

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

---

I don't see anywhere that tells me what the different levels will be able to do. I have seen a copy of it from one of the QASP members but I can't find it anywhere on the Bureau's web site. Also the attachment says Con-Ed Modules and Exam. Do you have any idea how much class time we are talking here? Will there be practicals involved? And how long would we have to transition if we decided to.

---

I have HUGE concerns over this new model. We have 6 Iowa Paramedics and 1 specialist working in Hardin County. We take All Paramedic transfers from Grundy Hospital and Ellsworth Hospital. If the Iowa Paramedics can't come up with the funds or the time to bridge up, those Hospitals and the people of the county would suffer tremendously. I have been told by a member of the QASP committee that it will be 400 hours and \$4,000 to bridge up. It is very hard for me to understand that the State would certify Iowa paramedics only to take away half their skills and make them pay more just to do the same thing they are already doing. Doing more clinicals would be a waste of time. I have learned more in the last 4 years running alone then I ever learned doing clinicals. My feeling are to grandfather in all the Iowa Paramedics with the Specialists like they did several years ago. I know several Specialists that took the same class I did and they were moved up as a specialist. I don't feel they are any better of a paramedic then I am. Leave it up to the Medical directors and service directors to make sure all their EMT's are proficient on their skills and knowledge. Offer more classes around the state (free of charge would be nice) on updating skills. As a volunteer in the state of Iowa it is very costly to be a paramedic which is funded by myself most of the time. The state needs to realize that if they make it too costly and time consuming they will lose many of the EMT they already have and we can't afford to loose any of them. Rural Iowa EMT's are stretched very thin between their families, jobs, and volunteer EMT time. It would be great if we could have more full time EMT's that are actually paid what they are worth but as you know Medicare keeps our rural ambulances in the red where they can't afford to even pay for EMT classes. Ok, I'm done venting for now. I'm sure I'll come up with more later that I will pass along but for now I would still like to see the proposed skills. Thanks for serving on the committee to help make Iowa a great place.

---

i would just like to put feedback on the changes that might happen to the certification levels in iowa. i am currently taking the Iowa Paramedic program. and im not very happy to hear that there is a possibility that you might be taking this certification away in the near future. i really dont think it is far. i just think that if you make changes that you let the people that already have the certifiacion keep what they have and still be called what they are. the iowa paramedic is a very popular certification in dubuque iowa. all im saying is that if it ends up being taken away, the county will loose a tremendous amout of Paramedics. so i guess what im saying is that i like Option 2 ( add new levels) we should still be what we are certified under the levels.

---

I want to first commend the state and the committee looking into this can of worms for what you are undertaking. I believe this has been a long time in coming and is a necessary evil to make our system more efficient. I have been in the EMS role since taking my Crash Injury management course back in the spring of 1978 using the old orange EMT books. The changes that have affected our system since that time have been for most part very positive. A lot of changes have come and gone in 30 years (remember calcium chloride?). I do think that the state took a bit of a wrong/sideways turn for a while in the 90's trying to appease too many people in too many places with the conglomeration of certifications that we now have. In reading the document sent out recently asking for comments I have come up with a few. My first, and what I think is really the most important that will cause the most wailing and gnashing of teeth is to make it simple. Option number 1 outlines having all EMS certifications move up, down or sideways into one of the four new categories. This should be

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

the \*/\_only\_/\* option. To make it even more of a life changing event for some people, no legacy certifications should go beyond the drop dead date set for moving to one of the four categories. The system needs to be the same in all 99 counties of Iowa. The state EMS system needs to clean house and start fresh. There should be no confusion as to what one can or cannot do when moving from one corner to the other. The four categories of certification are just fine. If people are truly interested in the continuation of their EMS duties, they will make the effort to move into one of the four categories. The argument that comes up is the lack of time or we can't force people because they are volunteers is a large bunch of drunken spider monkeys gone bad. ( I had other words in mind but thought better of it). The people that are truly interested in serving in the EMS community will take the effort. That is how they got to the point they are now. They went to classes and learned. They can and will do it again. It sometimes just takes the stern adult/authority figure to step in and Make it happen. If everyone is happy, then you probably haven't been doing your jobs. Make everyone comply with one of the new levels or take their toys away. Now to make the changes easier, it needs to be as simple as the move from EMT-A to EMT-B was back so many years ago. The process then was very simple and easy. If we make this a hard thing, it will only cause more teeth gnashing, people turning in their pagers and good intentioned nosy legislators trying to fix the problem with new rules and laws to fix what you are trying to fix. The process to move up must be user friendly and as easy as possible. To alienate those in the need of the move will not help the change. An example of this now in place is the bridge up from P to PS. I cannot express how absurd the system in place is to make this move. It should not be punishment to want to improve your level. As an instructor and a person directly involved in the upkeep of 46 people with certifications in two states, I can say that the current system is just too bulky. Trim it down and make it a lean machine that runs on bio-fuels. The use of the national standards will also help with teaching in the various levels, especially for those of us that border another state. I have students from three states that take classes locally. They all have different things that they can do when they get home. The first step to making it all work is by having everyone on the same page. There should not be a menu of what I can do here and not there. Those states around may or may not move to the national standards immediately, or may be on that page already. It doesn't matter, we need to be there so that when the rest of the country is on the same page, we are using the same music. Now for my concerns on skills. Reading the document, although admittedly sparse in information, I am concerned that some skills currently in use by all levels would be taken away from those that can use them. I speak mostly of the use of advanced airway devices such as the Combitube and the King airways. These should continue to be part of the arsenal of devices for all four levels of providers. To make these only available to advanced EMT's is a step backwards. Perhaps I do not read this part correctly, but the information provided reads that only the Advanced EMT will use such devices. I see this as a problem for those services that are currently B or I providers. As previously stated, I applaud your work. I think it should be on a faster time table. What you are doing is the right thing. It just won't be a popular thing in some circles.

---

Having been through the previously mentioned attempt to "transition" from the legacy levels and its difficulties that have left the legacy levels in place I read your proposal with skepticism at best... -I have concerns about the process. What is the cost and who will bear this burden? Will there be a better organized and accessible method of obtaining needed models? Will on-line course training with practicals be an option. -Being from an area that has a community college that covers a large area with few instructors - and long distances to get to a central training site, I project that an en-masse attempt to get everybody on "the same page" will be chaotic and prone to frustration. What will the didactic portion be? The 'old' attempt was poorly managed and implemented haphazardly. Classes were hard to find and clear plan was even harder to understand. I am not against reducing the amount of levels, I am confused as to the implementation... or why the need for implementation is being asked? What are you asking exactly? I am REALLY concerned about the "buy in" by

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

the rest of the nation. What guarantee do we have that all 50 states will play by these rules and use the same names for the levels? LPN's & RN's reciprocity is not even or a reality across the 50 US states yet, and yet the claim is that this will allow transfer in registry across the 50 states? What is the national timetable... should, as it is claimed, a paramedic from IA may work in IL \*\* OR \*\* vice versa? -What will the CEH's be for the new levels? -What will the effect on 'basic' units as far as equipment for the ambulance? What if they do NOT want ventilators? -What is the projected lifespan of these changes once implemented? -What will the training time be? VOLUNTEERISM is already at a low ebb - as it is - - - Are we heading back to the days a sparse coverage (at best) and lengthy response times? It seems many ideas are being born and projected for the metro iowa responder and no thought (or PR rather) is given to those in communities that are struggling as it is. I watch as class after class of young EMT's come through the system and leave their rural beginnings because of lack of opportunity... why are we not focusing on that? how are these changes going to adversely affect the rural responder? As a parent of 2 young children and full time employed I find training time limited as is . . . And what about those who work night time? Will there be day classes in the rural setting available? ICN offerings? - I predict many fire departments will drop FIRST RESPONDER status as they are already asked to meet increasing time demands for training standards - we rely on them heavily, yet there seems to be little or no consideration of the fire service by IDPH. I have already heard that many fire personnel are considering focusing on fire and dropping EMS CERTIFICATIONS. AS far as the level names and scopes are concerned - Why is the legacy name not going to be utilized in the First responder level? I believe that since this level is essentially unchanged and it is publicly recognizable it should remain the FIRST RESPONDER registration and name. Additionally EMR sounds more like a CommunityEmResponseTechnician level and not a "professional" rescuer. \* 9/11, the federal government and the media have used the First Responder name as a blanket over police, fire EMS and paramedics that has lead to confusion in the public. -the EMT might also benefit as remaining as named... EMT-basic or BEMT to differentiate from the Advanced level. Again publicly recognizable and identifiable. -Will the EMT (basic) still be able to maintain IV lines of NS? -How can a EMT(basic) transport a VENTILATOR with an airway they cannot place - or - replace should it become dislodged? Who will initiate said ventilator and via what airway? Do you mean CPAP? -I am confused as to why EMT's will no longer be able to place "blindly" inserted airway devices - IF you have ever been puked on in a code or recall it, one would appreciate as an AEMT or Paramedic arriving at a scene 10+ minutes after CPR is in progress to find a 'clean' airway to intubate and manage... a consideration if we regionalize our EMS system in iowa down the road in 10 years. -On the subject of OTC medications - what are the proposed OTC's - will EVERY medical director let EVERY EMT give EVERY one? PUBLIC comment: if ambulance service A can give tylenol why can't ambulance service B next door? -The AEMR is a misnomer if you consider that the public will make the leap that these are better trained 1st responders, but less that an EMT.... AEMT is more appropriate and descriptive. \* 12 lead interpretation? Manual defibrillation? Morphine? beta blockers? -What will become of the Critical Care paramedic level? That was not addressed. Chest tubes maintenance during transfer from rural hospital to trauma center? -What scope of practice in the ER setting will the new levels play?

---

I believe the best plan for the future would be Option 1: Transition.

---

I have read the 6 page pdf on the Bureau website from QASP Have a question specific to the current I-99 (aka. Iowa Paramedic) As a service director I fully understand options 1 and two when it comes to how many levels of EMS providers we have in the state. My issue as a rural provider is to what will happen to the I-99 under Option 1 in transitioning. We have several providers at the i-99 level that could have a potential issue if their only two options are to: A. Transition up to the new Paramedic B. Drop back to the new AEMT level I understand that when the new standards become effective that there will be no more new I-99 classes. My lack

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

of understanding is why apparently the legacy levels of pre-1995 FR, EMT-A and EMT-D are going to be allowed to continue to maintain their level, but apparently the I-99 do not have this option? This will impact our service and our community, in the realm of the AEMT not being able to utilize their cardiac monitoring skills and utilize cardiac medications, if they are not allowed to maintain their level. As far as the issue of confusion I believe most if not all current paramedic specialists will transition to the new Paramedic level since this is through continuing education that would still leave the "Iowa Paramedic" designation for the current I-99s until they drop from rosters due to attrition as the pre-95 FRs, EMT-As, and EMT-Ds have done since the 1994 to 2001 transition period.

---

I appreciate the need to combine so many groups of the EMS category's, but please take into consideration that a lot of the "small town" EMS groups are all volunteers. It is so hard now to get any new bodies to join our groups because of "no pay and sizeable tuitions". Adding any more costs and schooling will only drive some of our members away and we cannot afford to do this. It needs to be kept in mind how long we would have to transition to the new level and what the cost would be.

---

I feel that the first option would be the best choice of action. Adding additional levels of providers would most certainly cause additional confusion to the process. There is already enough confusion among many ER staff between P, PS and CCP. We don't need to add more confusion across the spectrum of care providers. I really like the idea of offering a means to allow the current EMT-I 85's the option to transition to the AEMT level. The additional skills of the AEMT certainly appear as stated, high benefit and low risk. I only hope that the transition process would not be so burdensome that the EMT-I would opt against transitioning. Having the AEMT level in rural Iowa would be a great asset to our residents. Many of our rural areas struggle with providing timely advanced care. In Toledo, as several of the communities in Tama county, we have one paid EMT-PS staff member along with volunteer EMT-Bs and EMT-Is. Obviously, that one person cannot be available 24/7/365. We must, therefore, rely on other agencies for advanced care. Many of these calls are of a nature that the AEMT would be capable of treating. The patient's would benefit with more timely and appropriate care. There would be a monetary benefit as well. Some tier agencies charge the transporting service and in times of tight budgets this is a real concern. Others charge the patient directly and as they are not the transporting service, many insurers will not cover these charges. This can be a real blow to those on fixed incomes or those that are missing work due to their illness. Having AEMT's in our rural communities would help to make EMS a more productive and cost effective aspect of the health care system.

---

I understand that many people have worked hard on this, but I also want to be honest with my comments. I come from a background of starting on a volunteer ambulance in 1995. I helped bring that volunteer service and others in Benton county to paramedic levels. Also working in rural services we utilize the Iowa Paramedic a lot. I think that the development of the Iowa Paramedic was a huge improvement to rural EMS in Iowa and I wouldn't want to lose that. It's a struggle to recruit volunteers and we shouldn't do anything to make that more difficult. Also I wouldn't want to take away any skills that we have given to FR and EMT-B's such as the combitube. We should strive to bring the best possible care to rural Iowans and not decrease that level just because it may be more simple and less confusing to go with the National levels. From my city council and ambulance administration background this is potentially another unfunded mandate. Who is going to pay for these transition classes (tuition, gas, time of work). I would prefer to see Option 2 implemented. I don't know the statistics, but I would imagine this will affect volunteer services the most. They probably are also the least likely to give input on this matter too. Well, those are my thoughts. I don't know how much this will actually

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

affect me at a paid service. I think it will be harder on part time paid paramedics than full time. Full are making a career and will probably do what is necessary to advance.

---

I am writing as a current Iowa Paramedic that works full time at ORHC in Ottumwa. I am definitely one that these changes would have a dramatic affect on. I am excited to hear that there are options. I have looked into the various bridge programs to the PS level. I would love to transition to lessen the confusion for everyone. The only problem is that the only bridge options that I have seen have been at least one year long and also at least 1 1/2 -2 hours from where I live. That is just not possible to continue to work full time and manage class. I would be more than willing to take additional classes at our local community college if they were available. In regards to the new scope of practice outlines, I would not like to see leaving all the levels as they are and adding additional levels. Speaking from experience working at the Iowa Paramedic level at a hospital based ambulance service, it is hard for the ambulance staff to keep skills straight, let alone all the other areas of the hospital and ER. There are very major differences in the Paramedic and PS level here at our facility. Pre-hospital the only skill that I currently can not do that we routinely see done is CPAP. In the ER of course there are a few more differences. I would like to see as few levels as possible to lessen the confusion and to also make things more consistent for those who come to Iowa from other states. I do not however want to try to have to transition with options like the current P to PS bridge option. I have heard from those in the past that transitioned levels at previous times that state they had to do the modules and it worked well. I would like to know more about what the education options might be to make a better decision on the two options. From what Cindy Hewitt has mentioned that has happened in the past the "modules" are not a bad option. As I stated earlier, I would be more than willing to take classes to upgrade to continue to maintain my skills and to add more. I would even be willing to do something similar to the national refresher course, have a weekend course or two to get all the information in a shorter amount of time. I would really like to stay informed with the options and changes to better plan for my future and the future of EMS in general. I am interested in doing what is best for the state. I do not believe that having so many different levels is a good option due to the confusion that already occurs with the different levels. I would like to see an easier transition than the current bridge that is available. Great to hear that you are looking for input from everyday providers. It is greatly appreciated. Anxious to hear what happens.

---

I am writing this letter in expressing my thoughts and concerns with the new Scope of Practice guidelines. I am in full support of Option #1. I feel, as a state, we need to support and move forth with the new guidelines at the fullest level. This means we should make everyone transition if they wish to hold EMS certifications in our state. I feel that as professionals and to be viewed as such we need to fully implement the new guidelines as well making sure everyone is made to transition to the new levels of knowledge and skill sets. There is great confusion in our state as it stands with having two levels of paramedics (Iowa-P and PS). Allowing the current certifications to stand will only further that confusion and compound it!! As a manager/shift supervisor, I feel that fully implementing the new guidelines as Option #1 will create ease for those of that are responsible for EMS delivery and management of personnel. Having numerous different EMS levels will only create increase of workload and confusion for those of us that have to manage certification levels, training, and delivery of critical services. We are already understaffed and overworked, and this will only compound that affect. I am sure that this same type of confusion and workload will also increase at the Bureau of EMS. Simplification is always the better road to take. Option #1 clearly supports that. I want to further state that I like these new guidelines and levels. I feel these new levels are representative at the true EMS levels that should be in the field. I also feel our past at trying to implement different levels and calling them different titles needs to stop. Implementing Option #2 will only further our past at attempting our own agenda and certification levels, which

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

was not the right thing to do at the time. Option #1 is our window of opportunity to now do things right. The National Registry should be held in high regards and utilized as such to be the standard across the nation. We should not attempt nor support doing our own thing. I thank you for your time at reviewing my thoughts regarding this critical issue.

---

I have looked at the model and i have a couple of questions. I am currently an Intermediate. By the model I have two choices, go back to a basic or become the new advanced is this correct? What does the continuing education entail to transition from the I to the Advanced? If I choose to go to the basic, how is this communicated to the state?

---

Regarding the Scope, after reading the proposals, I'm in favor of the first one. Just to be sure, the state will not be requiring any clinical or field time for any level to transition, right? The reason I ask is at NICC a friend of mine is taking the PS class and has to do a lot of clinical and field time. Should he have waited?

---

In response to the scope of practice in Iowa I am concerned about the additional training listed in option one. I am a national registered paramedic, making me a PS here in Iowa. I feel that I should not have to do additional training modules since I'm already a nationally registered paramedic and the state is adopting the national scope of practice. I already fall under that scope of practice. I can understand the additional training for the folks who want to move up in their certifications but me as a nationally registered paramedic would not be moving anywhere so no additional training is required. I don't agree with option two at all and feel it will cause nothing but problems. However option one is not the way to go either because of what I mentioned above. At least this is how I read the two options. And who is responsible for paying for all this additional training? It should not be the provider. It is not our fault the state is changing the levels and scope of practice. We have paid our dues and followed what the state has set up so I feel the state should pay for the extra training needed to get providers up to speed. And who will teach this training? Do we have people educated enough to provide the training state wide in a timely manner? And how will this affect folks who are in the middle of their certification periods? it is not fair to make them re-submit training to re certify. I think there are a lot of answers like these that the state needs to provide answers for. Everything I read in those two options are vague and needs to be thought out in more detail. I hope this helps and I would like a response to these questions and I would like to be corrected if I said things that are not accurate. Thanks for the opportunity to provide comments on this subject.

---

I would go with option 1. Option #2 is too confusing with all the different levels.

---

I would like to forward my response to your proposed changes to the EMS levels. With our service like many in rural Iowa we are approximately 30 minutes to the nearest hospital. We are not a paid service and all of our staff is totally volunteer. The amount of time that it will take to get the new training and testing I believe will force many to quit the EMS field making it harder for Iowa. I am in favor of the option 2 by saving the current levels and moving the new personal into the changed levels. Thank you

---

I talked to Joe already about some of this, but I am going to make it official by emailing you also. What is the time frame going to be for the transition for the Iowa Paramedic to the new National Paramedic scope of Practice? I think that this was put together very well, and I think that if the EMS providers in the state look at previous transitions to new levels of EMS provider that it has been a transition over a period of time and that

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

everyone will have the ability to remain as an EMS provider in the state at some level and it is their own choosing as to where they end up. I think this transition will make the state of Iowa more professional and will keep us in line with the National scope of Practice which will benefit providers if they move to another state as well as making the profession of EMS more professional by having a National standard instead of each state having their own scope of practice. That is all for now, I appreciate the work that everyone has done on this project.

---

Thank you for the opportunity to comment on this very important issue. I believe it not only important, but imperative that the state of Iowa (as well as the rest of the US) adopt the standards as crafted. This includes the four levels of provider and the scope within those four levels. As you have cited under option 1 of your document; current providers have the option of transitioning to these four levels over time. A single standard is consistent with the Education Agenda for the Future and Institutes of Medicine report and other comprehensive plans for EMS at the system level and serves to unite rather than fragment EMS professionals. Further, we are all aware of the many workforce issues facing the EMS community. Adopting this helps to address many of those. Additionally, it helps to achieve credibility and consistency. The process for development and refinement of the Standards has included not only subject matter experts and representatives from nearly every conceivable community of interest, but the general public as well. The process has afforded input and created support for the Standards in a way that was deliberately inclusive and meaningful to all parties. I recognize that there lie some challenges in implementation, but am confident in the Bureau's leadership in facing those. Should you have any questions, or need further information, please do not hesitate to contact me. I look forward to working with you to assure a successful transition.

---

My main concern is that if we need to transition, let's say such as myself, who is at the Iowa Paramedic level, I hope the transition method is something that will be something that will make it easier than taking the whole Paramedic Specialist course completely. I am very interested in doing that, but if we keep changing things every few years or taking away skills, giving them back, then taking them away again it becomes frustrating. Another example of this I feel is the system standards that was put on the county systems that we are required to meet to receive little funding. Sometimes I think that those out in Des Moines forget that the vast majority of the state is volunteer. Then they wonder why we have trouble in our recruiting in the rural communities. A lot of things are being crammed at us and we are expected to meet all sorts of expectations from different people (ie: city councils, health departments, Bureau of EMS, National organizations, boards of supervisors, NIMS, township trustees, OSHA, etc, etc, etc) and we scrape by with limited monies to do so. All the while we are spending countless hours of our own time to make sure our communities are safe. We will do whatever is asked of us, but remember the stress it puts on us and our families who have to do without us while we are trying to meet these new demands.

---

I have had the opportunity to review the Bureau's document on the National Scope of Practice Model in Iowa. While I fully understand that this document and the actual transition will create a great deal of controversy throughout the EMS Community. I feel that it would be regressive and irresponsible if we pursue any option other than option 1 listed in the document. While several have tried to obfuscate the issue by raising the flag that eliminating the "Iowa Paramedic" level will cause great harm to our state, I feel their arguments are unfounded. I believe if we could all remove the emotion and look only at the data that it would be clear that rather than harm we likely are working to protect those who we serve. Others have claimed that there really is no difference in the Iowa Paramedic vs. Paramedic Specialist anyway since they have the same skills. This claim is perhaps true in concept, but extremely unfounded if you look at educational components and decision making

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

abilities of the two levels. In comparison an LPN has essentially the same skills a RN and the Physician's Assistant the same skills as a physician. Their Educational background and decision making abilities are starkly different just as they are between the Iowa Paramedic and the Paramedic Specialist. If we expect to move EMS forward as a profession we cannot be regressive or happy with the status-quo. We must instead aggressively move forward with unity assuring for the safety of the communities we serve and future of those who choose our profession.

---

Being an EMS administrator and educator, it would drastically improve EMS as a system in any locale to have four levels of providers. Currently there is too much confusion about what is in the Scope of Practice for each level. For example, the Bureau of EMS should define what constitutes a Paramedic, and only call that level Paramedic. I have worked with several I/99 Paramedics who lack the critical thinking abilities that accompany the NREMT Paramedic training. It has made me wonder on several occasions if it is safe for those individuals to be administering the same medications and performing the same procedures with a limited amount of training. I have also spoke with several I/99 Paramedics who feel they should be "grandfathered" to the NREMT-P level. That would be a devastating injustice to the patients being treated. It would also be difficult for credentialing EMS providers if we continued with several levels of EMS providers in the State of Iowa, not to mention difficulty with reciprocity. It would improve care provided in our rural areas to have higher trained EMS providers working on volunteer services providing the limited advanced skills. A number of services provide service at the I/85 level. Those services could provide an even higher level of care to the communities they serve. It is sad to hear EMS providers threaten to quit because the Bureau of EMS is "forcing" more on them. If they would consider the improvement in care given to those they serve, they would not feel that way. As an EMS educator, it only makes sense to have four levels to educate. It would be very difficult to keep track of Scope of Practice and who needs what for re-certification. It is my opinion that the Bureau of EMS should make the decision to have four levels of EMS provider, define what the modules will be to get to those four levels, and set a date to have those modules completed. If an EMS provider chooses not to complete the requirements, they choose not be an EMS provider in the State of Iowa.

---

I am deeply disappointed in the Bureau of EMS in that they are going to make us Iowa Paramedics go back and do ride time and ER time when these changes come through. I have been in EMS 11 years and an Iowa Paramedic over 4. I work on 2 rural services and things have been going just fine. Now the Bureau once again without a thought for the patients receiveing care is going to ruin this. The old adage why fix it if it isnt broken is apt here I feel. You are going to make us do ride time and ER time for what? Do the things we have been doing for years? Make us do IVs and Med Admin all over again? That is just asinine. I am seriously thinking of leaving EMS as this hassle is not just worth it. And where are we supposed to come up with the money? We have been put down as a group since its inception and constantly take crap for not being "real paramedics". I can only speak for myself but I know of several other Iowa paramedics who will not bridge up. They are going to quit as I myself might. None of us find it acceptable to have skills taken away. The Bureau didnt even do this to the A's or D's, but once again the Iowa Paramedics get the short stick. Sad! And once again the rural patients suffer. Some solutions as I see it are leave us alone and let us work till we die off as a group or send us to the bridge up classes but no ride or ER time! We have been doing just fine out here in rural EMS but once again the big city medics will get all the say and us little guys out here are going to suffer. Steve Mercer had the right idea and you people are really going to screw this up! Iowa EMS is in a sad state of affairs and I can no longer say Im proud to be part of this community with these asinine and ignorant ideas!

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

I have read through the proposed options and agree that option one would work better. As a street Paramedic and as an educator I have found that there is great confusion about EMS levels already and adding four more would agonize this. One question that has been asked of me is concerning the CCP endorsement. This proposal currently does not address this. Many have asked whether or not the CCP endorsement will continue to be in effect or if it will be integrated into the new Paramedic scope. I hope that this can be addressed in the future. Thank you for your time.

---

This sounds like an okay idea, as long as the transition modules are not too difficult to complete. As EMS coordinator of our department, I have found that if you "throw" too many new requirements at us, it tends to discourage rather than encourage us to remain active. There is always going to be public confusion, no matter what changes are made. Perhaps we should have stayed with the original four, FR, EMT, EMTI and Paramedic.

---

I really think Option 1 Transition would be the easiest. I had to teach modules for EMT's that were from other states and needed the airway module or IV module for examples and it was not a problem at all. The way Iowa laid out the modules with a simple short test made things easy. For example our department has about 100 employees. About 60 are EMTB's so there would be no training needed. About 35 are Paramedic Specialists and no training would be needed. About 5 are EMTI and would need training in some of the modules to bring them up to AEMT. So in my opinion since there are not as many EMTI's and they are the ones that will require the training you are not looking at very many numbers in the big picture. My opinion is Option 1 and train the needed modules is the best option.

---

Having been through the previously mentioned attempt to "transition" from the legacy levels and its difficulties that have left the legacy levels in place I read your proposal with skepticism at best. I have concerns about the process. What is the cost and who will bear this burden? Will there be a better organized and accessible method of obtaining needed models? Will on-line course training with practicals be an option. Being from an area that has a community college that covers a large area with few instructors and long distances to get to a central training site, I project that an en-masse attempt to get everybody on "the same page" will be chaotic and prone to frustration. What will the didactic portion be? The 'old' attempt was poorly managed and implemented haphazardly. Classes were hard to find and clear plan was even harder to understand. I am not against reducing the amount of levels, I am confused as to the implementation or why the need for implementation is being asked? What are you asking exactly? I am REALLY concerned about the "buy in" by the rest of the nation. What guarantee do we have that all 50 states will play by these rules and use the same names for the levels? LPN's & RN's reciprocity is not even a reality across the 50 US states yet, and yet the claim is that this will allow transfer in registry across the 50 states? What is the national timetable should, as it is claimed, a paramedic from IA may work in IL OR vice versa? What will the CEH's be for the new levels? What will the effect on 'basic' units as far as equipment for the ambulance? What if they do NOT want ventilators? What is the projected lifespan of these changes once implemented? What will the training time be? VOLUNTEERISM is already at a low ebb as it is Are we heading back to the days a sparse coverage (at best) and lengthy response times? It seems many ideas are being born and projected for the metro iowa responder and no thought (or PR rather) is given to those in communities that are struggling as it is. I watch as class after class of young EMT's come through the system and leave their rural beginnings because of lack of opportunity why are we not focusing on that? how are these changes going to adversely affect the rural responder? As a parent of 2 young children and full time employed I find training time limited as is And what about those who work night time? Will there be day classes in the rural setting available? ICN offerings? -I predict many fire departments will drop FIRST RESPONDER status as they are already asked to meet increasing time demands for training

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

standards we rely on them heavily, yet there seems to be little or no consideration of the fire service by IDPH. I have already heard that many fire personnel are considering focusing on fire and dropping EMS certifications. AS far as the level names and scopes are concerned Why is the legacy name not going to be utilized in the First responder level? I believe that since this level is essentially unchanged and it is publiclly recognizable it should remain the FIRST RESPONDER registration and name. Additionally EMR sounds more like a CommunityEmResponseTechnician level and not a "professional" rescuer. 9/11, the federal government and the media have used the First Responder name as a blanket over police, fire EMS and paramedics that has lead to confusion in the public.-the EMT might also benefit as remaining as named... EMT-basic or BEMT to differentiate from the Advanced level. Again publiclly recognizable and identifiable. Will the EMT (basic) still be able to maintain IV lines of NS? How can a EMT(basic) transport a VENTILATOR with an airway they cannot place or replace should it become dislodged? Who will initiate said ventilator and via what airway? Do you mean CPAP? I am confused as to why EMT's will no longer be able to place "blindly" inserted airway devices IF you have ever been puked on in a code or recall it, one would appreciate as an AEMT or Paramedic arriving at a scene 10+ minutes after CPR is in progress to find a 'clean' airway to intubate and manage... a consideration if we regionalize our EMS system in iowa down the road in 10 years. On the subject of OTC medications - what ar ethe proposed OTC's - will EVERY medical director let EVERY EMT give EVERY one? PUBLIC comment: if ambulance service A can give tylenol why can't ambulance service B next door? The AEMR is a misnomer if you consider that the public will make the leap that these are better trained 1st responders, but less than an EMT.... AEMT is more appropriate and descriptive. 12 lead interpretation? Manual defibrillation? Morphine? beta blockers? -What will become of the Critical Care paramedic level? That was not addressed. Chest tubes maintenance during transfer from rural hospital to trauma center? What scope of practice in the ER setting will the new levels play?

---

As requested: Commentary regarding changes in the Iowa EMS System As requested I am offering my comments regarding the National Scope of Practice Model for the State of Iowa. I am very concerned about this because I am a service director for a rural municipal ambulance service (Hawarden, IA). To better understand the mentality behind this commentary please keep in mind that we are a small town “provisional intermediate” service. Most of our calls fall under BLS. Our squad consists of 29 volunteers of various provider levels and a paid service director. We run under a limited budget funded mostly in part by fees for service. Most of the fee income is generated from transfers to other facilities usually 40 to 50 miles away. First Responder and EMT B changes: We have found that our ability to place a Combi-tube or King airway has played a critical role in patient survival. Being that I personally started my career in South Dakota I was in awe that First Responders (EMR’s) could use the Combi-tubes and was relieved that the Combi-tube was standard practice for the EMT-Basic in Iowa. I shudder at the thought that this may go away because of these changes. I don’t think too many providers in Iowa have ever faced not being allowed to properly secure an airway because the state limited Combi-tube use, because it was not the standard. I can tell you from experience that it sucks (sorry, no other way to put it) it is like working with one hand tied behind your back and your foot stuck in a bucket. I mention the above because the previously mentioned airways are not listed in the brief description of the “EMT” National model. As we have learned in EMS if it isn’t documented it isn’t happening. Would the state seriously consider taking these skills away from the First Responder/EMR and EMT/B providers? On another note the EMT Basic in Iowa can monitor non-medicated IV’s. This has a tremendous impact on small towns around the state. In our community our ambulance services perform many transfers from our local hospital to others that are 40 – 50 miles away. In other states, like South Dakota, an RN had to ride along to transfer a patient with an IV medicated or not on a “Basic” service. This depletes hospital resources and incurs higher healthcare costs to the patient. I would hate to see this change happen to the people of Iowa. This minor change would drastically

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

reduce our abilities to conduct transfers. Without these transfers we would lose much of the funding needed for our service to stay afloat. If any changes are made on the state level we need to keep these basic abilities for the sake of our patients. Intermediate to Advanced EMT change: Currently our volunteer intermediates can start an IV in the field. This ability greatly increases survival for those in the agricultural community who may become entrapped with a long extrication time in agricultural equipment. Also, please keep in mind that with rural ambulance services we have long stretches of roads with limited extrication abilities. This means that someone entrapped in a vehicle on one of our highways or rural roads has a better chance of survival because of our abilities to start an IV. In regards to this change I have to look at our options if our squad were to be unable to start IV therapy on scene. We could call out assistance from a nearby community who has ALS abilities. Unfortunately, this can take 30 minutes at the minimum, as the nearest ALS service to us is 30 miles away. There is always the helicopter, that option is only viable if weather permits it. While statistics and numbers may convince people that most services do not need this ability I beg to differ. Being service director and training coordinator for the Hawarden Ambulance I become a 'human pin cushion' once a year because of our IV use and monitoring training. I can honestly say that those who have stuck me are very capable of using this skill in the above-mentioned situations. I would hate to see this taken away from them, as I don't think I could convince them to take a long and tedious "bridge course" to maintain this skill to work in the volunteer realm. Other Changes: While I understand that interoperability and standardization is important in the emergency services realm, every state, county and service area has it's own needs. I hope that those needs are taken into consideration as these important items are decided upon. However, it seems to me that most of these changes were sought for recognition of those in the EMS realm. For example there are some that do not like being referred to as an "ambulance driver" or some feel there is not enough credibility without some sort of degree in "para-medicine". Some are seeking a better income because of "higher credibility". I'll admit, I have been called everything from an "ambulance driver" to a "doctor" on a scene and was never bothered by it, maybe because my focus was patient care and not my title. I wonder however, has anyone heard any requests for change from actual patients? Have the sick, injured or just lonely "frequent fliers" said anything like "what do we call them?" or "they should have a degree to do that sort of thing". I have not heard anything from that from our patients. In fact the only things I have heard from our patients is the occasional "thank you". I always thought the reason we do this is for the patients, not for credibility or recognition. Thank you for your time, I have been a Iowa Paramedic since 2000. I took the very first class that was offered, I volunteer on a fire dept where 90% of our paramedics are Iowa paramedics. I feel with this change it is going to hurt the community. I feel that this change might make things easier on your side with 4 levels, but I also feel that if this takes place, I know for a fact our fire dept and our community will suffer plus a lot of others. Volunteer services have a hard time now keeping people and they keep changing and wanting more. Don't get me wrong I don't have a problem training learning is a good thing. but you have to see our side to, I have been certified in ACLS for 8 yrs and running codes, and pushing morphine for when my pt's are in extreme pain. And now all of a sudden I am not going to be able to do these things. My opinion is this. the people that have been functioning as Iowa Paramedics should still be able to do the skills they have been doing, and have been trained to do. If you want to get rid of the Iowa paramedic then that is fine, don't offer that class no more but leave what's done alone. I got on to help people in my community I think it would be a shame if all our Iowa paramedic on our volunteer fire/ems dept which is 90% could not function as paramedics, or at least do the skills they have been trained to do. I would just like to put feedback on the changes that might happen to the certification levels in Iowa. I am currently taking the Iowa Paramedic program. and im not very happy to hear that there is a possibility that you might be taking this certification away in the near future. I really dont think it is far. I just think that if you make changes that you let the people that already have the certification keep what they have and still be called what they are. the Iowa paramedic is a

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

very popular certification in dubuque iowa. all im saying is that if it ends up being taken away, the county will loose a tremendous amout of Paramedics. so i guess what im saying is that i like Option 2 ( add new levels) we should still be what we are certified under the levels.

---

I am an EMT – Basic. I would like to express my opinion on the implementation of the new National Scope of Practice. I have reviewed the IDPH Bureau of EMS document, as well as the actual National Scope of Practice as written on the NHTSA website. I believe that a national standard is needed for EMS across the country. Events like Katrina and 9-11 make it very clear that current practice of states being able to have their own certification levels makes response help from other states confusing, and possibly dangerous. The concern I have is how it affects us in small town rural Iowa. I live in the town of New Vienna (population 400), and work in Epworth (population 1,400). I am on the Fire Department and EMS crew in both communities. I respond to New Vienna's calls at night and weekends, and Epworth's during work hours. I also am the Chairperson of the Board of Directors of Bi County Ambulance in Dyersville Iowa (population 4,000). Being involved with three EMS services in the area, I see challenges that all three face on a daily basis. One of the biggest challenges that we face in the rural Iowa EMS system is volunteer recruitment. We do not have the luxury of having full time paid EMS staff to be on call 24/7, therefore we must rely solely on volunteers. The biggest hurdle we have to overcome with volunteers is the level of time commitment favor training, and continuing education. My concern is that if we take skills away, or make individuals test up to a higher level to keep their skills, that we will loose highly qualified, skilled EMS providers due to a lack of time to be able to commit to 'module up'. In this immediate area we rely heavily on the Iowa-Paramedic. One of the biggest reasons that this level of certification has been proven very successful is that it is not an unreasonable time commitment for many volunteers with full time jobs. I think we are facing a crisis in rural areas that is just starting to express itself. Our ability to draw volunteers from our local communities is fading. Where we once had waiting lists to get onto departments, we now have vacancies. People don't seem to have the time to commit with today's demanding jobs, entertainment options, and family obligations. I believe that at the base of this discussion needs to be a true thought of the quality of care we are able to provide as EMS personnel. Do we want to loose Iowa Paramedics due to an additional commitment for the volunteer to take more tests and modules to be able to do some of the things they have shown that they are able to do successfully now? I'll give you an example: If we get a full code in rural New Vienna now, New Vienna First Responders are dispatched, along with Holy Cross Ambulance. New Vienna gets on scene first and starts CPR along with Defib. Holy Cross Ambulance then arrives on scene and the Iowa Paramedic starts an IV, and runs the Code with drugs available to them currently while transporting. Life saved due to drug access by an Iowa Paramedic. If the National Scope is adopted and the current Iowa Paramedics do not have the time, or choose not to take modules and tests to become a National Paramedic, they then drop down to an Advanced EMT. If we run with the same scenario, when Holy Cross Ambulance shows up, they now only have an Advanced EMT on scene. We still do CPR, and Defib., but now the patient will not receive drugs to potentially save his life for 15-20 minutes while he is being transported to the nearest medical facility. Life lost due to length of time heart not functioning. We recently had a full code save due to the skills and drugs that an Iowa Paramedic can give to a patient. It would be a shame if that patient was not given the same chance of survival due to us wanting to make EMS classifications simpler. I would suggest that much thought is given with how to handle the existing classifications, and that we are careful with the time requirements we ask of these volunteers that are so valuable to the rural EMS system. I am not sure what the best solution is at this time, but please keep the time commitment for training and continuing education in mind that these volunteers are being asked to complete. They are essential to survival in our area.

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

I have been waiting to see this document in the making from IDPH. As an Iowa Paramedic I most assuredly have interest in the outcome of what is decided. I have several comments and concerns over what the IDPH wants to do. I hope this email will not be too long in nature, but...First, I frankly do not think that any of us have enough information from the IDPH to make a truly informed decision on what the future of us providers will be. The Implementation document lacks several points. If we are to decide to go with option one, what timeline will all of us have to decide to move up or down a level? One year, two, three?? If all EMT-I's and EMT-P's were to decide to move up I don't think it would be possible as these two groups together account for about 1700 providers (Jan.2008 numbers from IDPH). The training programs would be overwhelmed. It could not realistically be done in two or three years. My worst fear is that many would just say to heck with this and get out of EMS all together. This would make an already lack of providers even worse. I have heard some say that this is what they might do. Another concern. How is it that in the National Scope of Practice that the "new" EMT's cannot insert a Combi-tube or King LT? I see no mention of these devices in that document. It only states they can use oro-airways or naso-airways. Step backward in my opinion. The Iowa Implementation document warns against migrating skills from one level to another. Are you willing to migrate a skill from the AEMT level to the EMT level? See page 31 of the National Scope. It would be nice to have at least a working idea of what IDPH plans to have for a skill set for each level BEFORE a decision so vital is made. I had asked Joe Ferrell about being an ALS service. The question was if you have AEMT's on your service would you still be considered an ALS service. His answer was "Yes". If this is so, how is it that I can currently cardiovert, pace, and push frontline ACLS drugs now, but at some date certain not do that anymore? This would not be an ALS service, would it? Once again we need to see the skill sets for each level. What about cost to the provider if they choose to transition up? Is the State of Iowa going to come up with the funds to help with this. Many Iowa Paramedics who work in the Emergency rooms would have to spend a large sum of money on a shoestring salary just to keep their jobs. Do you realize you would be putting many people in jeopardy of losing their livelihoods? Once again this would over-stress an already over burdened EMS system. Option 1 in my opinion is not a workable solution. Option 2 would be a better way to go if this is to go through. We should keep the levels we already have and not start taking skills away from those who have already practiced them for years. Start to bring the four new levels online when ready. I'm sorry, but I don't buy your argument that the public will be more confused than they already are. Jeez, people already think we are just "ambulance drivers" or we are all Paramedics. The public has very little idea of what it takes to run or be on an ambulance service. Adding new levels does nothing to change this. I also am relatively sure that us service directors can keep the levels straight, as can most other healthcare providers. And as far as the terms "Paramedic", "Iowa Paramedic" and "Paramedic Specialist" what does it hurt to keep them? You can role the Paramedic Specialist into just Paramedic and change the scope of practice to the National Paramedic. By IDPH admission they are very similar anyway. The three legacy levels account for only 50-60 providers and I would bet most of those no longer are practicing anyway. Those could be done away with if there is concern over too many levels. They were given their time to advance or not. Just look at how many different levels of RN there are. I hear no complaints that there are too many RN levels. I will hold Mr. Schmitt to his word at the Code One conference in Cedar Rapids last year. He said at that conference that nobody at IDPH wants to take any skills away from them. On another note, nowhere in the document does it address the PA and RN exceptions. Would we be able to keep them? I have several RN's on my service. If they could no longer practice in the EMS field our service would be greatly affected. I already have a hard time keeping things staffed with limited responders. The proudest day of my life, (next to marriage and having kids of course) was when Joe Ferrell shook my hand and said "Congratulation, you passed your practicals on the first try, you may take the written". Don't take those feelings away from me and others who have worked and continue to work so hard at maintaining our skills. Just wanted to let you know that I am in favor of option # 2, I know this would create more of a headache for the

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

state, but the volunteer aspect is what I am after to maintain the same. The state levels would be FR, EMR (National EMR), EMT (National EMT), EMT-I, AEMT (National AEMT), EMT-Paramedic, Paramedic Specialist (National Paramedic) The PS is a national paramedic now, for instance if you get your '98 National Registry Paramedic then you come into Iowa as a Paramedic Specialist. Taking away skills and making some of these volunteers that have already done more than they wanted to, to help their communities is severely wrong. If this were a state that wasn't mostly volunteer, then maybe there would be another way to do this. Considering the population of the 20 largest cities in Iowa is only a mere 1,144,834 which is an average of about 57,000 per city, this is less than half of the population of the entire state, we need educated volunteers and we need to keep the ones we already have and not make them have to choose.

---

I like Option 1. It is cleaner and it moves us to the National goal. I am not sure the National Registry (NR) should be the only provider of a National Exam. It gives them too much power. But there should be a National exam that is the same for everyone. I know it takes time and money to write and maintain a good exam. So I suppose that the NR will end up providing the test. I just hope they work on their "We are the Gold standard attitude". Once we are ready to do the change and everything is ready we need to do it within 4 years. I do not like option 2. There are already ways to many levels in Iowa. Most of which can not provide care in an ambulance. Get rid of them, make your job easier.

---

Just my opinion but I think we need to down size the amount of certifications available in Iowa. There are too many and it is too confusing, we should all conform so that it is also easier for people coming and leaving the state. Of course, this is easy for me, I am just finishing up my Paramedic Specialist class and hope to be done soon. Quick question too, so there would be the "first responders", Advanced EMT's and Paramedics then, only the 3 different levels?

---

Anita the option one which means, having more training to meet the new level of experience from FR to EMR certification level for example. This would make paper work a lot simpler for everyone that has to keep track of in all departments of EMS.

---

I have read the 6 page pdf on the Bureau website from QASP. Have a question specific to the current I-99 (aka. Iowa Paramedic) As a service director I fully understand options 1 and two when it comes to how many levels of EMS providers we have in the state. My issue as a rural provider is to what will happen to the I-99 under Option 1 in transitioning. We have several providers at the I-99 level that could have a potential issue if their only two options are to: A. Transition up to the new Paramedic B. Drop back to the new AEMT level I understand that when the new standards become effective that there will be no more new I-99 classes. My lack of understanding is why apparently the legacy levels of pre-1995 FR, EMT-A and EMT-D are going to be allowed to continue to maintain their level, but apparently the I-99 do not have this option? This will impact our service and our community, in the realm of the AEMT not being able to utilize their cardiac monitoring skills and utilize cardiac medications, if they are not allowed to maintain their level. As far as the issue of confusion I believe most if not all current paramedic specialists will transition to the new Paramedic level since this is through continuing education that would still leave the "Iowa Paramedic" designation for the current I-99s until they drop from rosters due to attrition as the pre-95 FRs, EMT-As, and EMT-Ds have done since the 1994 to 2001 transition period.

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

I agree that we have a lot of levels for emergency care providers. I also agree that we still have a declining number of folks in Iowa EMS. If we are to retain current providers we need to make it as easy as possible. Forcing them to move would in my opinion drive another nail in the coffin of Iowa rural EMS. As far as the issue of the three paramedic levels, How about steps in the Paramedic level such as Paramedic 1,2 or 3.

---

This is in regards to Iowa EMS Recommendation. The EMT-Basic has a very important role in the EMS system as the first transporting level of EMS. They chose where the patient goes for treatments but they are currently very limited on their skills. Iowa has stayed ahead in EMS for a long time but they are starting to fall behind some other states. EMT-Basics have to know the actions and reasons for Albuterol and Nitro but they cannot carry it and administer it. Several states have started letting EMT's carry and administer these life saving drugs with excellent benefits. Why wait for a Paramedic for an asthma attack if the EMT has the knowledge and ability to administer a treatment which will help them. Why wait for a Paramedic for someone having severe chest pain when an EMT can provide treatment with nitro while the ALS unit is in route. Also another very simple and very helpful treatment is BiPAP and CPAP. I think Iowa should see what Wisconsin is doing and follow in a similar pattern. Iowa relies on BLS Services to provide treatment for ill and/or injured people in the rural areas. EMT-Basics can maintain an IV but cannot start one? What's the reasoning? I think that EMTs should also start IVs, make that a required training within a year and start covering that in the basic classes and 24 hour refresher courses. Allowing EMTs to start IVs would provide better patient care. The requirements would be the same as for all the other levels minimum 10 successful sticks in the hospital and/or Field with a RN or Paramedic supervising. This would also eliminate the EMT-I and just allow them to be EMTs. These are just some ideas that would really make the difference in the outcome of some patients. This would also allow Iowa to once again lead the EMS community. Thanks for your consideration,

---

The question I repeatedly have come up in conversation is, "What about counting field time as education hours for the transition?" Now, understanding there is no replace for classroom education, but why wouldn't time in the field count for at least a few hours. I understand that is probably not an option. Second, give a generous amount of time and allow transitioned PS's who are not EMSI's to teach the modules within their own place of operations. Maybe to make the transition smoother it could be treated as continuing ED. Allow it to be taught in house by instructors who are more familiar with their fellow EMTs. Also consider allowing other Paramedic Specialists to count the hours as formal training hours. Sometimes when "good ole' Joe" is teaching hard feelings are not developed, because everyone feels as equals in their own EMS System. More is absorbed than an "Instructor" attempting to force knowledge into an EMT's head. Some of the EMT's become very sore by being segregated and "looked down upon" by not obtaining their PS. I am not saying this could happen, but I know a few people who are very upset about this situation and refused to become knowledgeable about it due to the fact they feel segregated. We all do the same thing. If these non-EMSI educators, who teach within their own place of operations are allowed to take on this huge responsibility will the material, in a digital format or otherwise (such as power points, books, etc.) be provided at no or little cost or will there be such a cost that a smaller service will have to send their EMT-P's to the local community college or otherwise to obtain the needed curriculum? If non-EMSI's were allowed to teach in house I know I would be more than willing to help my colleagues make the transition after I have completed my needed course(s). A lot of us are willing to do so. I do not envy you in this time of transition. Good luck. I will try to help, ask questions, and keep informed in the weeks and months to come. Thank you for your time, it is much appreciated.

---

I took the time out of my workday today to review the proposed Scope of Practice that will likely be implemented in one form or another, soon. We (Titonka) like many rural Iowa units are 100% volunteer. Like

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

others, we face significant staffing issues. Recently, we signed an agreement with the Algona service to serve as back up transport for our day shift calls since there are only three EMT on days, we are all “old timers” and we are all working people with responsible jobs. It is only from “our” perspective that I can offer comment. Overall, I can see that the idea of “grandfathering in” us old farts and ending up with multi-levels of certification would be self-defeating on a national response level. Confusion would likely result. ON THE FLIP SIDE: I can absolutely assure you that if the training modules to update our certification from EMT-B to EMT in the proposed scope of practice involves a significant number of modules, our people with 15 and more years of service will simply retire. That will virtually eliminate ½ of our crew, possibly more. Frankly, that is what I believe the outcome will be. I can't see any other way to make this change but to put the burden of additional education on these volunteers. I don't know if you will understand this, let alone agree. I worked in city government for 12 years and have been in EMS for approx. 18. Now I am the “boss” at our small town newspaper office. I am watching this community and others of its ilk lose on one arena and then the next. We fight to retain our schools, we fight to maintain our Main Streets, and so this is just one more hurdle. We aren't city folk, or even big town folk and we are not alone. What we are is 22-25 miles from the closest county hospitals (Kossuth and Hancock) and 25 miles from the only other service that has enough hardware and enough recruits to cover us (Algona). They are excellent people, bar none, but in those instances of needed immediate care, they are too far out. Perhaps they might be willing to operate as a first response team, but I think most will simply throw in the towel. They've been there and done this at least once already. The only other comment I might make is this: By the time the new Scope of Practice becomes a reality and the timeline is generated for implementation, we may already be on our last leg without fresh, committed people. Without a crystal ball, I must refrain from making a firm prediction. A lot can happen between now and 2010. One question: How much education to retain EMT status? That's the first thing my crew is going to want to know.

---

After 24 years in EMS, I would believe that just four service provider levels is the best answer. I have read and heard much about the new scope of practice and I have to say " It's about time !" As a director, teacher, and an EMT -B, it is beyond my understanding why Iowa already has 7 level. If people want to stay active in EMS - they need to get off the fence. What is the point of keeping (for example) your EMT - A certificate if you can't perform to the level of your service (providing your a B or above unit). As EMS providers we want people to take us serious and treat us like professional, but our system is seriously flawed and you never know what level of care you will get. I am not crazy about the laws being governed by national as what works in New York City is not going to work in rural Iowa, but the basic level of care should be the same. I am not planning on leaving, but if I did leave or went to another state to help with a disaster, I should be able to go to that state and they and I could both know what kind of care I could provide. Uniformity is the only way to accomplish this. I do hope if they go this way, that they will allow step up course for those that are willing to make the step. As a volunteer rural area ambulance service, it is hard enough to get volunteers, without taxing them with a ton of new classes. Some will quite and for those that have been on for a good number of years (I have one on crew who has been on 30 + years) if they are not step up classes we will lose there dedication and knowledge. This would be a terrible tragedy for Iowa as we are mostly rural and if I remember right a good number of them are volunteers. We have a couple county wide ambulance services in neighboring counties, and I believe them to be a huge failure. Patient care has been compromise on several occasions. If we make the rules so hard to comply with that we squeeze out the volunteer services, what will we be able to offer our patients. We will be able to save money (patients will be bill the same) and they will have longer waits for transport. I do not believe that Webster County will ever go to this, but if National does not allow for the states that have rural volunteer services, Iowa could be in for some very big headaches. This, of course, is just my opinion on things. I have

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

encouraged my crew and all of Webster County to give their opinions. I hope you receive a lot of really good input.

---

I have read the information provided regarding the change in status of individuals currently holding certification in the state of Iowa and the proposed changes to a national system. There are a number of interesting issues that surround such a move, and I would recommend the following: If we are going to go to a national system that is standardized, then let's do it. It is confusing to have so many different levels of certification in this state. The waters simply get muddier as we go along. To add the national certification system as another four entities in addition to what is already there seems more cumbersome, more confusing, and there is no added benefit. Let's have a standard national term, educational level, curriculum and use it consistently. It makes the most sense in the long run. As far as moving individuals from one category to another, it was successful with the transition from EMT-A to EMT-B. Use the same template with a timeline, determine the didactic and psychomotor skills that need to be completed and transition. Some individuals may transition to a different level, but that is not necessarily a bad thing. That is my two cents worth. Four levels of certification which match the national standard is my vote. Thanks for taking the time to listen.

---

Hello: I am an "Iowa" paramedic from Allamakee county. I agree that we need to adopt to the national standards levels, I feel that what the questions that I hear is education. I am an evaluator and an educator and I hear lots of comments about "retaking the paramedic course to become a PS". I do not have the answer of what, where, or why. I hope that experience is taken into place when the education standards come out. I would not want to pay a school like Hawkeye 3500\$ for course that has the state P in it with the addition of the few skills. Also I can not see taking a year worth of clinical to succeed that. I believe the state P is a great thing for the rural areas and the volunteer services, but if the transition was fair, then I do see the advantage of the PS. I have worked in both the volunteer levels and the career levels along with the hospital based and the fire based, so I understand the questions at bay. Feel free to contact me with any questions or for further input. Thanks for all of your hard work and dedication.

---

I would like to provide my input regarding the National Scope Model. As the service director for multiple towns it's been difficult to find many providers that are above the current EMT-B level, let alone an experienced EMT B. It was my understanding that the I/99 program was intended for a "quick fix" to provide advanced care for rural service. Not having any I/99's on my service I don't have to worry about losing any, but now I have to worry about recruiting them. I am aware of some services where the current I-85 plays a huge role for their service. It would truly be a travesty to lose both the I-85 and I-99 levels. I imagine that it would cost the IDPH a substantial amount of money to maintain these levels. However, I foresee enormous simplicity with Option 1 where everyone would have to be one of the four levels. Your rural services must be heard and their opinions must be noted. I for one would much rather keep the current providers as is and add the national scope. I would however give every single active provider the choice to bridge up or down to the appropriate levels. So currently my choice is Option 2. By making I-85's convert to EMT and I-99's to AEMT you are doing their communities a disservice and ultimately taking a proven competent provider away from the patient and potentially cause traumatic harm to the patient when someone has skills they are trained in, and taken them away. I fear there would be a public outcry should they have found out that one day someone could have provided ALS care and then next they would not be able to administer any cardiac drugs. I thank you very much for allowing me to submit my comments.

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

I read the proposed EMS levels revision and found that if we use option 1 it may take a little longer but we would not have the confusion of so many different levels of care during the transition. I do think that the time frame for providers to move up or down should be shorter. ( the revision that we did back in the 90's gave them 7 years to complete. I think that is too long. Most people will do it whenever they have to and if you give them 7 years they will wait until 6 ½ years to start. If you get all of the curriculum and books available and then start the process it should go smoothly. I think that moving toward a unified level across the country is great. We need that standard of care from state to state. Let me know if there is anything that I can do to assist you with this project.

---

I'm just responding to put my little bit of input in on the new scope of practice. I think that this decision is long overdue and will help standardize patient care. As a current EMT-I and soon to be RN grad I think that we should adapt to the new standards and require a transition instead of just adding to the current levels. I think that adding the current levels would be far too confusing. I just hope that the transition time to move up to the next level would not be too lengthy as it may detour many from doing so. One question I have is would this effect RNs who plan to work EMS pre-hospital? Would Iowa keep the current policy for RNs exempting over to paramedic level?

---

After reviewing the National Scope of Practice Model I believe a national set of standards would be very beneficial for the state of Iowa and EMS on the national level. The only concern of mine is what the transition classes will consist of. I have completed three EMS courses (EMT-B, EMT-I) and currently hold the certification of Iowa Paramedic (EMT-I-99). The national or state transition classes need to be looked at carefully or some providers may choose not to transition to the next level or leave the EMS field entirely, especially in the rural setting where we cannot afford to loose EMS providers. I will be watching the IDPH website for updates. Thank you for your time

---

I am the nurse manager of Emergency Services at Trinity Regional Medical Center in Fort Dodge, Iowa. We have a hospital based paramedic ambulance service that is based in our ED. I am writing to you in regards to the proposed changes if Iowa were to adopt the National Scope of Practice Model. I am in agreement with having standardization across the states and to narrow the certification levels. However, I am quite interested and concerned with the transition period and the educational requirements that will be decided upon. We have 35 staff members on our ambulance and they range from EMT-B to Paramedic specialists. I am concerned with the transition of current EMT-I and Paramedics. Hopefully this transition plan will be organized and easily facilitated for current EMS staff

---

I read through the documentation and I think that if we want to go with a National Scope of Practice, we should implement it completely, and not use 9-13 different levels of EMT's. Our Service is an Intermediate Service, and I think you should start providing education so that we can ALL upgrade to the new levels. I understand that this might take some people out of the EMS industry, but the people who are truly dedicated to this profession, should be willing to improve their skills, or lower their skills to a level that is comfortable to them. I will pass this on to my crew, and tell them to read about these new levels, and encourage them to send their comments on to you.

---

I have reviewed the document and I think a middle ground between complete grandfather status for Iowa paramedics and an additional year of training to become a National P is preferable. Having instructed for years

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

and being a paramedic that was trained in '85, now as a nurse I think some additional module training would cover the transition. I could see an anatomy and physiology addition to the training. If the person had completed college level A and P that could suffice as well. Years of service should also be considered and type of service as well. As was done with the last change we must also look at what is being done to patient care during this transition. A precedent was set the last transition. I believe it was a 7 year period. This worked well then and could again be the goal. Many EMTs have let the certification go due to difficulty keeping up with training requirements. A middle ground must be found to suit all the needs. Financial burdens on hospitals, ambulance services, fire departments and EMTs are a reality right now. This should be a positive change, not a burdensome one.

---

I am truly disappointed at the way Iowa paramedics are being treated. They are being downgraded and can no longer be called a paramedic. The idea of the Iowa paramedic class was to establish paramedic skills where they wouldn't normally be, in the rural areas. I took the Iowa paramedic class and have been employed as a full time paramedic for the past 6 years. Now you want to take my job from me and call me an Advanced EMT. Thanks a lot!!! I am currently in school for Respiratory Care, not only because being in EMS doesn't pay very well, but also because of the IDPH. They will kick us in the back and continue to ruin small and volunteer services, with restrictions, and taking away the paramedics. The best thing that could happen at this point in time would be a two week course and Iowa test, to bring the Iowa paramedics to the level of Paramedic. It should not take longer than two weeks and should not include a national test, unless the IDPH is going to pay for it. I would also like to add that in the Rural areas we need EMT-I's. They play a vital part in traumas and many other calls. We cannot lose the EMT-I's. I feel we need to grandfather the Iowa Paramedics to the Paramedic level at the discretion of the medical directors and keep the EMT-I's. Just imagine having a car accident in a rural area like Wellsburg on 4 lane Hwy 20 and the closest hospital is 20 miles away with the nearest Paramedic level service being 30 miles away because you took away our Iowa Paramedics and EMT-I's. We would no longer be able to provide the services we have been providing and our patients would suffer greatly. You need to look at the state of Iowa and see that not every town is within 15 miles of a Paramedic level service or hospital. We don't all live in Des Moines, Waterloo, or Iowa City. Iowa has a vast amount of rural areas, and it will greatly effect us.

---

Im sure there are reasons for everything but as a Field provider for many years now I have watched changes occur over the years and not only is the public very confused but many providers are as well. Why did we ever change in the first place. It really used to be so very simple, and has become a nightmare over time. When we had FR, EMTB, EMT I, and EMTP everyone knew what each level did now the current levels are so messed up. Now we are adding more for more confusion and it also states the Paramedic will now be the highest level which really speaks nothing to all those providers that have obtained the PS level not to mention the CCP'S. I know im am a very small opinion but I have listned to many providers complain over the past years and this will just fuel the fire even more.

---

I am writing in response for public input about the National Scope of Practice Model for Iowa. As a Critical Care Paramedic I have concerns about implementing 4 new levels into the state of Iowa system. I would feel this would not only cause considerable confusion amongst the public (which I thought was one of the reasons for the scope of practice model was to lessen confusion) but also among ems services, medical directors, and hospitals. I also feel this would cause a significant amount of discontention among current providers who would feel they are now inferior to the new levels. Or vice versa the new levels feeling superior. I would encourage the transition of current levels into the 4 new levels. I feel there would be a lot of complaint from members in volunteer services who would feel the additional time and training would be a burden. However I feel in the

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

long run this would be what is best for the state, the EMS members, and the public. I think if the training is minimal and takes into consideration the amount of knowledge already possessed by the current levels then the vast majority would be willing to transition into the new levels. Thank you for taking the time to hear my concerns and opinions.

---

I like the way the National Scope of Practice is outlined. I personally don't have the time or resources to become a Paramedic Specialist. In our small town, we average about 80 – 100 calls per year, with only about 10-20 of those being a true ALS situation. I work out of town, (but close enough to respond if necessary) about six miles from the station. If I make 50% of the calls I would be on about 5-10 ALS runs a year. I would not feel comfortable as a full PS. I would, however, like to advance to an AEMT. I am an EMT-I currently and would enjoy the advancement of a few non-cardiac drugs as proposed. I work part time for a PS unit, and have been in EMS for 28 years. I have seen what D-50, albutol, and epi can do, and I believe it would make a huge difference in our little town. Time is always against us in these situations, and I think this would make a huge difference in the lives of our citizens. I would like to know what is proposed for the hours required for a bridge class, and what the proposed cost will be, as our department has limited funds for training. If the cost is held down, I think the state would see a much larger response to up-grading, rather than down-grading. Our state needs more advanced EMT's and I think this is a good time to jump on board with the National Scope. The other thing I would like to see happen, is to push this along rapidly. If we wait 3-4 years for implementation, I believe some responders will lose interest. Just my opinion. Thanks for taking the time to read this.

---

My name is Robert Davison and I am the Paramedic Department supervisor for the City of Forest City. After looking at this document I am happy to see this coming into effect. We have too many different levels and we need to get everyone on the same page. I believe very strongly that when this gets put into effect we need to go with option 1. I feel that going with option 2 will be a great disservice to our services and state. Option 2 would just add more levels and make things even more confusing. We need to narrow our levels down to only the four mentioned. There may be some who will balk at having to take more of the modules as listed in option 1, but the benefits of Option 1 outweigh the benefits of option 2. I feel that those people who will have a problem with Option 1 will do so mainly because of having to take more classes. This would be a defeatist attitude on their part and only projects the amount of professionalism they truly have. Please go with Option 1.

---

The first option makes the most sense to do but my concern is the training required to move up. As the current transition class to move from EMT-P to EMT-PS is longer than my original EMT-P class it keeps people like myself from moving up. I am a career fire officer on an EMT-B service but I also work for a local ambulance service as a Paramedic. I also volunteer for my local fire department ambulance. My original paramedic training cost me a lot with missed hours at my second job. I am the only paramedic on the volunteer service at this time. The volunteer department also has 1 EMT-I who works long hours at his job. If the transition is long requiring the review of our current skills people may decide not to take the additional training and drop back a level. This will hurt many services and the care available to our patients. The transition done about 10 years ago from EMT-D to EMT-B worked great. Just teach the people the new skills do not review the whole class again. Remember many budgets both city and person are tight and people and services may not be able to take time off to do a lot of training or it may put a great burden on budgets. Thank you for your time.

---

I am writing this letter in expressing my thoughts and concerns with the new Scope of Practice guidelines. I am in full support of Option #1. I feel, as a state, we need to support and move forth with the new guidelines at the

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

fullest level. This means we should make everyone transition if they wish to hold EMS certifications in our state. I feel that as professionals and to be viewed as such we need to fully implement the new guidelines as well making sure everyone is made to transition to the new levels of knowledge and skill sets. There is great confusion in our state as it stands with having two levels of paramedics (Iowa-P and PS). Allowing the current certifications to stand will only further that confusion and compound it!! As a manager/shift supervisor, I feel that fully implementing the new guidelines as Option #1 will create ease for those of that are responsible for EMS delivery and management of personnel. Having numerous different EMS levels will only create increase of workload and confusion for those of us that have to manage certification levels, training, and delivery of critical services. We are already understaffed and overworked, and this will only compound that affect. I am sure that this same type of confusion and workload will also increase at the Bureau of EMS. Simplification is always the better road to take. Option #1 clearly supports that. I want to further state that I like these new guidelines and levels. I feel these new levels are representative at the true EMS levels that should be in the field. I also feel our past at trying to implement different levels and calling them different titles needs to stop. Implementing Option #2 will only further our past at attempting our own agenda and certification levels, which was not the right thing to do at the time. Option #1 is our window of opportunity to now do things right. The National Registry should be held in high regards and utilized as such to be the standard across the nation. We should not attempt nor support doing our own thing. I thank you for your time at reviewing my thoughts regarding this critical issue.

---

To Whom It May Concern: I am a strong advocate of Iowa switching to the National model for Emergency personnel. However, I feel that allowing the existing levels in Iowa should be allowed to continue practice after the national curriculum has been implemented. Once the standards have switched to the National model, I feel that current levels in Iowa ( I-85 and Iowa Paramedic) should be given opportunities to convert to the national model. Iowa intermediate to AEMT for example, by way of bridge courses/modules and an exam as stated in the proposal. In a nutshell, allow the continued scope of Iowa providers, while making bridge content available for those who wish to switch to the National model. Thank you for your time!

---

I have browsed through the new model attempting to align Nationally. I think it looks great, but have a question as to what would be included in the con ed for PS to Paramedic? Maybe this has not been addressed yet, but more directly just wondering if a CCP endorsement covers that con ed? But all in all it looks great, great work.

---

Here are my thoughts on the proposed scope of practice: I can see where having a national standard that is the same everywhere would be nice, but not every location is the same. Some areas are very rural and then others contain many large cities in its self. Trying to make everyone follow the same standards will be very trying in the least. As far as the new proposed levels, this is the way I see it. First responder doesn't really change. The EMT-B loses the skill of combi-tube. As an EMS instructor, I find that the combi-tube is not all that difficult to teach and master. The EMT-I would have to lose the combi-tube and IV's. They have been trained to do these skills and I find it hard to believe that we should take them away. The EMT-P (Iowa Paramedic) this is where I fall into as far as my scope of practice. They stand to lose the most in this scenario. No longer can the intubate, they cannot give some of the lifesaving drugs that have been in their protocols since 1999. Needle decompressions is another skill that is taken away. I agree that we do not use all these skills everyday in our rural setting, but if it was just that one Pt. who needed these, I want to be able to assist. This is also why we have continuing ed. Classes to help keep our skills up. Along with ACLS, PALS, PHTLS, PEEP are all classes that I have taken and passed. I DO NOT WANT TO GO BACKWARDS. I feel that most all Iowa Paramedics and I have worked hard to accomplish our certification. Losing skills is not the right approach. EMT-P they do

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

not seem to have much to lose. I would like to point out that the EMT's that took the course prior to 1999 (I believe but the date may be incorrect) did not learn RSI, 12 Lead interpretation. Yes, they probably had more anatomy but their skill levels do not vary much from that of an I-99. They were "Grandfathered" into Paramedic. This is not really having the same scope of practice as a new paramedic since 1999. I could and would do some modules to become a Paramedic if the skills I was taught were the same as ALL other paramedics. It is my belief that paramedics before 1999 would also have to take these classes to keep us on the same level. Do not forget that ACLS classes would have to be redone, as I will not learn anything that is out of my scope of practice! Also, I think they should fit the setting we practice in. RIS in the field in rural Iowa maybe to advanced for our medical directors, and possibly me. I want you to know that I worked hard to get where I'm at today and would be very unhappy at any changes that would cause anyone to lose skill levels. If we started teaching the new skill levels as presented that would be fine and in about seven years most all EMS would be to the new level figuring that the turnover rate would assist you with this. There would be a few die-hards still in practice but I think this would happen. Start with the new and keep the levels as they are now.

---

I Currently am a registered nurse and volunteer as an EMT. I function at the I level and enjoy this current role with EMS. The rest of my crew are EMT-B's. We struggle as a service to get enough people to become EMT's and if you have to go through even more training it will decrease the already struggling volunteer services throughout the state of Iowa. I question if it is truly a problem. If it is not broken, do not try and fix it, leave it alone.

---

Hi: I would just like to take a minute of your time concerning the National EMS Scope of Practice Model. I am in favor of option 2: Add new Levels. I do not feel we should be taking away skills that people currently are able to perform just to align a system. Our current EMT-Paramedics should be able to function at their current level and maintain their current skills without the removal of critical skills. In a predominantly volunteer and rural state, we need all the help we can get. Don't punish those that choose to serve. Respectfully submitted,

---

We are at an interesting crossroads in Iowa in reference to the future of EMS, not just locally, but nationwide. This National Model for the future of EMS could either make or break the system as a whole. I feel that Iowa has the responsibility to look beyond our own level of training and expertise, but to look at EMS as a whole and work on improving our profession. There are many reasons for this, and I feel that adopting the Model wholeheartedly with few or no modifications is the only option for the advancement of EMS as a profession. The first reason that I feel that we need to adopt this model is so that Iowa can continue to be a leader in the advancement of EMS. If we make the leap to adopt the model, many other areas will follow suit, and jump on board with the standard as it is written. Many hours were put into this model nationwide that look at what is working and what is not. Adopting the model with few or no modifications will open the door for other states to do the same. This in turn will allow for more of a more national uniformity of provider levels, and that is the essence of the model to begin with. We are at a point where we can be leaders and creating our own path, instead of simply following everyone else. The aforementioned uniformity would also benefit in advancing professional reimbursement for services. The multitude of levels nationally is one reason reimbursement levels are low. The first step in professionalizing the EMS industry is uniformity of services rendered. If we have one voice nationally through scope of practice, we can then be able to lobby for change that would advance EMS in all areas of the country. A unified voice will assist in many things, including reimbursement issues. Higher reimbursement will lead to higher standards of care, of education, and of system performance. If we hold ourselves to a higher standard, then we can also command wages commensurate with responsibility and skill levels. Uniformity will also spur consistent care nationwide. With a uniform level of training, care, and

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

response, it will be easier to educate the public about what exactly EMS is. We currently do not have any means of answering that very question currently. EMS is different in different areas. Most of this is based upon differences in training and certification levels. A single voice can be utilized for marketing of EMS to the public and the rest of the healthcare system. EMS has been selling itself short for years, but with the ability to stand as one, care and training can advance above our current levels. Most of the negative comments about this change have come from those that appear to have a limited view of the subject. This is an issue in which we cannot look to only ourselves and our own certifications, but look at a broader frame. Questions that need to be answered are not in the realm of “how is this going to affect me?” but “what will make the best improvements in the system?” If we look beyond our personal ideals of what should and should not be, and look at what is best for the system, our patients, and our profession, then we would be on the proper path. Times of change sometimes call for difficult decisions. I understand that I may have to make concessions with things such as scope of practice, and possibly lose the ability to perform some skills, but this is necessary to ensure that the profession as a whole advances. I see the main reasons for the adoption of the model is for a unified EMS voice that will build a higher level of professionalism in the field. Many of the above reasons as well as many other associated benefits would follow suit. Providers would have more mobility to move and/or work in other states, consistency in care will spur a higher standard of care, and the educational process could become more efficient with more areas working together toward one goal. Adopting the model completely to me is the only option. Anita, feel free to include my contact information, or contact with any questions about my opinion. Vernon Schwarte Director of EMS Adair County Health System 609 SE Kent Greenfield, Iowa 50849 vschwarte@adaircountyhealthsystem.org 641-743-7229 office 712-249-5630 cell

---

I am all for going to just 4 levels of certification. Iowa has many levels now, and adding a few more would add to confusion. For the most part, I like what I see with the National Scope of Practice. There may be a few items I don't agree with, but I believe it is a good direction for Iowa. I think there may be numerous complaints initially, but I think many EMS providers will jump on board with the changes and embrace them. The one item that most FR and EMT-B will not like is not having the use of the combitube in their scope. I appreciate the hard work of all who have been involved in this. Keep up the good work. I think this can be a great step for EMS.

---

Comments regarding the potential transition of the Iowa EMS certifications to the new National Scope of Practice. Being in this field for going on 13 years, I've seen Iowa have a multitude of EMS levels. It at times has been very confusing to try to keep up with. With the new National Scope of Practice, I'd like to see Iowa mold their multiple EMS levels to meet the National ones. My reasons for my thinking are below: It would be more cost effective and easier to manage from the Bureau of EMS standpoint. If we maintained our current levels while having people with the new certifications, things would become a major mess real quick. It make things easier for medics leaving the state, looking for jobs in other states. Other than our current EMT-B's or PS's, things are a mess when attempting licensure in another state. I believe the goal of the National work is to make things similar if not the same across the country. In the post 9/11 and Post Katrina world, having EMT's / Paramedic's with similar if not identical training would allow medics to help people anywhere across the country much easier. A good example of this was the Coast Guard's response to Hurricane Katrina in New Orleans. Helo's were staffed my various crew members from all over the country. Because their training was similar, they were able effect rescues with little problems. In closing, I think it would be a huge waste of resources and money to maintain the current levels and then start the new ones. We successfully transitioned lots of EMT-A's to EMT-B's and I think we could do the same to migrate everybody to the new levels. We

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

already use the National Registry testing for our state tests, so I don't see why we can't keep on the same page as the rest of the country when dealing with the actual levels themselves.

---

iowaemsgroup@gmail.com is representing the majority of Iowa's Rural EMS Professionals. We think Iowa should keep the current levels too if they do adopt the National EMS Scope of Practice Model Levels and just start to use the new level for all NEW EMS providers. If Iowa fails to keep the current levels of EMS certification a lot of volunteer EMS Professionals will not go through with the transition and will leave the profession. Please remember the Rural EMS Professionals as you decide what you will do. Sincerely,  
iowaemsgroup@gmail.com Representing Rural Iowa EMS Professionals

---

To Whom It May Concern: Please accept these comments concerning the scope of practice issue now facing the state of Iowa. In reviewing the document posted on the IDPH website, I believe that Iowa would be best served by retaining the current levels of certification as functioning providers, and training new providers at the four levels identified in the National Scope of Practice document. When reviewing the skills list, there are a few skills that are vital to good patient care in Iowa, both at the current EMT-B level, and the Iowa paramedic level, that are not included in the Emergency Medical Technician and Advanced EMT levels. As a current practicing EMT-B, those providers are allowed to insert a combitube (or King LT), check a blood sugar, attach the cardiac monitor, monitor a non-medicated IV, and carry and use an epi-pen. The use of the combitube/King LT, and the epi pen are of considerable concern for the many volunteer transport services that are staffed at a B level, without immediate paramedic level providers available. Currently, a new EMT-B can train and be certified after just one class. With the proposed new levels, an EMT must train to the AEMT level in order to provide the basic care issues of combitube/King LT, epi pen, cardiac monitor, IV maintenance, and checking a blood sugar. From the information provided in the Skills comparison, it appears that a new provider will have to train through 3 classes in order to do the skills currently allowed today. I have grave concerns about recruiting new EMT's for a volunteer service and requiring that much of a time and money commitment to train to the level that EMT-B's are today. It will be vital that we keep those providers already certified to the EMT-B level. Current EMT-B's could transition to the EMT level, but skills that they already possess are not practiced at the new EMT level. There are concerns as well at the paramedic level. If you notice, Iowa paramedics can transition to the AEMT level without doing anything at all, but in order to function at the new paramedic level, education and testing are involved. Current Iowa paramedics can offer such skills as cardiac drugs and pain relief that are not included at the AEMT level, although there are a few drugs available to the AEMT. Rural volunteer services that now have functioning Iowa paramedics must be allowed to retain the skills and education that are currently practiced in order to provide good patient care. Again, the issue of recruitment and retention is going to arise when certifying new providers, and existing providers may not choose to take additional classes, but more importantly, will not want to take written and/or practical tests to perform skills that they already practice and are certified to do. For the above stated reasons, I hope to see that Iowa retains the certification levels currently in use, and add the four new levels listed for the National Scope of Practice.

---

I would like to forward my response to your proposed changes to the EMS levels. With our service like many in rural Iowa we are approximately 30 minutes to the nearest hospital. We are not a paid service and all of our staff is totally volunteer. The amount of time that it will take to get the new training and testing I believe will force many to quit the EMS field making it harder for Iowa. I am in favor of the option 2 by saving the current levels and moving the new personal into the changed levels.

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

I have a great concern on the new nationally EMS levels. I have worked long and hard to get where I'm today. I can't see why anybody would take skills away from some one, if they choose not go by new standards. If we choose to abide by the new curriculum then we should be grandfather in, just like they before for the Paramedic specialists years back. I would not mind going through modules and be signed off by our medical director. There are only a few skills that separate the Iowa-p and PS. There are a lot of IOWA-Paramedic's out there and the expense would be costly and hurt a lot of private and volunteer services. I'm on volunteer service and for our service to abide by the new levels could hurt us, because not all of our members want to continue, because of the time it would take away from our families and our jobs. I think the State of Iowa should support our EMS people and make it as easy as possible and not take skills away. There are a lot of Iowa-P's that have done this for years and would difficult to change their ways, if they choose not to go on with new levels.

---

I am an officer of the Asbury Community Fire Department and I feel that these new levels will put an additional strain on our existing Paramedics. I think this will cause many of the volunteer organizations to either shut down their operations or resort to reducing our emergency care back to 25 years ago when we could only respond and transfer. Many of our Paramedics have decided that if they are required to do additional schooling they will opt not to and let their Paramedic status revert. I don't feel that this program is in the best interest of patient care, it will restrict us on what we can do to save lives. We are not a paid department and I can't believe that this is I the best interest of the public. I understand that approximately 89% of the state of Iowa is volunteer and what response is the IDPH going to have when citizens find out that their emergency care is going to revert back 20 years because some bureaucrats have come up with a new plan for patient care that is going to possibly shut down many of the volunteer EMT programs. The IDPH needs to sit back and think about the public and what they need to do to maintain the service that is currently provided and whether it really needs to be upgraded, and if it does what are the repercussions. I will be actively involved in fighting these changes for our community because I feel our EMT's do an excellent job in saving lives and if this program changes they will end up having to sit there and not be able to perform the procedures they have been doing for many years to save a person's life and that is totally the wrong process. Think about every community not just the cities with paid fire departments because they are the minority.

---

The Louisa County EMS Association maintains a position as being in favor of Option 2 in the Scope of Practice document which is currently posted on the IDPH website. We feel that the citizens of our rural area will best be served for emergency response with staffing for our volunteer services at those levels currently practiced in Iowa. We maintain this position in light of the fact that within the current scope of practice for an EMT-B, is the availability of the combitube or King LT as a means of airway control. At the new proposed levels, this airway device is not available at the EMT level; it is not available until a provider has attained the Advanced EMT level. We feel that this device is essential for rural services that do not always have an advanced level practitioner available. In addition, IV monitoring, cardiac monitoring, MAST/PASG, blood glucose monitoring, and the carrying and administration of an epi-pen are no longer listed as being in the EMT scope of practice. While IV monitoring and cardiac monitoring are not of critical importance, we feel that blood glucose monitoring and the epi-pen are significantly important to basic emergency responders. Acquiring a blood sample for glucose analysis is a skill that many lay persons are performing daily, and is critical to the treatment of a patient with a blood glucose level that cannot be maintained for a 30 minute transport, as is common in rural Iowa. For a basic emergency responder to not have this skill available is not in the best interest of patient care. This same philosophy applies to the use of the epi-pen. An allergic reaction is a life-threatening situation that, without the assured availability of an advanced level provider, is critical to patient care. In addition to these concerns at the basic care level, the Louisa Co. EMS Association supports Option 2 for the advanced level

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

provider. At the current Iowa paramedic level, these providers have the option of administering cardiac drugs in the event of a serious cardiac arrhythmia or arrest, and they also have the option for pain control for a seriously injured or ill patient. At the AEMT level, these options disappear. We again feel that these interventions are crucial to patient care in rural Iowa. These skills are not available in the new scope of practice until a provider is educated to the Paramedic level, or transitions to the Paramedic level through continuing education and examination. Many, if not most, of the Iowa paramedics practice in the volunteer setting, and currently practice these skills, and we feel it is unlikely that we will be able to find new volunteers that will train to the Paramedic level, both in terms of time and monetary investment. We also feel it is unlikely that many of the current Iowa paramedics will opt for testing to transition to a new level to perform skills to which they currently have trained and tested. There are other skills currently allowed at the Iowa Paramedic level, such as needle decompression, intubation, needle cricothyroidotomy, tracheobronchial suctioning, 12 lead acquisition, cardioversion, manual defibrillation, transcutaneous pacing, maintenance of medicated IV's, and the administration of drugs for various emergencies that will no longer be allowed for those that train or transition to the AEMT level. These skills are not as critical as the cardiac drugs or pain control, but those providers have already attained these skills crucial to good patient care. We feel it is in the best interest of local citizens and all of Iowa to retain these skills and the providers which are allowed to practice them. These points have been considered by our local association, and we ask that you also consider these patient care issues when making a final decision concerning the levels of practitioners in Iowa.

---

Here are my comments regarding the adoption of the National Scope of Practice for Iowa. Of the two options listed in the information from QASP, option one is the only sensible option. As a training coordinator for an ALS ambulance service and the president of a county EMS association, I see first hand how the system in place is confusing and on the verge of ridiculous. I work with providers certified at all levels from volunteer first responders to career paramedic specialists. Given the location of Henry County, we also have situations with other individuals coming from out of state for continuing education classes and conferences. Following the national model will make this process much simpler and easier to understand. In order to promote the profession of EMS and pre-hospital care nationwide, the states have to come to an agreement on what is an EMT, what is a paramedic, etc. By aligning ourselves with other states under this model, we are taking a big step in that direction. My only concern with option one is with what the con-ed modules will be to facilitate the transition. As this has yet to be decided on or developed, I will hold that conversation until another time.

### **Comments received May 17-June 18, 2008**

Regarding the scope of Practice, in general I am glad to see the state following the national model. During public input on the national model, I asked that they consider the rural systems being volunteer based, possibly in bedroom communities and career/family demands. There are many in these communities who have the desire to do more for their patients, but are not willing to go through extensive training to get there. I believe that the four levels they recommended provide that, especially at the AEMT level. There is no question on the need for additional training to slide some of the current levels to a "higher" level. Those who have higher level EMS training understand the need to be able to understand how the body will react to interventions as well as recognizing how the body is reacting to the current insult. I believe the first option will be the best... to transition providers to the new levels without creating a legacy level. There will be confusion in the general public regardless of the options selected and they will have to be educated. This education should be done anyway, because my experience has been that nurses do not know the difference of scope of practice between and Paramedic, Paramedic Specialist, Critical Care Paramedic and an Intermediate. I am looking forward to

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

seeing how this develops. EMS will be going through a lot with provider changes and system development changes, all hopefully being implemented in over the next decade or less. I hope you find my comments useful. If for some reason, I have not been articulate enough, please feel free to call me or email me for further clarification.

---

Currently I am a EMT-B with Northeast Linn Ambulance. I have just completed my Paramedic Specialist training and testing but waiting on cards. Although this transition will not affect my level I feel we need to just transition into the new scope of practice model. I feel the even though it will be difficult to begin with in the long run it will pay off with just having 4 levels of care.

---

I am sending the e-mail today with great concern for the Iowa Paramedics and the EMT-I's in Iowa. I feel that all of the Iowa Paramedics should be able to take modules like you have suggested, but not be required to test. I feel that decision should be left up to the providers current medical director. The Iowa Paramedics have proved themselves and are only missing a few skills that could easily be taught over the course of a week. They should not be required to retest for all of the skills that they have already been tested on and since there is no upgrade test available at this time or ever will be in the future it is currently in the best interest of the state to do the Grandfather and be done with this once and for all. In the future we need to stick to the NREMT guidelines and quit jerking all of the EMS providers in Iowa around. As for the EMT-I's it would be a grave mistake to loose there valuable skills in the field and in many ER's across the state. I feel that we need to keep the EMT-Is and leave them alone. Thank you for your time

---

We have recently learned that your committee is looking at making some changes in our levels of practice. While we see the value of the changes, and the need to implement them, we are also concerned that forcing these changes onto small rural towns is going to ultimately leave some communities with a lesser degree of emergency care and a slower response time than we presently have. In some instances this will prove to be tragic. We are a typical small rural community with most of our crew members having full time jobs outside of EMS as our community cannot support career EMT's. Two years ago our crew was named volunteer crew of the year and our director was selected as individual volunteer of the year. I feel that this says a lot about our dedication to what we are doing in our small community. Most of our patients could no doubt survive if it were necessary to wait for ALS from a city that can afford to pay an EMT for their time, allowing them to choose EMS as a profession. Our concern is that some of the present rural volunteer Paramedics that have a great track record of being available and competent to serve the critical patient will decide that the job with which they make their living will have to take precedence if additional extensive classes, clinicals, practicals and testing are required to meet a new transition level. Therefore it is our hope that the committee will see the value of accepting "Option Two" as a way of retaining the level of care that we now have and avoiding the possibility of loosing some qualified volunteer Paramedics that could not in good conscious go on a call at a lesser level than they are capable of performing at and risk possibly losing a patient because they could no longer use the life saving drugs and procedures that they have been trained to use. Since the concern, (as we understand it) is a matter of conforming on a National level, possibly those who would be grandfathered in at their present level could accept staying in Iowa and doing what they do well, while those who choose to conform to the new levels would be the ones that could be recruited to go to other areas of our country to respond to a National emergency. We appreciate your consideration for those who have chosen to be volunteers and have already gone above and beyond in their desire to be of service. Please don't kill this desire by making it more difficult to reach your requirements.

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

---

I have read that you want input on the new scope of practice from active EMS personnel. I feel that the new scope of practice is TERRIBLE! Why would you rule out Iowa Paramedics when they can do everything that a specialist can do, except for RSI and 1 or 2 other things???? RSI can be combated with comitubes and the drug used can be off set by using versed(or relaxation) drugs! To penalize paramedics who plan to always live in Iowa with this new scope of practice, just shows how Kirk Schmidt is out of touch with the "real" life of EMS. Put him in an ambulance and to work and he will see "just" how often these minor skills of a specialist are really needed. Not much at all will be the results of a specialist vs. iowa "p". I know state is out to put every ambulance service out of business and replace them with paid people, but if he lived in the real world of rural Iowa, he just may see how EMS works. I am dedicated to EMS and am horrified how such changes have been done since Kirk Schmidt has become a person of power. It is sad to see good people walk away from EMS because of Schmidt's actions. In my opinion I would NOT enact this new scope of practice and penalize Iowa paramedics. I know no one will listen but I did need to let you know how the "real" people think!

---

I attended last weeks Black Hawk County EMS Association meeting, and we were treated with the break down of the National Scope of Practice, with regards to where Iowa could go. The first option was a new total sweep to 4 classifications, which I know you are aware of but I just want to make sure we are on the same page. My opinion is that this looks to be the best way to go. We don't need 14 different levels of EMS or how ever many there would be if the second option would be put into effect. Those that are dedicated will take care of the training they need to convert up or back down to the lower level should that be an option. But at least they will know where they are going, what is required, all of that. The extra training to transition up for whichever level is just an added plus. CEs are good, but those learning situations where the student is shooting for something do more than the CEs for someone trying to keep something they already earned. I am all for the 1st option.

---

I feel that the right direction for the quality of EMS in Iowa and the best interest of continuity of the profession is to go with option 1. I have a variety of reasons that I feel support this opinion. First and foremost, to gain the respect we so desire in EMS as a profession, we have to unify. I think every EMS professional has dealt with the misinformed title of "ambulance driver", but educating the public is a losing battle when each and every state can define what EMS professional means in their own way with their own levels. Selecting the second option as a state only keeps us in the game of further alienating our colleagues and perpetuating division amongst the levels. While I feel that Option One is the best route to take, I do have some questions (and the answers may be out there and I just am not fully educated on them, my error). First, when we chose to transition the 1985 paramedics to PS level, we required paperwork be completed to establish this transition. On the national level, this did not occur, 1985 paramedics were "grandfathered" in and not required additional steps. Is there such a disparity in the new scope that additional requirements are necessary? Again, I have not had ample time to study the latest revision of the draft and the current curriculum, I may be able to find the answer to my own question. The next issue I have is simply providing the education to the various levels to "transition". I am a former educator, so I think education is FANTASTIC, however, while I feel that education is important and all levels of providers in all aspects of the profession (paid vs. volunteer and rural vs. urban) should be on the same level and held to the same requirements, I do also have a heart for services, especially those without a large training budget. I am not sure the state can, or even wants to, regulate the modules, but I would hate to see a disparity in the training programs that offer significantly different lengths, content and, most importantly cost. Those comments said, again, I feel very strongly that option one is the right solution, a solution that serves the most important factor, and that is the patient. The decision needs to be made to support the profession of EMS, move it forward, for recognition, continuity and bottom line, funding. The decision also needs to be made that

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

will best support our patients. I have heard it said many times that we get caught up in the “name game”, the first option would change what many providers feel they “are” but the bottom line is not what they are called but what we can offer our customers. And the last of my comments, thank you to everyone who has spent so much time and effort working through this process. It is impossible to make everyone happy and I feel that these two options (while I only like one of them) were well thought out, fair, and comprehensive. I appreciate what my state officials do and I appreciate the drive to improve the process and ultimately the care provided in our state!

---

I am the Chairman of the Board of Directors for a small town Volunteer Ambulance service in Ackley, Iowa. I do feel that it is a very good idea to decrease the levels of care and to reach for a National Standard, so that all states can have an understanding of exactly what a paramedic is, an EMR, EMT or advanced EMT. I have great concern from a volunteer service. All of our members on the service have full time jobs. There needs to be a lot of consideration put into how these new standards will be met. These members cannot take time off from their full time jobs to attend classes, or clinical time. The second thing that needs to be looked at NOW for the training in the next 2 years is the financial aspect of this. Who is going to come up with the money? Is the EMS going to have monies set aside to provide training? Or is this going to fall on the city budgets, which I am sure you know that the small towns do not have much latitude in this. Yet, our ambulance service is a very important aspect of our community. Can you get the email addresses or any other contact information on people at a legislative level that I can contact about setting aside money for EMS. Thank You

---

Greetings. Since I have met and listened to you in classes at Spirit Lake, it is easier to respond to you. I practice in the first responder level as director of Rake First Responders and also as an EMT b with the Buffalo Center Ambulance. My point ..... Airways for a first responder are very important and not much additional training is need for a responder to use them . I have used the oral and the combi-tube several times, both as FR and as an EMTB. Second point is the glucose monitor. In this very rural area there are a lot of senior citizens with diabetes and the Hospitals really appreciate having a glucose number when we get there. Rake is 8 miles from Buffalo Center for the ambulance. Four minutes to the shed and then 10 to 12 minutes to Rake mean FR's are on scene for 10 to 15 minutes before the ambulance arrives. In my opinion FRs should be able to check glucose levees and continue use combitubes. Last comment. Will the King airway be available for the FRs and if so the combitube argument is a waste of time. Also I would like an explanation on why glucose monitoring is not important for ambulances.

---

This correspondence is in response to the proposed changes with EMS certification levels and the scope of practice in the State of Iowa. I am currently an EMT-B on the staff of Urbana Area Ambulance in Urbana, IA. I am writing to present my personal viewpoint as well as the general consensus of Urbana Area Ambulance personnel. We have a roster of approximately 20 members. Six of our members, including myself, have just completed the Iowa Paramedic curriculum through Hawkeye Community College in Waterloo, IA and are preparing to test for our certification in June. Obviously, the fact that we will have additional patient care skills and drug treatments is a huge benefit to the people of our community, especially considering that our drive time to definitive care averages 18-20 minutes. Now we understand that the EMS bureau is considering removing the “Iowa Paramedic” level as well as removing treatments and skills that are vital to our certification. For instance, removing cardiac drug treatment from our protocol only serves to disenfranchise the people of our community and the hundreds of communities like us in Iowa who expect the best medical care possible as quickly as possible. I understand that the “bridge” curriculum from Advanced EMT to Paramedic has not been established. It seems that this is the crux of the issue for many of us who have given time and money to go

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

through the Paramedic curriculum in order to be more effective health care providers. We are all working men and women, have families, and take time to serve as volunteers on this service. Not a one of us has the time to go through a PS type curriculum. I'm sure I speak for the majority of volunteer services, which I remind you are far and away more prevalent than paid services in this state. The bridge must be as concise and abbreviated as possible in order to continue the continuity of care to our citizens. The "modules" should be widely available and accessible to the providers who would like to bridge and should be able to be completed by working people as night or weekend classes or available by internet. Please understand the predicament we may find ourselves in and work to make the changes as fair as possible to the providers, but more importantly fair to our patients.

---

After reading the material about the migration options for the National Scope implementation in Iowa, I think it would be far better to transition (option 1). I'm speaking as a former State of Iowa paramedic (originally certified in 1996) who migrated to the paramedic specialist position already. I would prefer not to have to maintain an "odd duck" certification name for the remainder of my career simply because Iowa (again) did not want to completely follow national certification names. I'm sure this will create issues for the other certification levels that don't easily match up to the new guidelines, but we need to make it easier for the public to understand what type of emergency care they are receiving. It is difficult enough to understand what level of care they receive now; maintaining legacy certifications would worsen that. The other question I have is what happens to the critical care paramedic endorsement and requirements. I realize that is part of the current paramedic specialist level but I noticed it was not mentioned in this national scope of practice implementation document.

---

On the changes to the EMR and EMTB. I saw that they will not be able to use after the combi-tube or KING LT. I feel this change is going back wards in EMS. protecting the air way is one of the most important things in pt care. The first first responders and EMTBS have been using the combi-tube and taking this skill away will effect our pt care to help protect the airway til ALS units arrive plus telling the first responders and emts that that now they cannot use this tool can be very demoralizing. This change in the EMR and EMTB should be reconsidered.

---

As an EMT-B in Kossuth County, I would like to voice my concern with the glucose testing that we will not be able to do. We are 22 miles from the closest 2 hospitals. It is a known fact that diabetes is on the increase. We have a large number of known diabetics with in our service area. Diabetes is striking younger people. We need to be able to service or citizens. We find that the Er-doctor is displeased if we administer glucose without first testing. It is a simple test to do. It allows us to be able to administer glucose or food to the patient with a low reading and retest before we arrive at the hospital. We can call for a paramedic assist (TEAR) for a patient with a high reading. We are a long way from a hospital. As a diabetic myself, my husband will not always be available to administer the test for the ambulance service and I feel safer knowing my crew can take care of me. Please, keep this a part of our protocols.

---

Please do not add additional levels; we need to transition to the new Scope of Practice Model. Where does Law Enforcement stand in this?

---

I have been making myself aware of the new concepts of certification for scope of practice for EMS personnel within the state of Iowa. I would like to comment that I personally as a healthcare professional (Registered Nurse) and as a healthcare leader (Rural-CAH CEO), I am in favor of allowing the Iowa Paramedic (I-99) to

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

continue as a legacy certified following the transition to the new Scope of Practice. Access to EMS paramedic service is very important to my neighbors, family and friends in rural Iowa. Thank you for your consideration of my input.

---

I work for a rural hospital in Iowa and we depend on prehospital care for our community. We currently have access to an EMS paramedic service and feel very proud of the care they are able to provide. I would hope these providers, in question, could be continued as a legacy certification following the transition to the new scope of practice. If this is not granted our community will not always be able to provide a paramedic service as in the past, which we have grown to expect. A type of "grandfathering" clause would be very important for our rural community.

---

Thank you for the opportunity to submit comments on the proposed adoption of the National EMS Scope of Practice Model for the State of Iowa. Adopting this standard will assuredly accomplish many of the objectives detailed in the EMS Education Agenda for the Future: A Systems Approach ("enhance national consistency, improve patient care, ensure patient safety, facilitate reciprocity, and decrease confusion for the public and EMS personnel"). Adopting this standard does, however, present a unique challenge to at least two current levels of EMS providers and it is essential that the full impact of these changes is given serious consideration before deciding on how to most effectively implement the National Standard. Currently, EMT-Basics can utilize esophageal/trachea multi-lumen airway devices. Combitubes and King-Lt airways are an effective means to ventilate/oxygenate patients when endotracheal intubation is not available. The National EMS Scope of Practice Model lists "insertion of airways that are not intended to be placed into the trachea" under the psychomotor skills of the Advanced Emergency Medical Technician. Consequently, if the National Standard is adopted without allowing EMT-Basics to continue practicing under their current scope of practice, more than 1/2 of the 12,497 active emergency medical care providers in the State of Iowa would lose the ability to use this skill. EMT-Paramedics provide advanced, life-saving treatment to patients in metropolitan and rural areas throughout the State of Iowa. 631 of the 2436 (over 25%) advanced providers in this State are EMT-Paramedics. Although the EMT-Paramedic scope of practice is not as extensive compared to the EMT-Paramedic Specialist, they do have the ability to provide many of the same advanced treatments (needle decompression, medication assisted intubation, non-interpretive multi-lead monitoring, intraosseous initiation, and medication administration). If the State of Iowa chooses to adopt the National Standard without allowing EMT-Paramedics to continue under their current scope of practice, these providers will be required to complete continuing education modules and pass the examinations in order to continue providing essentially the same level of emergency medical care that they currently provide. Due diligence is required to consider the likelihood that EMT-Paramedics will choose not to complete the continuing education modules because of the time commitment and/or they can not successfully pass the NREMT examinations. The resulting consequence may adversely effect the provision of emergency medical care in the state of Iowa, particularly in the rural setting. It is also imperative that we consider how the training and testing costs associated with the National Standard will impact the providers and potentially influence their decision to transition to the National Paramedic. The Des Moines Fire Department has 55 EMT-Paramedics who must maintain their certification as a condition of their employment with the City. Adopting the National Standard without allowing EMT-Paramedics to continue under their current scope of practice will create a significant logistical and financial challenge to them, our Department and the City. The Department does not have the staffing capacity to allow 55 EMT-Paramedics time off from duty simultaneously to attend a bridge course/continuing education modules and maintain adequate delivery of services. Small group participation in the bridge course will require an adequate grace period by the Bureau of EMS to allow enough time to complete the course work. Another

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

important consideration is the financial impact of the overtime costs, training, and testing fees to transition 55 EMT-Paramedics to the National Standard. It is possible that the total costs of this initiative could exceed \$100,000 for the Des Moines Fire Department. I, personally and on behalf of the Des Moines Fire Department and Chief of the Department Phillip C. Vorlander, fully endorse and support adopting the National EMS Scope of Practice Model for the State of Iowa. I do, however, request that the benefits and consequences of this initiative be evaluated carefully before deciding to eliminate EMT-Basics from being able to use esophageal airway devices and EMT-Paramedics being mandated to complete a bridge course/continuing education modules and pass the certification examinations or reduce their scope of practice to that of the Advanced Emergency Medical Responder.

---

I can understand the thinking of those who feel it would be good to be consistent nationwide in the levels of emergency medical care providers. Things like that are always helpful. But one does have to consider the differences between operating an EMS organization in the rural areas as opposed to the city areas. We do not have as many people to choose from; however we are farther from advanced medical facilities when a major medical problem arises. We need to have people who can do advanced procedures while on the way to the larger hospitals and standardizing the levels could cause us to lose some of our paramedics--at least until they could get extra training. It would be best to allow the Iowa Paramedic (I-99) to continue as a legacy certification following the transition to the new "Scope of Practice."

---

I read the information forwarded to me on the National Scope of Practice Model. I have just few comments on the 2 options that were discussed. Looks as though (if you're an EMT-B) your in a pretty good spot. My only concern is what will be involved in the continuing education modules. The modules will be part of the certification renewal requirements, which is a good thing, as long as there are not a lot of extra hours beyond the 24 required every 2 years. Remember a lot of volunteers in rural areas are not only keeping up on EMS requirements, but also NFPA, OSHA, and other Fire related requirements. My other comment would be to keep it simple. If we're indeed trying to clarify and simplify, narrowing the levels of certification seems like the best thing to do. (Easy for me to say, since we are all at the EMT-B level.) Maybe I'm incorrect in this last comment, but doesn't Iowa tend to set the bar on EMS training and certifications? This has always been my perception since I became an EMT-B. If that's true, this should be an easier transition for us Iowans.

---

We have recently learned that your committee is looking at making some changes in our levels of practice. While we see the value of the changes, and the need to implement them, we are also concerned that forcing these changes onto small rural towns is going to ultimately leave some communities with a lesser degree of emergency care and a slower response time than we presently have. In some instances this will prove to be tragic. We are a typical small rural community with most of our crew members having full time jobs outside of EMS as our community cannot support career EMT's. Two years ago our crew was named volunteer crew of the year and our director was selected as individual volunteer of the year. I feel that this says a lot about our dedication to what we are doing in our small community. Most of our patients could no doubt survive if it were necessary to wait for ALS from a city that can afford to pay an EMT for their time, allowing them to choose EMS as a profession. Our concern is that some of the present rural volunteer Paramedics that have a great track record of being available and competent to serve the critical patient will decide that the job with which they make their living will have to take precedence if additional extensive classes, clinicals, practicals and testing are required to meet a new transition level. Therefore it is our hope that the committee will see the value of accepting "Option Two" as a way of retaining the level of care that we now have and avoiding the possibility of loosing some qualified volunteer Paramedics that could not in good conscious go on a call at a lesser level than

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

they are capable of performing at and risk possibly losing a patient because they could no longer use the life saving drugs and procedures that they have been trained to use. Since the concern, (as we understand it) is a matter of conforming on a National level, possibly those who would be grandfathered in at their present level could accept staying in Iowa and doing what they do well, while those who choose to conform to the new levels would be the ones that could be recruited to go to other areas of our country to respond to a National emergency. We appreciate your consideration for those who have chosen to be volunteers and have already gone above and beyond in their desire to be of service. Please don't kill this desire by making it more difficult to reach your requirements.

---

Here's some of my input on the National Scope of Practice Document. Let me explain where these comments are coming from--as you know, I am a volunteer with the Rock Valley, IA, ambulance, have an EMT-B certification but an RN exception to EMT-I. I am also a flight nurse for Avera McKennan in Sioux Falls (on my Iowa nursing license) and under medical control & protocols have the training to intubate, RSI, needle decompress a chest, insert chest tubes, give any drug known to man, and more, roughly equivalent to a Critical Care Paramedic. On these protocols, I can operate across state lines into Iowa, Minnesota, Nebraska, etc (anywhere I go) provided I am doing it as an employee of Careflight. Needless to say, I have seen a lot of different EMS systems. Now, I think the Nation Scope of Practice is a great idea--if all states would agree to it. I think option 1 would be the simplest way to go, as Option 2, in my opinion, would just cause more confusion. Some concerns I have: where would RN exceptions fall in the scheme of things?--my proposal is that they be allowed to "test out" at whatever level they choose, or simply follow the courses/testing to obtain the level that their current exception is at. For that matter, what would "conditional" ambulance squads do, or wouldn't that change? Rock Valley is still a conditional-I, and operates as such on 3 RN exceptions (all of whom are nurses who possess a valid EMT-B certificate). Myself--I would be willing to take a few classes to "upgrade" to AEMT, etc. Another concern is taking away skills--currently, our EMT-B's are able to place Combi-tubes under Rock Valley standing protocols. If I understand correctly, the corresponding level of certification would be the EMT, in which they could not place Combi-tubes. I think this is a valuable skill to have, and I know, our EMT's would have the option to take classes for the AEMT. I think there are a few that would. However, in the volunteer world where everyone is just about stretched to their limit, pressure to take more classes may be the last straw and we may lose personnel that are already on the edge. Now, that's worst case scenario, but I can see it happening. And, maybe that's a risk we have to take. Also, is NREMT on board with this? The reason I ask is regarding recert requirements that vary greatly from state to state. Thinking about my South Dakota counterparts, who recognize only a National Registry license at this point in time . . . what about RSI, etc. Will that still be dependent on medical director control? All in all, I think having a national standardization of certification levels would be excellent--good luck!!!! Just my \$.02!

I am in favor of Option 1 for Iowa's choice of routes to take when implementing the National Scope of Practice. I am confident that the transitioning of current providers will be as well-organized and easily attained as it was when the EMT-Basic was new across the country. It is important for Iowa to remain a progressive EMS state, and Option 1 will allow for that to be maintained. I realize that the biggest changes will be for the Iowa Paramedic level and the I-85 level. I have taught the Iowa P course a few times and have always been a strong supporter of these EMS providers when they are being ridiculed by others in the profession, simply because of the title that was given to them - something beyond their control. I feel that they can and do fill an important role in the EMS system and if they would take a thorough look at the new scope, they would understand that either direction they choose to go, they are still going to fill an important role. The I-85s will have the same opportunity to make a choice in the level of care they wish to be able to provide. Now is the time to take

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

advantage of the opportunity to clarify roles and titles with a transition process that would result in EMS levels in Iowa that are consistent with those in other states. Adding four new levels to our current five (not including what are considered the legacy levels) would simply be too confusing for the medical community and the public. Finally, I'd like to say that I appreciate that the QASP committee and the IDPH are working together on this project and that I believe we can trust their continued good judgment regarding decisions that affect EMS in Iowa.

---

After reading the National EMS Scope of Practice Model in Iowa document this EMS service wishes to voice as a group our concerns for EMS in Iowa and the effects of implementing the two given options of transition or adding new levels, known as 'option 1' and 'option 2' in the document. While we understand the benefits of the 4 new levels and the need for national standards we also believe it is extremely important to consider where we are now and how it best suits our communities, our patients, and our level of care given while we are adjusting to these new certification levels. While we can only speak for the Blirstown area and Benton County, we know similar communities in Iowa will have the same concerns. Option 1/Transition: Historically, Iowa has never forced those currently in EMS to fit into a new certification level and have allowed them to continue functioning at their current level. In Iowa, as you know, most of us are volunteers in the rural communities. We believe forcing current EMTs to fit into one of the new levels could cause many to make a decision to resign or fall back to the lowest level they will fit into. How does this affect our community? As Director at Blirstown and the Vice President of Benton County EMS, I can see many of our Iowa Paramedics choosing to resign IF the transition/bridge to the paramedic level requires too much time. Iowa Paramedics are almost all volunteer and volunteer status was the reason the Iowa EMTP was developed. It served its purpose well in getting paramedic level care to rural communities. The majority of volunteer EMTPs see transitioning to the new paramedic level as something they could do if not too expensive or too time consuming. Remember we are mostly volunteers. Now consider that we would gain a handful of skills that most of us will never use in the field by fitting into this new level. I can see too many of Benton County's Iowa Paramedics resigning as many will say, "I cannot go back to just starting IVs and maybe giving dextrose when I know what to do and why I do it for cardiac arrest victims, for the pneumothorax patient, for the diabetic who needs glucagon, for the emphysema/COPD patient who needs meds quickly." And at the same time many have years of experience and have all ready passed state exams and practical exams to be certified as a paramedic in Iowa. If Benton County loses most of its EMTPs, we will see a huge set back in EMS care in our communities. While we have a hand full of Paramedic Specialists, we have many Iowa Paramedics on our crews. Take them away and we will also see more calls for tiers with ALS from services from Cedar Rapids and Iowa City which takes them away from their communities as well and returns us to the same place we were many years ago before the EMTP level. We can also see many of our senior EMTBs and EMTIs not wishing to do more classes and either falling back to the lowest level or just deciding it's time to give up EMS. Blirstown has not 1 but 2 miracles in our town who were brought back from cardiac arrest by EMTPs. One responded only after being given cardiac medications and without that Iowa Paramedic we believe he would not have survived. Both of these patients returned home and have absolutely no neurologic deficits. As a service we see absolutely no benefit to our patients in forcing our EMTPs to fit into the new paramedic level as the skills gained will likely never be used and some are not even allowed by our protocols, such as RSI. The 12-lead project here in Benton County is underway and once in place all EMT levels will be able to attach the 12-lead and send a reading to the ER where it will be read. The need for the 12-lead to be read in the field will not be necessary. We do see many of our volunteer paramedics with many, many years of experience choosing to resign if required to do many more hours of class time, clinical, another written test, and another practical. Many will decide it is time to give up EMS. The effect on our communities is potentially devastating when it comes to getting advanced care quickly. While this

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

change may affect all levels of EMS certifications, we see it having the most effect for our EMTPs as it would most likely require the most time to transition and would involve the biggest number of skills compared to the other levels. Option 2/Add New Levels: While we understand the confusion of adding, yet again, more new levels into the EMS system, all of these levels were added by the state for a reason. Those of us providing care in our communities and functioning at our current level were not involved in those decisions but are hugely affected by them. Historically Iowa has continued to add levels as they come along. This is nothing new for our state. The general public knows they call 911 and they expect the best paramedic level of service to arrive and take care of everything because that is what they see on TV. The bigger issue with the rural public will be explaining to them why they no longer have very many paramedics IF you make the EMTP transition too long and time consuming for our volunteers. EMS providers, service directors, and medical directors understand the differences and will adjust to the new levels being added, just like we have in the past. Being nationally “compliant” and mobile in the EMS community nationally is important in many ways. We believe the change is a positive one for the future for certain. The issue is to NOT destroy what we have now! We will all continue to function nearly 100% of our time in our communities where we are. Few of us from small volunteer services will be asked to function out of state. A few move out of state and most I have heard of adjust with some classes or updates to their new state and new protocol. The new EMTs who fit into one of the 4 new categories will know they are nationally mobile when all states are on board. Which again, may take some time. Your decisions as to what will be required WILL affect our community. We ask that you consider our patients as they are our primary and only reason we function in EMS. Will your final decision improve their quality of care or will it cause many of us to say, enough is enough, and let EMS go? Therefore affecting number of care givers and the level of care available. We ask that you consider all of the patients of Iowa and make the decision that impacts them in the most positive way. If our motivation is not for the best care possible for our patients, it is our opinion we should not be in the EMS and healthcare. We thank you for hearing our concerns and taking on the responsibility to make the final decision on this issue for all of us in EMS and all of us who will ever need emergency care in the great state of Iowa.

---

While the concept is great and the end product would be beneficial to the entire State of Iowa and all of its citizens, the cost in terms of staff hours, overtime, curriculum and testing fees would be a great impact on both paid and volunteers services. I would recommend that a long transition to the new standards be implemented to allow for departments to budget and plan for the transition. Five years should be a minimum for a transition. Many departments work on a budget cycle that is as much as 18 months out and many departments would need several budget cycles to accomplish transitioning personnel to A-EMT and Paramedic. I would also recommend that the current certifications remain in place for a longer period, such as 10 years to allow those that are close to retirement to transition out of the system without having to take new classes and tests to maintain employment or fill the vital roles of voluntary emergency responders through out the state. I agree that the eventual elimination of all but the four new certifications would be an ideal goal, but without a long transition period it would be viewed as an un-funded mandate and cause a burden on all services in the state. The State should look at funding to assist in the transition. Any type of funding assistance would help both paid and volunteer services make the transition. Paid departments and services would have to look at raising taxes or fees. Volunteer services would have to raise additional funds or push the burden down to the individual. Retention of volunteers is hard enough without creating a greater financial burden and increased time commitment on them.

---

I have reviewed the National EMS Scope of Practice Model in Iowa document posted on the bureau of EMS web site. I have also reviewed this document with the Boyden Ambulance Service, and after a brief discussion,

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

we as a service feel that option #1 is the better of the two options. All members of our service are either a First Responder or an EMT-B which we feel makes the transition very simple. Some of us "Old Timers" survived the transition period in the late 90's so this shouldn't be too much different. I believe the only providers that will express an opposition to this are those EMT-I and EMT-P because they need to make a decision and need to complete an examination. We feel that the fewer number of levels will keep the confusion and understanding of the levels to not only the service members but also the public. Also if Iowa models the certification levels and curriculum with the national system, the transition of providers to and from Iowa will be easier and everyone will know that providers training level.

### Comments Received June 19-June 27, 2008

We have been always proud of our SECMS & Ambulance Service. These men & women have spent a lot of time to this service. Now new regulations are clouding up the programs. Let Iowa lead in clearing of the SEMS program.

---

To whom it may concern: I am writing to you in regards to the two options you considering for the current ambulance/EMT's to fit into the national based systems.. After reading through the information on the two systems it is my opinion that we as a rural state would function better with option 2. After working closely with the volunteer units for over 40 years and knowing how much training it takes to certified as EMT's and be recertified every two years I find that we will have problems with option 1. I feel the current system is meeting our needs now and with some updated training given the EMTS we already have will update the system we have. The citizens of Benton County are very satisfied with the care they are now receiving. Most of our Ambulance service now have some paramedics on there same services who would have to meet the new criteria. They are volunteers also who may not have the time to devote to the training along with keeping their family commitments. I have been around ambulance services that the Counties have had take over and found that our volunteer services are more timely and provide as good of service as those run by the government. I am a retired Sheriff of over 32 years and served as a Deputy Sheriff for 6 years along 3 years as a part-time police officer several of the smaller cities in our area. Over the years driven an ambulance when I was needed. I currently have a First Responder card for over 33 years. Thank you for your attention in this matter.

---

After reading the National EMS Scope of Practice Model in Iowa document this EMS service wishes to voice as a group our concerns for EMS in Iowa and the effects of implementing the two given options of transition or adding new levels, known as 'option 1' and 'option 2' in the document. While we understand the benefits of the 4 new levels and the need for national standards we also believe it is extremely important to consider where we are now and how it best suits our communities, our patients, and our level of care given while we are adjusting to these new certification levels. While we can only speak for the Blairstown area and Benton County, we know similar communities in Iowa will have the same concerns. Option 1/Transition: Historically, Iowa has never forced those currently in EMS to fit into a new certification level and have allowed them to continue functioning at their current level. In Iowa, as you know, most of us are volunteers in the rural communities. We believe forcing current EMTs to fit into one of the new levels could cause many to make a decision to resign or fall back to the lowest level they will fit into. How does this affect our community? As Director at Blairstown and the Vice President of Benton County EMS, I can see many of our Iowa Paramedics choosing to resign IF the transition/bridge to the paramedic level requires too much time. Iowa Paramedics are almost all volunteer and volunteer status was the reason the Iowa EMTP was developed. It served its purpose well in getting paramedic level care to rural communities. The majority of volunteer EMTPs see transitioning

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

to the new paramedic level as something they could do if not too expensive or too time consuming. Remember we are mostly volunteers. Now consider that we would gain a handful of skills that most of us will never use in the field by fitting into this new level. I can see too many of Benton County's Iowa Paramedics resigning as many will say, "I cannot go back to just starting IVs and maybe giving dextrose when I know what to do and why I do it for cardiac arrest victims, for the pneumothorax patient, for the diabetic who needs glucagon, for the emphysema/COPD patient who needs meds quickly." And at the same time many have years of experience and have all ready passed state exams and practical exams to be certified as a paramedic in Iowa. If Benton County loses most of its EMTPs, we will see a huge set back in EMS care in our communities. While we have a hand full of Paramedic Specialists, we have many Iowa Paramedics on our crews. Take them away and we will also see more calls for tiers with ALS from services from Cedar Rapids and Iowa City which takes them away from their communities as well and returns us to the same place we were many years ago before the EMTP level. We can also see many of our senior EMTBs and EMTIs not wishing to do more classes and either falling back to the lowest level or just deciding it's time to give up EMS. Blairstown has not 1 but 2 miracles in our town who were brought back from cardiac arrest by EMTPs. One responded only after being given cardiac medications and without that Iowa Paramedic we believe he would not have survived. Both of these patients returned home and have absolutely no neurologic deficits. As a service we see absolutely no benefit to our patients in forcing our EMTPs to fit into the new paramedic level as the skills gained will likely never be used and some are not even allowed by our protocols, such as RSI. The 12-lead project here in Benton County is underway and once in place all EMT levels will be able to attach the 12-lead and send a reading to the ER where it will be read. The need for the 12-lead to be read in the field will not be necessary. We do see many of our volunteer paramedics with many, many years of experience choosing to resign if required to do many more hours of class time, clinical, another written test, and another practical. Many will decide it is time to give up EMS. The effect on our communities is potentially devastating when it comes to getting advanced care quickly. While this change may affect all levels of EMS certifications, we see it having the most effect for our EMTPs as it would most likely require the most time to transition and would involve the biggest number of skills compared to the other levels. Option 2/Add New Levels: While we understand the confusion of adding, yet again, more new levels into the EMS system, all of these levels were added by the state for a reason. Those of us providing care in our communities and functioning at our current level were not involved in those decisions but are hugely affected by them. Historically Iowa has continued to add levels as they come along. This is nothing new for our state. The general public knows they call 911 and they expect the best paramedic level of service to arrive and take care of everything because that is what they see on TV. The bigger issue with the rural public will be explaining to them why they no longer have very many paramedics IF you make the EMTP transition too long and time consuming for our volunteers. EMS providers, service directors, and medical directors understand the differences and will adjust to the new levels being added, just like we have in the past. Being nationally "compliant" and mobile in the EMS community nationally is important in many ways. We believe the change is a positive one for the future for certain. The issue is to NOT destroy what we have now! We will all continue to function nearly 100% of our time in our communities where we are. Few of us from small volunteer services will be asked to function out of state. A few move out of state and most I have heard of adjust with some classes or updates to their new state and new protocol. The new EMTs who fit into one of the 4 new categories will know they are nationally mobile when all states are on board. Which again, may take some time. Your decisions as to what will be required WILL affect our community. We ask that you consider our patients as they are our primary and only reason we function in EMS. Will your final decision improve their quality of care or will it cause many of us to say, enough is enough, and let EMS go? Therefore affecting number of care givers and the level of care available. We ask that you consider all of the patients of Iowa and make the decision that impacts them in the most positive way. If our motivation is not for the best care

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

possible for our patients, it is our opinion we should not be in the EMS and healthcare. We thank you for hearing our concerns and taking on the responsibility to make the final decision on this issue for all of us in EMS and all of us who will ever need emergency care in the great state of Iowa.

---

Option 2 please. I think this will be the best option for area

---

Option 2 please. I think this is the best for me and our town

---

voting for option 2 our communitiy needs this. Please don't take this away from us.

---

I cast my vote for option # 2.

---

Voting Option 2 – EMT

---

This letter is in response to the QASP's recommendations regarding rertification levels for EMS workers in Iowa. As an EMT-B in a small rural community located approximately 25 minutes from the closest emergency room, I encourage the QASP to adopt option 2. Option 2 is the only option that will continue to offer quality emergency services to our small rural community. Requiring our volunteer EMS workers to again spend money to learn skills they are already well trained and prepared in will diminish our EMS work force. These last 2 weeks are a good example of why we need to be sure that our current EMS workers are able to continue to provide their current skills in emergency care. Our community was shut off by floods from all level one trauma facilities and had to take several detours increasing the ETA to the closest emergency room. Had our EMT-B's, EMT-I's and Paramedics been unable to perform some of the tasks that they currently can perform we may have had people who were unable to survive. Also, as a parent of a child who suffers from severe asthma and allergies, who has had to make numerous trips to the ER via ambulance, I can assure you that she would not be here today had the EMT-B's, who were able to successfully help her inject "epi" through her epi-pen, had not been able to provide that care. By chosing option 2 our current EMS workers will continue to provide the optimal care they are currently providing. They will also have the "option" to increase their skill levels, not be forced to, and become an even more skilled provider in the future. Thank you for your time and serious consideration. I vote for the 2nd choice

---

I vote for the 2nd choice

---

I am sending an e-mail regarding the future of Iowa Paramedics, I have been a State Paramedic for approximately 4 years. I truely love my job, and worked hard to get here! I work at a hospital based ambulance service and half of our service is Iowa Paramedics. I am concerned about the changes to come. I am hoping for a reasonable solution / answer to this situation. Due to the possible changes to come , I am concerned about my future as a Paramedic, being able to keep my job , having the finances and the time to go back to school, to upgrade to be able to keep my job and to continue to be a Paramedic! While I am not sure either what is the best solution for this , I do however have a few ideas. Is it possible for State Paramedics to have their Medical Director / service run their staff through the skills needed yet to upgrade to a National Paramedic ( Paramedic Specialist ), check them off and send in documentation of these skills to the state and Grandfather in so to speak? Then set a date for the new standards and future classes and such to begin the National Model? I do not want to be down graded as an EMS provider, but instead be upgraded to a PS or National Paramedic! I am

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

hoping to be Grandfathered in to a PS level, due to finances, and time to be able to take classes with a full time job and stuff not as easy to get time off and having the money to go to classes. If we did have to take classes to upgrade, what about the cost, having it over the ICN so it was easier to maybe do and get done to be able to obtain and achieve?! What colleges would offer this? Would the programs be a whole year long? Could the classes be shorter and just the skills we needed to become a PS? I do not think that making IA Paramedics Advanced EMT's is fair, because a few years back Iowa Grandfathered in those who were already paramedics to a PS level, without any additional schooling, and then the classes from there on were either IA Paramedic or PS based. I fear a lot of people will loose their jobs due to this, because some do and have been able to work in hospitals, clinics, and fire departments , and so on. I cannot afford to loose my job from being down graded, my service depends on Paramedics on staff, to cover calls and other service areas. Our call volume is increasing each year. Therefore , I am hoping and praying for Iowa to Grandfather IA Paramedics to the PS level, help us keep our status by upgrading us to the National Paramedic level. That is my first choice. Or somehow help us get what we need, as far as the classes over the ICN , giving us financial aid or funding to take classes, and keeping classes shorter, not a year long, or something? Again, I am not sure what the answer is but those are my ideas. I understand that this is not easy for you folks to be dealing with but, I do appreciate the opportunity to voice my opinions, and appreciate your valuable time! Please take all of this into consideration. Thank - You!

---

I would like to vote for option #2 for the EMT's in Iowa. Thank you for this opportunity Louisa County Ambulance Service is in support of option 2 of the Scope of Practice. We really feel the citizens of our community will be better served with the levels currently practiced. Thank you

---

i would like to help my parents and my town by voting for number 2. Thank you.

---

I would like to voice my support of option 2 in the Scope of Practice document which is posted on the IDPH website. I feel that our service is outstanding and the proposed changes would adversely affect our current EMS services which I have had to use on 2 occasions. Thank You

---

To Whom It May Concern: My family and I are concerned about the idea of implementing The National EMS Scope of Practice Model in Iowa. WE are against the modifying of the current levels of paid and/or volunteer EMS personnel within the state. I have talked to several current people involved in Fire & Ambulance & Police and they advise they have done their share (10-20 yrs) of the EMS stuff, and are happy in their current status/state. If they are forced to change then most if not all will let there certifications lapse, which would result in a longer response time from 5-10 minutes (city owned service-volunteer or private-paid) to anywhere from (for just drive time to the call (20-30 minutes & longer depending if one is available at that time) for the rural area. Obviously this would result is the MORITALITY rate to increase and/or undo pain & stress on the victim or family. At the expense of IOWANS, are we willing to let us die, so that someone might come, to the state and work. Even if we went to the NATIONAL STANDARDS, and one person died from the lack of immediate care, that ONE is too many. How would it be if that one person who died was you, your spouse, mom, dad, brother, sister, or your kid(s), and there was an ambulance sitting in a garage 1 mile away but no one to staff it. I wonder if you would think twice then about the decision you made to go to the national standard ems. Or would you just shrug it off as the cost of a better EMS system. I think that we have a current system that works for IOWA. We have the people here now saving life or helping victims. Yes it might need a little polishing here and there, but not at the cost of national standards. Everything in life needs a little polishing now & then.

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

Re: Emergency medical standards I think that we have a current system that works for IOWA. We have the people here now saving lives or helping victims. Updates our great but not at the expense of our emergency medical teams whether the expense be there time or monies to live up to these new standards. Lets no fix what is not broken!

---

I work in rural Iowa and know 1st hand of the service our EMS can provide. It is so very valuable to rural communities. Voting for option 2

---

I'm an emt-b with the louisa county ambulance. I would like to cast my vote for option #2 thanks

---

I want you to know that I chose option 2 in this important issue. Thanks I just know that in a small community like the one I live in - it's crucial to be able to have care on the way to the hospital since the closest one is almost a half hour away. I think the people that are willing to volunteer and already have the skills, should be allowed to use them and I don't care if mine is anonymous or not. Iowa has a lot of rural communities and we need to keep that in mind when making crucial decisions like this one. Thanks

---

Hello, Both my husband and I are "VOLUNTEER" EMTs with the Holy Cross/North Buena Vista Fire Department. I want to address the EMT status changes. Legislature is proposing that all EMT's are expected to go back to school to remain at the scope of practice that they are in now. I myself just finished EMT-Basic classes in May of 2007 at the department's expense, so that we can have adequate medical coverage for our territory, and now you are telling me that I will have to go to school again at MORE EXPENSE to keep my license. Remember I am a "VOLUNTEER" . If you penalize all volunteer EMTs, who give up their time to help save lives in their community, you will 'Lose" these volunteers, including both my husband and I. We simply cannot afford to do this. We attend classes and go through hours of training to keep up our CEU's. This should be sufficient Our only "volunteer" paramedics are being told that they cannot perform the procedures that they have been doing for years. How stupid is this! At the rate that you are going, we will not have anymore volunteers, and the mortality rate will be much higher.If there should ever be a disaster, I would think that they could use all the medical help that they can get. Vote NO to keep our system the way it is.

---

The reason for this message is that I am concerned for our community and the proposed changes to the EMS Scope of Practice Model. Our community doesn't have a depth of paramedic personnel. I think the model needs to allow the Iowans Paramedic (I-99) to continue as a legacy certification following the transition to the new Scope of Practice. By doing so, this will continue to allow paramedic service to rural Iowans. Thank you for your time,

---

I support Option 2.

---

We want option 2 for the Scope of Practice

---

OPTION 2 (please)

---

I would like the state to choose option two for the scope of practice. Concerned citizen,

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

---

Would like to voice my support of option 2 in the Scope of Practice document which is posted on the IDPH website. I feel that our service is outstanding and the proposed changes would adversely affect our current EMS services which our family has used on two different occasions (one time saving my father's life). Thank You

---

I am in favor of option 2 in the scope of practice document. I think option 1 would be too big of a burden to our rural service providers, who I feel do an excellent job.

---

I support option 2 regarding EMS in rural areas. Since this is a farming, community we are some times quite a distance from medical assistance. Having them nearby is a tremendous asset and one never knows....

---

Iowa Bureau of EMS: Our local "small town" EMT's are very professional and well trained. We cannot afford to lose them....They have saved lives which likely would have been lost if the patients would have had to wait for help from a distance. I respectfully request that you NOT enforce "Transition" and DO NOT require our devoted volunteers to comply with the new national standards. They would have to pay for additional training from their own pockets, taking precious time from their gainful employment and from their families. If you do require this, we will likely loose many of them!!

---

I would like the state of support Option #2 for the Scope of Practice. I think Option #1 would have a very negative effect on health care in rural Iowa. I hope our opinions really matter.Thank you,

---

i would like to vote for option 2!!

---

For what it's worth, here's my 2 cents worth regarding the Scope of Practice transition options being considered in Iowa. I understand that many EMS responders in the state of Iowa are volunteer. They perform their duties admirably and pursue training opportunities whenever and wherever they can. I also understand that most of these people have other careers and obligations that make it difficult for them to take extensive training in order to upgrade their skills to a nationally accepted norm. For this reason alone, Option 2 ("add new levels") might seem more popular among this population. However, looking at the bigger picture, I think Option 1 (transition) is more practical. Creating a total of 13 different levels as proposed by Option 2 would create headaches for everyone. Also, considering the frequency and extent of natural disasters or terrorist events requiring resources from neighboring states, it only seems sensible to minimize the number of levels to be in line with the rest of the country. I think that to support Option 1 is to keep in line with the spirit of the National Scope. To support this option is to support simplification and coordination of the various levels. Although it may be a burden to some initially, in the long run it will be considerably easier for providers to maintain their training as well as move in or out of state. Thanks for the effort that all of you have put in to this.

---

hi, my name is... I am assistant fire chief in holy cross ia. i became a first responder in 1994, late moved up to an emt-b. I strongly dis-agree with the change of scope of practice for emt-b & iowa paramedics. the extra class time required to maintain our current level of service would be almost impossible of most all of our volunteers. my guess is most would retire or simply quit. this is a bad deal for our community in rural iowa.

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

To whom this may concern, I feel my rural neighbors would best be served for emergency response with staffing of our volunteer responders at those levels currently practiced in Iowa. I'm not in favor of option one because I don't want to lose my skills that I have worked hard to gain and that could someday, save someone's life. Therefore, I vote for option two.

---

I am voting for option #2.

---

I feel that Iowa should adopt the standardized national scope of practice and abolish all current levels of certification. It is currently very confusing as to what each level's scope of practice is, and this new system would, I believe, eliminate all doubt as to a person's level and ability. Thank you for your time.

---

My family and I are concerned about the idea of implementing The National EMS Scope of Practice Model in Iowa. WE are against the modifying of the current levels of paid and/or volunteer EMS personnel within the state.

---

Reading the proposal and changes of the EMT levels I would like to see Option 2 continue however with the levels of: EMT-A, EMT-D, transition to EMT EMT-I, for the ones that do the training and class time should be able to keep the certification and not drop down. Should be able to keep their level of training if taken before this new date of change. (Grandfathered in) I think they should keep the EMT-I. Need to look at cost also for the ones that want to upgrade. What is it going to cost for volunteer departments that want to change.

---

I have 29 years of experience in EMS, certifying at EMT-A, EMT-D, EMT-I and EMT-P levels and am aware of the potential problems with EMS levels not meeting a national standard. But on the other hand, I am offended to think the State of Iowa would take away my EMT-P scope of practice I earned at age 50. I was certified by following your rules and guidelines. I am not a career paramedic, but rather serve my small rural community as a volunteer EMT-P. Option 1, for the most part, will take away the paramedic level of care from the towns of Adair and Casey. My community named the Adair EMT-P's as <sup>3</sup>Citizens of the Year<sup>2</sup> in 2005 for beginning the paramedic level of care for Adair Fire Department Ambulance. I don't care what you call me, but don't take away the current scope of practice for those who earned it through Iowa-approved training and testing. I spent more than 1,000 hours away from my family to go through the rigorous training program for the EMT-P level. There has always been confusion with other members of the EMS community about the levels of care in the field. Having only four certification levels instead of nine will not eliminate the confusion. I urge the committee to choose Option 2 to best serve the needs of our patients in rural small town Iowa.

---

I have been contacted by some of my rural EMS folks on the proposed rule changes for scope of practice of EMT's. I would urge that we approach this cautiously as it is very difficult to recruit and keep our rural EMS responders. I believe that the present system serves us well and change for the sake of change may not yield the results we hope for. Most rural responders are volunteers and local city budgets are very tight. I am concerned about the necessary costs of the con-ed modules, the availability of instructors, the timeline for completion of requirements as many people have full time jobs and finally the number of people who may decide that it just isn't worth jumping through more hoops and will walk away. Just my thoughts. Sincerely, Brian Schoenjahn  
Iowa Senate 12

---

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

---

To Whom It May Concern: The Grandview Township Trustees maintain a position as being in favor of Option 2 in the Scope of Practice document which is currently posted on the IDPH website. We feel that the citizens of our township in our rural area will be best served for emergency response with staffing for our volunteer services at those levels currently practiced in Iowa. We feel that the the combitube or King LT as a means of airway control should continue to be available at the EMT level. Also, IV monitoring, cardiac monitoring, MAST/PASG, blood glucose monitoring and carrying and administration of an epi-pen should continue to be part of the EMT scope of practice. We also support the Option 2 for the advanced level provider. We feel they should continue to be able to administer cardiac drugs in the event of a serious cardiac arrhythmia or arrest. We operate under a volunteer system that has served us very well in the past, and we hope to continue in the same system. We are fortunate to have our EMTs that serve our township. They are to be credited with not only giving many people in our rural area excellent care in time of need, but have also saved many lives. Most of our volunteers currently practice these skills and we feel it is unlikely that we will be able to find new volunteers that will train to the Paramedic level, both in terms of time and monetary investment. We also feel it is unlikely that many of the current Iowa paramedics will opt for testing to transitions to a new level to perform skills to which they currently have trained and tested. Our providers have already attained the skills crucial to good patient care. We feel it is in the best interest of our township citizens to retain these skills and the providers which are allowed to practice them. Please consider our views and these patient care issues when making your final decision concerning the levels of practitioners in Iowa. Sincerely, Grandview Township Trustees Earl McGill, Clerk

---

I just read about this today. I support option 2.

---

If you don't get this in time, I suspect that it will fall in line with the majority of EMS providers' feelings (I hope!) I believe we need to adopt the option #1 listed in the IDPH document regarding the national scope of practice. Iowa has led many aspects of EMS in the past, and we can continue to do so – however it will be easier to lead if we first comply with the national guidelines. I believe it will be too burdensome to create another layer of Iowa specific certifications that may live on for the next 20 years. A few questions have come up regarding scope of practice. Do we have any ideas about what CE modules will be necessary for the transition for Paramedic Specialists to the new Paramedic? Also, how does the National Registry play into the mix? If a PS is Nationally Registered as a Paramedic, will the same CE modules be necessary? I know these questions don't need answers right away – just a few random thoughts. Thanks for allowing the input – sorry it's at the 11th hour.

---

As training officer for the Holy Cross Volunteer Fire Department I feel it is important for me to pass on to you the opinion of many involved with our department. While we understand that the “state” feels the mandatory training requirements they continue to enforce are beneficial for everyone it continues to be extremely difficult for our volunteers to manage to accomplish all that is required. We have been informed that in many instances many people will be required to take additional training to maintain the current rank they hold in order to make all states equal. As an example, a paramedic may be required to take 450 additional class hours to remain a paramedic. It is our fear that very talented personnel will resign due to time constraints. Many have threatened to quit if the requirements continue to be added. Please keep in mind that many departments rely on volunteers only and cannot operate without them.

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

---

The Iowa EMS Association has long supported improvement and progress in the delivery of emergency medical care. One part of that undertaking is the support of the EMS Agenda for the Future. This project began several years ago and looks at the best practices in EMS. It has identified several areas for review and possible avenues for improvement. One part of this entire agenda is a scope of practice developed with a national continuity of care as its goal. This scope is also now the blueprint for the development of educational guidelines to match these levels. Iowa has been on the leading edge of EMS development throughout its history. Many of the current standards of care are the result of projects started here in Iowa. The next step in being a leader in providing the best emergency care possible for our citizens is to streamline the training and staffing of our EMS systems. With that said, the Iowa EMS Association will support the Quality Assurance, Standards and Protocol (QASP) committee “*Option 1*” as explained in the document, “The National EMS Scope of Practice Model in Iowa.” We feel that this is the best option in promoting the progressive quality of EMS in Iowa.

This proposal calls for all EMS providers in Iowa to be transitioned to one of four levels outlined in the National Scope of Practice Model. These levels are:

1. Emergency Responder
2. EMT
3. Advanced EMT
4. Paramedic

### *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.*

*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.*

## National Scope of Practice Implementation Document

Comments have been transcribed as received without alteration to grammar or content.

*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.*

As the only professional organization representing nearly 2800 providers and services in the state, IEMSA strongly supports Option 1 of the National Scope of Practice Model in Iowa. IEMSA's support of this proposal is based on many factors:

1. First and foremost is the input from our members. This has been obtained through personal conversations, correspondence, and several surveys. Whatever the method, the support was overwhelmingly in support of this option.
2. Transitioning to the four new levels will maintain a greater degree of continuity across state borders. In support of a "National Scope of Practice" with four levels we can begin a transition in provider equality across the nation. This will allow EMS to join our partners in healthcare and other professions by providing portability in our certification.
3. Equality of certification through the use of common validated evaluation and testing procedures utilizing national standards.
4. Healthcare is a dynamic profession and is constantly in a state of change. Iowa EMS providers have risen to the challenges of transition before and we are confident that they are ready to do so again to continue to provide the best care to the citizens we serve.

In summary, IEMSA mission is to provide a voice and promote the highest quality and standards of Iowa's Emergency Medical Services. We feel that the only way to do that is to support Option 1.

Iowa EMS Association Board of Directors

---

Nothing follows.