Approved: 3-12-09
Date

MINUTES OF THE SENATE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman Pete Brungardt at 10:30 a.m. on February 26, 2009, in Room 136-N of the Capitol.

All members were present except:
Senator Tim Owens- excused

Committee staff present:
Jason Long, Office of the Revisor of Statutes
Julian Efird, Kansas Legislative Research Department
Dennis Hodgins, Kansas Legislative Research Department
Connie Burns, Committee Assistant

Conferees appearing before the committee:
Robert Waller, Executive Director , Kansas Board of Emergency Medical Services
Jon Friesen , Kansas EMS Association
Mark Willis, Kansas Professional Fire Chiefs Association
Gary Winter, Region 1 EMS Coordinator

Others attending:
See attached list.

Chairman Brungardt called for approval of minutes for January 27, 29, February 4, 5, 10, 11, 12, 17, and 18 distributed on February 19, 2009.

Senator Ostmeyer made a motion to approve the minutes as written. Senator Francisco seconded the motion. The motion carried.

SB 223 - Emergency medical services board, authority to issue subpoenas.

Chairman Brungardt opened the hearing on **SB 223**.

Robert Waller, Executive Director , Kansas Board of Emergency Medical Services, spoke in favor of the bill. (Attachment 1) The bill would allow the Investigation Committee of the Kansas Board of Emergency Medical service to issue subpoenas in acquiring information. Under current law; the Board has no subpoena power regarding education, training, hospital records, QA/QI records, personnel records, operational records (DEA drug repository) or criminal history records when conducting an investigation. The language in part is from the Board of Nursing and Board of Healing Arts statutes.

Jon Friesen , Kansas EMS Association, appeared neutral on the bill. (Attachment 2) The Association understands the need for the Board of EMS to be able to investigate issues relating to emergency medical care, and the proposed legislative package relating to EMS issues, a move to bolster the enforcement component of the Board's responsibilities. But it is the Association's firm belief that the quality of pre-hospital care cannot be improved through disciplinary action.

Chairman Brungardt closed the hearing on **SB 223.**

SB 224 - Emergency medical services board authorized to assess civil fines.

Chairman Brungardt opened the hearing on **SB 224**.

Robert Waller, Executive Director , Kansas Board of Emergency Medical Services, appeared in favor of the bill. (Attachment 3) The bill would grant the Kansas Board of Emergency Medical services the ability to assess a civil fine against any person granted a license or certificate to practice emergency medical services by the Board for a violation of a law. The civil fine would not exceed $1,000.

Jon Friesen , Kansas EMS Association, spoke in opposition to the bill. (Attachment 4) EMS in the state of

Minutes of the Senate Federal And State Affairs Committee at 10:30 a.m. on February 26, 2009, in Room 136-N of the Capitol.

Kansas has been and remains dependent upon the dedication of volunteer EMS providers; the volunteer ambulance service remains the sole provider of emergency medical services in many areas of our state; the declining numbers of volunteers is an increasing concern for ambulance services. The threat of the Board of EMS being able to fine an attendant up to $1,000 will add one more reason for people to reject an invitation to serve their community and add to the demise of volunteer services.

Mark Willis, Kansas Professional Fire Chiefs Association, appeared in opposition to the bill. (Attachment 5)The Board of EMS already possesses statutory authority to suspend, modify, or revoke certification and licensure. The impact of having a State agency having the ability to level fines to emergency responders, many who provide their time and talents as volunteers, could further inhibit future recruitment and retention of firefighters and emergency medical providers.

Terry David, Rice County EMS, provided written testimony in opposition to the bill. (Attachment 6)

Chairman Brungardt closed the hearing on **SB 224**.

SB 262 - Emergency medical services attendants scope of practice and titles.

Chairman Brungardt opened the hearing on **SB 262**.

Robert Waller, Executive Director , Kansas Board of Emergency Medical Services, spoke in favor of the bill. (Attachment 7) The bill revised the Scope of Practice for the four levels of attendants regulated by the Board. The changes are:

1. Changes the names of the three attendant levels
2. Mandates that attendants must practice under medical protocols
3. Sets a Scope of Practice "ceiling" for the levels of EMR, EMT, and AEMT
4. Sets the actual Scop of Practice in Rules and Regulations

Also provided a copy of the EMS Attendant Skills Sets Recommendations. (Attachment 8)

Jon Friesen , Kansas EMS Association, appeared in favor of the bill. (Attachment 9) The bill will revamp the title of EMS attendants in Kansas from current to be in line with the National EMS Scope of Practice. This move is congruent with the National EMS Scope of Practice Document that was released by the National Highways Safety and Traffic Administration. (NHTSA)

Gary Winter, Region 1 EMS Coordinator, spoke in favor of the bill. (Attachment 10) Region I supports passage of this bill in its current form, with emphasis on maintaining Emergency Medical Responders as part of the patient care team.

Chairman Brungardt closed the hearing on **SB 262**.

The next meeting is scheduled for March 3, 2009. The meeting was adjourned at 11:39 am

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE FEDERAL AND STATE AFFAIRS COMMITTEE
GUEST LIST

DATE 2-26-09

NAME	REPRESENTING
Joe Mosimann	Hein Law
Kari Presley	Kearney & Associates
Melissa Wangemann	KAC
Jon E. Frieden	Kansas [illegible] Association
Mark Willis	KS Pro Chiefs Association
Camille Nohe	Atty General
Pat Lehman	KFSA
Teri Canfield	Atty General
Carolyn Middendorf	Ks St N. Assn
Kristina D. Hill	student MSW Washburn
Spencer Duncan	Capitol Connection LLC
Sean Miller	
Jerry Cunningham	KS Brd of EMS
Tina Wood	Faust-Goudeau
Robert Wall	KBEMS
Robert Jones	Jo Co MED-ACT
Dan Leong	KHA
Steve Cotter	Sedgwick County EMS
Dalen Deer	Sedgwick County EMS / KEMSA
Gary Winter	Region I EMS
Brad Smoot	CMH
Chris Tilden	KDHE
Jane Carlson	KDHE

KANSAS

DENNIS ALLIN, M.D., CHAIR
ROBERT WALLER, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

Testimony

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Robert Waller, Executive Director

RE: 2009 Senate Bill 223

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Robert Waller. I am the Executive Director for the Kansas Board of Emergency Medical Services (KBEMS). I would like to provide testimony on 2009 Senate Bill 223.

2009 SB 223 amends current law (K.S.A. 65-6130) to allow the Investigation Committee of the Kansas Board of Emergency Medical Service to issue subpoenas in acquiring information above merely the "operation of ambulance services and the conduct of attendants". Under current law, the Board has no subpoena power regarding educational, training, hospital records, QA/QI records, personnel records, operational records (DEA drug repository), or criminal history records when conducting an investigation. The language was in part taken from current language contained with the Board of Nursing and Board of Healing Arts statutes.

Through the current Investigation process, respondents have replied to the request for records and have provided all documents. However, in reading current law, the respondents have had no legal responsibility to provide the level of documentation current requested. KBEMS would request passage of 2009 SB 223 to afford the Investigations Committee the same level of access to information to close cases as other regulatory agencies. The language does not attempt to gain or access any information than is currently being accessed within law for an agency with the regulatory responsibility outlined by the State. KBEMS believes the language merely establishes within law access to information (through the Investigatory process) that is necessary to protect the citizens of that State while conducting its duties.

Conclusion

Thank you for allowing me to testify in support of Senate Bill 223. KBEMS believes the language above is purely a clarification of activities currently engage in by the Board. KBEMS hopes for passage of the bill, and therefore a continuation of current investigative processes and duties.

TESTIMONY

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Jon E. Friesen
President
Kansas EMS Association

RE: 2009 Senate Bill 223
Board of EMS Subpoena Authority

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Jon Friesen. I am the president of the Kansas Emergency Medical Services Association. We represent 1,250 individual EMS attendants in Kansas as well as 116 of the 171 Kansas ambulance services. I am providing in this written testimony comments regarding 2009 Senate Bill 223 with regards to the subpoena power of the Board of EMS.

We understand the need for the Board of EMS to be able to investigate issues relating to emergency medical care. By having the power of subpoena, the Board of EMS can ensure that persons will be more likely to appear before the investigations committee.

Having said this, KEMSA also recognizes in the proposed legislative package relating to EMS issues a move to bolster the enforcement component of the Board's responsibilities. It is our firm belief that the quality of prehospital care cannot be improved through disciplinary action. Rather, the Board of EMS should be focusing its efforts on providing assistance to services and technicians whenever possible to eliminate the need for disciplinary action.

On behalf of our members, KEMSA takes a neutral stance on this legislation.

Thank you for allowing me the opportunity to testify on behalf of our membership regarding the 2009 Senate Bill 223. I am happy to answer any questions that you have.

Respectfully submitted,

Jon E. Friesen
President
Kansas EMS Association
316.660.9066
jfriesen@sedgwick.gov

(3)

KANSAS

DENNIS ALLIN, M.D., CHAIR
ROBERT WALLER, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

Testimony

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Robert Waller, Executive Director

RE: 2009 Senate Bill 224

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Robert Waller. I am the Executive Director for the Kansas Board of Emergency Medical Services (KBEMS). I would like to provide testimony on 2009 Senate Bill 224.

2009 SB 224 would grant the Kansas Board of Emergency Medical Services the ability to assess a civil fine against any person granted a license or certificate to practice emergency medical services by the Board for a violation of a law. The civil fine would not exceed $1,000

The Investigations Committee conducts an estimated 50 investigations per year. The KBEMS Board has a sanctioning grid that assists the Investigations Committee in its investigatory duties, and the ability to issue civil fines would be added to the ability of the Board to deny, revoke, limit, modify, or suspend a certificate. The bill, as introduced, would represent no additional operating costs or revenue to KBEMS. Civil fines would be deposited in the State General Fund, and therefore KBEMS would not have access to the monies imposed from fines.

Conclusion

Thank you for allowing me to testify in support of Senate Bill 224.

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(4)

TESTIMONY

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Jon E. Friesen
President
Kansas EMS Association

RE: 2009 Senate Bill 224
Board of EMS Authority to Level Civil Fines

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Jon Friesen. I am the president of the Kansas Emergency Medical Services Association. We represent 1,250 individual EMS attendants in Kansas as well as 116 of the 171 Kansas ambulance services. I am providing in this written testimony comments regarding 2009 Senate Bill 224 with regards to the ability of the Board of EMS to level civil fines.

EMS in the state of Kansas has been and remains dependent upon the dedication of volunteer EMS providers. Often described as the backbone of Kansas EMS, the volunteer ambulance service remains the sole provider of emergency medical services in many areas of our state. Declining numbers of volunteers is an increasing concern for ambulance services. The Kansas Board of EMS has been working with the Critical Illness and Trauma Foundation of Bozeman, Montana to address this issue over the past year. The need to shore up the volunteer ranks is paramount to the provision of prehospital care in Kansas. Without it, large geographic areas will either be without timely emergency medical response or will be forced to increase the tax burden on citizens in order to subsidize paid personnel.

Let me be very clear on the tie of volunteerism to this proposed legislation. In a time where local ambulance services are finding it hard to attract and retain qualified volunteer personnel, the threat of the Board of EMS being able to fine an attendant up to $1,000 will add one more reason for people to reject an invitation to serve there community.

In short, this legislation is antithetical to the very work the Board of EMS has been paying a consultant to perform in the past year. It will add to the demise of our volunteer services.

With regards to ambulance services, this hardly seems like an appropriate time to pursue fines. As you know from your own struggles with the state budget; these economic times have hit government entities hard. Budgets have been reduced and services are already beginning to experience decreases in staffing. The idea of leveling fines to organizations that are struggling financially is counter intuitive. The Board of EMS already has the power to suspend, modify, or revoke certification and licensure. In other words, they have the ability to effectively deal with those persons who choose to not follow rules, regulations, or statutes.

On behalf of our members, KEMSA opposes this proposed legislation and strongly encourages the Committee to let the proposed legislation die without progressing to the full Senate.

Thank you for allowing me the opportunity to testify on behalf of our membership regarding the 2009 Senate Bill 224. I am happy to answer any questions that you have.

Respectfully submitted,

Jon E. Friesen
President
Kansas EMS Association
316.660.9066
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(5)

Kansas Professional Fire Chiefs Association

Gary Curmode, President 316-660-3490 7750 N Wild West Dr Park City, Kansas 67147-7929

Testimony

February 26, 2009

From: Gary Curmode, Chief
Sedgwick County Fire District #1
President, Kansas Professional Fire Chiefs Association

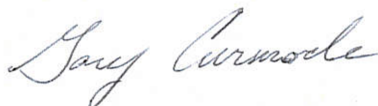
RE: Senate Bill 224- Opposition to Board of EMS authority to level civil fines

Good morning, Chairman Brungardt and members of the Senate Committee on Federal and State Affairs. I serve as President of the Kansas Professional Fire Chiefs Association, an organization representing Career and Combination Professional Fire Departments that serve jurisdictions in Kansas.

Whether in providing EMS transport services, or serving as medically trained first responders, the vast majority of our members hold some level of medical certification through the Kansas Board of EMS. This certification provides us the privilege of serving our citizens and visitors in their time of need; we provide this service with pride and honor. As it stands today, the Board of EMS already possesses statutory authority to suspend, modify, or revoke certification and licensure. Does this state agency really need authority to levy fines against public servants? The impact of having a State agency having the ability to level fines to emergency responders, many whom provide their time and talents as volunteers, could very well serve to further inhibit future recruitment and retention of firefighters and emergency medical providers. Furthermore, municipalities and counties who furnish these services should not be faced with the concern of having their employees, or their Fire and EMS Departments, facing the possibility of receiving fines from a state regulatory agency.

In summary, I appreciate the opportunity to express our opposition to Senate Bill 224. I have appointed Newton Fire/EMS Deputy Chief Mark Willis to stand for questions.

Respectfully,



Gary Curmode, President

Written Testimony to the Senate Ways & Means Committee
Opposition to Senate Bill No. 224 – 26, February 2009

Thank you for allowing me the opportunity to provide written testimony regarding Senate Bill No. 224. I apologize for not being here in person to provide testimony however I am the only Paramedic available in Rice County today and duty calls.

My name is Terry L. David and I am the Emergency Medical Services Director for Rice County. In addition, I also serve as the Director of Emergency Management for Rice County and I am the current President of the Kansas Society of EMS Administrators.

I offer my testimony as not only an EMS Administrator of a small service but also as someone who has had the opportunity to work with other EMS Service Directors across the state. Since Senate Bill No. 224 is rather short, I will keep my comments short as well.

With the majority of EMS services in the State of Kansas providing care to the citizens of our communities with people who are volunteers and receive little or no pay for their service to their community, this bill is a counterproductive to those who already are faced with many pressures to continue to provide service. Also, after the bill becomes law and the first fine is implemented, rest assured that the word will spread across the State of Kansas in the EMS world that itself will substantially reduce the number of people who would subject themselves to becoming a First Responder or EMT as a volunteer.

As an example of the difficulties we face, Rice County EMS began a First Responder Class just last Tuesday evening and 12 of the 17 interested parties showed up for the first night of class. This program is presented at NO COST to any of the participates and allows people in our communities to get the training required to become Emergency Medical Responders in their respective communities and respond prior to the ambulance arriving. History in our system tells us that out of the 12 people who showed up, 10 will pass the program with another 2 not passing the state exam and out of the remaining 8 only half will continue to serve after 5 years. The point being is that we have enough difficulty without the prospect of fines.

In addition, with many EMS services struggling to keep their doors even open and being forces to operate on ever decreasing funds, allowing the Board of EMS to levy fines will be the only catalyst needed to close services that are already on the brink of shutting down.

The question that should be asked is WHAT PROBLEM ARE WE TRYING TO FIX? For a state agency that tells providers that it is there to help us, this bill seriously questions the intent of the Kansas Board of EMS.

Terry L. David
Director, Rice County EMS

KANSAS

DENNIS ALLIN, M.D., CHAIR
ROBERT WALLER, EXECUTIVE DIRECTOR

KATHLEEN SEBELIUS, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

Testimony

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Robert Waller, Executive Director

RE: 2009 Senate Bill 262

Chairman Brungardt and members of the Senate Committee on Public Health and Welfare, my name is Robert Waller. I am the Executive Director for the Kansas Board of Emergency Medical Services (KBEMS). I would like to provide comments on 2009 Senate Bill 262.

2009 Senate Bill 262, as introduced, revises the Scope of Practice for the four (4) levels of attendants the Kansas Board of Emergency Medical Services regulates. To accomplish this task, the Board commissioned the Kansas Emergency Medical Services Systems Approach for the Future (KEMSSAF) Committee. The Committee was charged with identifying and recommending to the 13 member Board of Emergency Medical Service the effects, impact, and implementation of the National Scope of Practice and the Education Agenda for the Future, Rural Health Agenda for the Future, and Agenda for the Future in Kansas. The Committee was made up of the following:

- 4 members of the Board of EMS
- 1 Member of each of the Kansas EMS Regional Councils
- 1 Member of the following Associations:
  - Kansas Emergency Medical Technicians Association (KEMTA)
  - Kansas Emergency Medical Services Association (KEMSA)
  - Kansas Air Medical Services (KanAMS)
  - Kansas State Fire Fighters Association
- 1 Member of each of the Community Colleges
  - Butler County, Cloud County, Hutchinson, Dodge City, Cowley County, Barton County, Flint Hills Technical, Seward County, Coffeyville, Colby, Johnson County, Highland, Garden City, and Kansas City
- Member selected by the Executive Director
- 4 Members At Large

To accomplish the commissioned goal, the Committee met from January 2008 through June 2008 to discuss and recommend to the Board the language contained within 2009 SB 262. The Board approved the language during its regular December 2008 Board meeting. The bill has four components:

1. Changes the names of the 3 attendant levels;
   - First Responder to Emergency Medical Responder (EMR)
   - Emergency Medical Technician remains the same
   - Emergency Medical Technician – Intermediate (I) and Defibrillator (D) to Advanced EMT (AEMT)
   - Mobile Intensive Care Technician to Paramedic

2. Mandates that attendants must practice under medical protocols;

3. Sets a Scope of Practice "ceiling" for the levels of EMR, EMT, and AEMT:

The KBEMS Board requested an Attorney General's Opinion on medical directors and their ability to issue medical protocols which allow an attendant to practice above their scope of practice. Attorney General Opinion, No. 2009-4, which states,

> "Due to the conflict in the interpretation of K.S.A 2007 Supp. 65-28, 127, the conclusions in Attorney General Opinions No. 2000-26 and 2008-6 are withdrawn." The AG opinion concerned KBEMS request in interpreting a medical director's authority to issue medical protocols which allow an attendant to provide care above their statutorily delineated scope of practice. "

Through the language introduced, the Board attempts to clearly delineate the medical director's responsibility in developing protocols relating to an attendants scope of practice; and

4. Sets the actual Scope of Practice in Rules and Regulations

The scope of practices, as outlined by law, would be outlined (specifically) in rules and regulations as opposed to listed in Statute.

Once the Committee completed its task, a report was developed and sent out to the Regional Councils for distribution and comment. The Board received one complaint on the report from the Kansas City Metro area which dealt with the EMR and the increased level of activities outlined within the report. That complaint conflicted with the western half of the State which utilizes the EMR consistently as the second attendant on a transporting vehicle. The Board believes in maintaining the ability for rural services to utilize the EMR as was approved in the KEMSSAF report as passed in December 2008.

Conclusion

Thank you for allowing me to provide testimony on 2009 SB 262. The Board would like to thank all that assisted in revising the scope of practice for Kansas EMS attendants and would request favorable passage of the bill as introduced.

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EMS Attendant Skills Sets Recommendations

Kansas EMS Systems Approach to the Future (KEMSSAF) Workgroup

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Section I

INTRODUCTION

8-3

Kansas Board of EMS		
Dennis	Allin	Chair
J.R.	Behan	Chair, Education Committee
Joe	Megredy	Chair, Planning & Operations Committee
Deb	Kaufman	Board Member
Dale	Wasson	Chair, Investigations Committee
Regions		
David	Stithem	Region I
Brad	Sisk	Region II
Terry	David	Region III
Marvin VanBlaricon/Wendy Gronau		Region IV
Rob	Jones	Region V/MARC
Chris Way/Kenny Yoakum		Region VI
Professional Organizations		
Bob	Pruitt	KEMTA
John	Friesen	KEMSA
K.C.	Jones	KanAMS
Shane	Pearson	KS Firefighters Association
Community/Technical Colleges EMS Training		
Jeb	Burress	Butler County Community College
Chy	Miller	Hutchinson Community College
Chris	Cannon	Cowley County Community College
Robert	Binder	Flint Hills Technical
Greta	Rexwinkle	Coffeyville Community College
Ray	Wright	Johnson County Community College
Bill	Young	Garden City Community College
Donna	Olafson	Kansas City Kansas Comm. College
Chad	Pore	Barton County Community College
John	Ralston	Seward County Community College
Christine	Ellison	Colby Community College
Mary	Herbel	
Members-at-Large		
Jason	Jenkins	Member at Large
Gary	Winter	Member at Large
Brandon	Russell	Member at Large
Lillian	Slater	Member at Large
Kerry	McCue	Member at Large
Mark	Willis	Member at Large
Easter	Randy	Member at Large
Chris	Tilden	KDHE

PROJECT APPROACH

1. During the <u>initial</u> phases of the process the workgroup focus will be to address KS EMS Systems needs without regard to National Plans and/or documents.

2. Given the focus, participants will include in their deliberations, approaching each topic considering State-wide needs, rather than simply their geographical region needs.

3. If your educational institution or ambulance service does not teach or employ the level of attendant being discussed, and you have limited knowledge of the topic being discussed, please recognize this fact and limit your input.

4. As we progress through the process, we will consider the National plans and their impact, if any, on the Board's Implementation Strategy.

MISSION STATEMENTS

1. To systematically analyze Kansas EMS attendant authorized activities, and KS EMS Systems needs to optimize the level of out-of-hospital care provided to the citizens of Kansas.

2. To identify modalities to provide the highest quality education available to EMS students and for individuals who provide emergency medical services, including first responders, emergency medical technicians, intermediates and paramedics.

3. To focus on those skills and knowledge that encourage disparate groups to communicate and join together forming the foundation for an integrated Statewide EMS delivery system and its continued sustainment.

4. To identify a recommended course of action to meet or exceed those needs, represent optimal standards of care irrespective of geographic and/or jurisdictional variables in protocols or operational procedures at the local, intrastate, regional and state levels.

Section II

EMERGENCY MEDICAL RESPONDER (EMR)

8-7

Emergency Medical Responder (EMR) Recommendations

GENERAL

1. Adoption of the title “Emergency Medical Responder” to replace “First Responder”.
2. Concurrence with National recommendation of EMR to operate under Medical Protocols.
3. Non-concurrence to National recommendation for elimination of EMR as an ambulance attendant.
4. KS adoption of enhanced National Scope attendant level skills set.
5. Validation of medical protocols for maintenance of EMR Certification.

TRANSITION PLAN (FR to EMR)

1. Transition will be accomplished over a three year period via two recertification cycles.
2. First Responders will be required to take specific classes identified as being incorporated in the new skills sets/curricula.

3. Once validation of new CE requirements is achieved, new title (Emergency Medical Responder) will awarded to currently certified First Responder attendants.

4. Those failing to achieve new recertification standards will lose their First Responder certification.

SPREADSHEET LEGEND: The letters below are used in the following pages to indicate the following;

In the “CURRENT” column;

X is used to indicate that the skill is currently an authorized activity for this attendant in level.

O is used in the “current” column to indicate that the skill is an optional skill, such as advanced initiatives for the EMT-B and/or intubation for the EMT-I.

In the “SCOPE” column;

C is used to indicate the skill is a component of the National skill set for this level of attendant.

- is used to indicate the assumption that the skills is included but the depth and breadth of the intervention is not specified in the Scope document.

In the “KEMSSAF” column,

E is used (enrichment) to identify a skill not included in the Scope document but is recommended for inclusion by KEMSSAF in the authorized skills set at the attendant level identified.

Is used to indicate a new skills for this attendant level in comparison to current law

	SKILLS SET COMPARISON	CURRENT	SCOPE	KEMSSAF
	AIRWAY & BREATHING			
1	Airway – Oral (Oropharyngeal)		C	
2	Airway – Nasal (Nasopharyngeal)		C	
3	Bag-valve-mask (BVM) ventilation	X	C	
4	Bag-valve-ETT/CombiTube® ventilation			E
5	Cricoid pressure (Sellick maneuver)	X	C	
6	Head-tilt/chin-lift	X	C	
7	Jaw thrust	X	C	
8	Jaw-thrust - Modified (trauma)	X	C	
9	Modified chin lift	X	C	
10	Mouth-to-Barrier	X		E
11	Mouth-to-Mask	X	C	
12	Mouth-to-Mouth			E
13	Mouth-to-Nose	X	C	
14	Mouth-to-Stoma	X	C	
15	Manual Airway Maneuvers	X	C	
16	Obstruction--manual (Heimlich, finger sweep, chest thrusts) upper airway	X	C	
17	Oxygen Therapy – Humidifiers			E
18	Oxygen Therapy – Nasal Cannula		C	
19	Oxygen Therapy – Non-rebreather Mask	X	C	
20	Oxygen Therapy – Partial Rebreather Mask			E
21	Oxygen Therapy – Regulators	X		E
22	Oxygen Therapy – Simple Face Mask			E
23	Oxygen Therapy - Blow-by delivery			E
	AIRWAY & BREATHING (continued)			
24	Suctioning--upper airway (nasal)			E
25	Suctioning--upper airway (oral)	X	C	
26	Suctioning – Upper Airway (Soft & Rigid)			E
27	Suctioning-meconium aspiration (BULB SYRINGE)			E
	ASSESSMENT			
28	Auscultate breath sounds (presence/absence)	X		E
29	Blood Glucose Monitoring			E
30	Blood Pressure – Automated	X		E
31	Blood Pressure – Manual	X	C	
32	Blood pressure-auscultation	X		E
33	Blood pressure-electronic noninvasive	X		E
34	Blood pressure-palpation	X		E
35	Level of consciousness (LOC)	X	C	

36	Pulse Oximetry			E

ASSESSMENT (continued)

37	Using Glasgow Coma Scale (GCS)			E
38	Vital sign-body temperature	X		E
39	Vital sign-pulse	X		E
40	Vital sign-pupils	X		E
41	Vital sign-respirations	X		E
42	Vital sign-skin color/temperature and condition (CTC)	X		E
43	Auscultate breath sounds (presence/absence)	X		E

PATIENT MANAGEMENT

44	Provide care to a patient with a chest injury	X	–	E
45	Provide care to a patient with a painful, swollen, deformed extremity	X	–	E
46	Provide care to a patient with a soft tissue injury	X	–	E
47	Provide care to a patient with a suspected head injury	X	–	E
48	Provide care to a patient with a suspected spinal injury	X	–	E
49	Provide care to a patient with an acute amputation	X	–	E
50	Provide care to a patient with an impaled object	X	–	E
51	Provide care to a patient with an open abdominal injury	X	–	E
52	Provide care to a patient with shock (Hypoperfusion).	X	–	E
53	Provide care to an infant or child with a fever	X	–	E
54	Provide care to an infant or child with a suspected blood disorder	X	–	E
55	Provide care to an infant or child with a suspected communicable disease	X	–	E
56	Provide care to an infant or child with abdominal pain	X	–	E
57	Provide care to an infant or child with cardiac arrest	X	–	E
58	Provide care to an infant or child with respiratory distress	X	–	E
59	Provide care to an infant or child with seizure	X	–	E
60	Provide care to an infant or child with shock (hypoperfusion)	X	–	E
61	Provide care to an infant or child with suspected abuse or neglect	X	–	E
62	Provide care to an infant or child with trauma	X	–	E
63	Provide care to suspected overdose patient	X	–	E
64	Provide care to the mother immediately following delivery of a newborn	X	–	E
65	Provide care to the newborn	X	–	E
66	Provide care to the patient experiencing a seizure	X	–	E
67	Provide care to the patient experiencing an allergic reaction	X	–	E
68	Provide care to the patient with a gynecological emergency	X	–	E
69	Perform a rapid extrication of a trauma patient	X	–	E
70	Provide care for a patient with a history of diabetes.	X	–	E
71	Provide care for a patient with a suspected blood disorder	X	–	E
72	Provide care for a patient with a suspected communicable disease	X	–	E
73	Provide care for a patient with abdominal pain	X	–	E
74	Provide care for a patient with an endocrine disorder other than diabetes.	X	–	E

8-10

PATIENT MANAGEMENT (continued)

#	Skill			
75	Provide care for a patient with head pain	X	–	E
76	Provide care for a possible poisoning patient	X	–	E
77	Provide care for external bleeding.	X	–	E
78	Provide care for the obstetric patient	X	–	E
79	Provide care to a near-drowning patient	X	–	E
80	Provide care to a patient experiencing a behavioral problem	X	–	E
81	Provide care to a patient experiencing cardiovascular compromise	X	–	E
82	Provide care to a patient experiencing non-traumatic chest pain/discomfort.	X	–	E
83	Provide care to a patient exposed to cold	X	–	E
84	Provide care to a patient exposed to heat	X	–	E
85	Provide care to a patient who has been bitten or stung by an animal or insect	X	–	E
86	Provide care to a patient with a burn injury	X	–	E
87	Assist with the delivery of an infant	X	–	E
88	Assisting a patient in administering his/her own prescribed medications, including auto-injection (self, buddy and pt assisted)	X	–	E
89	Resuscitate a patient in cardiac arrest.	X	–	E
90	Behavioral--Restrain violent patient	X	–	E
91	Burns--chemical, electrical, inhalation, radiation, thermal	X	–	E
92	Childbirth (abnormal/complications) - patient positioning	X	–	E
93	Childbirth (normal)--cephalic delivery	X	–	E
94	Childbirth--umbilical cord cutting	X	–	E
95	Eye care	X	–	E
96	EMT-Basic Assessment	X	–	E

PHARMACOLOGICAL INTERVENTION

#	Techniques of Medication Administration			
97	Unit dose auto-injector for self or peer care (MARK I)		C	
98	Auto-Injector (Self, buddy and patient assisted)			E
99	Oral			E
	Administered Medication			
100	Oxygen	X	C	
101	Aspirin (ASA) for chest pain (ONLY W/ MEDICAL DIRECTION)			E
	Administered Medication (continued)			
102	Mark I Auto Injector (For Self & Crew)		C	
103	Oral Glucose			E
104	Auto-Injected Epinephrine			E
105	Medicated Inhaler – Prescribed			E

EMERGENCY TRAUMA CARE

106	Cervical collar	X		E
107	Manual head/Neck Stabilization	X	C	
108	Manual Extremity Splinting	X	C	
109	Application of Commercial Extremity Splints	X		E
110	Anatomical Extremity splinting	X		E
111	Eye Irrigation		C	
112	Spinal Immobilization – Based on mechanics of injury	X		E
113	Spinal Immobilization – Cervical Collar	X		E
114	Spinal Immobilization – Long Board			E
115	Spinal Immobilization – Manual Stabilization	X		E
116	Spinal Immobilization – Seated Patient	X		E
117	Spinal Immobilization – Seated Patient (KED, etc.) (Assist only)			E
118	Spinal immobilization--helmet stabilization or removal			E
119	Spinal immobilization--long board w/pt supine and standing			E
120	Spinal immobilization--manual stabilization and cervical collar	X		E
121	Spinal immobilization--rapid extrication	X		E
122	Splinting extremity – Soft	X		E
123	Splinting extremity – Anatomical (No return to position of function)	X		E
124	Splinting extremity – Manual stabilization	X	C	
125	Splinting extremity – Vacuum			E
126	Hemorrhage Control – Direct Pressure	X	C	
127	Hemorrhage Control – Pressure Point	X	–	
128	Hemorrhage Control – Tourniquet	X	–	
129	Trendelenberg Positioning	X		E
130	Hemorrhage Control - Pressure Bandaging		–	E

MEDICAL/CARDIAC CARE

	Cardiac Care			
131	Cardiac monitoring--apply electrodes			E
132	Cardiopulmonary Resuscitation (CPR)	X	C	
133	Cardiopulmonary resuscitation (CPR) adult, infant, child, one and two person	X		E
134	CPR - Mechanical Device			E
135	Provide post-resuscitation care to a cardiac arrest patient	X		E
135	Defibrillation - Automated/Semi Automated (AED/SAED)			E
136	Defibrillation - automated external defibrillator (AED)	X	C	
	Medical			E
137	Assisted normal delivery		C	
138	Assist with the delivery of an infant			E

8-12

AMBULANCE OPERATIONS

139	Assess the need for additional resources at the scene.	X		E
140	Drive the emergency vehicle in a non-emergency situation	X		E
141	Drive the emergency vehicle in an emergency situation (theory)	X		E
142	Obtain consent for providing care	X		E
143	Give consideration for potential organ retrieval			E
144	Incident Command System (ICS)		—	
145	Make decisions based on Do Not Resuscitate (DNR) orders			E
146	Make decisions regarding abandonment, negligence, etc.			E
147	Multiple Casualty Incident (MCI)	X		E
148	Participate in the quality improvement process	X		E
149	Prepare the emergency vehicle and equipment before responding to a call.	X		E
150	Preserve the crime scene	X		E
151	Triage (prioritizing patients) - use of tags	X		E
152	Provide education on emergency medical services to the public	X		E
153	Provide for safety of self, patient and fellow workers	X		E
154	Provide injury prevention education to the public, such as seat belt usage, helmet usage, pool safety, etc.	X		E
155	Use methods to reduce stress in a patient, bystanders and co-workers	X		E
156	Use physician medical direction for authorization to provide care (Off-line)			E

Communications

157	Communicate with bystanders, other health care providers and patient family members while providing patient care	X		E
158	Communicate with patient while providing care	X		E
159	Communications with PSAPs, medical command facilities (Off line control)			E
160	Provide a report to RECEIVING PERSONNEL of assessment findings and emergency care given			E
161	Verbal patient report to receiving personnel			E

Documentation

162	Complete a prehospital care report			E
163	Out-of-Hospital Do Not Resuscitate (DNR) orders			E
164	Patient Care Report completion			E

Hazardous Materials

165	Contaminated equipment disposal (sharps and PPE)	X		E
166	Decontamination	X		E
167	Disinfection	X		E
168	Dispose of materials contaminated with body fluids.	X		E
169	Dispose of sharps (needles, auto-injectors, etc)	X		E
170	Perform unit dose auto-injectors for self or peer care (MARK I)		C	
171	PPE (personal protection equipment) use	X		E

AMBULANCE OPERATIONS (continued)

	Hazardous Materials			
172	PRN Self or peer care (Bio/chem)	X		E
173	Take infection control precautions (body substance isolation)	X		E
	Lifting & Moving Patients			
174	Move patients using a carrying device	X		E
175	Move patients without a carrying device	X		E

AMBULANCE OPERATIONS (Continued)

	Lifting & Moving Patients			
176	Patient lifting, moving and transfers	X		E
177	Patient restraints on transport devices	X		E
178	Use body mechanics when lifting and moving a patient.	X		E
179	Emergency moves for endangered patients	X	C	
	Rescue			
180	Patient access and extrication	X	—	
181	Rapid extrication	X	—	
	NOTE: Scope requires EMR to function under medical control			

8-14

EMERGENCY MEDICAL TECHNICIAN (EMT)

8-15

Emergency Medical Technician (EMT) Recommendations

GENERAL

1. Adoption of the title "Emergency Medical Technician" to replace "Emergency Medical Technician - Basic".

2. Concurrence with National recommendation of EMT to operate under Medical Protocols.

3. KS adoption of enhanced National Scope attendant level skills set.

4. Incorporate language of addressing categories/classes of devices rather than specific devices.

5. Any medications authorized will be addressed by class/category instead of name.

TRANSITION PLAN (EMT to EMT-B)

1. Transition will be accomplished over a three year period via two recertification cycles.

2. EMT-Basics will be required to take specific classes identified as being incorporated in the new skills sets/curricula.

3. Once validation of new CE requirements is achieved, new title (Emergency Medical Technician) will awarded to currently certified Emergency Medical Technician – Basic attendants.

4. Those failing to achieve new recertification standards will lose their Emergency Medical Technician – Basic certification.

SPREADSHEET LEGEND: The letters below are used in the following pages;

In the "CURRENT" column;

X is used to indicate that the skill is currently an authorized activity for this attendant in level.

O is used in the "current" column to indicate that the skill is an optional skill, such as advanced initiatives for the EMT-B and/or intubation for the EMT-I.

In the "SCOPE" column;

C is used to indicate the skill is a component of the National skill set for this level of attendant.

- is used to indicate the assumption that the skills is included but the depth and breadth of the intervention is not specified in the Scope document.

In the "KEMSSAF" column,

E is used (enrichment) to identify a skill not included in the Scope document but is recommended for inclusion by KEMSSAF in the authorized skills set at the attendant level identified.

Is used to indicate a new skills for this attendant level in comparison to current law

	SKILLS SET COMPARISON	Current	Scope	KEMSSAF
	AIRWAY & BREATHING			
1	Airway – Oral (Oropharyngeal)	X	C	
2	Airway - Esophageal obturator airway (EOA)	X		E
3	Airway - Esophageal Gastric Tube Airway (EGTA)	X		E
4	Airway - Advanced - Multi Lumen	X		E
5	Airway - Advanced - Single Lumen (*NOT LMA or ET)	X		E
6	Airway - Esophageal/Tracheal - Multi Lumen	X		E
7	Airway – Lumen (Non-Visualized)(* NOT LMA or ET)	X		E
8	Airway – Nasal (Nasopharyngeal)	X	C	
9	Airway--esophageal tracheal--dual lumen CombiTube®	X		E
10	Airway--pharyngeal tracheal lumen (PTL)	X		E
11	Resuscitation - Bag-valve-mask (BVM) ventilation	X	C	
12	Resuscitation - Bag-valve-mask ETT/CombiTube® ventilation	X		E
13	Resuscitation - Bag-valve-mask with in-line small-volume nebulizer			E
14	Resuscitation - Automatic Transport Ventilator (ATV)		C	
15	Resuscitation - Manually Triggered Ventilator (MTV)		C	
16	Resuscitation - Oxygen Demand valve	X		E
17	Resuscitation - Flow restricted oxygen powered ventilation device			E
18	Procedure- Head-tilt chin lift	X	C	
19	Procedure- Cricoid pressure (Sellick maneuver)	X	C	
20	Procedure- Jaw thrust	X	C	
21	Procedure- Jaw-thrust - Modified (trauma)	X	C	
22	Procedure- Mouth to barrier	X	C	
23	Procedure- Mouth to Mask	X	C	
24	Procedure- Mouth to nose	X	C	
25	Procedure- Mouth to stoma	X	C	
26	Procedure- Obstruction-Manual (Heimlich, finger sweep, chest thrusts)	X	C	
27	Procedure- Obstruction – Forceps (Direct Visual)			E
28	Oxygen Therapy – Humidifiers	X	C	
29	Oxygen Therapy – Nasal Cannula	X	C	
30	Oxygen Therapy - Nebulizer			E
31	Oxygen Therapy – Non-rebreather Mask	X	C	
32	Oxygen Therapy – Partial Rebreather Mask	X	C	
33	Oxygen Therapy – Regulators	X	C	
34	Oxygen Therapy – Simple Face Mask	X	C	
35	Oxygen Therapy – Venturi Mask	X	C	
36	Oxygen therapy--blow-by delivery	X		E
37	Suctioning - Upper airway (oral)	X	C	
38	Suctioning – Oropharyngeal	X		E

39	Suctioning –Upper Airway (Soft & Rigid)	X		E
	AIRWAY & BREATHING (continued)			
42	Suctioning--upper airway (nasal)	X		E
40	Suctioning--meconium aspiration (BULB SYRINGE)	X		E
41	Suctioning--stoma	X		E
42	End Tidal C02 Monitoring/Capnometry			E
43	End Tidal CO2 Monitoring			E
44	Extubation **(WITH ANY AUTHORIZED DEVICE)**	X		E
45	Gastric Decompression – NG Tube **W/ ANY AUTHORIZED DEVICE**			E
46	Gastric Decompression – OG Tube **W/ ANY AUTHORIZED DEVICE**			E
	ASSESSMENT			
47	Automatic BP	X	C	
48	Level of consciousness (LOC)	X		E
49	Using Glasgow Coma Scale (GCS)	X		E
50	Vital sign--body temperature	X		E
51	Vital sign--pulse	X		E
52	Vital sign--pupils	X		E
53	Vital sign--respirations	X		E
54	Vital sign--skin color/temperature and condition (CTC)	X		E
55	Blood pressure--auscultation	X		E
56	Blood pressure--electronic noninvasive	X		E
57	Blood pressure--palpation	X		E
58	Auscultate breath sounds identify breath sounds (quality)	X		E
59	Auscultate breath sounds (presence/absence)	X		E
60	Blood Glucose Monitoring	O		E
61	Assist with the delivery of an infant	X		E
62	Blood Pressure – Automated	X	C	
63	Blood Pressure – Manual	X	C	
64	Blood pressure--auscultation	X		E
65	Level of consciousness (LOC)	X	C	
66	Pulse Oximetry	O		E
67	Using Glasgow Coma Scale (GCS)	X		E
68	Vital sign--body temperature	X	C	
69	Vital sign--pulse	X	C	
70	Vital sign--pupils	X	C	
71	Vital sign--respirations	X	C	
72	Vital sign--skin color/temperature and condition (CTC)	X	C	
73	EMT-Basic Assessment	X	C	
	Administered Medication			
74	PRN (Bio/chem)		C	
75	ASA for chest pain (of suspected ischemic origin)	O	C	

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ASSESSMENT (continued)				
Administered Medication - Mode of Delivery (continued)				
76	Oral analgesics		C	
77	Administer MD-approved OTC medications (activated charcoal, oral glucose, oral analgesics, ASA for chest pain of suspected ischemic origin)		C	
Administered Medication - Mode of Delivery				
78	Intramuscular (IM)			E
79	Nebulized	O		E
80	Oral	X	C	
81	Sub-Lingual (SL)	X		E
82	Buccal	X	C	
83	Auto-injected epinephrine--primary use--not patient's own prescription	O		E
84	Unit dose auto-injector for self or peer care	X	C	
Administered Medication - Pt Assisted				
85	Activated Charcoal	X		E
86	Beta-agonist			E
87	Atrovent	O		E
88	Auto-Injected Epinephrine	X		E
89	Medicated Inhaler – Prescribed	X		E
90	Nitroglycerin	X		E
91	Oral Glucose	X		E
Administered Medication - By Protocol				
92	Activated Charcoal	X		E
93	Administer Inhaled beta agonist for dyspnea & wheezing			E
94	Administer SL Nitro for chest pn of suspected ischemic origin	X		E
95	Aspirin (ASA) for chest pain (ONLY W/ MEDICAL DIRECTION)	O		E
96	Aspirin (ASA) for chest pain	O	C	E
97	Epi-Pen – Carrying & Administration (By Protocol)	O		E
98	Glucagon auto-injector			E
99	Mark I Auto Injector (For Self & Crew)		C	
100	Nitroglycerin (SL only)	X		E
101	Nitroglycerine preparation – sublingual or oral spray.	X		E
102	Oral Glucose	X		E
PATIENT MANAGEMENT				
103	Provide care to a patient with a chest injury	X	–	E
104	Provide care to a patient with a painful, swollen, deformed extremity	X	–	E
105	Provide care to a patient with a soft tissue injury	X	–	E
106	Provide care to a patient with a suspected head injury	X	–	E
107	Provide care to a patient with a suspected spinal injury	X	–	E
108	Provide care to a patient with an acute amputation	X	–	E
109	Provide care to a patient with an impaled object	X	–	E

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110	Provide care to a patient with an open abdominal injury	X	—	E
	PATIENT MANAGEMENT (continued)			
111	Provide care to a patient with shock (Hypoperfusion).	X	—	E
112	Provide care to an infant or child with a fever	X	—	E
113	Provide care to an infant or child with a suspected blood disorder	X	—	E
114	Provide care to an infant or child with a suspected communicable disease	X	—	E
115	Provide care to an infant or child with abdominal pain	X	—	E
116	Provide care to an infant or child with cardiac arrest	X	—	E
117	Provide care to an infant or child with respiratory distress	X	—	E
118	Provide care to an infant or child with seizure	X	—	E
119	Provide care to an infant or child with shock (hypoperfusion)	X	—	E
120	Provide care to an infant or child with suspected abuse or neglect	X	—	E
121	Provide care to an infant or child with trauma	X	—	E
122	Provide care to suspected overdose patient	X	—	E
123	Provide care to the mother immediately following delivery of a newborn	X	—	E
124	Provide care to the newborn	X	—	E
125	Provide care to the patient experiencing a seizure	X	—	E
126	Provide care to the patient experiencing an allergic reaction	X	—	E
127	Provide care to the patient with a gynecological emergency	X	—	E
128	Provide post-resuscitation care to a cardiac arrest patient	X	—	E
129	Triage (prioritizing patients)-use of tags	X	—	E
130	Obtain consent for providing care	X	—	E
131	Perform a rapid extrication of a trauma patient	X	—	E
132	Provide care for a patient with a history of diabetes.	X	—	E
133	Provide care for a patient with a suspected blood disorder	X	—	E
134	Provide care for a patient with a suspected communicable disease	X	—	E
135	Provide care for a patient with abdominal pain	X	—	E
136	Provide care for a patient with an altered mental state	X	—	E
137	Provide care for a patient with an endocrine disorder other than diabetes.	X	—	E
138	Provide care for a patient with head pain	X	—	E
139	Provide care for a possible poisoning patient	X	—	E
140	Provide care for external bleeding.	X	—	E
141	Provide care for the obstetric patient	X	—	E
142	Provide care to a near-drowning patient	X	—	E
143	Provide care to a patient experiencing a behavioral problem	X	—	E
144	Provide care to a patient experiencing cardiovascular compromise	X	—	E
145	Provide care to a patient experiencing non-traumatic chest pain/discomfort.	X	—	E
146	Provide care to a patient exposed to cold	X	—	E
147	Provide care to a patient exposed to heat	X	—	E
148	Provide care to a patient who has been bitten or stung by an animal or insect	X	—	E
149	Provide care to a patient with a burn injury	X	—	E

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PATIENT MANAGEMENT (continued)				
150	Assist with the delivery of an infant	X	C	
151	Assisting a patient in administering his/her own prescribed medications, including auto-injection (self, buddy and pt assisted)	X	C	
152	Resuscitate a patient in cardiac arrest.	X	C	
153	Burns--chemical, electrical, inhalation, radiation, thermal	X		E
154	Childbirth (abnormal/complications)	X	C	
155	Childbirth (normal)--cephalic delivery	X	C	
156	Childbirth--umbilical cord cutting	X		E
157	Eye care	X		E
158	Eye Irrigation	X		E
159	Splinting- Pelvic Wrap			E
160	Splinting extremity – Rigid	X		E
EMERGENCY TRAUMA CARE				
161	Cervical collar	X	C	
162	Manual head/Neck Stabilization	X	C	
163	Manual Extremity Spinting	X	C	
164	Application of Commercial Extremity Splints	X	C	E
165	Anatomical Extremity splinting	X	C	
166	Eye Irrigation	X	C	
167	Rapid extrication	X	C	
168	Spinal Immobilization – Based on mechanics of Injury	X		E
169	Spinal Immobilization – Cervical Collar	X	C	
170	Spinal Immobilization – Long Board	X	C	
171	Spinal Immobilization – Manual Stabilization	X	C	
172	Spinal Immobilization – Seated Patient	X	C	
173	Spinal Immobilization – Seated Patient (KED, etc.) (Assist only)	X	C	
174	Spinal immobilization--helmet stabilization or removal	X		E
175	Spinal immobilization--long board w/pt supine and standing	X		E
176	Spinal immobilization--manual stabilization and cervical collar	X	C	
177	Spinal immobilization--rapid extrication	X	C	
178	Splinting extremity – Soft	X	C	
179	Splinting extremity – Anatomical	X	C	
180	Splinting extremity – Manual stabilization	X	C	
181	Splinting extremity – Vacuum	X	C	
182	Hemorrhage Control – Direct Pressure	X	C	
183	Hemorrhage Control – Pressure Point	X	C	
184	Hemorrhage Control – Tourniquet	X	C	
185	Trendelenberg Positioning	X	C	
186	Hemorrhage Control - Pressure Bandaging	X	C	
EMERGENCY CARDIAC CARE				

8-21

187	Cardiac monitoring--apply electrodes			E
188	Cardiac monitoring--multi lead (acquire but non -interpretive)			E
189	Cardiopulmonary Resuscitation (CPR)	X	C	
190	Cardiopulmonary resuscitation (CPR) adult, infant, child, one and two person	X	C	
191	CPR - Mechanical Device	X	C	
192	Defibrillation - Automated/SemiAutomated (AED/SAED)	X		E
193	Defibrillation--automated external defibrillator (AED)	X	C	
	EMERGENCY MEDICAL CARE			
194	Monitor IV line	X		E
195	Capillary Blood Sampling – Obtaining (blood glucose monitoring)	O		E
196	Capillary Blood Sampling – Obtaining (other than blood glucose monitoring)			E
197	Maintenance – Non-Medicated IV Fluids (#2 CRYSTALLOIDS, #3 PERIPHERAL)	X		E
198	Urinary catheterization **(ASSESSING & MONITORING ONLY)**			E
199	Assisted normal delivery	X	C	
200	Assisted complicated delivery	X	C	
201	Childbirth (abnormal/complications) - patient positioning	X		E
202	Childbirth (abnormal/complications)	X		E
203	Childbirth (normal)--cephalic delivery	X	C	
204	Childbirth--umbilical cord cutting	X	C	
205	Maintenance – Non-Medicated IV Fluids	X		E
	AMBULANCE OPERATIONS			
206	Assess the need for additional resources at the scene.	X	—	E
207	Drive the emergency vehicle in a non-emergency situation	X	—	E
208	Drive the emergency vehicle in an emergency situation (theory)	X	—	E
209	Give consideration for potential organ retrieval	X	—	E
210	Incident Command System (ICS)	X	—	E
211	Make decisions based on Do Not Resuscitate (DNR) orders	X	—	E
212	Make decisions regarding abandonment, negligence, etc.	X	—	E
213	Multiple Casualty Incident (MCI)	X	—	E
214	Participate in the quality improvement process	X	—	E
215	Prepare the emergency vehicle and equipment before responding to a call.	X	—	E
216	Preserve the crime scene	X	—	E
217	Provide education on emergency medical services to the public	X	—	E
218	Provide for safety of self, patient and fellow workers	X	—	E
219	Provide injury prevention education to the public, such as seat belt usage, helmet usage, pool safety, etc.	X	—	E
220	Use methods to reduce stress in a patient, bystanders and co-workers	X	—	E
221	Use physician medical direction for authorization to provide care (Off-line)	X	—	E
222	Use the incident command system	X	C	

8-22

	Documentation			
	AMBULANCE OPERATIONS (continued)			
223	Out-of-Hospital Do Not Resuscitate (DNR) orders	X	C	E
224	Patient Care Report completion	X	C	E
	Communications			
225	Communicate with bystanders, other health care providers and patient family members while providing patient care	X		E
226	Communicate with patient while providing care	X		E
227	Communications with PSAPs, hospitals, medical command facilities	X		E
228	Provide a report to RECEIVING PERSONNEL of assessment findings and emergency care given	X		E
229	Provide a report to medical direction of assessment findings and emergency care given	X		E
230	Verbal patient report to receiving personnel	X		E
	Lifting & Moving			
231	Lifting & Moving - Move patients using a carrying device	X	C	
232	Lifting & Moving - Move patients without a carrying device	X	C	
233	Lifting & Moving - Patient lifting, moving and transfers	X	C	
234	Lifting & Moving - Patient Physical Restraint Application	X	—	E
235	Lifting & Moving - Patient restraints on transport devices	X	C	
236	Lifting & Moving - Use body mechanics when lifting and moving a patient.	X	C	
237	Behavioral--Restrain violent patient	X	—	E
	Hazardous materials			
238	Decontamination	X	—	E
239	Disinfection	X	—	E
240	Dispose of materials contaminated with body fluids.	X	C	
241	Dispose of sharps (needles, auto-injectors, etc)	X	—	E
242	Perform unit dose auto-injectors for self or peer care (MARK I)	X	C	
243	PPE (personal protection equipment) use	X	C	
244	PRN Self or peer care (Bio/chem)	X	C	
245	Take infection control precautions (body substance isolation)	X	C	

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ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)

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Advanced Emer Med Tech (AEMT) Recommendations

GENERAL

1. Adoption of the title "Advanced Emergency Medical Technician" to replace "Emergency Medical Technician - Intermediate".
2. KS adoption of enhanced National Scope attendant level skills set.
3. Elimination of LMA as a prehospital airway device at this level.
4. Elimination of endotracheal intubation at this level.
5. Adoption of manual defibrillation at this level (at former EMT-D level).
6. Incorporate language of addressing categories/classes of devices rather than specific devices.
7. Any medications authorized will be addressed by class/category instead of name.

TRANSITION PLAN (EMT-I to AEMT)

1. Transition will be accomplished over a three year period via two recertification cycles.
2. EMT-Basics will be required to take specific classes identified as being incorporated in the new skills sets/curricula.
3. Once validation of new CE requirements is achieved, new title (Advanced - Emergency Medical Technician) will be awarded to currently certified Emergency Medical Technician – Intermediate attendants.
4. Those failing to achieve new recertification standards will lose their Emergency Medical Technician – Intermediate certification.

SPREADSHEET LEGEND: The letters below are used in the following pages;

In the "CURRENT" column;

X is used to indicate that the skill is currently an authorized activity for this attendant in level.

O is used in the "current" column to indicate that the skill is an optional skill, such as advanced initiatives for the EMT-B and/or intubation for the EMT-I.

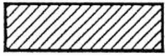
In the "SCOPE" column;

C is used to indicate the skill is a component of the National skill set for this level of attendant.

- is used to indicate the assumption that the skills is included but the depth and breadth of the intervention is not specified in the Scope document.

In the "KEMSSAF" column,

E is used (enrichment) to identify a skill not included in the Scope document but is recommended for inclusion by KEMSSAF in the authorized skills set at the attendant level identified.

 Is used to indicate a new skills for this attendant level in comparison to current law.

	SKILLS SET COMPARISON	Current KS	Scope (MIN)	KS-R(D) (MAX)
	AIRWAY & BREATHING			
1	Oral (Oropharyngeal)	X	C	
2	Esophageal obturator airway (EOA)	X		E
3	Esophageal Gastric Tube Airway (EGTA)	X		E
4	Advanced - Multi Lumen	X	C	
5	Advanced - Single Lumen (*NOT LMA or ET)	X		E
6	Esophageal/Tracheal - Multi Lumen	X		E
7	Lumen (Non-Visualized)(*NOT LMA or ET)	X		E
8	Nasal (Nasopharyngeal)	X	C	
9	Esophageal tracheal--dual lumen CombiTube®	X	C	E
10	Pharyngeal tracheal lumen (PTL)	X	C	
11	Bag-valve-mask (BVM) ventilation	X	C	
12	Bag-valve-mask esophageal/tracheal or multi -lumen airway ventilation	X	C	
13	Bag-valve-mask endotracheal tube ventilation	X	C	
14	Bag-valve-mask with in-line small-volume nebulizer			E
15	Automatic Transport Ventilator (ATV)		C	
16	Manually Triggered Ventilator (MTV)		C	
17	Oxygen Demand valve	X		E
18	Flow restricted oxygen powered ventilation device			E
19	Head-tilt chin lift	X	C	
20	Cricoid pressure (Sellick maneuver)	X	C	
21	Jaw thrust	X	C	
22	Jaw-thrust - Modified (trauma)	X	C	
23	Mouth to barrier	X	C	
24	Mouth to Mask	X	C	
25	Mouth to nose	X	C	
26	Mouth to stoma	X	C	
27	Obstruction-Manual (Heimlich, finger sweep, chest thrusts) upper airway	X	C	
28	Obstruction – Forceps (Direct Visual)	X		E
29	Oxygen Therapy – Humidifiers	X	C	E
30	Oxygen Therapy – Nasal Cannula	X	C	E
31	Oxygen Therapy - Nebulizer	X		E
32	Oxygen Therapy – Non-rebreather Mask	X	C	
33	Oxygen Therapy – Partial Rebreather Mask	X	C	
34	Oxygen Therapy – Regulators	X	C	
35	Oxygen Therapy – Simple Face Mask	X	C	
36	Oxygen Therapy – Venturi Mask	X	C	
37	Oxygen therapy--blow-by delivery	X	C	

38	Suctioning - Upper airway	X	C	
39	Suctioning - Oropharyngeal	X	C	

AIRWAY & BREATHING (continued)

40	Suctioning –Upper Airway (Soft & Rigid)	X	C	
41	Suctioning--meconium aspiration (BULB SYRINGE)	X	C	
42	Suctioning--stoma	X	C	
43	Suctioning--upper airway (nasal)	X	C	
44	Suctioning--upper airway (oral)	X	C	
45	End Tidal C02 Monitoring/Capnometry			E
46	End Tidal CO2 Monitoring			E
47	Endotracheal Intubation	X		—
48	Extubation **(WITH AUTHORIZED DEVICE)**	X		E
49	Gastric Decompression – OG Tube **W/ ANY AUTHORIZED DEVICE**			E

ASSESSMENT

50	Automatic BP	X	C	
51	Level of consciousness (LOC)	X	C	
52	Using Glasgow Coma Scale (GCS)	X	C	
53	Vital sign--body temperature	X	C	
54	Vital sign--pulse	X	C	
55	Vital sign--pupils	X	C	
56	Vital sign--respirations	X	C	
57	Vital sign--skin color/temperature and condition (CTC)	X	C	
58	Blood pressure--auscultation	X	C	
59	Blood pressure--electronic noninvasive	X	C	
60	Blood pressure--palpation	X	C	
61	Auscultate breath sounds (identify specifics)	X	C	
62	Auscultate breath sounds (presence/absence)	X	C	
63	Blood Glucose Monitoring	X	C	
64	Pulse Oximetry	X	C	
65	Refer patients to non-emergent medical care based upon an examination	X	C	
66	EMT-Basic Assessment	X	C	

PHARMACOLOGICAL INTERVENTIONS

Administered Medication

67	PRN (Bio/chem)		C	
68	ASA for chest pain (of suspected ischemic origin)	X	C	
69	Oral analgesics		C	
70	Administer MD-approved OTC medications (activated charcoal, oral glucose, oral analgesics, ASA for chest pain of suspected ischemic origin)	X	C	

Administered Medication - Mode of Delivery

71	Aerosolized		C	
72	Buccal		C	

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73	Intramuscular (IM)	X	C	

PHARMACOLOGICAL INTERVENTIONS

Administered Medication - Mode of Delivery

74	Peripheral IV Push (D50 and narcotic antogonist only)		C	
75	Nebulized	X	C	
76	Oral (PO)	X	C	
77	Sub-Lingual (SL)	X	C	
78	Auto-injected epinephrine--primary use--not patient's own prescription	X	C	
79	Unit dose auto-injector for self or peer care		C	
80	Intranasal		C	
81	Rectal			E
82	Subcutaneous (SC)		C	

Administered Medication - Pt Assisted

83	Activated Charcoal	X		E
84	Beta-agonist			E
85	Atrovent	X		E
86	Auto-Injected Epinephrine	X		E
87	Medicated Inhaler – Prescribed	X		E
88	Nitroglycerin	X		E

Administered Medication - By Protocol

89	Oral Glucose	X		E
90	Activated Charcoal	X		E
91	Administer Inhaled beta agonist for dyspnea & wheezing		C	
92	Administer SL Nitro for chest pn of suspected ischemic origin	X	C	
93	Aspirin (ASA) for chest pain (ONLY W/ MEDICAL DIRECTION)	X	C	
94	Aspirin (ASA) for chest pain	X	C	
95	Epi-Pen – Carrying & Administration (By Protocol)	X	C	
96	Glucagon auto-injector			E
97	Mark I Auto Injector (For Self & Crew)		C	
98	25% and 50% dextrose.			E
99	Adenosine			
100	Administer a narcotic antagonist		C	
101	Administer MD approved medications			
102	Administer MD-approved OTC medications (activated charcoal, oral glucose, oral analgesics, ASA for chest pain of suspected ischemic origin)	X	C	
103	Administer nitrous oxide for pain relief (medical protocol)		C	
104	Administer SQ or IM Epinephrine for anaphylaxis (IM only)	X	C	
105	Aerosolized or nebulized beta-2 specific bronchiodilators.			E
106	Albuterol & Atrovent - Premix Combined			
107	Albuterol (Nebulized)	X		E
108	Amiodarone (Bolus only)			

109	Ativan (Lorazepam) for Seizures only			

PHARMACOLOGICAL INTERVENTIONS (continued)

Administered Medication - By Protocol (continued)

110	Atropine sulfate			
111	Atrovent (Nebulized)			
112	Bretylium tosylate			
113	Calcium chloride			
114	Dextrose 50%			E
115	Diazepam			
116	Diphenhydramine hydrochloride			
117	Dopamine hydrochloride			
118	Epinephrine 1:10,000 (Cardiac Arrest Only)			E
119	Epinephrine Auto-Injector or Manually drawn 1:1000	X		E
120	Furosemide			
121	Glucagon		C	
122	Lasix			
123	Lidocaine (Bolus Only)			
124	Midazolam			
125	Mark I Auto Injector (For Self & Crew)		C	
126	Monitor and adjust heparin infusion during interfacility transport.			
127	Monitor and adjust nitroglycerine infusion during interfacility transport			
128	Morphine			
129	Narcan (Narcotic antagonist)		C	
130	Oral Glucose	X	C	
131	Valium (Diazepam) for seizures only ???? Benzodiazepam)			
132	Vasopressin			
133	Nitroglycerin (SL only)	X	C	
134	Nitroglycerine preparation – sublingual or oral spray	X	C	
135	Oral Glucose	X	C	

EMERGENCY TRAUMA CARE

136	Cervical collar	X	C	
137	Manual head/Neck Stabilization	X	C	
138	Manual Extremity Splinting	X	C	
139	Application of Commercial Extremity Splints	X	C	
140	Anatomical Extremity splinting	X	C	
141	Eye Irrigation	X	C	
142	Rapid extrication	X	C	
143	Spinal Immobilization – Based on mechanics of injury	X	C	
144	Spinal Immobilization – Cervical Collar	X	C	
145	Spinal Immobilization – Long Board	X	C	

EMERGENCY TRAUMA CARE (continued)

146	Spinal Immobilization – Manual Stabilization	X	C	
147	Spinal Immobilization – Seated Patient	X	C	
148	Spinal Immobilization – Seated Patient (KED, etc.) (Assist only)	X	C	
149	Spinal immobilization--helmet stabilization or removal	X	C	
150	Spinal immobilization--long board w/pt supine and standing	X	C	
151	Spinal immobilization--manual stabilization and cervical collar	X	C	
152	Spinal immobilization--rapid extrication	X	C	
153	Splinting extremity – Soft	X	C	
154	Splinting extremity – Anatomical	X	C	
155	Splinting extremity – Manual stabilization	X	C	
156	Splinting extremity – Vacuum	X	C	
157	Hemorrhage Control – Direct Pressure	X	C	
158	MAST/PASG	X	C	
159	Hemorrhage Control – Pressure Point	X	C	
160	Hemorrhage Control – Tourniquet	X	C	
161	Hemorrhage Control - Pressure Bandaging	X	C	
162	Trendelenberg Positioning	X	C	
163	Eye care	X	C	
164	Eye Irrigation	X	C	
165	Splinting- Pelvic Wrap	X	C	
166	Splinting extremity – Rigid	X	C	
167	Provide care to a patient with a burn injury	X	C	
168	Provide care to a patient with a chest injury	X	C	
169	Provide care to a patient with a painful, swollen, deformed extremity	X	C	
170	Provide care to a patient with a soft tissue injury	X	C	
171	Provide care to a patient with a suspected head injury	X	C	
172	Provide care to a patient with a suspected spinal injury	X	C	
173	Provide care to a patient with an acute amputation	X	C	
174	Provide care to a patient with an impaled object	X	C	
175	Provide care to a patient with an open abdominal injury	X	C	
176	Provide care to a patient with shock (Hypoperfusion).	X	C	
177	Provide care to an infant or child with trauma	X	C	
178	Provide care to a patient with a burn injury	X	C	
179	Provide care for external bleeding.	X	C	
180	Burns--chemical, electrical, inhalation, radiation, thermal	X	C	
	EMERGENCY CARDIAC CARE			
181	Provide care to an infant or child with cardiac arrest	X	C	
182	Cardiac monitoring--apply electrodes	**(D)**		X
183	Cardiac monitoring--multi lead (acquire but non-interpretive)	**(D)**		X

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EMERGENCY CARDIAC CARE (continued)				
184	Cardiopulmonary resuscitation (CPR) adult, infant, child, one and two person	X	C	
185	CPR - Mechanical Device	X	C	
186	Cardiac Monitoring - Multi Lead (non-interpretive)	(D)		X
187	Cardiac Monitoring – Single Lead (interpretive) [EMT-D focus]	(D)		X
188	Cardiac Monitoring – Single Lead (non-interpretive)	(D)		X
189	Defibrillation - Automated/Semi Automated (AED/SAED)	X		X
190	Defibrillation – Manual	(D)		X
191	Defibrillation--automated external defibrillator (AED)	X		X
192	Defibrillation--Counter shock--manual	(D)		X
193	Defibrillation - Automated/Semi Automated (AED/SAED)	X	C	
194	Defibrillation--automated external defibrillator (AED)	X	C	
EMERGENCY MEDICAL CARE				
195	Resuscitate a patient in cardiac arrest.	X	C	
196	Provide post-resuscitation care to a cardiac arrest patient	X	C	
197	Provide care for a patient with a history of diabetes.	X	C	
198	Provide care for a patient with abdominal pain	X	C	
199	Provide care for a patient with an altered mental state	X	C	
200	Provide care for a patient with an endocrine disorder other than diabetes.	X	C	
201	Provide care for a patient with head pain	X	C	
202	Provide care for a possible poisoning patient	X	C	
203	Provide care for external bleeding.	X	C	
204	Provide care for the obstetric patient	X	C	
205	Provide care to a near-drowning patient	X	C	
206	Provide care to a patient experiencing a behavioral problem	X	C	
207	Provide care to a patient experiencing cardiovascular compromise	X	C	
208	Provide care to a patient experiencing non-traumatic chest pain/discomfort.	X	C	
209	Provide care to a patient exposed to cold	X	C	
210	Provide care to a patient exposed to heat	X	C	
211	Provide care to a patient who has been bitten or stung by an animal or insect	X	C	
212	Provide care to an infant or child with a fever	X	C	
213	Provide care to an infant or child with a suspected blood disorder	X	C	
214	Provide care to an infant or child with a suspected communicable disease	X	C	
215	Provide care to an infant or child with abdominal pain	X	C	
216	Provide care to an infant or child with respiratory distress	X	C	
217	Provide care to an infant or child with seizure	X	C	
218	Provide care to an infant or child with shock (hypoperfusion)	X	C	
219	Provide care to an infant or child with suspected abuse or neglect	X	C	
220	Provide care to suspected overdose patient	X	C	
221	Provide care to the mother immediately following delivery of a newborn	X	C	
EMERGENCY MEDICAL CARE (continued)				

222	Provide care to the newborn	X	C	
223	Provide care to the patient experiencing a seizure	X	C	
224	Provide care to the patient experiencing an allergic reaction	X	C	
225	Provide care to the patient with a gynecological emergency	X	C	
226	Urinary catheterization **(ASSESSING & MONITORING ONLY)**			E
227	Assisted normal delivery	X	C	
228	Assisted complicated delivery	X	C	
229	Assist with the delivery of an infant	X	C	
230	Childbirth (abnormal/complications) - patient positioning	X		E
231	Childbirth (abnormal/complications)	X		E
232	Childbirth (normal)--cephalic delivery	X	C	
233	Provide care to an infant or child with a fever	X	C	
234	Perform a rapid extrication of a trauma patient	X	C	
235	Provide care for a patient with a history of diabetes.	X	C	
236	Provide care for a patient with an altered mental state	X	C	
237	Provide care for a patient with an endocrine disorder other than diabetes.	X	C	
238	Provide care for a patient with head pain	X	C	
239	Provide care for a possible poisoning patient	X	C	
240	Provide care for the obstetric patient	X	C	
241	Provide care to a near-drowning patient	X	C	
242	Provide care to a patient experiencing a behavioral problem	X	C	
243	Provide care to a patient experiencing cardiovascular compromise	X	C	
244	Provide care to a patient experiencing non-traumatic chest pain/discomfort.	X	C	
245	Provide care to a patient exposed to cold	X	C	
246	Provide care to a patient exposed to heat	X	C	
247	Provide care to a patient who has been bitten or stung by an animal or insect	X	C	
248	Assist with the delivery of an infant	X	C	
249	Assisting a patient in administering his/her own prescribed medications, including auto-injection (self, buddy and pt assisted)	X	C	
250	Childbirth (abnormal/complications) - patient positioning	X	C	
251	Childbirth (normal)--cephalic delivery	X	C	
252	Childbirth--umbilical cord cutting	X	C	
253	Urinary catheterization (monitoring only)			E
	INTRAVENOUS INITIATION/MANAGEMENT			
254	Arterial line--capped--transport			E
255	IV Push D50		C	
256	IV Solutions- D5W, Normal Saline,	X	C	
257	Lactated Ringers			E
258	Capillary Blood Sampling – Obtaining (other than blood glucose monitoring)		C	
	INTRAVENOUS INITIATION/MANAGEMENT (continued)			
259	Crystalloids		C	

260	Saline lock insertions as no-flow IV			E
261	Indwelling intravenous catheters (peripheral)			E
262	Intraosseous – initiation (adult & pediatric)		C	
263	IV (push and infusion)		C	
264	IV Push D50		C	
265	Lactated Ringers	X		E
266	Peripheral venous--initiation (cannulation)	X	C	
267	Venous Blood Sampling – Obtaining	X		E
268	Monitor IV line	X	C	
269	Maintenance – peripheral non-medicated crystalloid IV Fluids	X	C	
	AMBULANCE OPERATIONS			
270	Assess the need for additional resources at the scene.	X	C	
271	Drive the emergency vehicle in a non-emergency situation	X	C	
272	Drive the emergency vehicle in an emergency situation (theory)	X	C	
273	Give consideration for potential organ retrieval	X	C	
274	Incident Command System (ICS)	X	C	
275	Make decisions based on Do Not Resuscitate (DNR) orders	X	C	
276	Make decisions regarding abandonment, negligence, etc.	X	C	
277	Multiple Casualty Incident (MCI)	X	C	
278	Participate in the quality improvement process	X	C	
279	Prepare the emergency vehicle and equipment before responding to a call.	X	C	
280	Preserve the crime scene	X	C	
281	Provide education on emergency medical services to the public	X	C	
282	Provide for safety of self, patient and fellow workers	X	C	
283	Obtain consent for providing care	X	C	
284	Provide injury prevention education to the public, such as seat belt usage, helmet usage, pool safety, etc.	X	C	
285	Use methods to reduce stress in a patient, bystanders and co-workers	X	C	
286	Use physician medical direction for authorization to provide care (Off-line)	X	C	
287	Deliver or assist in delivery of home health care (To level of authorized activities)	X	C	
288	Triage (prioritizing patients)-use of tags	X	C	
	Documentation			
289	Out-of-Hospital Do Not Resuscitate (DNR) orders	X	C	
290	Complete a prehospital care report	X	C	
291	Patient Care Report completion	X	C	
	AMBULANCE OPERATIONS (continued)			
	Communications			

292	Communicate with bystanders, other health care providers and patient family members while providing patient care	X	C	
293	Communicate with patient while providing care	X	C	
294	Communications with PSAPs, hospitals, medical command facilities	X	C	
295	Provide a report to RECEIVING PERSONNEL of assessment findings and emergency care given	X	C	
296	Provide a report to medical direction of assessment findings and emergency care given	X	C	
297	Verbal patient report to receiving personnel	X	C	
	Lifting & Moving			
298	Lifting & Moving - Move patients using a carrying device	X	C	
299	Lifting & Moving - Move patients without a carrying device	X	C	
300	Lifting & Moving - Patient lifting, moving and transfers	X	C	
301	Lifting & Moving - Patient Physical Restraint Application	X	C	
302	Lifting & Moving - Patient restraints on transport devices	X	C	
303	Lifting & Moving - Use body mechanics when lifting and moving a patient.	X	C	
304	Behavioral--Restrain violent patient	X	C	
	Hazardous materials			
305	Decontamination	X	C	
306	Disinfection	X	C	
307	Dispose of materials contaminated with body fluids.	X	C	
308	Dispose of sharps (needles, auto-injectors, etc)	X	C	
309	Perform unit dose auto-injectors for self or peer care (MARK I)	X	C	
310	PPE (personal protection equipment) use	X	C	
311	PRN Self or peer care (Bio/chem)	X	C	
312	Take infection control precautions (body substance isolation)	X	C	
	Rescue			
313	Patient access and extrication	X	C	
314	Rapid extrication	X	C	

PARAMEDIC

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Paramedic Recommendations

GENERAL

1. Adoption of the title "Paramedic" to replace "Mobile Intensive Care Technician".

2. No change in current authorized level of activities. Potential changes in terminology, language, title, other than clean up as necessary.

TRANSITION PLAN (MICT to Paramedic)

NONE REQUIRED

SPREADSHEET LEGEND: Does NOT apply.

TESTIMONY

Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Jon E. Friesen
President
Kansas EMS Association

RE: 2009 Senate Bill 262
EMS Scope of Practice

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Jon Friesen. I am the president of the Kansas Emergency Medical Services Association. We represent 1,250 individual EMS attendants in Kansas as well as 116 of the 171 Kansas ambulance services. I am providing in this written testimony comments regarding 2009 Senate Bill 262 with regards to the scope of practice for Kansas EMS providers.

The proposed legislation in this bill will revamp the title of EMS attendants in Kansas from current to be in line with the National EMS Scope of Practice. This move is congruent with the National EMS Scope of Practice Document that was released by the National Highway Safety and Traffic Administration (NHTSA).

The Board of EMS worked with representatives from each Kansas EMS Regional Council as well as from each community college directly involved in the education of EMS attendants in Kansas and the professional associations tied to emergency medical services. Working through the course of 2008, this committee defined the desired scope of practice for attendants at each level of the National Scope model.

While there is some difference of opinion regarding what specific levels should or should not do; it should be noted that the Board of EMS was inclusive in the process of discerning the scope for each level. At the end of the process, the group made recommendations for the scope of practice for each level of attendant using the input and majority opinion of the group.

This move to align titles with the National EMS Scope of Practice document is the correct thing for Kansas to do. Despite some variance of opinion about specific practices in the scope, Kansas EMS is well positioned to move forward with implementing the proposed scope should the legislature approve the bill. In the end, these changes maintain a high standard for the care of the sick and injured well into the future.

On behalf of our members, KEMSA supports this proposed legislation and strongly encourages the Committee to approve the 2009 Senate Bill 262 and move it to the full Senate.

Thank you for allowing me the opportunity to testify on behalf of our membership regarding the 2009 Senate Bill 262. I am happy to answer any questions that you have.

Respectfully submitted,

Jon E. Friesen
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Date: February 26, 2009

To: Senate Committee on Federal and State Affairs

From: Gary Winter, Region I EMS Coordinator

Re: 2009 Senate Bill 262

Testimony

Chairman Brungardt and members of the Senate Committee on Federal and State Affairs, my name is Gary Winter. I am the Regional Coordinator for Region I Emergency Medical Services Council. Region I is comprised of the eighteen northwest Kansas counties. I would like to make comments on 2009 Senate Bill 262.

Region I represents 21 licensed ambulance services. Taking into account all ambulance services in Region I, 85.17% of the staff is volunteer. Region I has two full time paid ambulance services. When you remove those services from the equation, the remaining 16 counties in Region I are 96% volunteer. As you can see, the ambulance services in Region I have to utilize volunteers to help provide care for our citizens.

Figures obtained from service directors on Emergency Medical Services license renewal applications indicate that 12 of the 21 (57%) licensed services in Region I utilize First Responders (Emergency Medical Responders) as a part of their crews. In visiting with several of the Service Directors that did not indicate any Emergency Medical Responders on their roster, they expressed an enthusiastic willingness to utilize Emergency Medical Responders if and when they become available.

For those ambulance services that indicated Emergency Medical Responders on their roster, the percentage of EMRs on the rosters range from a low of 3% to a high of 29%. The availability plays a significant role in the large

variance, but as you can see Region I does have ambulance services that rely heavily on EMRs.

Region I is predominately rural and staffing issues have long been a concern. The ability or availability of people to volunteer is dwindling as our population ages, number of people decreases, the state of the economy, etc., etc. There are many factors that have greatly reduced the number of potential attendants that could be trained and used to help staff our ambulances. In preparing and caring for the sick and injured, the ability to train and utilize Emergency Medical Responders as a part of the crew has allowed many ambulance services to maintain staffing.

If Emergency Medical Responders, as part of the patient care team, were removed it could have very devastating effects on the counties ability to maintain staffing for their ambulance service and ultimately care for the general public.

In conclusion, Region I supports passage of this bill in its' current form, with emphasis on maintaining Emergency Medical Responders as part of the patient care team.

Thank you for your time and consideration of this very important matter.

Respectfully submitted,

Gary Winter, Coordinator
Region I Emergency Medical Services Council

Serving the Counties of Region I: Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Ness, Norton, Phillips, Rawlins, Rooks, Rush, Russell, Sheridan, Sherman, Thomas, Trego, Wallace