this bill.

Sincerely,

Douglas P. Hinkin, M.D.
Medical Advisor, Riley County Ambulance Service

DPH/mf

Testimony for the

COMMITTEE ON LOCAL GOVERNMENT

Given in Hearings held
March 5th and 6th, 1991

Regarding Senate Bill No. 271

Jerree Forbes
Coodinator
EMS Program
Hutchinson Community College

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3-5-91
Attachment 3

INTRODUCTION

Thank you for the opportunity to speak on Senate Bill No. 271. I will be speaking as a proponent of the bill. I am representing the EMS Training Program at Hutchinson Community College.

HCC EMS PROGRAM BACKGROUND

The EMS program begin in 1978 with course offerings only involving the Emergency Medical Technician level. HCC began to provide Mobile Intensive Care Training (MICT) in 1983. There are now 20 course offerings in the program. In the last academic year, there were over 1,000 participants in the EMS Program at Hutchinson Community College. More than 80 courses in initial and continuing education were offered to EMS professionals in more than 20 communities. Participants were from virtually every geographical region of Kansas. The Hutchinson Community College EMS program offers courses at basic and advanced levels to include the MICT, or paramedic, level. There are five full-time instructors and 61 part-time employees in the program.

SENATE BILL NO. 271 AND MOBILE INTENSIVE CARE TECHNICIAN TRAINING

The MICT is trained in an intensive program of study which is

required by statute or regulation to be at a minimum, 1200 clock hours in length. The HCC program involves approximately 1400 hours in the classroom, the skills laboratory, the hospital clinical setting, and in an advanced life support unit in the field. The hospital clinical training is currently required to be at least 400 hours in length. MICT students rotate through various hospital units to include intensive care areas, pediatrics, geriatrics, psychiatric areas, emergency departments, operating rooms, and burn units. This exposure helps to form the basis for the MICT's development of skills and knowledge needed in the field to care for many different types of patients. The hospital and field experiences are a significant contribution towards the successful attainment of required competencies.

This experience is only beneficial, however, if MICT students are actually involved in the delivery of patient care and the entire health care process to include assessment and intervention. The MICT student must be allowed to perform those functions which are required of him or her in the work environment. Senate Bill No. 271 would allow for this very essential activity and would help to ensure that competent MICTs were graduating from Kansas training programs.

Language inserted in the bill would allow students to perform those skills and activities during their training which is necessary to attain the required competencies for success in a specific program of study. MICT students, for example,

would be able to perform MICT level objectives in the clinical setting during their initial training program. This provision is supported by a number of points.

The Joint Review Committee of the American Medical Association's Committee on Allied Health Accreditation and Education requires that MICT students are:

> ...assigned in clinical settings where experiences are educationally efficient and effective in achieving the program's objectives.

The program's objectives are outlined in the National Department of Transportation and National Highway Safety Administration's EMT-Paramedic curriculum. That curriculum is specifically required in Kansas MICT training programs. These objectives require the student to intervene with the patients and provide care at the MICT level. An example would be National Department of Transportation objective S4.1.31, which states:

> The student will be able to:
>
> Demonstrate the ability to appropriately administer the following drugs for the adult and pediatric patient:
>
> Oxygen
> Epinephrine
> Bronkosol
> Racemic Epinepherine
> Aminophylline
> Diphenhydramine

There are several hundred of these objectives which require the student to **perform** skills during their clinical

experience at the level for which they are training. The accrediting body for paramedic, or MICT, programs requires these objectives be met by each student to the degree possible in clinical settings. Senate Bill No. 271 would allow for this type of objective to be accomplished during the training program.

Educational curriculum specialists, such as James DeCecco as well as Glasser and others view this "clinical interaction" by students as an essential part in the learning of such skills as are required of the MICT.

Hutchinson Community College graduate follow up studies have also confirmed that MICT student learning in the clinical setting is essential to their ultimate function on advanced life support units and to their delivery of quality patient care.

The Kansas Department of Education EMT-Paramedic Profile which describes the MICT states:

> Teaching of psychomotor skills and application in the clinical environment are critical aspects of this course of instruction. Patient, staff, and student interaction as well as the correlation between didactic and clinical presentations are key elements of this experience. Laboratory facilities, equipment, and instruction faculty must be available in sufficient quantity. Clinical facilities must provide students with an adequate quantity of quality clinical experiences...

This description of MICT training emphasizes the need for

MICT and other EMS students to be able to perform those skills and interactions necessary to develop the outcomes needed to care for patients at their level of training. Senate Bill No. 271 would allow for performance of these essential activities to occur during training.

The American Medical Association, Kansas statutes or regulation, the Kansas Department of Education, recognized curriculum specialists, and the National Department of Transportation support, and in cases require, the participation of the EMS student at a level which coincides with the training program in which they are participating. Senate Bill No. 271 is essential to these guidelines being adhered to and to the quality of training Kansans have come to expect form EMS programs.

SENATE BILL No. 271 AND MOBILE INTENSIVE CARE TECHNICIAN ACTIVITIES

Mobile Intensive Care Technician's Contribution to the Health Care System

The Mobile Intensive Care Technician has been providing health care to Kansans since the early 1970s. Recognition of the significant contribution made by MICTs has been outlined by a number of studies and their role in community health care is now clearly established as beneficial. A recent study published in EMS Insider Newsletter by the Journal of Emergency Medical Services sited a study of more than 18,000

trauma patients which found that patients who received paramedic services were more than twice as likely to live than those who did not receive paramedic care. The "Golden Hour" has become a standard for trauma patients and paramedics are an integral part of the trauma system. The American Heart Association stated in it's Advanced Cardiac Life Support Text, 1983 edition, that:

> ...patients with acute myocardial infarction who have care by mobile unit personnel within the first hour after symptom onset have a better outlook in terms of hospital mortality and morbidity, including frequency and severity of shock and congestive heart failure.
>
> Furthermore, stabilization of these patients in the field has resulted in as much as a five-fold reduction in the incidence of cardiac arrest en route to the hospital.

MICTs have made a significant impact in decreasing disability and in decreasing deaths from illness or injury. Paramedics have been instrumental in the care of many who have survived different types of crisis.

The public has come to expect that EMS providers are capable of rendering the services they need. Communities have committed a number of resources to ensuring Kansans are "protected" and that EMS coverage is present in a quality form in their area.

Approximately 130,000 responses will be made each year by EMS personnel to those in need of their services. The majority of those responses are not for "emergencies". An estimated

75,000 or more of those calls are non-emergency. The MICT and other EMS personnel must be allowed to continue to care for those patients. The needs of these patients are legitimate and the services provided to them have come to be an essential part of the services in any community. Any limitation of the MICT which would decrease the present level of care and service would be a significant loss to Kansas.

Senate Bill No. 271 would allow for EMS to continue to provide the services needed in communities across the state. The bill is not calling for a change in the system, but rather it is calling for the continuation of essential services to Kansans. It would be less than prudent to allow limitations on MICTs which required voice contact before care was rendered to a patient. MICTs must continue to be allowed to work from standing physician order so that delays are not imposed on those who need care.

The current activities and practices of MICTs have proven to be effective in saving lives and reducing disability. Altering the role of the MICT so that emergency and non-emergency activities become part of the equation would bring drastic and numerous reductions in patient care and services. It is imperative that MICTs and other EMS providers be allowed to perform their authorized activities in emergent and non-emergent circumstances.

TESTIMONY OF LESTER RICHARDSON, D. O., IN SUPPORT OF S.B. 271

-Bill allows physicians, nurses, I.C.'s and MICT's to appropriately supervise MICT students in clinical and field settings--an important aspect of original training.

-By removing the phrase "during an emergency," the expectations of a trained paramedic are clarified. If the "emergency" is rectified by the paramedic's initial actions, does that mean he or she cannot render additional care to the patient? A paramedic is trained to deliver health care, and that care should not be made conditional upon any circumstances other than the needs of the patient.

-The other changes provided by this bill regarding training periods for various attendant levels, I.C. requirements, and elimination of CIMT level is supported without further comment.

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TESTIMONY OF LESTER RICHARDSON, D.O., IN SUPPORT OF S.B. 273

-We support the extension of the definition of health care provider to include first responders and attendants.

-It is important that quality assurance and case review activities (peer review) occur in EMS. Extending the privilege of not having this information subject to discovery or subpoena helps ensure the validity of the peer review process, and allows the process and the participants in the process to concentrate on health care activities and quality improvements, without concern for legal liability or compulsion to release that information (except as provided for by the Act and KSA 60-437).

-This Act allows EMS to behave more like a health care provider organization, and could result in improved EMS for the citizens of our state.

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3-5-91
Attachment 5

McPHERSON EMERGENCY MEDICAL SERVICE

1000 Hospital Drive • McPherson, Kansas 67460 • (316) 241-2250

R.D. Easter, MICT
Director

R.L. Goldberg, MICT
R.A. Owens, MICT
C.M. Welch, MICT
Captains

M.G. Platner, MICT
EMT I/C
Training Officer

3-4-91

Senator Montgomery
Chairperson
State and Local Government Committee
State Capital Building
Topeka, Kansas

Dear Senator Montgomery and Committee:

I would like to take just a few minutes of your time to address a very important issue to the people of Kansas, (S.B. 271). Quality, along with affordable health care, has become a struggle for the rural areas of this state. It seems like every time we turn around, there is one more regulation or statue effecting health care. Rural health care does not need to be further burdened by uncessary and confining laws.

For over the past 13 years, I have had the honor and privilege of caring for the people of Kansas in a rural community setting. The system that has worked so well for the citizens of the City and County of McPherson are now in question. Memorial Hospital and its' Type I Paramedic Ambulance Service, have work together to provide a professional, high-quality emergency services program. This progam would not have achieved its goals without cooperation between emergency services employees and the flexibility in utilization of staff.

Kansas has been noted for its high level of prehospital care. To imped the delivery of professional and qualified health care would, in my opinion, be a devastating turn of events in Kansas.

In closing, I strongly urge the adoption of S.B. 271 as ammended. If you or your committee have further questions that I may be able to help with, please contact me.

Sincerely,

Randy D. Easter

Randy D. Easter, MICT
Director
Memorial Hospital / McPherson E.M.S.

Senate L.G.
3-5-91
Attachment 6

February 28, 1991

Senator Don Montgomery, Chairman Fred Thorp
Committee on Local Government

Re: Senate Bill 271, Emergency Medical Services

Let it be understood the Kansas City, Kansas Fire Department is on record in support of S.B. 271 and the proposed amendments.

K.A.R.E. has provided the citizens of Kansas City and Wyandotte County prehospital emergency medical services since August 5, 1974. K.A.R.E.s advanced life support units are under medical control/supervision at all times as they practice life saving skills in accordance to Kansas Statute and Regulations.

One of K.A.R.E.'s unique features now utilized by most services is the authorization of extensive "standing order/protocols" by the Wyandotte County Medical Society, Emergency Medical Care Committee (cf Section 2. (c)(d). Confidence of the medical society was earned by personnel demonstrating competence as an extension of hospital based medical control.

It was only a short time period before our physicians recognized the absolute need to execute certain procedures without any loss of time establishing communications with someone authorized to issue medically prudent orders. Most services still experience difficulty with hospital communications more frequent than we like. Written protocols approved by the local component medical society permit our technicians to employ specific techniques during the critical period in time these techniques will likely be successful or not. I cannot emphasize enough the critical factor is TIME!

Like many other systems, a physician is not always available to discuss a case with the field technicians over the radio or telephone. The reason varies, but in our case the physicians usually are concerned with immediate needs of other patients. Our technicians when necessary will discuss critical patient cases with physicians at other hospitals because of the over-load situation. In some cases where it is difficult to talk with a physician because of cultural differences, technicians may prefer talking with a nurse they understand.

I understand an assistant attorney general rendered an opinion nurses cannot issue orders and technicians cannot take care of patients in the hospital or during transfers not categorized as an emergency. THIS OPINION could severely hamper even a urban service such as Kansas City. Essentially, the opinion ties our hands should a nurse intermediary be prohibited. Easily, 50% of our orders are relayed to the field units by emergency nurses on behalf of physicians who cannot physically come to the radio.

Secondly, the assistant attorney general opinion would require physicians to be on the ambulance during a critical transfer. Such use of Kansas resources is foolish and should not be permitted to stand.

I urge committee approval of S.B. 271 essentially as it is today. It appears to be reasonable and sound. Thank you for hearing my remarks.

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3-5-91
Attachment 7

MEDEVAC

March 5, 1991

To: Senate Committee on Local Government

From: R.E. "Tuck" Duncan and Thomas L. Little
Medevac Medical Services, Inc.

RE: Senate Bill 271

We appear in support of Senate Bill 271.

This bill is necessary in order to clarify permissible activities of E.M.I.C.T.s in light of the Attorney General's Opinion 90-134 affecting E.M.I.C.T. activities in non-emergency situations.

While the law provides that ambulance services are organizations which transport sick or injured persons "whether or not such persons may be in need of emergency or medical care in transit," [K.S.A. 65-6112(c)] the Attorney General's opinion limits the utilization of an E.M.I.C.T.'s capabilities to only times when "an unforeseen combination of circumstances which calls for immediate action." [A.G.Opin. 90-134 p.3].

There are times when an E.M.I.C.T. may need to perform during intensive care "non-emergency" transports, or neonatal "non-emergency" transports tasks for which they are qualified as set out in K.S.A. 65-6119(d) which the Attorney General states may not be perform in non-emergency situations [at p.3].

Rather than the amendments being offered by the Board of Nursing, the Nursing Association and the Emergency Medical Services Board, a better solution in our judgment would be to enact a definition of non-emergency transports that allow the personnel licensed under the Emergency Medical Services Act to perform tasks for which they are licensed. A "non-emergency" transport is one in which an individual is in need of continuing medical care where a foreseen combination of circumstances calls for continuing action. This action may be prescribed by protocol, written orders of a doctor or nurse, or vis a vi voice contact with a medical care faciltiy. This would also require adding where appropriate authority to perform tasks in the "non-emrgency" circumstance. (such as in sec. (e) of K.S.A. 65-6119 at page 4, line 1 of S.B. 271).

Thank you for your consideration of this matter.

(18wp)SB271.doc

Senate L.G.
3-5-91
Attachment 8

March 1, 1991

To Whom This May Concern:

I have been following with interest and also that of concern the Kansas State Board of Nursing's opinion and the most recent Attorney General's opinion reguarding the scope of practice for the Mobile Intensive Care Technician's (MICT's) and their delivery of emergency care.

I began utilizing MICT's in our emergency room in 1987 to complement my registered nurse staffing at peak hours of operation. It was obvious to me that these individuals possess special skills which could be utilized and also greatly benefit my being able to operate a department safely and efficiently. In 1988, our small community hospital was feeling the direct effects of the nursing shortages and we are still feeling these effects. We advertized for R.N. positions for months without any results. I was then placed in a position to look elsewhere for assistance or lose the R.N. staff that I already had. I spent days reviewing the MICT's educational preparation that they received from Southwestern College in Winfield and also the Kansas statutes guiding their practice. I then looked at the hours they had spent in clinicals and then I decided to approach administration of our facility to consider giving me approval to fill vacancies with MICT's. I obtained their approval in June 1988 and then began the tasks of developing an orientation program, job descriptions and skills checklists. I currently have one MICT in a full-time position on the 11-7 shift and four others who work as I need them. These individuals take medication tests, cardiac dysrhythmia tests, must be certified in Advanced Cardiac Life Support and meet the other requirements our hospital has set forth in policy. My R.N. staff and I have developed detailed patient care standards also in an effort to guide the clinical practice for all of my staff. I tell you all of this because I want

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3-5-91
Attachment 9

of hiring R.N.'s or L.P.N.'s to provide the necessary and needed emergency medical care. Myself as well as others Department Managers in emergency rooms across Kansas have been forced to look at other alternatives. My working relationship with the MICT's has been a positive one. I continue to struggle with staffing vacancies; and would hire an interested R.N. or L.P.N. if and when they become available. Salaries and benefits at my institution are very competitive. So where are the R.N.'s and L.P.N.'s?

As you review the proposed changes in Senate Bill #271, please keep in mind the staffing plight many rural hospitals are facing. Our communities need access to medical care also. Don't close our doors !

Sincerely,

Tonja M . Seusy R.N.

Department Manager
Emergency Department
Susan B. Allen Memorial Hospital
ElDorado, Ks. 67042

9-2

FAMILY PRACTICE ASSOCIATES
400 WEST FOURTH STREET
McPHERSON, KANSAS 67460

(316) 241-7400

RICHARD A. FERREE, M.D. GREGORY M. THOMAS, M.D. DAVID L. BULLER, M.D.

March 4, 1991

Senator Montgomery, Chairperson
State and Local Government Committee
Topeka, Kansas

Dear Sir:

This letter is in support of Senate Bill #271. In McPherson, our hospital functions extensively with the use of paramedic personnel in the hospital setting, working under protocol by physician order. The system has worked well for over a decade and any further restriction of the capabilities of the EMICT personnel would add a significant load and burden to health care delivery in our rural system. The County, the Hospital and the population all benefit from the current arrangement as being both cost efficient and professionally rewarding practice situation.

If our paramedics are only able to function by protocol under emergencies, we would have significant difficulties making routine transfers from nursing homes, inter-hospital transfers and many routine functions that are currently done in the emergency room setting of our hospital.

Please contact me if you have any questions or need further clarification of these matters. I consider this an urgent matter for health care delivery in our community.

Sincerely,

Gregory M. Thomas, M.D.
Medical Director, Emergency Room
McPherson Memorial Hospital

Senate L.G.
3-5-91
Attachment 10