

## The National EMS Scope of Practice Model in Iowa

As the Iowa EMS Community considers the impact of implementing the *National Scope of Practice Model* (Model) in the state, it is important to consider the events that led to the development of the *Model*, the implications of the *Model* and possible implementation options. This document explains the issues that preceded the development of the *Model*. It will also explain the proposed levels of emergency medical care providers described in the *Model*. Finally, the implications of adopting, or not adopting, the *Model* in Iowa will be explained. The intent of this document is to be a starting point for public input on this subject, which will affect Emergency Medical Services on the local, state and national level.

The implementation of the *Model* will have a large effect on EMS in the State of Iowa. In order to make good recommendations to the Bureau of EMS, the Quality Assurance Standards and Protocols (QASP) subcommittee of the EMS Advisory Council (EMSAC) is asking for the input of everyone who has an interest in the future of EMS in Iowa, including, emergency medical care providers, service directors, medical directors, other health care providers and the public. Please submit your input by June 25<sup>th</sup>, 2008. Comments may be submitted to Anita Bailey at [abailey@idph.state.ia.us](mailto:abailey@idph.state.ia.us) or Evelyn Wolfe at [ewolfe@idph.state.ia.us](mailto:ewolfe@idph.state.ia.us). Comments may also be mailed to: Bureau of EMS, Lucas State Office Building, 321 E 12<sup>th</sup> St, Des Moines, IA 50319. Comments will be gathered by the Bureau of EMS and submitted to the QASP subcommittee at the July 9, 2008 meeting. Information concerning the EMSAC meetings may be found on the Bureau of EMS website at: [http://www.idph.state.ia.us/ems/adv\\_council.asp](http://www.idph.state.ia.us/ems/adv_council.asp).

### Background on the *Model*

In 1993, the National Registry of Emergency Medical Technicians (NREMT) released the *National EMS Education and Practice Blueprint* (Blueprint). The *Blueprint* identified the need for consistently identified levels for emergency medical care providers in the United States. With four curriculum levels nationally, the *Blueprint* identified 40 levels of emergency medical care providers (National Academies of Science, 2006).

The National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) published the 1996 *EMS Agenda for the Future* (Agenda). The *Agenda* called for EMS to be integrated into the healthcare system while remaining, “the public’s emergency medical safety net (NHTSA).” Education was one of fourteen attributes identified in the *Agenda*. The identification of education as an attribute of a comprehensive EMS system led to the development of the 2000 *EMS Education Agenda for the Future: A Systems Approach* (Education Agenda) (NHTSA).

The *Education Agenda* identified the components of an educational system that would lead to a consistent and quality process to ensure well-trained EMS providers graduated from training programs. The *Education Agenda* identified five components as necessary for putting a high-achieving educational system in place:

1. National EMS Core Content
2. National EMS Scope of Practice Model
3. National EMS Education Standards
4. National EMS Education Program Accreditation
5. National EMS Certification (NHTSA, 2000)

The development of the *Model* was based on input of medical directors, state EMS offices, analysis of EMS practice across the nation and review of national studies and data (NHTSA, 2007). The first draft of the *Model* was released in the fall of 2004 for public comment. In Iowa, EMSAC, the Iowa EMS Association (IEMSA) and the EMS Education Programs submitted comments on the first draft. The *Model* went through two more drafts, with public comment, before being submitted to NHTSA. In 2007, NHTSA released the final model.

The EMS community in Iowa became engaged in the *Model* early in the process. Besides providing input on the first draft, in October of 2005 EMSAC recognized the model as being a good transition for Iowa (EMSAC Minutes). The Bureau developed a fact sheet concerning the effects of adapting or deviating from the *Model*. A link to the fact sheet is in the references at the end of this document. In January of 2008, EMSAC was presented with possible implementation options. EMSAC then advised the Bureau to develop documents for public comment for review at the July 2008 QASP subcommittee meeting (EMSAC Minutes, January 2008).

### The National EMS Scope of Practice Model

The current varied levels and scope of practices across the nation have led to public confusion, difficulties with mobility and reciprocity, and an inefficient EMS system. The implementation of the national standards will address these issues and, if implemented, improve the public's understanding of their emergency medicine safety net (NHTSA, 2007). Understanding and support of the public will be vital to the viability of EMS.

The *Model* consists for four levels, Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician and Paramedic. These four levels were developed to serve the diverse needs of the nation while remaining practical for the development of educational guidelines, teaching material and certification examinations. The levels have distinctive differences in skills. The Scope of Practice Model cautions against migrating skills from higher levels to lower levels. While a skill itself may be simple to perform, the knowledge behind the application of the skill may be much more complex (NHTSA 2007).

The Emergency Medical Responder (EMR) is similar to the current First Responder (FR). The provider at the EMR level is performs lifesaving care to critical patients with minimal equipment. The EMR will deliver on-scene emergency care prior to the arrival of a transporting service, though the EMR may also function as part of a transport service. The skills of the EMR are non-invasive and include the use of oxygen, oropharyngeal airways, automated external defibrillators, bleeding control and manual stabilization.

The Emergency Medical Technician (EMT) is similar to the current EMT-Basic (EMT-B). The EMT provides basic emergency care. EMT care is the minimum for transporting services. The EMT performs the skills of the EMR and uses basic equipment commonly carried by ambulances including, automated transport ventilators, over-the counter medications and use of the pneumatic anti-shock garment. EMTs also assist patients in taking prescription medications (NHTSA 2007).

The Advanced Emergency Medical Technician (AEMT) is a level unlike any of the current certification levels. The skills of the AEMT fall between the current Iowa certification levels of EMT-Intermediate (EMT-I) and EMT-Paramedic (EMT-P). The skills of the AEMT include those of the EMT with

additional advanced skills. The advanced skills of the AEMT are high impact, lower risk procedures such as insertion of airways other than those intended to be placed in the trachea, initiation of intravenous access, and administration of a limited set of medications (NHTSA 2007).

The Paramedic level is similar to the current Iowa Paramedic Specialist certification. Paramedics are the highest level of out-of-hospital care and care is determined based on advanced assessment and the formulation of a field impression. The Paramedic has the largest set of skills, including invasive skills and pharmacological interventions.

#### What Needs to Be Done?

While the *Model* has been finalized, there are items that must be completed prior to implementation. The National Association of EMS Educators (NAEMSA) is currently developing Education Standards for the four levels. The first draft of the Education Standards were released in the fall of 2007 for public comment. The final draft is due to NHTSA in the fall of 2008.

After receiving the Education Standards from NAEMSE, NHTSA will review and give final approval. It is projected that this approval will be completed by the spring of 2009, with educational materials such as textbooks being ready from the publishers in the fall of 2009. Certification examinations should be prepared for the 2010-2011 academic year. It is important to remember that the dates, other than the Education Standards delivery dates, are projected dates and are subject to change.

In Iowa, the EMS system needs to decide how the four new levels of certification will be implemented with the current five certification levels. Because of the issues previously discussed, EMSAC does not believe it is feasible for the State of Iowa to “go it alone” concerning the certification of emergency medical care providers. The following describes two options presented to QASP at the January 2008 meeting.

#### Option 1: Transition

This requires all providers certified at one of the five current certification levels (FR, EMT-B, EMT-I, EMT-P and PS) to become certified at one of the four new certification levels. At the current FR, EMT-B and PS levels, the transition to EMR, EMT or Paramedic would consist of update training that could be completed as modules. The modules would be completed and submitted as part of the certification renewal requirements. When the modules are completed, and the emergency medical care provider completes the renewal application, the certification would be updated to the new levels. The training requirements, and the transition timelines, will be developed when the Education Standards are completed based on the differences between the current and new levels.

Since the current EMT-I and EMT-P certifications do not fall directly in-line with the new levels, providers at these levels will have to make a decision concerning the certification they will hold. The current EMT-I Scope of Practice falls between the EMT and AEMT levels. EMT-I providers who wish to be certified as an EMT will be able to transition to that level without taking additional training. If a provider at the EMT-I level wishes to transition to the AEMT level, they will be required to complete additional training and testing at the AEMT level. The training requirements, and the transition timelines, will be developed when the Education Standards are completed based on the differences between the EMT-I and AEMT levels.

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Providers certified at the EMT-P level will also have to decide on a new certification level. To become certified at the AEMT level, the current EMT-P will be able to transition without additional training or testing. If a provider at the EMT-P level wishes to transition to the Paramedic level, he or she will be required to complete additional training and testing at the Paramedic level. The training requirements, and the transition timelines, will be developed when the Education Standards are completed based on the differences between the EMT-P and Paramedic levels.

Providers at the pre-1995 FR levels, the EMT-Ambulance level and the EMT-Defibrillator level were given seven years to transition to the current First Responder or EMT-Basic levels, ending in 2001. Providers active at one of the legacy levels would be able to maintain their current level but would not be eligible to transition to the new levels.

A visual representation of the transitions may be found in attachment 1 of this document.

#### Option 2: Add New Levels

Another option to implement the *Model* would be to add the new levels of certification as they come online with certification testing. The current levels of EMS providers would continue under their current Scopes of Practice but all new providers certified in Iowa would be at the EMR, EMT, AEMT or Paramedic levels. Providers certified at the current levels would be able to transition to the new levels, if they desire.

While this option is the least burdensome for current providers, there are issues which would need to be addressed. One issue is what to do with the term "Paramedic." If the four levels are added to the current levels utilized in Iowa, providers will be certified at the EMT-Paramedic, Paramedic Specialist and Paramedic levels with three potentially different Scope of Practices. How would these be differentiated to avoid confusion for the other health-care professionals the EMS profession works with?

Similarly, adding four new levels of certification will bring the total numbers of active certifications to thirteen, including the legacy levels. While the legacy levels do not meet minimum staffing requirements, there would be nine levels that do. At the January 2008 QASP meeting, concern was voiced that adding four new levels will cause confusion for service directors, medical directors and the public.

#### Input Needed

The QASP subcommittee appreciates the interest Iowa's EMS community has shown in the issues related to the National Scope of Practice Model and is looking forward to the comments that will be received. There is much remaining to discuss concerning how this Model can best work for Iowa and all the people who depend on the EMS system. Successful implementation will depend on all aspects of the EMS system working together.

Please submit your input by June 25<sup>th</sup>, 2008. Comments may be submitted to Anita Bailey at [abailey@idph.state.ia.us](mailto:abailey@idph.state.ia.us) or Evelyn Wolfe at [ewolfe@idph.state.ia.us](mailto:ewolfe@idph.state.ia.us). Comments may also be mailed to: Bureau of EMS, Lucas State Office Building, 321 E 12<sup>th</sup> St, Des Moines, IA 50319. Comments will be gathered by the Bureau of EMS and submitted to the QASP subcommittee at the July 9, 2008 meeting.

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More information concerning the Agenda's for the future, the National Scope of Practice Model and the Institute of Medicine report may be found at [http://www.idph.state.ia.us/ems/scope\\_of\\_practice.asp](http://www.idph.state.ia.us/ems/scope_of_practice.asp).

References

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Attachment 1  
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