Approved: April 29, 2010
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Brenda Landwehr at 1:30 p.m. on February 3, 2010, in Room 784 of the Docking State Office Building.

All members were present except:
Representative Owen Donohoe- excused
Representative Clark Shultz - excused

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Ken Wilke, Office of the Revisor of Statutes
Kathie Sparks, Kansas Legislative Research Department
Debbie Bartuccio, Committee Assistant

Conferees appearing before the Committee:
Robert Waller, Executive Director, Kansas Board of Emergency Medical Services (Attachments 1, Attachment 2, Attachment 3, Attachment 4 and Attachment 5)
Christopher Way, MICT, BA, President, Kansas Emergency Services Association (Attachment 6)
Chy Miller, Department Chair, Public Safety, Hutchinson Community College (Attachment 7)
Chad Pore, Director, Kiowa County, EMS (Attachment 8)
Bob Prewitt, MICT I/C, Director, Kansas Emergency Medical Services, Finney County (Attachment 9)
J. R. Behan, Paramedic, KBEMS Board Member (Attachment 10)

Others attending:
See attached list.

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

Chairperson Landwehr opened the hearing on **SB 262**.

Robert Waller, Executive Director, Kansas Board of Emergency Medical Services, presented testimony in support of the bill. (Attachment 1) The bill revises the Scope of Practice for the four (4) levels of attendants the Kansas Board of Emergency Medical Services regulates. He proceeded to review information concerning the history of the project, the importance of the scope of practice revision, the options considered, and the process of the Committee to develop a document for review. The KEMSSAF Committee determined that in enhancing and implementing the scope of practice for Kansas, positive impact could be achieved and pre-hospital care enhanced. The specific impacts related to the following: 1) medical intervention, 2) transport times, 3) availability, 4) education, 5) Kansas needs versus the baseline National Scope of Practice (NSP) and 6) hours to transition.

The following additional attachments were provided:
- A balloon to amend the bill based on agreement between KBEMS, Kansas Medical Society, and Kansas Board of Nursing. (Attachment 2)
- Attendant Level Review, a side-by-side comparison of the balloon core components. (Attachment 3)
- The detailed scope of practice revision report. (Attachment 4)
- A transition timetable. (Attachment 5)

Christopher Way, President, Kansas Emergency Medical Services Association, presented testimony in support of the bill. (Attachment 6) He reviewed the following four points:

1) The bill moves Kansas certification level titles in line with the National EMS Scope of Practice recommendation.
2) The bill defines a new and standard of care "current" scope of practice for each level of certified technician.
3) The change in scope of practice keeps Kansas current with the National Scope and with standard of care as scientifically defined.
4) The bill reflects the work of the Board of EMS to ensure stakeholder input and opportunity to define what will be used at the local level in providing quality emergency medical services.

Minutes of the House Health and Human Services Committee at 1:30 p.m. on February 3, 2010, in Room 784 of the Docking State Office Building.

Chy Miller, Deputy Chair - Public Safety, Hutchinson Community College, provided testimony in strong support of the bill in order to give the Kansas Board of EMS the ability to implement the new EMS Scope of Practice. (Attachment 7)

Chad Pore, Director, Kiowa County EMS, presented testimony in support of the bill. (Attachment 8) He reviewed the following four important aspects of the bill:

1) The ability to market job openings on a national level as this bill brings Kansas certification levels in line with the National EMS Scope of Practice.
2) The bill ensures services and technicians in Kansas are held to the current trends and standards of care in EMS, and the current scientific findings for what care is beneficial to patients.
3) The bill ensures that local involvement is still a key aspect of pre-hospital care, allowing services and physicians to meet the needs of their communities while maintaining high standards in the pre-hospital environment.
4) The bill provides the ability to enhance pre-hospital care in rural areas of Kansas, which makes up the majority of the State.

Robert Prewitt, Director, Finney County EMS, provided testimony in support of the bill. (Attachment 9)

J. R. Behan, Paramedic and KBEMS Board Member, deferred to his written testimony in support of the bill. (Attachment 10)

David Stithem, Chair, Region I EMS, provided written testimony in support of the bill. (Attachment 11)

Chaiperson Landwehr asked if there was anyone else wanting to speak.

Dan Morin, Kansas Medical Society expressed their thanks to the Board of EMS for taking the time and attention to listen to the concerns. The meeting was very productive. There are some technical amendments being worked on that will be ready for when the Committee works the bill.

Chairperson Landwehr also expressed her appreciation to the groups for getting together and producing a much better product.

The Chair gave the committee members the opportunity to ask questions and when all were answered, the hearing on **HB 262** was closed.

Chairperson Landwehr requested a motion to approve the January 13 and January 21 committee meeting minutes. The motion was made by Representative Finney and seconded by Representative Hermanson. The motion carried.

The next meeting is scheduled for February 8, 2010.

The meeting was adjourned at 2:24 p.m.

HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2-3-10

NAME	REPRESENTING
Chris Way	Kansas EMS Association
Terry L David	Rice Co. EMS
Grant Helferich	Butler County
Jeff Smith	City of Lenexa Fire Department
Robert Walk	KBEMS
Miriam Slaugh RN	Washburn University Grad Student
Diane Glynn	KSBN
Alma Hecker	Att Gen / KSBN
Chy Miller	Hcc EMS Education
Debra Brown	KEMTA
Randy Cardonell	KEMTA
Bob Prewitt	Finney CoEMS
Jon Friesen	Sedgwick Co. / KEMSA
Dalene Beck	KEMSA / Sedgwick County
Steve Cotter	KEMSA / Sedgwick County
Kathy Outland	KSNA
Phil Griffin	KDHE
Brenda Walker	KDHE
Michelle Butler	Cap. Strategies

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HOUSE HEALTH & HUMAN SERVICES COMMITTEE

DATE: 2-3-10

NAME	REPRESENTING
Steve Sutton	KBEMS
Coreman Allen	KBEMS
David Stithem	Reg I EMS Council
Natalie Bruflo	Bright & Carpenter

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KANSAS

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

MARK PARKINSON, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

Testimony

Date: January 27, 2009

To: House Health and Human Services

From: Robert Waller, Executive Director

RE: 2009 Senate Bill 262

Madam Chairwoman Landwehr and members of the House Health and Human Services Committee, 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.

History

In 1996, the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) published the national consensus document titled *EMS Agenda for the Future (Agenda).* The intent of the *Agenda* was to create a common vision for the future of EMS and designed for use by government and private organizations at the national, state and local levels to help guide EMS planning, decision making, and policy including EMS education. In 2000, the *Agenda* was followed by the *EMS Education Agenda for the Future: A Systems Approach (Education Agenda).* The purpose of the *Education Agenda* was to establish a system of EMS education that more closely paralleled that of other allied health care professions. This vision has been 14 years in the making. The *EMS Agenda for the Future* was the first to describe the outcomes and goals for EMS Education. Kansas believed that as the other States and territories began the process of revising their scope of practice based on these documents, Kansas EMS must also evaluate the importance of the *Agenda.* Based on that evaluation, a system was established to develop the Kansas scope, oversee the implementation of the scope, and evaluate and mitigate its impact on Kansas EMS.

Importance of Scope of Practice Revision

As the *Agenda* and the *Education Agenda* were developed, the core basis of those documents was to create, establish, and promote the following:

- Establish a national EMS education system that would align EMS with other health professions and enhance the professional credibility of EMS practitioners.

- Create a *National EMS Education Standard (Education Standards)* that replaces the N al Standard Curricula (NSC) in order to increase instructor flexibility and provide a greater abi.. to adapt to local needs and resources. Those standards would permit the introduction of new technologies and evidence-based medicine without requiring a full revision of the entire program of education.

- The *Education Agenda* would assist states in standardizing provider levels across the Nation affording ease of reciprocity and greater opportunities for career growth in EMS.

- The National EMS Certification exams at all levels would be consistent with the *Scope of Practice Model.*

- The public would be assured that persons who carry the specific title of Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) or Paramedic have attained knowledge consistent with others who carry that title.

- States that receive attendants from another state could expect that those who transfer licensure or certification based on a particular EMS level have at least been prepared at that level's knowledge and skills sets. The model is used to facilitate reciprocity when attendants are called upon to participate in interstate mutual aid activities that support a wide area disaster response under the National Incident Management System (NIMS.)

Options

As Kansas undertook the task of reviewing the Kansas Scope of practice, there were several options to consider. The Board considered implementing none, some, or ALL components of the *Agenda*, *National Scope of Practice (NSP)*, and *Education Agenda.* Implementing none of the *NSP* would commit the Board to education methods that would not match publisher texts and curricular materials. It would force the Board to develop and defend a valid and reliable Kansas certification examination, institute a reduced opportunity for reciprocity among states, and damage the consistency of the EMS educational structure and thus the professionalism of the industry. To not implement the *Scope of Practice* as written, would have an adverse affect on Kansas EMS as well. It would reduce activities currently being performed, affect the ability for attendants certified in other States to fill vacancies at Kansas EMS services, and place Kansas EMS in a position in which current standards of care would be reduced or eliminated. In reviewing the above, the Kansas Board of Emergency Medical Services believed that the importance of a baseline scope of practice between States was important. The baseline scope not only enables EMS services to be able to recruit and retain, but establishes an educational standard that relies on evidence based practice researched by a myriad of allied health professionals coming together to evaluate medical care and how that medical care is provided. With this said, the Board also recognizes the needs of rural Kansas and the restrictions and constraints placed upon such sparsely populated areas. Therefore, the Board has elected to adopt the *National Scope of Practice,* while maintaining many of the currently practiced activities to assure facilitation of effective patient care throughout the State.

Development

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 Services the effects and impact that implementation of the *National Scope of Practice* and the *Education Agenda*, *Rural Health Agenda for the Future*, and the *Agenda for the Future* would have in Kansas. The Committee was made up of the following:

- 4 members of the Board of EMS
- 1 Member from each Kansas EMS Regional Councils
- 1 Member from 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 from each Community College currently teaching EMS education
  - 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 five components:

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

2. Mandate that attendants must practice under medical protocols;

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

4. Create a Medical Director Advisory Committee under the Kansas Board of Emergency Medical Services Board to continuously review medical trends and changes in the profession

5. The scope of practices, as outlined by law, would be outlined (specifically) in rules and regulations.

Once the Committee completed its task, the Kansas Emergency Medical Services System Approach to the Future (KEMSSAF) report was developed and sent out to the Regional Councils for distribution and comment. The document identifies skills sets, by level, current law, the *National Scope of Practice* as written, and those activities that would be added. Those details are outlined within the report.

Implementation

The magnitude of Scope of Practice was far too complicated and arduous to be taken on by KBEMS staff. Therefore, the KBEMS Board issued a request for proposal (RFP) to develop the transition courses which will move Kansas EMS from the old scope of practice to the new scope of practice. The Friesen Group (based in Newton, Kansas) was contracted and hired by the State of Kansas to develop and distribute to educators (both instructor coordinators (ICs) and training officers (TOs) curricula that will transition first responders to *Emergency Medical Responders*, EMT-Basics to *EMTs*, and EMT-Intermediates to *Advanced EMTs*. As the transition courses are being developed, the KBEMS Board has maintained a "Transition Course Task Force" to manage the project and report to the Board. The Task Force is comprised of Kansas EMS educators and attendants to assist in creating a smooth transition.

Method of Obtaining

The transition courses will be provided locally by services or by EMS training programs or EMS educators. The local level (directors and educators) will hold the responsibility to schedule and conduct classes. In addition to local service classes, community colleges and technical schools may hold transition courses to assist in meeting the demand. As the Transition Group has maintained from the initiation of the transition plan, continuing education modules must be completed by every certified first responder, EMT, EMT-D, and EMT-I during their renewal cycle. These continuing education modules will be mandated for one renewal cycle and will be completed in lieu of other continuing education, not in addition to current continuing education requirements. The individual attendant must choose a transition path.

- First responders must transition to the EMR level
- EMT's and EMT-D's may choose between transitioning to the new EMT level or down to the EMR level
- EMT-I's may choose between transiting to the new AEMT level or down to the EMT or EMR levels

Attendants not wishing to complete the transition modules would forfeit their certification.

Impact on Kansas EMS

The composition of the KEMSSAF Committee was selected specifically to ensure that Committee members would represent their communities of interest and provide the group with a level of expertise in their respective areas. Whether representing an association, rural or urban EMS, educators, attendants, or educational institutions, all members had equal presentation and voting privileges. The Board convened the group to assist in addressing the concerns of all facets, locations, operations, and financial levels of services. As the Committee made its final recommendation, the basis of the decisions centered on not only enhancing and maintaining the current level of EMS care in the State, but having the ability through education, medical direction, research, and collaboration to continue to sustain a heightened range of pre-hospital care. As discussed previously, the *National Scope of Practice* is the recommended baseline of pre-hospital care knowledge and skill sets. It was established to provide a base "floor" for the individual States to use in the development of a scope of practice. Kansas EMS, in reviewing the entire *Scope*, understood there were some aspects of the *National Scope of Practice* that should not be implemented, some that could be implemented, and some that must be changed or amended to fit into current operations and not adversely affect frontier, rural, and urban EMS. The Committee determined that in enhancing and implementing the scope of practice for Kansas, positive impact could be achieved and pre-hospital care enhanced. Those specific impacts relate to the following:

- *Medical intervention.* Adding pharmaceutical interventions to the Advanced EMT enables a greater level of pre-hospital treatment for the constituents of those areas that may find it fiscally impossible to employ paramedics. Allowing the AEMT to provide pharmaceutical interventions facilitates advanced level care to areas in which a medical director desires advanced interventions enroute to the receiving facility. The *National Scope of Practice* is intended to be updated periodically and was created in a way that it can adapt to the introduction of new technologies and evidence-based medicine. Kansas recognized such adaptation, and looked to the AEMT to demonstrate and employ that level of activity. The *Scope of Practice* for Kansas can and will be reviewed frequently as acceptable pre-hospital interventions change. It is not a statistic document, and therefore is managed by patient care and the needs of patients.

- *Transport times.* The demographics of rural and frontier areas often dictates longer transport times to facilities capable of providing patients with the level of care necessary to assure positive outcomes. An enhanced, medically supported, and robust education based scope of practice will provide frontier and rural services a greater ability to care for and sustain patients that may not have survived if air transport

is unavailable. The STEMI and Stroke initiatives currently being researched and implemented he Board through the American Heart Association, for example, could then be managed and sustai by that higher level of care. Rural and frontier EMS services will be able to greatly enhance the level of care provided to their communities. The ability to provide a greater level of care cannot be under estimated. The bill will facilitate a service's ability to enhance advance life support protocols by not only sustaining current activities, but adding additional interventions.

- *Availability*. The Board, in preparing for the implementation of the bill, will make the transition courses available at the local level. The courses will be placed in the hands of educators and institutions that already provide attendants and students with continuing education hours (CEU). Services should be able to provide those modules to attendants at a minimal or no cost, due to the development of the classes into modules. Attendants who recertify December 31, 2011 will have until December 31, 2013 to obtain the course. The remaining attendants will have until December 31, 2012 to obtain the transition course for their level of certification or the level below, if transitioning down a level(s). The Board will also review the possibility of an online course to further ease the burden placed on those who would find it difficult to attended face-to-face scheduled classes due to the their volunteer status or location of the available courses. With the current plan in place, the Board believes that no matter the location of the student the time to cover the module and the location of the course will not overly burden or hamper current attendants' ability to complete the required education.

- *Education*. "A mind once stretched by a new idea never regains its original dimensions." EMS has now reached that state. The Board understands the concerns many have with a change in educational standards and access to that education. However, the Board realizes that emergency medical services as they functioned in the 1970's are not the same as they are now. Educational standards should always be reviewed, managed, and amended as the needs of the citizenry, technology, research, and best practices present themselves. Over the last 14 years the *Agenda* and *National Scope of Practice* were developed, Kansas EMS has now reached the point where we must review how we provide care and not simply continue to maintain what is most comfortable. "Education is not the answer to the question. Education is the means to the answer to all questions." (William Allin). The Board is in no way oblivious to the needs of Kansas EMS, and in particular, frontier and rural EMS. Thus, the Board has developed the overall scope implementation plan and transition courses to enable all attendants, educators, and services the ability to manage this time of transition in the most efficient, economical, and least evasive way possible. From the beginning, the Board has considered the smaller, frontier, rural, and volunteer services and their needs in developing the transition plan. The Board understands how new education standards will affect them, but the methods of delivery, access, and the opportunities for both better and increased education and thus a greater level of care both benefits the attendants and the community as a whole.

- *Kansas needs v. the baseline National Scope of Practice (NSP)*. As the Board reviewed the *National Scope of Practice*, it understood that the document could not simply be implemented in Kansas without compromising the level of care already provided. The EMR for example, under the *NSP*, is not allowed to function as an attendant on an ambulance. To remove the EMR as an attendant would place many services in a position of not being able to staff ambulances. The Board reviewed and compared the *NSP* versus Kansas standards to determine Kansas' unique needs with a view of care, scope, and operational implementation. In comparison, the Board agreed with the removal of intubation from the AEMT scope because medical research indicates new devices available for securing an airway are quicker to apply, as effective and more beneficial to the majority of patient conditions. The amount of time, review, and effort made to compare and contrast Kansas needs and the *National Scope of Practice* is clearly demonstrated by the provided documentation and testimony. Kansas EMS, medical directors, attendants, and educators completed that task, and that effort should not be discounted nor dismissed.

Hours to Transition. Finally, the Task Force continues to discuss and review the number of hours necessary to transition the first responder to emergency medical responder, the EMT-Basic to the AEMT and the EMT-Intermediate to the AEMT. However, since the transition courses have not been finalized, the Task Force and the Board cannot apply a specific hour requirement at this time. The final curriculum develop plan will be available and set in August 2010. Once the transition courses are complete the goal of the new *Education Standards* is to focus on outcomes, not the time spent achieving them. The *Education Agenda* supports participation of students by creating an opportunity for efficiency in the delivery of essential content. Although hours to complete a transition course may be greater than the current hours necessary to maintain certification, the evaluation of competency (i.e. the ability to demonstrate whether an attendant can perform what they've learned) cannot be undervalued. The AEMT, in particular, has a great deal more responsibility and the hours and education necessary to obtain the knowledge and skill sets must reflect these changes. However, the Board will ensure that the education standards and hours necessary are not so burdensome that attendants (no matter their level or location) cannot obtain and maintain their desired certification.

Conclusion

So what should adapt and change? Our day-to-day practices adapt and change . . . sometimes by decade and sometimes by the hour. As EMS began, the local funeral home director provided transportation to the hospital in a vehicle that doubled as an ambulance and a hearse. This vehicle was the only one in town where a person could be loaded in the back and rushed to the hospital with a whirling light atop. In the late 1970's, the show "Emergency" demonstrated the need for emergency medical services and the expertise of those who provided that care. Then, in the mid-1990's the full-time, 24/7/365, paramedic service appeared on the scene . . . big and significant changes. Now in 2009, the scope of practice for Kansas EMS is changing and adapting to the circumstances across the state and country, through current research, to better align with the *National Scope of Practice*. However, in this transition of day-to-day practices, the core values and principles of Kansas EMS will remain constant, strong, and evident.

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 2009 SB 262.

[As Amended by Senate Committee of the Whole]

Session of 2009

SENATE BILL No. 262

By Committee on Ways and Means

2-11

AN ACT concerning emergency medical services; scope of practice of certain attendants; titles of certain attendants; amending K.S.A. 19-4608, 21-2511, 44-1204, 65-6121, 65-6129c, 65-6135, 65-6144, 65-6145 and 66-1810 and K.S.A. 2008 Supp. 8-1001, 65-6001, 65-6112, 65-6119, 65-6120, 65-6124, 65-6129, 75-4364 and 80-2518 and repealing the existing sections.

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

Section 1. K.S.A. 2008 Supp. 65-6112 is hereby amended to read as follows: 65-6112. As used in this act:

(a) "Administrator" means the executive director 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 first~~ *an emergency medical* responder, emergency medical technician, *advanced* emergency medical technician ~~intermediate, emergency medical technician-defibrillator~~ or a ~~mobile intensive care technician~~ *paramedic* certified pursuant to this act.

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

(f) "Emergency medical service" means the effective and coordinated delivery of such care as may be required by an emergency which includes the care and transportation of individuals by ambulance services and the performance of authorized emergency care by a physician, professional nurse, a licensed physician assistant or attendant.

(g) "Emergency medical technician" means a person who holds an emergency medical technician certificate issued pursuant to this act.

~~(h) "Emergency medical technician-defibrillator" means a person~~

Add: 65-6111

Section (?). KSA 2008 Supp. 65-6111 is hereby amended to read as follows: 65-6111. As used in this act:
(a) Adopt any rules and regulations necessary to carry out the provisions of this act;
(b) review and approve the allocation and expenditure of moneys appropriated for emergency medical services;
(c) conduct hearings for all regulatory matters concerning ambulance services, attendants, instructor-coordinators, training officers and providers of training;
(d) submit a budget to the legislature for the operation of the board;
(e) develop a state plan for the delivery of emergency medical services;
(f) enter into contracts as may be necessary to carry out the duties and functions of the board under this act;
(g) review and approve all requests for state and federal funding involving emergency medical services projects in the state or delegate such duties to the administrator;
(h) approve all training programs for attendants, instructor-coordinators and training officers and prescribe application fees by rules and regulations;
(i) approve methods of examination for certification of attendants, training officers and instructor-coordinators and prescribe examination fees by rules and regulations;
(j) appoint a medical consultant for the board. Such person shall be a person licensed to practice medicine and surgery and shall be active in the field of emergency medical services; and
(k) approve providers of training by prescribing standards and requirements by rules and regulations and withdraw or modify such approval in accordance with the Kansas administrative procedures act and the rules and regulations of the board.

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Action: Strike "(J)", and add the following

(j) appoint a medical advisory committee of not less than two board members and six non-board members shall be established by the board to advise and assist the board in medical standards and practices as determined by the board. The advisory committee shall meet at least annually. Non-board members of the advisory shall be licensed to practice medicine and surgery in the State of Kansas and shall be active in the field of emergency medical services.

Delete "EMT-D"

Delete (All - line 43)

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~~who holds an emergency medical technician defibrillator certificate issued pursuant to this act.~~

(i) "*Advanced* emergency medical technician~~-intermediate~~" means a person who holds an *advanced* emergency medical technician~~-intermediate~~ certificate issued pursuant to this act.

(j) "~~First~~ *Emergency medical* responder" means a person who holds ~~a first~~ *an emergency medical* responder certificate issued pursuant to this act.

(k) "Hospital" means a hospital as defined by K.S.A. 65-425, and amendments thereto.

(l) "Instructor-coordinator" means a person who is certified under this act to teach initial courses of certification of instruction and continuing education classes.

(m) "Medical adviser" means a physician.

(n) "Medical protocols" mean written guidelines which authorize attendants to perform certain medical procedures prior to contacting a physician, or professional nurse authorized by a physician. These protocols shall be developed and approved by a county medical society or, if there is no county medical society, the medical staff of a hospital to which the ambulance service primarily transports patients.

(o) "~~Mobile intensive care technician~~ *Paramedic*" means a person who holds a ~~mobile intensive care technician~~ *paramedic* certificate issued pursuant to this act.

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

(q) "Nonemergency transportation" means the care and transport of a sick or injured person under a foreseen combination of circumstances calling for continuing care of such person. As used in this subsection, transportation includes performance of the authorized level of services of the attendant whether within or outside the vehicle as part of such transportation services.

(r) "Operator" means a person or municipality who has a permit to operate an ambulance service in the state of Kansas.

(s) "Person" means an individual, a partnership, an association, a joint-stock company or a corporation.

(t) "Physician" means a person licensed by the state board of healing arts to practice medicine and surgery.

(u) "Physician assistant" means a person who is licensed under the physician assistant licensure act and who is acting under the direction of a responsible physician.

(v) "Professional nurse" means a licensed professional nurse as defined by K.S.A. 65-1113, and amendments thereto.

(w) "Provider of training" means a corporation, partnership, accred-

Delete: All in lines 1 and 2, reletter accordingly

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ited postsecondary education institution, ambulance service, fire department, hospital or municipality that conducts training programs that include, but are not limited to, initial courses of instruction and continuing education for attendants, instructor-coordinators or training officers.

(x) "Responsible physician" means responsible physician as such term is defined under K.S.A. 65-28a02 and amendments thereto.

(y) "Training officer" means a person who is certified pursuant to this act to teach initial courses of instruction for ~~first~~ *emergency medical* responders and continuing education as prescribed by the board.

Sec. 2. K.S.A. 2008 Supp. 65-6119 is hereby amended to read as follows: 65-6119. Notwithstanding any other provision of law, ~~mobile intensive care technicians~~ *paramedics* may:

(a) Perform all the authorized activities identified in K.S.A. *65-6120,* 65-6121, *65-6144 and in rules and regulations adopted by the board under these statutes,* and amendments thereto; *and*

(b) ~~perform cardiopulmonary resuscitation and defibrillation;~~

~~(c) when voice contact or a telemetered electrocardiogram is monitored by a physician, physician assistant where authorized by a physician or licensed professional nurse where authorized by a physician and direct communication is maintained, and upon order of such person may administer such medications or procedures as may be deemed necessary by a person identified in subsection (c);~~

~~(d) perform, during an emergency, those activities specified in subsection (c) before contacting a person identified in subsection (c) when specifically authorized to perform such activities by medical protocols; and~~

~~(e)~~ perform~~, during nonemergency transportation,~~ those *additional* activities ~~specified in this section when~~ specifically authorized ~~to perform such activities~~ by medical protocols.

Sec. 3. K.S.A. 2008 Supp. 65-6120 is hereby amended to read as follows: 65-6120. *(a)* Notwithstanding any other provision of law to the contrary, an *advanced* emergency medical technician~~-intermediate~~ may:

~~(a)~~ Perform any of the activities identified by K.S.A 65-6121, and amendments thereto, ~~*and in rules and regulations adopted by the board under this statute;*~~

~~(b) when approved by medical protocols and where voice contact by radio or telephone is monitored by a physician, physician assistant where authorized by a physician or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such person, 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, endotracheal intubation and administration of nebulized albuterol;~~

Do not delete (lines 16 through 26).
Maintain current language

Maintain original Statutory language:

"perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols."

Strike: "and in rules and regulations adopted by the board under this statute"

Add: "and any of the following interventions or use of the devices, medications and equipment, or any combination thereof, as specifically identified in rules and regulations after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols or when voice contact by radio, telephone, or video conference is monitored by a physician, physician assistant where authorized by a physician, or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such a person:

~~(c) perform, during an emergency, those activities specified in subsection (b) before contacting the persons identified in subsection (b) when specifically authorized to perform such activities by medical protocols; or~~

~~(d) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.~~

~~*(b) An advanced emergency medical technician may perform enhanced activities, as specified by rules and regulations of the board, in addition to any other activities an advanced emergency medical technician may be authorized by law to perform, if the advanced emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.*~~

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

~~(a) Patient assessment and vital signs;~~

~~(b) airway maintenance including the use of:~~

~~(1) Oropharyngeal and nasopharyngeal airways;~~

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

~~(3) multi-lumen airway; and~~

~~(4) oxygen demand valves.~~

~~(c) Oxygen therapy;~~

~~(d) oropharyngeal suctioning;~~

~~(e) cardiopulmonary resuscitation procedures;~~

~~(f) control accessible bleeding;~~

~~(g) apply pne~~

~~(h) manage c~~

~~(i) extricate p~~

~~(j) manage m~~

~~and bandaging w~~

~~or strains;~~

~~(k) use of ba~~

~~(l) administe~~

~~(m) monitor~~

~~during interfacili~~

~~(1) The phys~~

~~technician;~~

~~(2) no medic~~

~~fluids; and~~

identified in K.S.A. 65-6144, and amendments thereto, and any of the following interventions or devices or equipment, or any combination thereof, as specifically identified in rules and regulations after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols:

(1) Airway maintenance including use of:

(A) Single lumen airways as approved by board;

(B) multilumen airways;

(C) ventilator devices;

(D) forcep removal of airway obstruction;

(E) CO2 monitoring;

(F) airway suctioning;

(2) apply pneumatic anti-shock garment; (3) assist with childbirth; (4) monitor urinary catheter; (5) capillary blood sampling; (6) cardiac monitoring; (7) administration of patient assisted medications as approved by board; (8) administration of medications as approved by board by appropriate routes; and (9) monitor, maintain, or discontinue flow of IV line if a physician approves transfer by an emergency medical technician.

Add: "(1) Continuous positive airway pressure devices;
(2) advanced airway management; (3) referral of patient of alternate medical care based on assessment; (4) transportation of a patient with a capped arterial line; (5) veni-puncture for obtaining blood sample; (6) initiation and maintenance of intravenous infusion or saline lock; (7) initiation of intraosseous infusion; (8) nebulized therapy; (9) intravenous D50;
(10) manual defibrillation and cardioversion; (11) cardiac monitoring;
(12) medication administration via:
(A) Aerosolization; (B) nebulization; (C) intravenous; (D) intranasal; (E) rectal; (F) subcutaneous; (G) intraosseous (H) intramuscular (I) sublingual

Delete all in lines 8 and 14 and add:
(a) Rules and regulations adopted by the board under this section which identify activities to be performed by advanced emergency medical technicians shall be consistent with the education, training and qualifications of advanced emergency medical technicians authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an advanced emergency medical technician certificate and are specifically authorized to perform such activities by medical protocols.

~~(3) the emergency medical technician may monitor, maintain and shut off the flow of intravenous fluid;~~

~~(n) use automated external defibrillators;~~

~~(o) administer epinephrine auto-injectors provided that:~~

~~(1) The emergency medical technician successfully completes a course of instruction approved by the board in the administration of epinephrine; and~~

~~(2) the emergency medical technician serves with an ambulance service or a first response organization that provides emergency medical services; and~~

~~(3) the emergency medical technician is acting pursuant to medical protocols;~~

~~(p) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols; or~~

~~(q) when authorized by medical protocol, assist the patient in the administration of the following medications which have been prescribed for that patient: Auto-injection epinephrine, sublingual nitroglycerin and inhalers for asthma and emphysema. *as defined by rules and regulations of the board.*~~

~~*(b) An emergency medical technician may perform any of the activities as specified by rules and regulations of the board, in addition to any other activities an emergency medical technician may be authorized by law to perform, if the emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.*~~

Sec. 5. K.S.A. 2008 Supp. 65-6124 is hereby amended to read as follows: 65-6124. (a) No physician, physician assistant or licensed professional nurse, who gives emergency instructions to ~~a mobile intensive care technician *paramedic*, emergency medical technician defibrillator or *advanced* emergency medical technician intermediate~~ during an emergency, shall be liable for any civil damages as a result of issuing the instructions, except such damages which may result from gross negligence in giving such instructions.

(b) No ~~mobile intensive care technician *paramedic*, emergency medical technician defibrillator or *advanced* emergency medical technician intermediate~~ who renders emergency care during an emergency pursuant to instructions given by a physician, the responsible physician for a physician assistant or licensed professional nurse shall be liable for civil damages as a result of implementing such instructions, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of such ~~mobile intensive care technician *paramedic*,~~

Delete: Line 19 "as defined" through Line 20 "board"

Rules and regulations adopted by the board under this section which define activities which may be performed by emergency medical technicians shall be consistent with the education, training and qualifications of emergency medical technicians authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an emergency medical technician and are specifically authorized to perform such activities by medical protocols.

Delete: Line 30 "mobile" through Line 32 "technician". Add: " an attendant as defined by KSA 65-6112"

Delete: Line 36 "mobile" through Line 38 "technician". Add: "attendant as defined by KSA 65-6112"

Delete: Line 43 "mobile" through "paramedic". Add: "attendant as defined by KSA 65-6112"

~~emergency medical technician defibrillator or *advanced* emergency medical technician intermediate rendering such emergency care.~~

~~(c) No first *emergency medical* responder who renders emergency care during an emergency shall be liable for civil damages as a result of rendering such emergency care, except for such damages which may result from gross negligence or from willful or wanton acts or omissions on the part of the first *emergency medical* responder rendering such emergency care.~~

(d) No person certified as an instructor-coordinator and no training officer shall be liable for any civil damages which may result from such instructor-coordinator's or training officer's course of instruction, except such damages which may result from gross negligence or by willful or wanton acts or omissions on the part of the instructor-coordinator or training officer.

(e) No medical adviser who reviews, approves and monitors the activities of attendants shall be liable for any civil damages as a result of such review, approval or monitoring, except such damages which may result from gross negligence in such review, approval or monitoring.

Sec. 6. K.S.A. 2008 Supp. 65-6129 is hereby amended to read as follows: 65-6129. (a) Application for an attendant's certificate shall be made to the board. The board shall not grant an attendant's certificate unless the applicant meets the following requirements:

(1) (A) Has successfully completed coursework required by the rules and regulations adopted by the board; or

(B) has successfully completed coursework in another jurisdiction that is substantially equivalent to that required by the rules and regulations adopted by the board; and

(2) (A) has passed the examination required by the rules and regulations adopted by the board; or

(B) has passed the certification or licensing examination in another jurisdiction that has been approved by the board.

(b) (1) The board shall not grant a temporary attendant's certificate unless the applicant meets the following requirements:

(A) If the applicant is certified or licensed as an attendant in another jurisdiction, but the applicant's coursework is determined not to be substantially equivalent to that required by the board, such temporary certificate shall be valid for one year from the date of issuance or until the applicant has completed the required coursework, whichever occurs first; or

(B) if the applicant has completed the required coursework, has taken the required examination, but has not received the results of the examination, such temporary certificate shall be valid for 120 days from the date of the examination.

Delete Line 1 through 8" and renumber accordingly

(2) An applicant who has been granted a temporary certificate shall be under the direct supervision of a physician, a physician's assistant, a professional nurse or an attendant holding a certificate at the same level or higher than that of the applicant.

(c) The board shall not grant an initial *advanced* emergency medical technician~~-intermediate~~ certificate or an initial ~~mobile intensive care technician~~ *paramedic* certificate as a result of successful course completion in the state of Kansas, unless the applicant for such an initial certificate is certified as an emergency medical technician.

(d) An attendant's certificate shall expire on the date prescribed by the board. An attendant's certificate may be renewed for a period of two years upon payment of a fee as prescribed by rule and regulation of the board and upon presentation of satisfactory proof that the attendant has successfully completed continuing education as prescribed by the board.

(e) All fees received pursuant to the provisions of this section shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the ~~state general fund~~ ***[emergency medical services operating fund established by K.S.A. 65-6151, and amendments thereto]***.

(f) If a person who was previously certified as an attendant applies for an attendant's certificate after the certificate's expiration, the board may grant a certificate without the person completing an initial course of instruction or passing a certification examination if the person has completed education requirements and has paid a fee as specified in rules and regulations adopted by the board.

(g) The board shall adopt, through rules and regulations, a formal list of graduated sanctions for violations of article 61 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto, which shall specify the number and severity of violations for the imposition of each level of sanction.

Sec. 7. K.S.A. 65-6129c is hereby amended to read as follows: 65-6129c. (a) Application for a training officer's certificate shall be made to the emergency medical services board upon forms provided by the administrator. The board may grant a training officer's certificate to an applicant who: (1) Is an emergency medical technician, *advanced* emergency medical technician~~-intermediate~~, ~~emergency medical technician-defibrillator, mobile intensive care technician~~ *paramedic*, physician or professional nurse; (2) successfully completes an initial course of training approved by the board; (3) passes an examination prescribed by the board; (4) is appointed by a provider of training approved by the board; and (5) has paid a fee established by the board.

Delete "EMT-D"

Add: physician's assistant

7-8

(b) A training officer's certificate shall expire on the expiration date of the attendant's certificate if the training officer is an attendant or on the expiration date of the physician's or professional nurse's license if the training officer is a physician or professional nurse. A training officer's certificate may be renewed for the same period as the attendant's certificate or the physician's or professional nurse's license upon payment of a fee as prescribed by rules and regulations and upon presentation of satisfactory proof that the training officer has successfully completed continuing education prescribed by the board and is certified as an emergency medical technician, *advanced* emergency medical technician ~~intermediate, emergency medical technician defibrillator, mobile intensive care technician~~ *paramedic*, physician or professional nurse. The board may prorate to the nearest whole month the fee fixed under this subsection as necessary to implement the provisions of this subsection.

(c) A training officer's certificate may be denied, revoked, limited, modified or suspended by the board or the board may refuse to renew such certificate if such individual:

(1) Fails to maintain certification or licensure as an emergency medical technician, *advanced* emergency medical technician ~~intermediate, emergency medical technician defibrillator, mobile intensive care technician~~ *paramedic*, physician or professional nurse;

(2) fails to maintain support of appointment by a provider of training;

(3) fails to successfully complete continuing education;

(4) has made intentional misrepresentations in obtaining a certificate or renewing a certificate;

(5) has demonstrated incompetence or engaged in unprofessional conduct as defined by rules and regulations adopted by the board;

(6) has violated or aided and abetted in the violation of any provision of this act or the rules and regulations promulgated by the board; or

(7) has been convicted of any state or federal crime that is related substantially to the qualifications, functions and duties of a training officer or any crime punishable as a felony under any state or federal statute and the board determines that such individual has not been sufficiently rehabilitated to warrant public trust. A conviction means a plea of guilty, a plea of nolo contendere or a verdict of guilty. The board may take disciplinary action pursuant to this section when the time for appeal has elapsed, or after the judgment of conviction is affirmed on appeal or when an order granting probation is made suspending the imposition of sentence.

(d) The board may revoke, limit, modify or suspend a certificate or the board may refuse to renew such certificate in accordance with the provisions of the Kansas administrative procedure act.

Add: , Physician's Assistant

Add: , Physician's Assistant

Add: , Physician's Assistant

Delete: EMT-D

Add: , Physician's Assistant

(e) If a person who previously was certified as a training officer applies for a training officer's certificate within two years of the date of its expiration, the board may grant a certificate without the person completing an initial course of training or taking an examination if the person complies with the other provisions of subsection (a) and completes continuing education requirements.

Sec. 8. K.S.A. 65-6135 is hereby amended to read as follows: 65-6135. (a) All ambulance services providing emergency care as defined by the rules and regulations adopted by the board shall offer service 24 hours per day every day of the year.

(b) Whenever an operator is required to have a permit, at least one person on each vehicle providing emergency medical service shall be an attendant certified as an emergency medical technician, *advanced* emergency medical technician ~~intermediate~~, ~~emergency medical technician-defibrillator,~~ a ~~mobile intensive care technician~~ *paramedic*, a physician, a licensed physician assistant or a professional nurse.

Sec. 9. K.S.A. 65-6144 is hereby amended to read as follows: 65-6144. ~~A first~~ *(a) An emergency medical* responder may perform ~~any of the following~~ activities:

~~(a) Initial scene management including, but not limited to, gaining access to the individual in need of emergency care, extricating, lifting and moving the individual;~~

~~(b) cardiopulmonary resuscitation and airway management;~~

~~(c) control of bleeding;~~

~~(d) extremity splinting excluding traction splinting;~~

~~(e) stabilization of the condition of the individual in need of emergency care;~~

~~(f) oxygen therapy;~~

~~(g) use of oropharyngeal airways;~~

~~(h) use of bag valve masks;~~

~~(i) use automated external defibrillators; and~~

~~(j) other techniques of preliminary care a first responder is trained to provide as approved by the board. *as specified by rules and regulations of the board.*~~

(b) ~~*An emergency medical responder may perform any activities as defined by rules and regulations of the board, in addition to any other activities an emergency medical responder may be authorized by law to perform, if the emergency medical responder has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.*~~

Sec. 10. K.S.A. 65-6145 is hereby amended to read as follows: 65-6145. Nothing in this act shall be construed: (a) To preclude any munic-

Delete: EMT-D

any of the following interventions or use of devices or equipment, or any combination thereof, as specifically identified in rules and regulations, after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols:
(1) Emergency vehicle operations; (2) initial scene management; (3) patient assessment and stabilization;
(4) cardiopulmonary resuscitation and airway management;
(5) control of bleeding; (6) extremity splinting; (7) spinal immobilization;
(8) oxygen therapy; (9) use of bag-valve-mask;
(10) use of automatic external defibrillator; (11) nebulizer therapy; (12) intramuscular injections with autoinjector for attendant and patient assisted medication; (13) administration of oral glucose; (14) administration of aspirin; (15) recognize and comply with advanced directives; (16) insertion and maintenance of oral and nasal airways; (17) use of blood glucose monitoring; and (18) other techniques and devices of preliminary care an emergency medical responder is trained to provide as approved by the board.

Delete: Line 33 "as specified" to Line 34 "board"

Rules and regulations adopted by the board under this section which define activities which may be performed by an emergency medical responder shall be consistent with the education, training and qualifications of emergency medical responders authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an emergency medical responder certificate and are specifically authorized to perform such activities by medical protocols.

ipality from licensing or otherwise regulating ~~first~~ *emergency medical* 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 emergency medical responder~~ from providing assistance during an emergency so long as such individual does not represent oneself to be ~~a certified first emergency medical responder.~~

an attendant as defined by K.S.A. 65-6112, and amendments thereto

Sec. 11. K.S.A. 2008 Supp. 8-1001 is hereby amended to read as follows: 8-1001. (a) Any person who operates or attempts to operate a vehicle within this state is deemed to have given consent, subject to the provisions of this act, to submit to one or more tests of the person's blood, breath, urine or other bodily substance to determine the presence of alcohol or drugs. The testing deemed consented to herein shall include all quantitative and qualitative tests for alcohol and drugs. A person who is dead or unconscious shall be deemed not to have withdrawn the person's consent to such test or tests, which shall be administered in the manner provided by this section.

(b) A law enforcement officer shall request a person to submit to a test or tests deemed consented to under subsection (a): (1) If the officer has reasonable grounds to believe the person was operating or attempting to operate a vehicle while under the influence of alcohol or drugs, or both, or to believe that the person was driving a commercial motor vehicle, as defined in K.S.A. 8-2,128, and amendments thereto, while having alcohol or other drugs in such person's system, or was under the age of 21 years while having alcohol or other drugs in such person's system; and one of the following conditions exists: (A) The person has been arrested or otherwise taken into custody for any offense involving operation or attempted operation of a vehicle while under the influence of alcohol or drugs, or both, or for a violation of K.S.A. 8-1567a, and amendments thereto, or involving driving a commercial motor vehicle, as defined in K.S.A. 8-2,128, and amendments thereto, while having alcohol or other drugs in such person's system, in violation of a state statute or a city ordinance; or (B) the person has been involved in a vehicle accident or collision resulting in property damage or personal injury other than serious injury; or (2) if the person was operating or attempting to operate a vehicle and such vehicle has been involved in an accident or collision resulting in serious injury or death of any person and the operator could be cited for any traffic offense, as defined in K.S.A. 8-2117, and amendments thereto. The traffic offense violation shall constitute probable cause

for purposes of paragraph (2). The test or tests under paragraph (2) shall not be required if a law enforcement officer has reasonable grounds to believe the actions of the operator did not contribute to the accident or collision. The law enforcement officer directing administration of the test or tests may act on personal knowledge or on the basis of the collective information available to law enforcement officers involved in the accident investigation or arrest.

(c) If a law enforcement officer requests a person to submit to a test of blood under this section, the withdrawal of blood at the direction of the officer may be performed only by: (1) A person licensed to practice medicine and surgery, licensed as a physician's assistant, or a person acting under the direction of any such licensed person; (2) a registered nurse or a licensed practical nurse; (3) ~~any qualified medical technician, including, but not limited to,~~ an *advanced* emergency medical technician ~~intermediate~~ or ~~mobile intensive care technician~~ *a paramedic*, as those terms are defined in K.S.A. 65-6112, and amendments thereto, authorized by medical protocol or (4) a phlebotomist.

(d) A law enforcement officer may direct a medical professional described in this section to draw a sample of blood from a person:

(1) If the person has given consent and meets the requirements of subsection (b);

(2) if medically unable to consent, if the person meets the requirements of paragraph (2) of subsection (b); or

(3) if the person refuses to submit to and complete a test, if the person meets the requirements of paragraph (2) of subsection (b).

(e) When so directed by a law enforcement officer through a written statement, the medical professional shall withdraw the sample as soon as practical and shall deliver the sample to the law enforcement officer or another law enforcement officer as directed by the requesting law enforcement officer as soon as practical, provided the collection of the sample does not jeopardize the person's life, cause serious injury to the person or seriously impede the person's medical assessment, care or treatment. The medical professional authorized herein to withdraw the blood and the medical care facility where the blood is drawn may act on good faith that the requirements have been met for directing the withdrawing of blood once presented with the written statement provided for under this subsection. The medical professional shall not require the person to sign any additional consent or waiver form. In such a case, the person authorized to withdraw blood and the medical care facility shall not be liable in any action alleging lack of consent or lack of informed consent.

(f) Such sample or samples shall be an independent sample and not be a portion of a sample collected for medical purposes. The person collecting the blood sample shall complete the collection portion of a

Delete: Line 13 "any through Line 14 "to,".

2-11

document provided by law enforcement.

(g) If a person must be restrained to collect the sample pursuant to this section, law enforcement shall be responsible for applying any such restraint utilizing acceptable law enforcement restraint practices. The restraint shall be effective in controlling the person in a manner not to jeopardize the person's safety or that of the medical professional or attending medical or health care staff during the drawing of the sample and without interfering with medical treatment.

(h) A law enforcement officer may request a urine sample upon meeting the requirements of paragraph (1) of subsection (b) and shall request a urine sample upon meeting the requirements of paragraph (2) of subsection (b).

(i) If a law enforcement officer requests a person to submit to a test of urine under this section, the collection of the urine sample shall be supervised by persons of the same sex as the person being tested and shall be conducted out of the view of any person other than the persons supervising the collection of the sample and the person being tested, unless the right to privacy is waived by the person being tested. When possible, the supervising person shall be a law enforcement officer. The results of qualitative testing for drug presence shall be admissible in evidence and questions of accuracy or reliability shall go to the weight rather than the admissibility of the evidence. If the person is medically unable to provide a urine sample in such manner due to the injuries or treatment of the injuries, the same authorization and procedure as used for the collection of blood in subsections (d) and (e) shall apply to the collection of a urine sample.

(j) No law enforcement officer who is acting in accordance with this section shall be liable in any civil or criminal proceeding involving the action.

(k) Before a test or tests are administered under this section, the person shall be given oral and written notice that: (1) Kansas law requires the person to submit to and complete one or more tests of breath, blood or urine to determine if the person is under the influence of alcohol or drugs, or both;

(2) the opportunity to consent to or refuse a test is not a constitutional right;

(3) there is no constitutional right to consult with an attorney regarding whether to submit to testing;

(4) if the person refuses to submit to and complete any test of breath, blood or urine hereafter requested by a law enforcement officer, the person's driving privileges will be suspended for one year for the first occurrence, two years for the second occurrence, three years for the third occurrence, 10 years for the fourth occurrence and permanently revoked

for a fifth or subsequent occurrence;

(5) if the person submits to and completes the test or tests and the test results show for the first occurrence:

(A) An alcohol concentration of .08 or greater, the person's driving privileges will be suspended for 30 days for the first occurrence; or

(B) an alcohol concentration of .15 or greater, the person's driving privileges will be suspended for one year;

(6) if the person submits to and completes the test or tests and the test results show an alcohol concentration of .08 or greater, the person's driving privileges will be suspended for one year for the second, third or fourth occurrence and permanently revoked for a fifth or subsequent occurrence;

(7) if the person is less than 21 years of age at the time of the test request and submits to and completes the tests and the test results show an alcohol concentration of .08 or greater, the person's driving privileges will be suspended for one year except the person's driving privileges will be permanently revoked for a fifth or subsequent occurrence;

(8) refusal to submit to testing may be used against the person at any trial on a charge arising out of the operation or attempted operation of a vehicle while under the influence of alcohol or drugs, or both;

(9) the results of the testing may be used against the person at any trial on a charge arising out of the operation or attempted operation of a vehicle while under the influence of alcohol or drugs, or both; and

(10) after the completion of the testing, the person has the right to consult with an attorney and may secure additional testing, which, if desired, should be done as soon as possible and is customarily available from medical care facilities willing to conduct such testing.

(l) If a law enforcement officer has reasonable grounds to believe that the person has been driving a commercial motor vehicle, as defined in K.S.A. 8-2,128, and amendments thereto, while having alcohol or other drugs in such person's system, the person shall also be provided the oral and written notice pursuant to K.S.A. 8-2,145 and amendments thereto. Any failure to give the notices required by K.S.A. 8-2,145 and amendments thereto shall not invalidate any action taken as a result of the requirements of this section. If a law enforcement officer has reasonable grounds to believe that the person has been driving or attempting to drive a vehicle while having alcohol or other drugs in such person's system and such person was under 21 years of age, the person also shall be given the notices required by K.S.A. 8-1567a, and amendments thereto. Any failure to give the notices required by K.S.A. 8-1567a, and amendments thereto, shall not invalidate any action taken as a result of the requirements of this section.

(m) After giving the foregoing information, a law enforcement officer

shall request the person to submit to testing. The selection of the test or tests shall be made by the officer. If the test results show a blood or breath alcohol concentration of .08 or greater, the person's driving privileges shall be subject to suspension, or suspension and restriction, as provided in K.S.A. 8-1002 and 8-1014, and amendments thereto.

(n) The person's refusal shall be admissible in evidence against the person at any trial on a charge arising out of the alleged operation or attempted operation of a vehicle while under the influence of alcohol or drugs, or both.

(o) If a law enforcement officer had reasonable grounds to believe the person had been driving a commercial motor vehicle, as defined in K.S.A. 8-2,128, and amendments thereto, and the test results show a blood or breath alcohol concentration of .04 or greater, the person shall be disqualified from driving a commercial motor vehicle, pursuant to K.S.A. 8-2,142, and amendments thereto. If a law enforcement officer had reasonable grounds to believe the person had been driving a commercial motor vehicle, as defined in K.S.A. 8-2,128, and amendments thereto, and the test results show a blood or breath alcohol concentration of .08 or greater, or the person refuses a test, the person's driving privileges shall be subject to suspension, or suspension and restriction, pursuant to this section, in addition to being disqualified from driving a commercial motor vehicle pursuant to K.S.A. 8-2,142, and amendments thereto.

(p) An officer shall have probable cause to believe that the person operated a vehicle while under the influence of alcohol or drugs, or both, if the vehicle was operated by such person in such a manner as to have caused the death of or serious injury to a person. In such event, such test or tests may be made pursuant to a search warrant issued under the authority of K.S.A. 22-2502, and amendments thereto, or without a search warrant under the authority of K.S.A. 22-2501, and amendments thereto.

(q) Failure of a person to provide an adequate breath sample or samples as directed shall constitute a refusal unless the person shows that the failure was due to physical inability caused by a medical condition unrelated to any ingested alcohol or drugs.

(r) It shall not be a defense that the person did not understand the written or oral notice required by this section.

(s) No test results shall be suppressed because of technical irregularities in the consent or notice required pursuant to this act.

(t) Nothing in this section shall be construed to limit the admissibility at any trial of alcohol or drug concentration testing results obtained pursuant to a search warrant.

(u) Upon the request of any person submitting to testing under this section, a report of the results of the testing shall be made available to

such person.

(v) This act is remedial law and shall be liberally construed to promote public health, safety and welfare.

(w) As used in this section, "serious injury" means a physical injury to a person, as determined by law enforcement, which has the effect of, prior to the request for testing:

(1) Disabling a person from the physical capacity to remove themselves from the scene;

(2) renders a person unconscious;

(3) the immediate loss of or absence of the normal use of at least one limb;

(4) an injury determined by a physician to require surgery; or

(5) otherwise indicates the person may die or be permanently disabled by the injury.

Sec. 12. K.S.A. 19-4608 is hereby amended to read as follows: 19-4608. (a) All hospital moneys, except moneys acquired through the issuance of revenue bonds, shall be paid to the treasurer of the board, shall be allocated to and accounted for in separate funds or accounts of the hospital, and shall be paid out only upon claims and warrants or warrant checks as provided in K.S.A. 10-801 to 10-806, inclusive, and K.S.A. 12-105a and 12-105b, and amendments to these statutes. The board may designate a person or persons to sign such claims and warrants or warrant checks.

(b) The board may accept any grants, donations, bequests or gifts to be used for hospital purposes and may accept federal and state aid. Such moneys shall be used in accordance with the terms of the grant, donation, bequest, gift or aid and if no terms are imposed in connection therewith such moneys may be used to provide additional funds for any improvement for which bonds have been issued or taxes levied.

(c) Hospital moneys shall be deemed public moneys and hospital moneys not immediately required for the purposes for which acquired may be invested in accordance with the provisions of K.S.A. 12-1675 and amendments thereto. Hospital moneys acquired through the receipt of grants, donations, bequests or gifts and deposited pursuant to the provisions of K.S.A. 12-1675 and amendments thereto need not be secured as required under K.S.A. 9-1402 and amendments thereto. In addition, hospital moneys may be invested in joint enterprises for the provision of health care services as permitted by subsection (c) of K.S.A. 19-4601 and amendments thereto.

(d) Hospital moneys which are deposited to the credit of funds and accounts which are not restricted to expenditure for specified purposes may be transferred to the general fund of the hospital and used for operation of the hospital or to a special fund for additional equipment and

capital improvements for the hospital.

(e) The board shall keep and maintain complete financial records in a form consistent with generally accepted accounting principles, and such records shall be available for public inspection at any reasonable time.

(f) Notwithstanding subsections (a) to (e), inclusive, the board may transfer any moneys or property a hospital receives by donation, contribution, gift, devise or bequest to a Kansas not-for-profit corporation which meets each of the following requirements:

(1) The corporation is exempt from federal income taxation under the provisions of section 501(a) by reason of section 501(c)(3) of the internal revenue code of 1954, as amended;

(2) the corporation has been determined not to be a private foundation within the meaning of section 509(a)(1) of the internal revenue code of 1954, as amended; and

(3) the corporation has been organized for the purpose of the charitable support of health care, hospital and related services, including the support of ambulance, emergency medical care, ~~first~~ *emergency medical* responder systems, medical and hospital staff recruitment, health education and training of the public and other related purposes.

(g) The board may transfer gifts under subsection (f) in such amounts and subject to such terms, conditions, restrictions and limitations as the board determines but only if the terms of the gift do not otherwise restrict the transfer. Before making any such transfer, the board shall determine that the amount of money or the property to be transferred is not required by the hospital to maintain its operations and meet its obligations. In addition, the board shall determine that the transfer is in the best interests of the hospital and the residents within the county the hospital has been organized to serve.

Sec. 13. K.S.A. 21-2511 is hereby amended to read as follows: 21-2511. (a) Any person convicted as an adult or adjudicated as a juvenile offender because of the commission of any felony; a violation of subsection (a)(1) of K.S.A. 21-3505; a violation of K.S.A. 21-3508; a violation of K.S.A. 21-4310; a violation of K.S.A. 21-3424, and amendments thereto when the victim is less than 18 years of age; a violation of K.S.A. 21-3507, and amendments thereto, when one of the parties involved is less than 18 years of age; a violation of subsection (b)(1) of K.S.A. 21-3513, and amendments thereto, when one of the parties involved is less than 18 years of age; a violation of K.S.A. 21-3515, and amendments thereto, when one of the parties involved is less than 18 years of age; or a violation of K.S.A. 21-3517, and amendments thereto; including an attempt, conspiracy or criminal solicitation, as defined in K.S.A. 21-3301, 21-3302 or 21-3303 and amendments thereto, of any such offenses provided in this subsection regardless of the sentence imposed, shall be required to sub-

mit specimens of blood or an oral or other biological sample authorized by the Kansas bureau of investigation to the Kansas bureau of investigation in accordance with the provisions of this act, if such person is:

(1) Convicted as an adult or adjudicated as a juvenile offender because of the commission of a crime specified in subsection (a) on or after the effective date of this act;

(2) ordered institutionalized as a result of being convicted as an adult or adjudicated as a juvenile offender because of the commission of a crime specified in subsection (a) on or after the effective date of this act; or

(3) convicted as an adult or adjudicated as a juvenile offender because of the commission of a crime specified in this subsection before the effective date of this act and is presently confined as a result of such conviction or adjudication in any state correctional facility or county jail or is presently serving a sentence under K.S.A. 21-4603, 21-4603d, 22-3717 or K.S.A. 2007 Supp. 38-2361, and amendments thereto.

(b) Notwithstanding any other provision of law, the Kansas bureau of investigation is authorized to obtain fingerprints and other identifiers for all persons, whether juveniles or adults, covered by this act.

(c) Any person required by paragraphs (a)(1) and (a)(2) to provide such specimen or sample shall be ordered by the court to have such specimen or sample collected within 10 days after sentencing or adjudication:

(1) If placed directly on probation, that person must provide such specimen or sample, at a collection site designated by the Kansas bureau of investigation. Collection of specimens shall be conducted by qualified volunteers, contractual personnel or employees designated by the Kansas bureau of investigation. Failure to cooperate with the collection of the specimens and any deliberate act by that person intended to impede, delay or stop the collection of the specimens shall be punishable as contempt of court and constitute grounds to revoke probation;

(2) if sentenced to the secretary of corrections, such specimen or sample will be obtained as soon as practical upon arrival at the correctional facility; or

(3) if a juvenile offender is placed in the custody of the commissioner of juvenile justice, in a youth residential facility or in a juvenile correctional facility, such specimen or sample will be obtained as soon as practical upon arrival.

(d) Any person required by paragraph (a)(3) to provide such specimen or sample shall be required to provide such samples prior to final discharge or conditional release at a collection site designated by the Kansas bureau of investigation. Collection of specimens shall be conducted by qualified volunteers, contractual personnel or employees designated by the Kansas bureau of investigation.

(e) (1) On and after January 1, 2007 through June 30, 2008, any adult arrested or charged or juvenile placed in custody for or charged with the commission or attempted commission of any person felony or drug severity level 1 or 2 felony shall be required to submit such specimen or sample at the same time such person is fingerprinted pursuant to the booking procedure.

(2) On and after July 1, 2008, except as provided further, any adult arrested or charged or juvenile placed in custody for or charged with the commission or attempted commission of any felony; a violation of subsection (a)(1) of K.S.A. 21-3505; a violation of K.S.A. 21-3508; a violation of K.S.A. 21-4310; a violation of K.S.A. 21-3424, and amendments thereto, when the victim is less than 18 years of age; a violation of K.S.A. 21-3507, and amendments thereto, when one of the parties involved is less than 18 years of age; a violation of subsection (b)(1) of K.S.A. 21-3513, and amendments thereto, when one of the parties involved is less than 18 years of age; a violation of K.S.A. 21-3515, and amendments thereto, when one of the parties involved is less than 18 years of age; or a violation of K.S.A. 21-3517, and amendments thereto; shall be required to submit such specimen or sample at the same time such person is fingerprinted pursuant to the booking procedure.

(3) Prior to taking such samples, the arresting, charging or custodial law enforcement agency shall search the Kansas criminal history files through the Kansas criminal justice information system to determine if such person's sample is currently on file with the Kansas bureau of investigation. In the event that it cannot reasonably be established that a DNA sample for such person is on file at the Kansas bureau of investigation, the arresting, charging or custodial law enforcement agency shall cause a sample to be collected. If such person's sample is on file with the Kansas bureau of investigation, the law enforcement agency is not required to take the sample.

(4) If a court later determines that there was not probable cause for the arrest, charge or placement in custody or the charges are otherwise dismissed, and the case is not appealed, the Kansas bureau of investigation, upon petition by such person, shall expunge both the DNA sample and the profile record of such person.

(5) If a conviction against a person, who is required to submit such specimen or sample, is expunged or a verdict of acquittal with regard to such person is returned, the Kansas bureau of investigation shall, upon petition by such person, expunge both the DNA sample and the profile record of such person.

(f) All persons required to register as offenders pursuant to K.S.A. 22-4901 et seq., and amendments thereto, shall be required to submit specimens of blood or an oral or other biological sample authorized by

the Kansas bureau of investigation to the Kansas bureau of investigation in accordance with the provisions of this act.

(g) The Kansas bureau of investigation shall provide all specimen vials, mailing tubes, labels and instructions necessary for the collection of blood, oral or other biological samples. The collection of samples shall be performed in a medically approved manner. No person authorized by this section to withdraw blood, and no person assisting in the collection of these samples shall be liable in any civil or criminal action when the act is performed in a reasonable manner according to generally accepted medical practices. The withdrawal of blood for purposes of this act may be performed only by: (1) A person licensed to practice medicine and surgery or a person acting under the supervision of any such licensed person; (2) a registered nurse or a licensed practical nurse; or (3) ~~any qualified medical technician including, but not limited to,~~ an *advanced* emergency medical technician~~-intermediate~~ or ~~mobile intensive care technician~~ *a paramedic*, as those terms are defined in K.S.A. 65-6112, and amendments thereto, or a phlebotomist. The samples shall thereafter be forwarded to the Kansas bureau of investigation. The bureau shall analyze the samples to the extent allowed by funding available for this purpose.

(h) The DNA (deoxyribonucleic acid) records and DNA samples shall be maintained by the Kansas bureau of investigation. The Kansas bureau of investigation shall establish, implement and maintain a statewide automated DNA databank and DNA database capable of, but not limited to, searching, matching and storing DNA records. The DNA database as established by this act shall be compatible with the procedures specified by the federal bureau of investigation's combined DNA index system (CODIS). The Kansas bureau of investigation shall participate in the CODIS program by sharing data and utilizing compatible test procedures, laboratory equipment, supplies and computer software.

(i) The DNA records obtained pursuant to this act shall be confidential and shall be released only to authorized criminal justice agencies. The DNA records shall be used only for law enforcement identification purposes or to assist in the recovery or identification of human remains from disasters or for other humanitarian identification purposes, including identification of missing persons.

(j) (1) The Kansas bureau of investigation shall be the state central repository for all DNA records and DNA samples obtained pursuant to this act. The Kansas bureau of investigation shall promulgate rules and regulations for: (A) The form and manner of the collection and maintenance of DNA samples;

(B) a procedure which allows the defendant to petition to expunge and destroy the DNA samples and profile record in the event of a dis-

Delete: Line 13 "any" through line 14 "to,"

missal of charges, expungement or acquittal at trial; and

(C) other procedures for the operation of this act.

(2) These rules and regulations also shall require compliance with national quality assurance standards to ensure that the DNA records satisfy standards of acceptance of such records into the national DNA identification index.

(3) The provisions of the Kansas administrative procedure act shall apply to all actions taken under the rules and regulations so promulgated.

(k) The Kansas bureau of investigation is authorized to contract with third parties for the purposes of implementing this section. Any other party contracting to carry out the functions of this section shall be subject to the same restrictions and requirements of this section, insofar as applicable, as the bureau, as well as any additional restrictions imposed by the bureau.

(l) In the event that a person's DNA sample is lost or is not adequate for any reason, the person shall provide another sample for analysis.

(m) Any person who is subject to the requirements of this section, and who, after receiving notification of the requirement to provide a DNA specimen, knowingly refuses to provide such DNA specimen, shall be guilty of a class A nonperson misdemeanor.

Sec. 14. K.S.A. 44-1204 is hereby amended to read as follows: 44-1204. (a) On and after January 1, 1978, no employer shall employ any employee for a workweek longer than ~~forty-six (46)~~ *46* hours, unless such employee receives compensation for employment in excess of ~~forty-six (46)~~ *46* hours in a workweek at a rate of not less than ~~one-and-one-half (1½)~~ *1½* times the hourly wage rate at which such employee is regularly employed.

(b) No employer shall be deemed to have violated subsection (a) with respect to the employment of any employee who is covered by this section, who is engaged in the public or private delivery of emergency medical services as a ~~crash injury management technician, emergency medical technician or mobile intensive care technician~~ *paramedic*, or who is engaged in fire protection or law enforcement activities, including any member of the security personnel in any correctional institution, and who is paid compensation at a rate of not less than ~~one-and-one-half (1½)~~ *1½* times the regular rate at which such employee is employed:

(1) In any work period of ~~twenty-eight (28)~~ *28* consecutive days in which such employee works for tours of duty which in the aggregate exceed ~~two hundred fifty-eight (258)~~ *258* hours; or

(2) in the case of any such employee to whom a work period of at least seven ~~(7)~~ but less than ~~twenty-eight (28)~~ *28* days applies, in any such work period in which such employee works for tours of duty which in the aggregate exceed a number of hours which bears the same ratio to the

an attendant as defined by K.S.A. 65-6112, and amendments thereto,

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number of consecutive days in such work period as ~~two hundred fifty-eight (258)~~ 258 hours bears to ~~twenty-eight (28)~~ 28 days.

(c) The provisions of this section shall not apply to the employment of:

(1) Any employee who is covered under the provisions of section 7 of the fair labor standards act of 1938 as amended (29 U.S.C.A. § 207), and as amended by the fair labor standards amendments of 1974 and any other acts amendatory thereof or supplemental thereto; or

(2) any employee who is primarily engaged in selling motor vehicles, as defined in subsection (b) of K.S.A. 8-126, for a nonmanufacturing employer primarily engaged in the business of selling such vehicles to ultimate purchasers;

(3) any person who is sentenced to the custody of the secretary of corrections and any person serving a sentence in a county jail.

(d) For the purposes of this section, the agreement or practice by employees engaged in fire protection or law enforcement activities of substituting for one another on regularly scheduled tours of duty, or a part thereof, shall be deemed to have no effect on hours of work if:

(1) The substituting is done voluntarily by the employees and not at the behest of the employer;

(2) The reason for substituting is due not to the employer's business practice but to the employee's desire or need to attend to a personal matter;

(3) A record is maintained by the employer of all time substituted by the employer's employees; and

(4) The period during which time is substituted and paid back does not exceed ~~twelve (12)~~ 12 months.

Sec. 15. K.S.A. 2008 Supp. 65-6001 is hereby amended to read as follows: 65-6001. As used in K.S.A. 65-6001 to 65-6007, inclusive, and K.S.A. 65-6008, 65-6009 and 65-6010, and amendments thereto, unless the context clearly requires otherwise:

(a) "AIDS" means the disease acquired immune deficiency syndrome.

(b) "HIV" means the human immunodeficiency virus.

(c) "Laboratory confirmation of HIV infection" means positive test results from a confirmation test approved by the secretary.

(d) "Secretary" means the secretary of health and environment.

(e) "Physician" means any person licensed to practice medicine and surgery.

(f) "Laboratory director" means the person responsible for the professional, administrative, organizational and educational duties of a laboratory.

(g) "HIV infection" means the presence of HIV in the body.

(h) "Racial/ethnic group" shall be designated as either white, black, Hispanic, Asian/Pacific islander or American Indian/Alaskan Native.

(i) "Corrections officer" means an employee of the department of corrections as defined in subsections (f) and (g) of K.S.A. 75-5202, and amendments thereto.

(j) "Emergency services employee" means an attendant ~~or first emergency medical responder~~ as defined under K.S.A. 65-6112, and amendments thereto, or a firefighter.

(k) "Law enforcement employee" means:

(1) Any police officer or law enforcement officer as defined under K.S.A. 74-5602, and amendments thereto;

(2) any person in the service of a city police department or county sheriff's office who performs law enforcement duties without pay and is considered a reserve officer;

(3) any person employed by a city or county who is in charge of a jail or section of jail, including jail guards and those who conduct searches of persons taken into custody; or

(4) any person employed by a city, county or the state of Kansas who works as a scientist or technician in a forensic laboratory.

(l) "Employing agency or entity" means the agency or entity employing a corrections officer, emergency services employee, law enforcement employee or jailer.

(m) "Infectious disease" means AIDS.

(n) "Infectious disease tests" means tests approved by the secretary for detection of infectious diseases.

(o) "Juvenile correctional facility staff" means an employee of the juvenile justice authority working in a juvenile correctional facility as defined in K.S.A. 2008 Supp. 38-2302, and amendments thereto.

Sec. 16. K.S.A. 66-1810 is hereby amended to read as follows: 66-1810. When any contact with or damage to any underground facility occurs, the operator shall be informed immediately by the excavator. Upon receiving such notice, the operator immediately shall dispatch personnel to the location to provide necessary temporary or permanent repair of the damage. If the protective covering of an electrical line is penetrated or dangerous gases or fluids are escaping from a broken line, the excavator immediately shall inform emergency personnel of the municipality in which such electrical short or broken line is located and take any other action as may be reasonably necessary to protect persons and property and to minimize hazards until arrival of the operator's personnel or emergency ~~first~~ *medical* responders.

Sec. 17. K.S.A. 2008 Supp. 75-4364 is hereby amended to read as follows: 75-4364. (a) As used in this section:

(1) "Kansas educational institution" means and includes area voca-

Delete: Line 6 "or first" through Line 7 "responder"

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tional schools, area vocational-technical schools, community colleges, the municipal university, state educational institutions, and technical colleges.

(2) "Public safety officer" means a law enforcement officer or a firefighter or an emergency medical services attendant.

(3) "Law enforcement officer" means a person who by virtue of office or public employment is vested by law with a duty to maintain public order or to make arrests for violation of the laws of the state of Kansas or ordinances of any municipality thereof or with a duty to maintain or assert custody or supervision over persons accused or convicted of crime, and includes wardens, superintendents, directors, security personnel, officers and employees of adult and juvenile correctional institutions, jails or other institutions or facilities for the detention of persons accused or convicted of crime, while acting within the scope of their authority.

(4) "Firefighter" means a person who is: (1) Employed by any city, county, township or other political subdivision of the state and who is assigned to the fire department thereof and engaged in the fighting and extinguishment of fires and the protection of life and property therefrom; or (2) a volunteer member of a fire district, fire department or fire company.

(5) "Emergency medical services attendant" means ~~a first~~ *an* ~~*emergency medical* responder, emergency medical technician, *advanced* emergency medical technician intermediate, emergency medical technician defibrillator or a mobile intensive care technician~~ *paramedic* ~~certified by the emergency medical services board pursuant to the statutory provisions contained in article 61 of chapter 65 of Kansas Statutes Annotated.~~

attendant as defined by KSA 65-6112

(6) "Dependent" means (A) a birth child, adopted child or stepchild or (B) any child other than the foregoing who is actually dependent in whole or in part on the individual and who is related to such individual by marriage or consanguinity.

(7) "State board" means the state board of regents.

(8) "Military service" means any active service in any armed service of the United States and any active state or federal service in the Kansas army or air national guard.

(9) "Prisoner of war" means any person who was a resident of Kansas at the time the person entered service of the United States armed forces and who, while serving in the United States armed forces, has been declared to be a prisoner of war, as established by the United States secretary of defense, after January 1, 1960.

(10) "Resident of Kansas" means a person who is a domiciliary resident as defined by K.S.A. 76-729, and amendments thereto.

(11) "Spouse" means the spouse of a deceased public safety officer or deceased member of the military service who has not remarried.

(b) Every Kansas educational institution shall provide for enrollment

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without charge of tuition or fees for: (1) Any dependent or spouse of a public safety officer who died as the result of injury sustained while performing duties as a public safety officer so long as such dependent or spouse is eligible; (2) any dependent or spouse of any resident of Kansas who died on or after September 11, 2001, while, and as a result of, serving in military service; and (3) any prisoner of war. Any such dependent or spouse and any prisoner of war shall be eligible for enrollment at a Kansas educational institution without charge of tuition or fees for not to exceed 10 semesters of undergraduate instruction, or the equivalent thereof, at all such institutions.

(c) Subject to appropriations therefor, any Kansas educational institution, at which enrollment, without charge of tuition or fees, of a prisoner of war or a dependent or spouse is provided for under subsection (b), may file a claim with the state board for reimbursement of the amount of such tuition and fees. The state board shall include in its budget estimates pursuant to K.S.A. 75-3717, and amendments thereto, a request for appropriations to cover tuition and fee claims pursuant to this section. The state board shall be responsible for payment of reimbursements to Kansas educational institutions upon certification by each such institution of the amount of reimbursement to which entitled. Payments to Kansas educational institutions shall be made upon vouchers approved by the state board and upon warrants of the director of accounts and reports. Payments may be made by issuance of a single warrant to each Kansas educational institution at which one or more eligible dependents or spouses or prisoners of war are enrolled for the total amount of tuition and fees not charged for enrollment at that institution. The director of accounts and reports shall cause such warrant to be delivered to the Kansas educational institution at which any such eligible dependents or spouses or prisoners of war are enrolled. If an eligible dependent or spouse or prisoner of war discontinues attendance before the end of any semester, after the Kansas educational institution has received payment under this subsection, the institution shall pay to the state the entire amount which such eligible dependent or spouse or prisoner of war would otherwise qualify to have refunded, not to exceed the amount of the payment made by the state in behalf of such dependent or spouse or prisoner of war for the semester. All amounts paid to the state by Kansas educational institutions under this subsection shall be deposited in the state treasury and credited to the state general fund.

(d) The state board shall adopt rules and regulations for administration of the provisions of this section and shall determine the qualification of persons as dependents and spouses of public safety officers or United States military personnel and the eligibility of such persons for the benefits provided for under this section.

Sec. 18. K.S.A. 2008 Supp. 80-2518 is hereby amended to read as follows: 80-2518. (a) All hospital moneys, except moneys acquired through the issuance of revenue bonds, shall be paid to the treasurer of the board, shall be allocated to and accounted for in separate funds or accounts of the hospital, and shall be paid out only upon claims and warrants or warrant checks as provided in K.S.A. 10-801 to 10-806, inclusive, and K.S.A. 12-105a and 12-105b, and amendments to these statutes. The board may designate a person or persons to sign such claims and warrants or warrant checks.

(b) The board may accept any grants, donations, bequests or gifts to be used for hospital purposes and may accept federal and state aid. Such moneys shall be used in accordance with the terms of the grant, donation, bequest, gift or aid and if no terms are imposed in connection therewith such moneys may be used to provide additional funds for any improvement for which bonds have been issued or taxes levied.

(c) Hospital moneys shall be deemed public moneys and hospital moneys not immediately required for the purposes for which acquired may be invested in accordance with the provisions of K.S.A. 12-1675 and amendments thereto. Hospital moneys acquired through the receipt of grants, donations, bequests or gifts and deposited pursuant to the provisions of K.S.A. 12-1675 and amendments thereto need not be secured as required under K.S.A. 9-1402 and amendments thereto. In addition, hospital moneys may be invested in joint enterprises for the provision of health care services as permitted by subsection (b) of K.S.A. 80-2501 and amendments thereto.

(d) Hospital moneys which are deposited to the credit of funds and accounts which are not restricted to expenditure for specified purposes may be transferred to the general fund of the hospital and used for operation of the hospital or to a special fund for additional equipment and capital improvements for the hospital.

(e) The board shall keep and maintain complete financial records in a form consistent with generally accepted accounting principles, and such records shall be available for public inspection at any reasonable time.

(f) Notwithstanding subsections (a) to (e), inclusive, the board may transfer any moneys or property a hospital receives by donation, contribution, gift, devise or bequest to a Kansas not-for-profit corporation which meets each of the following requirements:

(1) The corporation is exempt from federal income taxation under the provisions of section 501(a) by reason of section 501(c)(3) of the internal revenue code of 1954, as amended;

(2) the corporation has been determined not to be a private foundation within the meaning of section 509(a)(1) of the internal revenue code of 1954, as amended; and

(3) the corporation has been organized for the purpose of the charitable support of health care, hospital and related services, including the support of ambulance, emergency medical care, ~~first~~ *emergency medical* responder systems, medical and hospital staff recruitment, health education and training of the public and other related purposes.

(g) The board may transfer gifts under subsection (f) in such amounts and subject to such terms, conditions, restrictions and limitations as the board determines but only if the terms of the gift do not otherwise restrict such transfer. Before making any such transfer, the board shall determine that the amount of money or the property to be transferred is not required by the hospital to maintain its operations and meet its obligations. In addition, the board shall determine that the transfer is in the best interests of the hospital and the residents within the district the hospital has been organized to serve.

Sec. 19. K.S.A. 19-4608, 21-2511, 44-1204, 65-6121, 65-6129c, 65-6135, 65-6144, 65-6145 and 66-1810 and K.S.A. 2008 Supp. 8-1001, 65-6001, 65-6112, 65-6119, 65-6120, 65-6124, 65-6129, 75-4364 and 80-2518 are hereby repealed.

Sec. 20. This act shall take effect and be in force from and after January 1, 2011, and its publication in the statute book.

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

Attendant Level	Current Law	2009 SB 262 (as introduced)	2009 SB 262 (with list)
First Responder	**65-6144 Same; authorized activities.** A first responder may perform any of the following activities: a) Initial scene management including, but not limited to, gaining access to the individual in need of emergency care, extricating, lifting and moving the individual; b) cardiopulmonary resuscitation and airway management; c) control of bleeding; d) extremity splinting excluding traction splinting; e) stabilization of the condition of the individual in need of emergency care; f) oxygen therapy; g) use of oropharyngeal airways; h) use of bag valve masks; i) use automated external defibrillators; and j) other techniques of preliminary care a first responder is trained to provide as approved by the board.	Sec. 9. K.S.A. 65-6144 is hereby amended to read as follows: 65-6144. (a) An emergency medical responder may perform any of the following activities as specified by rules and regulations of the board. (b) An emergency medical responder may perform any activities as defined by rules and regulations of the board, in addition to any other activities an emergency medical responder may be authorized by law to perform, if the emergency medical responder has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.	Sec 16. Emergency Medical Responder: scop practice. Notwithstanding any other provision of law to the contrary, an emergency medical responder may perform any of the following interventions and/or use of devices or equipment as specifically identified in rules and regulations, after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols: a) Emergency vehicle operations b) Initial scene management c) Patient assessment and stabilization d) Cardiopulmonary resuscitation and airway management e) Control of bleeding f) Extremity splinting g) Spinal immobilization h) Oxygen therapy i) Use of bag-valve-mask j) Use of automatic external defibrillator k) Nebulizer therapy or Intramuscular injections with auto-injector for patient assisted med. l) Administration of oral glucose m) Administration of aspirin n) Recognize and comply with advanced directives o) Insertion and Maintenance of oral and nasal airways p) Use of blood glucose monitoring q) Other techniques and devices of preliminary care an emergency medical responder is

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

					trained to provide as approved by the board ~~(b) An emergency medical responder may perform any activities as defined by rules and regulations of the board, in addition to any other activities an emergency medical responder may be authorized by law to perform, if the emergency medical responder has successfully completed a course of instruction approved by the board for the performance of such activities~~ (c) Rules and regulations adopted by the board under this section which define activities which may be performed by an emergency medical responder shall be consistent with the education, training and qualifications of emergency medical responders authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an emergency medical responder certificate and are specifically authorized to perform such activities by medical protocols.

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

Attendant Level	Current Law	2009 SB 262 (as introduced)	2009 SB 262 (with list)
EMT	**65-6121 Emergency medical technician; authorized activities.** Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following activities: a) Patient assessment and vital signs; b) airway maintenance including the use of: • Oropharyngeal and nasopharyngeal airways; • esophageal obturator airways with or without gastric suction device; • multi-lumen airway; and • oxygen demand valves. c) Oxygen therapy; d) oropharyngeal suctioning; e) cardiopulmonary resuscitation procedures; f) control accessible bleeding; g) apply pneumatic anti-shock garment; h) manage outpatient medical emergencies; i) extricate patients and utilize lifting and moving techniques; j) manage musculoskeletal and soft tissue injuries including 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; m) monitor peripheral intravenous line delivering intravenous fluids during interfacility transport with the following restrictions: • The physician approves the transfer by an	Sec. 4. K.S.A. 65-6121 is hereby amended to read as follows: 65-6121. (a) Notwithstanding any other provision of law to the contrary, an emergency medical technician may perform any of the following activities as defined by rules and regulations of the board. (b) An emergency medical technician may perform any of the activities as specified by rules and regulations of the board, in addition to any other activities an emergency medical technician may be authorized by law to perform, if the emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.	Sec. 13. Emergency Medical Technician; scope of practice. Notwithstanding any other provision of law to the contrary, and emergency medical technician may perform any of the activities identified in KSA 65-6144 and amendments thereto; and any of the following interventions and/or devices or equipment as specifically identified in rules and regulations after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols. a) Airway maintenance including use of: • Single lumen airways as approved by Board • Multilumen airways • Ventilator devices • Forcep removal of airway obstruction • CO2 monitoring • Airway suctioning b) Apply pneumatic anti-shock garment c) Assist with childbirth d) Monitor urinary catheter e) Capillary blood sampling f) Cardiac monitoring g) Administration of patient assisted medications as approved by Board h) Administration of medications as approved by Board by appropriate routes i) Monitor, maintain, or discontinue flow of IV line if j) Physician approves transfer by EMT

emergency medical technician;

- no medications or nutrients have been added to the intravenous fluids; and
- the emergency medical technician may monitor, maintain and shut off the flow of intravenous fluid;

n) use automated external defibrillators;

o) administer epinephrine auto-injectors provided that:

- The emergency medical technician successfully completes a course of instruction approved by the board in the administration of epinephrine;
- and the emergency medical technician serves with an ambulance service or a first response organization that provides emergency medical services; and
- the emergency medical technician is acting pursuant to medical protocols;

p) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols; or

q) when authorized by medical protocol, assist the patient in the administration of the following medications which have been prescribed for that patient: Auto-injection epinephrine, sublingual nitroglycerin and inhalers for asthma and emphysema.

109-3-2 Outpatient medical emergencies.

~~(b) An emergency medical technician may perform ny of the activities as specified by rules and regulations of the board, in addition to any other activities an emergency medical responder may be authorized by law to perform, if the emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities~~

(c) ~~Rules and regulations adopted by the board under this section which define activities which may be performed by emergency medical technicians shall be consistent with the education, training and qualifications of emergency medical technicians authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an emergency medical technician and are specifically authorized to perform such activities by medical protocols.~~

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

		a) If the requirements specified in subsections b) (b) and (c) are met, any emergency medical technician may manage an outpatient medical emergency by providing the following patient care: (1) Adminstering aspirin for chest pain; (2) monitoring the saturation level of arterial oxygen in the blood by using a pulse oximeter; (3) adminstering a bronchodilator by nebulization; and (4) monitoring blood glucose levels. (b) Each emergency medical technician shall successfully complete a course of instruction on outpatient medical emergencies approved by the board. (c) When providing any of the services listed in subsection (a), each emergency medical technician shall act pursuant to medical protocols				

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

Attendant Level	Current Law	2009 SB 262 (as introduced)	2009 SB 262 (with list)
EMT-I EMT-D EMT-I/D	**65-6120 Emergency medical technician-intermediate; authorized activities.** Notwithstanding any other provision of law to the contrary, an emergency medical technician-inter-mediate may: (a) Perform any of the activities identified by K.S.A. 65-6121, and amendments thereto; (b) when approved by medical protocols and where voice contact by radio or telephone is monitored by a physician, physician's assistant where authorized by a physician or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such person, 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, endotracheal intubation and administration of nebulized albuterol; (c) perform, during an emergency, those activities specified in subsection (b) before contacting the persons identified in subsection (b) when specifically authorized to perform such activities by medical protocols; or (d) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols. **65-6123 Emergency medical technician-defibrillator; authorized activities.** Notwithstanding any other provision of law to the contrary, an emergency	Sec. 3. K.S.A. 2008 Supp. 65-6120 is hereby amended to read as follows: 65-6120. (a) Notwithstanding any other provision of law to the contrary, an advanced emergency medical technician-intermediate may: (a) Perform any of the activities identified by K.S.A 65-6121, and amendments thereto, and in rules and regulations adopted by the board under this statute; (b) An advanced emergency medical technician may perform activities, as specified by rules and regulations of the board, in addition to any other activities an emergency medical technician may be authorized by law to perform, if the advanced emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities and is specifically authorized to perform such activities by medical protocols.	Sec. 12. Advanced emergency medical technician; scope of practice. Notwithstanding any other provision of law to the contrary, and advanced emergency medical technician may perform any of the activities identified in KSA 65-6121, and amendments thereto; and any of the following interventions and/or use of the devices, medications, and equipment as specifically identified in rules and regulations after successfully completing an approved course of instruction, local specialized device training and competency validation and when authorized by medical protocols or when voice contact by radio or telephone is monitored by a physician, physician's assistant where authorized by a physician, or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such a person. a) Continuous positive airway pressure devices b) Advanced airway management c) Referral of patient of alternate medical care based on assessment d) Transportation of a patient with a capped arterial line e) Veni-puncture for obtaining blood sample f) Initiation and maintenance of intravenous infusion or saline lock g) Initiation of intraosseous infusion h) Nebulized therapy i) Intravenous D50 j) Manual defibrillation and cardioversion k) Cardiac monitoring l) Medication administration via:

		medical technician-defibrillator may: (a) Perform any of the activities identified in K.S.A. 65-6121, and amendments thereto; (b) when approved by medical protocols and where voice contact by radio or telephone is monitored by a physician, physician's assistant where authorized by a physician or licensed professional nurse where authorized by a physician, and direct communication is maintained, upon order of such person, may perform electrocardiographic monitoring and defibrillation; (c) perform, during an emergency, those activities specified in subsection (b) before contacting the persons identified in subsection (b) when specifically authorized to perform such activities by medical protocols; or (d) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.			• Aerosolization • Nebulization • Intravenous • Intranasal • Rectal • Subcutaneous • Intraosseous ~~(b) An advanced emergency medical technician may perform activities, as specified by rules and regulations of the board, in addition to any other activities an advanced emergency medical technician may be authorized by law to perform, if the advanced emergency medical technician has successfully completed a course of instruction approved by the board for the performance of such activities~~ ~~(d) Rules and regulations adopted by the board under this section which identify activities to be performed by advanced emergency medical technicians shall be consistent with the education, training and qualifications of advanced emergency medical technicians authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed, in a manner consistent with the public health and safety, by persons holding an advanced emergency medical technician certificate and are specifically authorized to perform such activities by medical protocols.~~

Kansas Board of Emergency Medical Services (KBEMS) Medical Scope of Practice Review

Attendant Level	Current Law	2009 SB 262 (as introduced)	2009 SB 262 (with list)
Mobile Intensive Care Technician (MICT)	**65-6119 Mobile intensive care technicians; authorized activities.** Notwithstanding any other provision of law, mobile intensive care technicians may: (a) Perform all the authorized activities identified in K.S.A. 65-6120, 65-6121, 65-6144, and amendments thereto; (b) perform cardiopulmonary resuscitation and defibrillation; (c) when voice contact or a telemetered electrocardiogram is monitored by a physician, physician's assistant where authorized by a physician or licensed professional nurse where authorized by a physician and direct communication is maintained, and upon order of such person may administer such medications or procedures as may be deemed necessary by a person identified in subsection (c); (d) perform, during an emergency, those activities specified in subsection (c) before contacting a person identified in subsection (c) when specifically authorized to perform such activities by medical protocols; and (e) perform, during nonemergency transportation, those activities specified in this section when specifically authorized to perform such activities by medical protocols.	Sec. 2. K.S.A. 2008 Supp. 65-6119 is hereby amended to read as follows: 65-6119. Notwithstanding any other provision of law, mobile intensive care technicians paramedics may: (a) Perform all the authorized activities identified in K.S.A. 65-6120, 65-6121, 65-6144 and in rules and regulations adopted by the board under these statutes, and amendments thereto; and perform those additional activities specifically authorized by medical protocols.	Sec. 11. Paramedic ~~Notwithstanding any other provision of law, paramedics may:~~ ~~(1) Perform all the authorized activities identified in K.S.A. 65-6120, 65-6121, 65-6144 and in rules and regulations adopted by the board under these statutes, and amendments thereto; and~~ ~~(2) perform those additional activities specifically authorized by medical protocols.~~ ~~(b) Rules and regulations adopted by the board under this section which identify authorized activities to be performed by paramedics shall be consistent with the education, training and qualifications of paramedics authorized to perform such activities and shall be consistent with activities generally recognized in the performance of emergency medical services as capable of being performed in a manner consistent with the public health and safety by persons holding a paramedic certificate.~~ Maintain current language ~~Make references to other attendants KSA 65-61's~~

EMS Attendant Skills Sets Recommendations

Kansas EMS Systems Approach to the Future (KEMSSAF) Workgroup

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Section I

INTRODUCTION

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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 initial 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)

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.

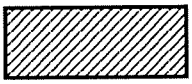
In the "SCOPE" column;

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

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	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

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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
PATIENT MANAGEMENT (continued)				

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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

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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
	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

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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			

Section III

EMERGENCY MEDICAL TECHNICIAN (EMT)

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.

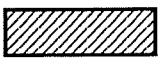
In the "SCOPE" column;

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	

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

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			

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	

	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	

Section IV

ADVANCED EMERGENCY MEDICAL TECHNICIAN (AEMT)

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.

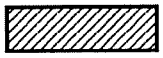
In the "SCOPE" column;

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	

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

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	

Section V

PARAMEDIC

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.

KANSAS EMS TRANSITION
Moving to the new scope of practice

Transition Timeline

Element													
Board Approval													5Dec 2008
Needs Assessment									31Aug 2009				
Gap Analysis									31Aug 2009				
Meeting with KMS, Nursing, and KBEMS									31Aug 2009				
Task List										30Sep 2009			
Task Analysis													31Dec 2009
Objectives													31Dec 2009
Legislative Approval (2009 SB 262)		Jan 2010											
Transition Task Force Meeting (discussion of unresolved dates)		6 Jan 2010											
Lesson Plans			28Feb 2010										
Methods, Media, & Activities						31May 2010							
Evaluation Tools							30Jun 2010						
Support Materials								31July 2010					
Board Approval of Transition Course									7Aug 2010				

Train the Trainer Classes Delivered									Aug 2010	←	→	Nov 2010		
Effective date (2009 SB 262)		Jan 2011												
Transition Course for all levels		Jan 2011	←									→	DEC 2013	
NREMT "Switch"		Jan 2013												
Initial Course "Switch" to new curriculum		Unknown												
Development of Text Books		Unknown												
Development / Providing new curriculum guidelines		Unknown												
Switch of KBEMS Database		Unknown												
Practical Exam review		Unknown												
AEMT written exam review		Board Review (Feb 2009)												
Board Approval of "Unknown" dates		Unknown												

Initial Meeting to discuss "unknowns" will take place with the Transition Task Force

	Legislative / Board Action Required		Item Undecided		Date Determined		Blank

A descriptive breakdown of the design steps is as follows:

Needs Assessment (Assess)

A needs assessment will be conducted utilizing four (4) different mechanisms.

1. An assessment of the skill level changes to each level of attendant will be conducted to determine a baseline for the tasks needed in each transition course.
2. Secondly, an Internet based survey tool will be developed and targeted to existing educators (Training Officers and Instructor/Coordinators) in Kansas. The purpose of the needs assessment will be to determine inclusion elements for the course.
3. Three (3) focus sessions will be held across the state to verify the data obtained in the survey process. These will be open to all interested parties.
4. Work will be conducted with the Kansas Board of EMS staff to ensure that the needs process is inclusive.

Gap Analysis (Assess)

The gap analysis will be conducted using the information from the survey results AND the feedback from the focus sessions. The gap will outline the difference between the needs identified for each level of transition and the current knowledge of providers. This process will be validated with feedback from educators.

Task List

From the gap analysis, a task list will be developed for each level of transition. These will be validated with feedback from educators.

Task Analysis

A three (3) column task analysis will be developed for each skill or procedure identified in the transition courses. These three columns will be: 1. Procedure, 2. Steps, and 3. Rationale. Each task analysis will be referenced to current information available in the public domain and through publishers. Every attempt will be made to include at least two (2) references for each task analysis.

Objectives

Objectives will be developed in an ABCD (Audience, Behavior, Condition, Degree) format. Objectives will be directly tied to the needs assessment and gap analysis. Each objective will be tied to the corresponding level in Bloom's Taxonomy of learning (Cognitive, Psychomotor, and Affective domains).

Objectives will be structured in such a manner that necessary enabling objectives will be included to show the full extent of terminal objectives.

Lesson Plans

Lesson plans will be developed for each transition course based on the corresponding objectives. Lesson plans will include suggested time frames, content, media, methods, and activities. They will be structured in a three column format to support these areas.

Methods, Media, and Activities

All methods, media, and activities will be created after the completion of the content portion of the lesson plan. These will support the lesson plan and the corresponding objectives.

Methods of instruction will be defined in the lesson plan for each lesson in each course.

Media will be developed that is appropriate to support the delivery of each lesson. A determination of the appropriate media type will be made once the content of the lesson plan is in place. Any slideware will be created in Microsoft PowerPoint®. External media references may be given that are optional for instructors to use. All materials used in the media package will be free of copyright infringement.

Activities will be developed to support the objectives of each class and will be driven by the content of specific lesson plans.

Evaluation Processes

Kirkpatrick Level 1 Evaluation

Post course reaction forms will be developed for use by instructors to determine the student assessment of the course materials. These will be used both locally by instructors and by the Kansas Board of EMS to determine the reaction by attendees to the course and material.

Kirkpatrick Level 2

In class quizzes, tests, and practical tests will be developed to support the learning in each course module. These will be constructed based off of the course objectives to reflect the learning outcomes. Both pre test and post test methodologies will be used as indicated by the course design.

Kirkpatrick Level 3

The course developer will work with the Kansas Board of EMS to develop and implement evaluation processes to determine the amount of content transfer that has taken place.

Kirkpatrick Level 4

The course developer will work with the Kansas Board of EMS to develop and implement evaluation processes to determine the results of the transition courses.

Support Materials

All of the items requested by the RFP will be developed to support the objectives for each level of transition course. This includes the student manuals, sample course syllabi, and sample course schedules. These will be developed following the development of the course lesson plans and the media, methods, and activities. This will allow the materials to support instruction rather than detract from instruction.

Train the Trainer Classes

Six (6) train the trainer courses will be delivered in the fall of 2010. One in each of the six (6) EMS regional councils. These train the trainer sessions will be no more than eight (8) hours in length and will provide an overview of each of the three (3) transition courses.

Instructor Support

On-going support will be available to EMS educators as they gear up to teach the course. A forum will be available via the Internet for instructor collaboration. This forum will be monitored by the course developer and Kansas Board of EMS staff will have the ability to monitor and interact in discussion.

Additionally, updates and enhancements to the lesson plans that result from forum discussion will be available for download from a web source.

The Kansas EMS Association

January 25, 2010

Chairwoman Brenda Landwehr
Kansas House Health and Human Services Committee
Kansas House of Representatives

Dear Chairwoman Landwehr:

On behalf of the Kansas Emergency Medical Services Association (KEMSA) please accept this letter in support of Senate Bill 262 regarding the EMS scope of practice.

We have been in support of this bill since its introduction last year and remain committed to working to see this proposed legislation is passed. The bill provides for several areas that are paramount to ensuring the quality of emergency medical service response in Kansas. In brief, these are:

1. This bill moves Kansas certification level titles in line with the National EMS Scope of Practice recommendation. This is important as providers come to Kansas from other states with existing certification from state or national bodies. This is relevant to Kansas EMS agencies finding providers to work in their services and addresses a shortage situation that exists currently.
2. This bill defines a new and standard of care "current" scope of practice for each level of certified technician. This is important. The Kansas Board of EMS worked openly and diligently with EMS stakeholders and physicians to identify and define these scopes to reflect not only current trends, but also the stakeholder defined needs within their local communities.
3. The change in scope of practice keeps Kansas current with the National Scope and with standard of care as scientifically defined.
4. This bill reflects the work of the Board of EMS to ensure stakeholder input and opportunity to define what will be used at the local level in providing quality emergency medical services. Our industry has a long history of disagreement between rural and urban, career and volunteer. This is an excellent example of how these elements can come together to produce a plan that meets many of the needs of all venues of EMS in Kansas. Please honor that effort.

As an association, we are aware that some individuals and agencies have concerns about this legislation due to the changes proposed to the scope of practice. We want to clearly state that the scope changes recommended by the stakeholders who were willing to engage in the process reflects the needs stated by Kansas EMS agencies, the current trends and standards of care in EMS, and the current scientific findings for what care is beneficial to patients.

Continued on page 2

785-447-0416 (Phone) P.O. Box 441 Clay Center, KS 67432

Our encouragement to you as legislators is to view this proposed bill as an opportunity to meet the needs of very real people in Kansas who, when in need of emergency medical care, have a right to expect those who respond to be functioning at a level that meets the standard of care for field medicine. This proposed legislation is not about individuals or agencies. It is not about infringing on other disciplines and areas of practice. It is about quality care.

The Kansas Emergency Medical Services Association is committed, on behalf of our members, of doing whatever it takes to meet the dynamic and challenging changes in our profession.

Respectfully,

Christopher Way

President
Kansas Emergency Medical Services Association

785-447-0416 (Phone) P.O. Box 441 Clay Center, KS 67432 785-632-6050 (Fax)

January 25, 2010

Chairwoman Brenda Landwehr
Kansas House Health and Human Services Committee
Kansas House of Representatives

Dear Chairwoman Landwehr:

This letter is provided to you and your committee as a demonstration of our strong support for the passage of Senate Bill 262. The bill gives the Kansas Board of EMS the ability to implement the new EMS Scope of Practice.

Kansas EMS Communities of Interest have worked diligently to develop, design, and implement the Kansas EMS Scope of Practice that benefits the needs of Kansas EMS and those we serve. Additionally, these efforts have been and continue to be aligned with the National EMS Agenda for the Future, National EMS Education Agenda for the Future and our national industry "norm" testing.

Failure to pass Senate Bill 262 will have an immediate and drastic negative impact on the "state" of EMS, especially EMS Education. While most of the nation makes the change, failure on our part to pass SB262 will most likely force Kansas EMS students and volunteers to be ineligible for nationally accepted and proven testing processes. This leaves the Kansas Board of EMS to once again fund a process previously proven inadequate and unacceptable by most testing standards as well as unsupported by an appropriate budget.

Additionally, since SB262 will allow Kansas to closely mimic the national model, failure to pass this bill potentially leaves Kansas EMS educational institutions facing the risk of very few viable options for textbooks, educational guidelines, online resources, and instructional overviews since most publishers have moved to the National Scope of Practice Model. This could potentially cause programs the inability, or high cost, to develop and deliver the necessary information in a manner most accurate and consistent to current EMS educational practices.

It is our hope you strongly consider supporting the passage of Senate Bill 262.

Sincerely,

Chy Miller
Department Chair – Public Safety
Hutchinson Community College

HEALTH AND HUMAN SERVICES
DATE: 2-3-10
ATTACHMENT: 7-1

Kiowa County Emergency Medical Services
700 West Kansas St. Greensburg, KS 67054 (620) 723-3341 ext 320

January 25, 2010

Chairwoman Brenda Landwehr
Health and Human Services Committee
Kansas House of Representatives

Dear Chairwoman Landwehr:

On behalf of Kiowa County EMS in Greensburg please accept this letter in support of Senate Bill 262 regarding the EMS scope of practice.

We support this bill as it is good for Kiowa County and Kansas EMS as a whole. Some important aspects of the bill as they pertain to our role as EMS services include:

- The ability to market job openings on a national level as this bill brings Kansas certification levels in line with the National EMS Scope of Practice. This will allow services in Kansas to pull from a larger applicant pool to ensure we can combat the current shortage situation in Kansas EMS.
- The bill ensures services and technicians in Kansas are held to the current trends and standards of care in EMS, and the current scientific findings for what care is beneficial to patients. Patients deserve scientifically backed care that is reflected in current standards throughout the country.
- This bill ensures that local involvement is still a key aspect of prehospital care, allowing services and physicians to meet the needs of their communities while maintaining high standards in the prehospital environment.
- The bill provides the ability to enhance prehospital care in rural areas of Kansas, which makes up the majority of the State. Rural services are not afforded the ability to hire and retain paramedics due to call volume and low pay. By allowing AEMTs the ability to provide some higher level care you can ensure rural citizens have access to some of the same care available in urban areas for less cost and less time commitment. In the end everyone wins as patients receive the care they deserve and services are able to enhance the care they provide.

As a rural EMS service, we fully support the approval of Senate Bill 262 and the higher level of care for rural citizens throughout Kansas. We also fully support any training and education necessary to support this bill. Approval of Senate Bill 262 is a fundamental step towards ensuring everyone in Kansas, whether a citizen or visitor, can expect to receive the prehospital care they deserve. Thank you for your time and consideration.

Sincerely,

Chad Pore
Director, Kiowa County EMS
cpore@kcmh.net
620-723-3341

HEALTH AND HUMAN SERVICES
DATE: 2-3-10
ATTACHMENT: 8-1

FINNEY COUNTY KS
EMERGENCY MEDICAL SERVICES
803 W. Mary • Garden City, KS 67846 • (620) 272-3822

Testimony for Senate Bill 262

From: Robert D. Prewitt MICT, I/C
Director, Finney Co. EMS

1/26/2010

To: House and Human Services
Madam Chairwoman Landwehr

My name is Bob Prewitt and I am director of Finney County EMS in Garden City, Kansas and I would like to make a few comments on (2009)SB 262.

I have been fortunate enough to have been associated with EMS in Kansas since 1970 and sat as a member of the first Gov's advisory council on EMS and served as a member of the council a second time as well. I had the pleasure of working with the legislature on the statutes and regulations at various times then and numerous occasions in the last 30 years. This revision is another in a long line of processes that will help to stabilize our industry and allow us to provide the care necessary for the people of the great State of Kansas. The suggested changes were reviewed by a large group of active personnel, both volunteer and paid from all regional areas of Kansas EMS. A great deal of deliberation and discussion about the best solution for the provision of EMS in Kansas was held at various times during the first six months of 2008. Both volunteer and paid representatives from all 6 regional areas of EMS attended and represented the diversity in the approach and delivery along with the adaptation of changes facing Kansas EMS profession for the next several years. The presented language and process of SB 262 was agreed on by those present but not without considerable revisions and refinements agreeable to all. A model of all inclusiveness was utilized and great amounts of separation and dissention has been dealt with in the deliberation of this language. The EMS professionals were concerned that the approach should be progressive enough to handle changes as diverse as the "National Scope of Practice" and how Kansas EMS would adapt to the delivery, evaluation and implementation of the proposed changes. The very vocal and diverse group became focused and identified many of the areas of concern with a vengeance and addressed the issues with creditability and expertise of people who are in the business of the delivery of EMS to Kansas. This approach had not been used in Kansas in many years and the results are, I believe, a very strong consistent approach to the most appropriate platform for the identification and preparation of EMS education, testing, transition and modification of regulations and statutes for the betterment of EMS in Kansas. Personnel who are not in the professional delivery of Emergency Medical Care do not understand the scope or the broad based approach to a very specific transition issues this bill addresses. I also do not believe there are major changes to the current scope of practice for EMS personnel except for the advanced EMT and that level would be of great benefit to the rural areas of Kansas IF we can develop an appropriate transition program acceptable to the rural areas. I believe SB 262 provides the platform to allow that to happen.

HEALTH AND HUMAN SERVICES
DATE: 2-3-10
ATTACHMENT: 9-1

Much work has been done and I'm sure much more will be required to develop all the aspects of this transition. However, without a stable solid base to build upon there will be very little positive direction or need to continue to work with the current process and Kansas will be behind at least 5 years again. I truly believe this is in the best interest of Kansas and has the input and participation of all areas of the State. EMS personnel from all across the state have had at least 2 years to input the process and a great deal of discussion and diversity has already been addressed in this process. The reality of this is that Kansas EMS has a great opportunity to be a progressive leader again in EMS and SB 262 is the first step in allowing the process to continue and grow.

Thank You for your time and effort with this legislation but the time has arrived for SB 262 to pass and provide the leadership structure for transition and development as proposed.

Very Sincerely,

Bob Prewitt

Bob Prewitt, MICT I/C

KANSAS

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

MARK PARKINSON, GOVERNOR

BOARD OF EMERGENCY MEDICAL SERVICES

Testimony

Date: January 27, 2009

To: House Health and Human Services

From: J.R. Behan, Paramedic and KBEMS Board Member

RE: 2009 Senate Bill 262

Madam Chairwoman Landwehr and members of the House Health and Human Services Committee, my name is J.R. Behan. I am a Paramedic with Finney County EMS and the Vice-Chairman 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. As the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) published the national consensus document titled *EMS Agenda for the Future (Agenda),* and in 2000, the *Agenda* was followed by the *EMS Education Agenda for the Future: A Systems Approach (Education Agenda)*, the Board understood that the agency must review and discuss the adoption of the new scope of practice in Kansas and its impact on Kansas services and attendants.

KBEMS issued a request for proposal (RFP) to develop the transition courses to move Kansas EMS from the old scope of practice to the new scope of practice. The Kansas Emergency Medical Services System Approach to the Future (KEMSSAF) task force was created to provide the Board with a recommended pathway to develop and implement the new scope of practice. The Task Force was comprised of the following:

- 4 members of the Board of EMS
- 1 Member from each Kansas EMS Regional Councils
- 1 Member from 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 from each Community College currently teaching EMS education
  - 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

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Beginning in January 2008 through June 2008, the Task Force met and provided its recommendation to the Board. Following the approval of the draft document, the Board directed Staff to provide the document to all EMS Associations and Regional Councils, Fire Associations and organizations, and medical directors for input. From June 2008 through December 2008, the Board received 5 letters of concerns relating to the Scope. The Board addressed those concerns (relating to the Emergency Medical Responder) level, and approved the new Kansas Scope of Practice for bill introduction. The Board holds that the development of the task force report, public input, research, and national scheme foundation has established a sound and medically based scope of practice to allow Kansas attendants to function under protocols based on national standards, medical research, and Kansas specific activities to provide optimum pre-hospital care to the citizens of our State.

The establishment of the transition course over a three (year) period will allow attendants the ability (through modules) to attend classes provided by local services or EMS training programs or EMS educators. The local level (directors and educators) will hold the responsibility to schedule and conduct classes. Additionally, the Board will provide access to the course by community colleges and technical schools to assist in meeting the demand. The Board understands the concerns raised by the adoption of the new scope of practice and the transition course. The time, access to, and educational standards demanded for Kansas EMS attendants will change. However, with the time given and modular access, the Board believes that this transition period can be managed efficiently and the adverse affects that such a transition may have on attendants minimized.

Conclusion

As the regulatory agency for emergency medical services (EMS), the Board understands its responsibility not only to Kansas law, but as a resource and supporter to local services and attendants. As testimony has been provided, the Board did not arrive at the KEMSSAF report without significant research, public input, and answering questions as to the implementation and impact of its decisions Kansas. The Board would ask for the passage of SB 2009, as amended, to allow the continued progression and evolution of EMS in Kansas.

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.

REGION I EMS COUNCIL

Gary Winter-Region I Coordinator
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Date: February 3, 2010
To: House Health and Human Services Committee
From: David Stithem, Chair, Region I EMS
RE: Senate Bill 262

Madam Chairwoman Landwehr and members of the House Health and Human Services Committee, my name is David Stithem. I am the Chair for Region I EMS. I would like to provide comments in favor of 2009 Senate Bill 262.

Region I is comprised of the eighteen counties in the northwest portion of the state. The twenty services in this region are made up of mostly volunteers, with a small number of full-time services. All together, these services provide twenty-four hour prehospital emergency care to 17,085 square miles of Kansas.

In early 2008, a large group of professionals from the State, Regional EMS Councils, Professional Organizations, Colleges and Technical Schools met to discuss the benefits of moving toward a national scope of practice for EMS. Following months of meetings, the current document was recommended as being the most beneficial to Emergency Medical Services across the state and for the public they serve.

While the changes proposed in this bill are in the best interest of Kansas as a whole, there are important considerations for Region I. The current First Responders are utilized by many services as the second technician on an ambulance. This allows an EMT to provide patient care during transportation without taking a second EMT away from a service with an already limited roster. The First Responder will transition to an Emergency Medical Responder (EMR) under this bill. Without the Kansas specific changes recommended, the EMR would not be allowed on an ambulance. This could severely hinder those services currently operating with First Responders.

Less than a third of the services in Region I operate with paramedics on their staff. Of those services, half function with a single paramedic on their roster. Many services have employed Emergency Medical Technicians – Intermediates (EMT-Is) as a way to provide additional services in those areas where paramedics are not available. The changes in this bill would allow the current EMT-I to transition to an Advanced Emergency Medical Technician (AEMT). With the appropriate training and medical supervision, the new scope would allow the AEMT to provide expanded patient care during local emergencies. It would also provide additional options for the large number of interfacility transfers from the small, rural hospitals to the larger, specialty care facilities.

The third attendant level change would rename the Mobile Intensive Care Technician (MICT) to Paramedic. This certification has often been referred to as paramedic, even though it was not the official term used in statutes and regulations. Passage of this bill

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would allow patient care to be based upon the needs of the location and the wishes of the local medical society. This ability to provide prehospital care based upon the specific needs of the area will obviously be a benefit to all regions of the state, not just within Region I.

In summary, the proposed changes to the Scope of Practice are based upon the new National Scope of Practice. Region I participated in the development and review of this document. The end result is a Scope of Practice considered to be in the best interest of not only Region I EMS, but all of EMS in the state.

Thank you for allowing me to provide testimony on this bill. Region I EMS would respectfully request passage of SB 262.