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Topeka, KS 66612-1228

Kansas
Board of
Emergency Medical Services

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Dr. Joel E Hornung, Chair
Joseph House, Executive Director

Laura Kelly, Governor

Executive Committee

Chad Pore – Acting Chair

AGENDA
September 30, 2021 – 11:00am

PHYSICAL LOCATION:
LANDON STATE OFFICE BUILDING
900 SW Jackson, Room 509; Topeka, Kansas

VIRTUAL LOCATION(S):

From your computer, tablet or smartphone – Remember to Mute.
https://global.gotomeeting.com/join/483129309

Dialing in using your phone – Remember to Mute.
United States: +1 (571) 317-3112
Access Code: 483-129-309

1. Standing Items

1.1 Legislative Update – None at time of publishing agenda

2. Old Business

2.1 KBEMS Legislative Meeting Follow-Up – Potential Action

KBEMS held their annual legislative brainstorming session on July 13. Summary of that meeting and prioritization was provided at the August meeting. Discussion to determine any potential legislative plan for the Board.

- Legislative Summary

2.2 Medication List Regulations – 109-3-3 and 109-3-5 – Potential Action

Review of comments received during the public comment period and hearing. Recommendation for Board adoption of these revised regulations.

- K.A.R. 109-3-3 (stamped version)
- K.A.R. 109-3-5 (stamped version)
- Board approved medication list – dated June 4, 2021
- Comment(s) received (only those received prior to publishing of packet)
- Proposed response for comment(s) submitted prior to publishing of packet

3. New Business

3.1 KEMSIS v2 database – Information only

On September 13, the KEMSIS system based upon NEMSIS version 2 data definitions was officially retired. All data has been transferred to an accessible alternative solution and PDF copies of the patient care reports for services utilizing

NOTES: Those in physical attendance must adhere to all policies and guidance related to COVID instituted by both Shawnee County and the Governor. Upon publication of this agenda, that includes self-temperature screening at the kiosk upon entry into the building, the donning of face masks while in public settings, and the practice of social distancing where possible.

the state system for direct entry will be developed over the course of the next year and submitted back to the services to meet their record retention guidelines.

4. Public Comment

Public comment time on the agenda is limited to no more than 5 minutes by any one speaker. If an individual would like to comment on an agenda item after committee discussion but before a vote, the individual should notify the Chair prior to the start of the meeting.

5. Adjournment

NOTES: Those in physical attendance must adhere to all policies and guidance related to COVID instituted by both Shawnee County and the Governor. Upon publication of this agenda, that includes self-temperature screening at the kiosk upon entry into the building, the donning of face masks while in public settings, and the practice of social distancing where possible.

Agenda Item: 2.1 – KBEMS Legislative Meeting Follow-Up

Committee: Executive

BACKGROUND

Annually, KBEMS conducts a legislative brainstorming session to identify any potential statutes, rules, or regulations that may need to be enacted or revised. A summary of that meeting including the topics and ideas discussed were provided at the August meeting.

An ask was made to identify which topics would fit within the Board's primary focus and then to identify by what means: statute, regulation, or policy that could be achieved.

DISCUSSION

Statutory Change/Addition anticipated (highest to lowest priority from weighted average)

1. Regulation of behavioral health transports/secure transports – 4.0
2. Creating protected regional peer review specific for EMS – 3.9
3. Establishing a standard of care for EMS in Kansas – 3.7
4. Regulation of EMRA/First Response Agencies – 3.7
5. Medical Advisory Council – structure meeting the need – 3.6
6. Term limits for KBEMS Board Members – 3.5
7. Adding point of care ultrasound as an authorized activity at AEMT level – 2.4

Regulatory Change/Addition anticipated (highest to lowest priority from weighted average)

1. Clearly identify where an order during non-emergency/interfacility transports falls under authorized activities – 4.3
2. Mandated initial education for service directors – 3.6
3. Mandated ongoing education for service directors – 3.3
4. Creation of a new classification of ambulance service – private transport – 2.8
5. Creation of a new classification of ambulance service – no 24/7 requirement – 2.6

Policy Change/Addition/Emphasis anticipated (highest to lowest priority from weighted average)

1. Enhancing/developing recruitment/retention programs, incentives, etc. – 4.5
2. Obtaining a better understanding of the EMS workforce in Kansas – 4.1
3. Linking EMS data and Health Information Exchange (HIE) data – 3.9
4. Linking EMS data and Trauma data through Biospatial – 3.7
5. Linking EMS data and Crash Report data – 3.4

FINANCING

There is a financial impact from most, but not all, of these items. A more complete look at the financial impact would be explored upon any item deemed a priority for the remainder of this fiscal year or the next (FY22 or FY23).

ALTERNATIVES

The Committee may:

1. Develop a recommendation for the Board with the information provided
2. Request additional information from staff for a recommendation to be developed by the committee by the December meeting
3. Table the item.

RECOMMENDATION

Board staff recommendation is to develop the following recommendation for a 3-year legislative plan for the Board:

1. Proceed with drafting potential legislation for Statutory Item #2 with introduction in the 2022 session.
2. Proceed with meetings and discussion related to legislation for Statutory Items #1, #3, and #4 with planned introduction in the 2023 session.
3. Do not proceed with any legislation towards Statutory Items #5, #6, and #7.
4. Support those items listed in the regulation area through assignment of all 5 ideas to the Planning and Operations Committee for development of a plan to address.
5. Support those items listed in the policy area through assignment of all 5 ideas to the Planning and Operations Committee for development of a plan to address.

POSSIBLE MOTION(S)

To recommend the Board proceed with staff's recommendation on a 3-year legislative plan.

To recommend that the Board proceed with staff's recommendation on a 3-year legislative plan as modified.

Enclosures:

1. Legislative Meeting Notes with Prioritization and Grouping

Kansas Board of EMS Legislative Meeting
9:00 am – 11:15 am
Tuesday, July 13, 2021
Milford Conference Center; Acorns Resort; Milford, KS

MEETING NOTES

Attendance:

Bob Kelly – Logan County EMS
Bradly Klein – Winfield Fire/EMS
Brandon Beck – Lyon County/Emporia FD
Con Olson – Nemaha County EMS / TECHS
Craig Isom – Med-Trans Corporation
Dave Beam – Dickinson County EMS
Dave Johnston – KEMSA / Reno County EMS
David Adams – Riley County EMS
Debra Brown – Haskell County Amb. Serv.
Diedre Stout – Clay County EMS
Dillon McArthur – Butler County EMS
Frank Burrow – Miami County EMS
Jason White – MARCER
Jered Schulte – Coffey County EMS
John Hultgren – Dickinson County EMS
Karl Leech – Minneapolis Amb. Serv.
Kent Vosburg – Junction City FD
Rocky Cramer – Clay County EMS
Ron Marshall – Kansas Hospital Association
Scott Harris – Pratt County EMS
Sean Gatewood – KEMSA
Shane Pearson – Salina FD and KBEMS
Jeri Smith – Arkansas City FD and KBEMS
Chad Pore – KBEMS
Ed Klumpp – KSA; KACP; and KPOA
James Reed – KBEMS Staff
Joe House – KBEMS Staff

Virtual Attendance:

Pete Rogers; Kassy DeWitt – Phillips County EMS
Chris Steiner – Claflin Ambulance Service Assoc.
Deb Kaufman – Sheridan County EMS
Caroline Scoville – City of Washington EMS
Brenda Heimlich-Birney – Scott County EMS
Rosa Hettinger – Kiowa County EMS
Mickie Helberg – Graham County EMS
(25 in physical attendance, 8 in virtual attendance, and 2 Board staff)

- ***Welcome and Introductions***

- ***2021 Legislative Update***
  - An update was provided on the following:
    - HB 2234 (now SB 238) – Medical Director Bill - passed and effective on June 3rd
    - Passed and effective on July 1st - Trauma peer review sunset has been eliminated and the expedited licensure law goes into effect.
    - SB 306 – Sales tax exemption for county ambulance service districts – will be pursued in the 2022 session.
    - Rural Emergency Hospital Act – Ron Marshall provided the group with an update on where the state was with the newly enacted Federal and State laws allowing for a critical access hospital to designate as a rural emergency hospital.

- ***2021 Regulatory Update***
  - An update was provided on the following that are all still proceeding in the process and nearing their official public comment period. Anticipating all to be in effect by the end of 2021 if adopted:

- Sponsoring organization regulations
- Inactive status
- Medication list changes – list approved at the June 4, 2021 meeting is scheduled for public comment on September 29th with the hopes for adoption on October 1st and in effect by November 1st.
- Discontinuing paper applications
- Roster change notification

- ***Colorado Ketamine Bill – House Bill 21-1251***
  - Group was provided an overview of the requirements listed within the newly enacted (July 6, 2021) bill in Colorado regarding the administration of Ketamine by EMS providers.
  - It was shared that there has been interest expressed by at least 2 Kansas legislators to do something similar in Kansas. Both KEMSA and Ed Klumpp, representing three law enforcement groups in Kansas, offered their assistance in addressing this with the legislators. *UPDATE – communicated with both legislators and this no longer appears to be of concern.*

- ***Idea Gathering (ordered as discussed/introduced) – asterisked items were discussed in previous years as well. (All of these items were brought forward by attendees)***
  - Post-traumatic stress disorder being covered as a line of duty injury for worker's compensation (specific to public safety – EMS, Fire, and Law Enforcement)
  - *Medicaid supplemental programs
    - FRA / Provider tax – purpose of pursuing is to grow closer to being reimbursed at the Medicare Allowable Rates for Medicaid patients.
  - Direct appropriation increase to increase reimbursement for Medicaid patients (no program)
  - Treatment in place
    - Pursuing the mechanisms necessary to allow for reimbursement of treatment of patients whether transportation is included or not.
    - Federal government made an exception to allow this for COVID patients – federal law being introduced to expand it to all patients.
  - *Community paramedicine
    - Pursuing the necessary mechanisms to receive reimbursement for providing community paramedicine services within the community.
  - Alternate destinations
    - Pursuing the necessary mechanisms to receive reimbursement for providing transportation to an alternate destination (rehab, detox, crisis center, etc.) other than a hospital.
  - Protected regional peer review for EMS
    - To allow for peer review to occur among EMS within a specific region and it be protected from disclosure.
    - To allow for the establishment of a standard of care of EMS in Kansas
  - Mandated education for service directors – initial and ongoing
    - Idea was presented for something similar to an Educator workshop specifically designed for service directors.
    - Offering would provide regulatory updates, statewide trends, and basics for success as well as providing leadership growth opportunities.
  - *Ground billing and surprise medical billing act (Federal legislation)

    - To ensure that Kansas ambulance services are not adversely affected by these pieces of proposed legislation.
- KP&F / KPERS
    - Looking to potentially decrease the time necessary for EMS providers to divest in these retirement programs.
- *Term limits for KBEMS Board Members
- Authorized activities
    - Looking to clearly identify where an order during non-emergency/interfacility transports falls under the authorized activities
    - Addition of point-of-care ultrasound at the AEMT level
- *Emergency Medical Response Agencies / First Response Agencies
    - Looking to include a mechanism of providing regulatory oversight of these agencies thereby affording them the legal ability to provide these services and the statutorily granted liability protections.
- *Medical Advisory Council
    - Question as to whether its current structure is meeting the needs of the Board or whether there is another mechanism to achieve that clinical expertise.
- Behavioral health / secure transports
    - Are ambulance services the correct resource to utilize for these transports
    - Currently, non-ambulance service agencies providing these transports are not regulated.
- *Creation of a new classification of ambulance service specifically for private transport
    - No 24/7 requirement
    - Variance from other regulations, like the allowance to store an ambulance outside.
- Seeking an exemption for ambulances to tolls levied by the Kansas Turnpike Authority
    - Butler County shared that this can already be done and will provide contact information.
- Linkage of EMS data to Trauma data
    - With the Biospatial rollout, gaining a better understanding of the data and our patients by linking with other proven data sources.
    - Could also include linkage with Crash Reporting databases (KDOT) and health information exchanges (KMS and KHA).
- Obtaining a better understanding of the EMS Workforce
    - Trying to determine how many EMS providers are providing primary care in the EMS setting vs. providing in another setting vs. not providing care at all.
    - Trying to determine why we are seeing increased shortages at the ambulance service level when provider numbers are higher than in previous years.
- *Recruitment / Retention
    - Not only EMS providers, but also EMS Instructors.
    - Are there funding sources, programs, etc. designed to support this?
    - Are there incentives that would assist in recruitment/retention?
        - Previous ideas – tax credit for EMS providers; loan forgiveness program for EMS providers.
    - Mention of the Kansas Promise Act – available to most students taking EMS courses through a Kansas Board of Regents institution.

- ***Prioritizing and Grouping***
    - The thought is that whereas all items listed may require a statutory, regulatory, or policy change, the Board of EMS should focus solely on those statutory areas that would pertain to the protection of public welfare through the regulation of attendants, operators, services, and educators and allow other groups/entities to focus on changes that may better align with their vision and mission.
    - It was noted that a survey would be created to rank, prioritize, and group these ideas by the participants and that those results would be presented to the Board.

- ***Adjournment and Thanks***

Meeting organizer note: As in previous years, I would especially like to thank those in attendance, both in-person and virtually, for their openness and willingness to provide input and feedback to the Board and Board Staff. This information will prove extremely beneficial in moving forward EMS in Kansas and continuing to provide better out-of-hospital care to our patients. Thank you for taking of your busy schedule to participate in this process! Joe

Prioritization of Ideas

Survey sent out on July 28th via Survey Monkey with a request to provide an answer by noon on August 4th for inclusion in this section. Of the 33 participants, 10 responded to the survey. Participants were asked to rank each of the ideas and answers were weighted to provide an average score.

Available rankings and weights: No desire to pursue – 1 point; 1 to 5 years – 4 points; 10 or more years – 2 points; As quickly as possible – 5 points; 5 to 10 years – 3 points

Prioritization is as follows from high to low:

Score	Idea	As quickly as possible	1 to 5 years	5 to 10 years	10 or more years	No desire to pursue
4.6	Medicaid supplemental program to increase reimbursement	6	4	0	0	0
4.5	PTSD being covered as line of duty injury for work comp. purposes	6	3	1	0	0
4.5	Enhancing/developing recruitment/retention programs, incentives, …	5	5	0	0	0
4.3	Clearly identify where an order during non-emergency/interfacility transports falls under authorized activities	4	5	1	0	0
4.3	Direct appropriation increase to increase reimbursement for Medicaid	4	5	1	0	0
4.1	Obtaining a better understanding of the EMS workforce	4	5	0	0	1
4.0	Regulation of behavioral health transports/secure transports	3	5	1	1	0
3.9	Linking EMS data and Health Information Exchange (HIE) data	3	5	1	0	1
3.9	Creating protected regional peer review specific for EMS	3	3	4	0	0
3.8	Funding for transport to alternate destinations	2	5	2	1	0
3.7	Establishing a standard of care for EMS in Kansas	4	3	1	0	2
3.7	Linking EMS data and Trauma data through Biospatial	2	6	0	1	1
3.7	Funding for treatment in place	3	2	4	1	0
3.7	Regulation of EMRA / First Response Agencies	1	6	2	1	0
3.6	Medical Advisory Council – structure meeting the need	3	3	2	1	1
3.6	Mandated initial education for service directors	2	4	3	0	1
3.5	Term limits for KBEMS Board Members	2	5	1	0	2
3.4	Linking EMS data and Crash Report data	2	4	1	2	1
3.3	Mandated ongoing education for service directors	1	5	2	0	2
3.3	Decreasing the time necessary for EMS to divest in KP&F/KPERS	1	5	2	0	2
3.3	Funding for community paramedicine	0	6	2	1	1
3.1	Ground billing and surprise medical billing pieces of legislation	2	2	3	1	2
2.8	Creation of a new classification of ambulance service – private transport	1	2	4	0	3
2.6	Creation of a new classification of ambulance service – no 24/7	0	4	2	0	4
2.4	Add point-of-care ultrasound as an authorized activity at AEMT level	1	1	3	1	4

No shading indicates that the idea could be a better fit for another entity's focus, than the Board's focus.

Shading Key: Blue = Statutory Green = Rule/Regulation Orange = Policy

Agenda Item: 2.2 – Medication List Regulations – 109-3-3 and 109-3-5

Committee: Executive

BACKGROUND

The Advanced Emergency Medical Technician (AEMT) is the intermediate level of certification between the Emergency Medical Technician (EMT) and the Paramedic. The AEMT level of certification came with Kansas' alignment of levels of certification with the National EMS Scope of Practice Model. For Kansas, it was designed to replace the EMT-Intermediate, the EMT-Defibrillator, and the EMT-Intermediate/Defibrillator levels of certification.

Those with a level of certification being discontinued were provided at least a 4-year window to transition to either the EMT scope of practice or the AEMT scope of practice. Transition courses were developed and offered to complete this task.

The scope of practice for the AEMT has been the topic of significant discussion in the years leading up to the transition and in the years after. This level was initially sought to provide an advanced level of care for interfacility transports in areas where Paramedics were not as populous. This evolved into the current authorized activities and medications.

In the National EMS Scope of Practice Model, the AEMT should be able to "perform focused advanced skills and pharmacological interventions that are engineered to mitigate specific life-threatening conditions, medical, and psychological conditions with a targeted set of skills beyond the level of an EMT."

Since implementation of the first medication list for the AEMT, there have been consistent requests for additional medications to be added to the approved medication list. These requests were forwarded to the Medical Advisory Council (MAC) of the Board for their deliberation and recommendation. In April 2018, a modified medication list was presented and discussed within the MAC and it was asked for a period of public comment upon the proposed list. These comments were compiled and presented to the MAC for their August 2018 meeting. At that meeting, some slight changes were made and the resulting medication list was presented as a recommendation to the Board during their October 2018 meeting.

Polarized comments were received leading up to the October 2018 meeting and at that meeting, the Executive Committee of the Board directed the formation of the AEMT Excellence Committee with Chad Pore as the chair and one portion of their charge was to review the AEMT portion of the medication list.

After multiple meetings of the AEMT excellence committee, it was determined that the medication list should proceed towards approval and the focus should be shifted to ensuring that educational components, both initial and continuing education, are adjusted to adequately assess that the AEMT is competent to administer each of the listed medications. Multiple ideas were discussed on how to ensure that this educational piece is in place.

In August 2020, the Executive Committee voted to advance the proposed medication list changes into the regulatory process. In June 2021, there was an ask to amend the proposed medication list changes still in process to address the addition of Ketorolac at the AEMT level and to address intranasal administration of glucagon at the EMR, EMT, and AEMT level.

DISCUSSION

The committee will be provided all comments received during the public comment period and hearing. Discussion will revolve around the potential adoption of the revised regulations.

FINANCING

This item has no anticipated fiscal effect upon the Board.

ALTERNATIVES

The Committee has the following alternatives concerning the matter at hand. The Committee may:

1. Recommend the Board adopt K.A.R. 109-3-3 and 109-3-5 as provided.
2. Return the list to committee for additional revision.
3. Table the item.

RECOMMENDATION

That the committee recommend the Board adopt K.A.R. 109-3-3 and 109-3-5 as provided.

POSSIBLE MOTION(S)

To recommend to the full Board the adoption of K.A.R. 109-3-3 and K.A.R. 109-3-5 as provided.

Enclosures:

1. K.A.R. 109-3-3 (stamped version)
2. K.A.R. 109-3-5 (stamped version)
3. Medication List – 2021-06-04
4. Comment(s) received
5. Proposed response for comment(s) received

109-3-3. Emergency medical responder; authorized activities. Each emergency medical responder shall be authorized to perform any intervention specified in K.S.A. 65-6144, and amendments thereto, and as further specified in this regulation:

(a) Emergency vehicle operations:

(1) Operating each ambulance in a safe manner in nonemergency and emergency situations. "Emergency vehicle" shall mean ambulance, as defined in K.S.A. 65-6112 and amendments thereto; and

(2) stocking an ambulance with supplies in accordance with regulations adopted by the board and the ambulance service's approved equipment list to support local medical protocols;

(b) initial scene management:

(1) Assessing the scene, determining the need for additional resources, and requesting these resources;

(2) identifying a multiple-casualty incident and implementing the local multiple-casualty incident management system;

(3) recognizing and preserving a crime scene;

(4) triaging patients, utilizing local triage protocols;

(5) providing safety for self, each patient, other emergency personnel, and bystanders;

(6) utilizing methods to reduce stress for each patient, other emergency personnel, and bystanders;

(7) communicating with public safety dispatchers and medical control facilities;

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(8) providing a verbal report to receiving personnel;

(9) providing a written report to receiving personnel;

(10) completing a prehospital care report;

(11) setting up and providing patient and equipment decontamination;

(12) using personal protection equipment;

(13) practicing infection control precautions;

(14) moving patients without a carrying device; and

(15) moving patients with a carrying device;

(c) patient assessment and stabilization:

(1) Obtaining consent for providing care;

(2) communicating with bystanders, other health care providers, and patient family members while providing patient care;

(3) communicating with each patient while providing care; and

(4) assessing the following: blood pressure manually by auscultation or palpation or automatically by noninvasive methods; heart rate; level of consciousness; temperature; pupil size and responsiveness to light; absence or presence of respirations; respiration rate; and skin color, temperature, and condition;

(d) cardiopulmonary resuscitation and airway management:

(1) Applying cardiac monitoring electrodes;

(2) performing any of the following:

(A) Manual cardiopulmonary resuscitation for an adult, child, or infant, using one or two attendants;

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(B) cardiopulmonary resuscitation using a mechanical device;

(C) postresuscitative care to a cardiac arrest patient;

(D) cricoid pressure by utilizing the sellick maneuver;

(E) head-tilt maneuver or chin-lift maneuver, or both;

(F) jaw thrust maneuver;

(G) modified jaw thrust maneuver for injured patients;

(H) modified chin-lift maneuver;

(I) mouth-to-barrier ventilation;

(J) mouth-to-mask ventilation;

(K) mouth-to-mouth ventilation;

(L) mouth-to-nose ventilation;

(M) mouth-to-stoma ventilation;

(N) manual airway maneuvers; or

(O) manual upper-airway obstruction maneuvers, including patient positioning, finger sweeps, chest thrusts, and abdominal thrusts; and

(3) suctioning the oral and nasal cavities with a soft or rigid device;

(e) control of bleeding, by means of any of the following:

(1) Elevating the extremity;

(2) applying direct pressure;

(3) utilizing a pressure point;

(4) applying a tourniquet;

(5) utilizing the trendelenberg position; or

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(6) applying a pressure bandage;

(f) extremity splinting, by means of any of the following:

(1) Soft splints;

(2) anatomical extremity splinting without return to position of function;

(3) manual support and stabilization; or

(4) vacuum splints;

(g) spinal immobilization, by means of any of the following:

(1) Cervical collar;

(2) full-body immobilization device;

(3) manual stabilization;

(4) assisting an EMT, an AEMT, or a paramedic with application of an upper-body spinal immobilization device;

(5) helmet removal; or

(6) rapid extrication;

(h) oxygen therapy by means of any of the following:

(1) Humidifier;

(2) nasal cannula;

(3) non-rebreather mask;

(4) partial rebreather mask;

(5) regulators;

(6) simple face mask;

(7) blow-by;

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(8) using a bag-valve-mask with or without supplemental oxygen; or

(9) ventilating an inserted supraglottic or subglottic airway;

(i) administration of medications according to the board's "approved medication list," dated ~~April 5, 2019~~ June 4, 2021, which is hereby adopted by reference;

(j) recognizing and complying with advanced directives by making decisions based upon a do-not-resuscitate order, living will, or durable power of attorney for health care decisions; and

(k) providing the following techniques for preliminary care:

(1) Cutting of the umbilical cord;

(2) irrigating the eyes of foreign or caustic materials;

(3) bandaging the eyes;

(4) positioning the patient based on situational need;

(5) securing the patient on transport devices;

(6) restraining a violent patient, if technician or patient safety is threatened;

(7) disinfecting the equipment and ambulance;

(8) disposing of contaminated equipment, including sharps and personal protective equipment, and material;

(9) decontaminating self, equipment, material, and ambulance;

(10) following medical protocols for declared or potential organ retrieval;

(11) participating in the quality improvement process;

(12) providing EMS education to the public; and

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(13) providing education on injury prevention to the public. (Authorized by K.S.A. 2020 Supp. 65-6111; implementing K.S.A. 65-6144; effective March 9, 2012; amended May 5, 2017; amended Jan. 24, 2020; amended P-_____.)

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109-3-5. Advanced emergency medical technician; authorized activities. Each advanced emergency medical technician shall be authorized to perform any intervention specified in the following:

(a) K.S.A. 65-6144, and amendments thereto, and as further specified in K.A.R. 109-3-3;

(b) K.S.A. 65-6121, and amendments thereto, and as further specified in K.A.R. 109-3-4; and

(c) K.S.A. 65-6120, and amendments thereto, and as further specified in the following paragraphs:

(1) Advanced airway management, except for endotracheal intubation; and

(2) administration of patient-assisted and nonpatient-assisted medications according to the board's "~~advanced EMT~~ approved medication list," ~~dated November 6, 2013,~~ which is ~~hereby~~ adopted by reference in K.A.R. 109-3-3. (Authorized by K.S.A. ~~2013~~ 2020 Supp. 65-6111; implementing K.S.A. ~~2013~~ 2020 Supp. 65-6120; effective March 9, 2012; amended Nov. 2, 2012; amended Aug. 29, 2014; amended P-_____.)

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***Where a drug class, type, or category is listed, specific agents shall be selected and approved through local medical protocols.**

Abbreviations:

MDI = Metered Dose Inhaler	IN = Intranasal	IV/IO = Intravenous/Intraosseous
INH = Inhalation	IM = Intramuscular	
NEB = Nebulized	SL = Sublingual	

Medication	EMR	EMT	AEMT
Activated Charcoal	**Not Approved**	Oral	Oral
B2-agonist and/or anticholinergic bronchodilator*	MDI	MDI; Neb	MDI; Neb
Amiodarone	**Not Approved**	**Not Approved**	IV/IO
Antidote*	Oral; Autoinjector; IN	Oral; Autoinjector; IN	Oral; Autoinjector; IN; IV/IO
Aspirin	Oral	Oral	Oral
Benzodiazepine*	**Not Approved**	**Not Approved**	IM; IV/IO; IN; Rectal
Corticosteroids*	**Not Approved**	**Not Approved**	Oral; IM; IV/IO
Dextrose	**Not Approved**	**Not Approved**	IV/IO
Diphenhydramine	Oral	Oral	Oral; IM; IV/IO
Epinephrine (1:1,000)	Autoinjector; IM	Autoinjector; IM	Autoinjector; IM
Epinephrine (1:10,000)	**Not Approved**	**Not Approved**	IV/IO
Glucagon	IM; IN	IM; IN	IM; IN
Glucose	Oral	Oral	Oral
Isotonic Crystalloid IV Fluids*	**Not Approved**	IV/IO	IV/IO
IV fluids with electrolyte additives*	**Not Approved**	**Not Approved**	IV/IO
IV fluids with antibiotic additives*	**Not Approved**	**Not Approved**	IV/IO
Ketorolac	**Not Approved**	**Not Approved**	IM; IV
Lidocaine	**Not Approved**	**Not Approved**	IV/IO
Naloxone	Autoinjector; IN; IM	Autoinjector; IN; IM	Autoinjector; IN; IM; IV/IO
Nitroglycerine	**Not Approved**	SL; Transdermal	SL; Transdermal
Nitrous Oxide	**Not Approved**	**Not Approved**	INH
Antiemetic*	**Not Approved**	Oral; SL	Oral; SL; IM; IN; IV/IO
Opioid*	**Not Approved**	**Not Approved**	Oral; IM; IN; IV/IO
Over the Counter Antipyretics*	**Not Approved**	Oral	Oral
Over the Counter Non-opioid analgesics*	**Not Approved**	Oral	Oral
Oxygen	INH	INH	INH
Tranexamic Acid (TXA)	**Not Approved**	**Not Approved**	IV/IO
Patient Assisted Medications*	**Not Approved**	Prescribed Route ONLY	Prescribed Route ONLY

***Where a drug class, type, or category is listed, specific agents shall be selected and approved through local medical protocols.**

House, Joe [BEMS]

From: [redacted]
Sent: Saturday, September 04, 2021 2:58 PM
To: House, Joe [BEMS]
Subject: Comments on Emergency Medical Services Board proposed regulations for 09-29-2021 public hearing.

Follow Up Flag: Follow up
Flag Status: Flagged

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Please complete the following
Name: Proposed AEMT Medication list
Regulation Number: 109-3-3(i)
Comments:

Comments on Proposed Approved Medication List KAR109-3-3(i)

Background

I am an AEMT having transitioned from EMT-I to AEMT when that was available. I have been a street level AEMT since that time. I have also designed, implemented and taught the AEMT program [redacted]. I worked for [redacted] for a number of years where most of the time I had a paramedic partner. Occasionally I would have another AEMT partner and rarely an EMT partner. I now work for [redacted] where I mostly have an EMT partner and I must perform as the sole ALS provider. We have four active paramedics [redacted]. While there is usually a paramedic I can call if I need assistance the reality is that they are often enough distance away that they are of no practical on scene assistance. These comments are presented from the prospective of a provider such as myself.

General Comments

The removal of when to use the medications is a good thing as it allows the Medical Director to decide what they do and do not want the technicians doing. Likewise the moving to classes of medications is a good thing as it allows the service to carry the drugs it choses within the class.

These comments are intended to be helpful and are designed to address some practical problems that exist in the current list which are not addressed in the proposed list as well as some problems seen in the list as proposed.

Infusion Comment

If I read the literature correctly at least two of the medications which are on the proposed list recommend that the bolus be followed by a maintenance drip/infusion. These are Amiodarone and TXA. It would seem that if an AEMT is authorized to bolus those medications they should be allowed to prepare and administer the maintenance drip as recommended for that medication. As I read the proposed list this would not be permitted as they are neither electrolytes nor antibiotics.

Two other drugs which often follow the bolus with infusions are Lidocaine and Nitroglycerin. Again neither of those appear to be permitted for the same reason and also that Nitroglycerin is only authorized SL and transdermal.

If I am misreading the intent of the list then I would ask for clarification in the list.

Dextrose Comment

Some of the services are going to D10 for treatment of hypoglycemia . As we know D10 is less necrotic and thus less dangerous for the patient. The practice has been for an IV to be started and 100 ml of a 250 ml bag squeezed in and the bag shut off and after 10 minutes if no improvement the remaining 150 ml is squeezed in. This has been viewed as a bolus and not an administration of IV fluids. I believe this should be specifically spelled out as permitted in the list.

Transfer Comment

In the smaller rural communities transfers are very common as we take patients to a larger metropolitan area with a higher level of care. Here is a very common scenario. I am the ALS provider on duty and an emergent transfer is paged out at 2 am. I call the hospital and find that the patient is on a (pick the non-antibiotic or non-electrolyte medication) drip. Under the proposed list I cannot take that transfer and I must call and wake up paramedics until I find one available. Some services have even fewer paramedics and might have to call a neighboring service, all while the emergent transfer is waiting.

Since the AEMT would not be involved in the mixing of these medications, I would suggest that a provision be made in the list to allow an AEMT to "Monitor, maintain and administer any premixed medication or medication started by a transferring facility". The language I have used probably needs to be better said. This would allow the AEMT to take virtually any transfer assuming it was allowed by their protocol.

Missing Medications Comment

In thinking about the kinds of presentations that we see in the field, it seems that two (potentially critical) medications are missing from the list. One for bradycardia and one for tachycardia.

[redacted]

[redacted]

[redacted]

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Dr. Joel E Hornung, Chair
Joseph House, Executive Director

Laura Kelly, Governor

Response to Public Comment(s) Received

Regulations: K.A.R. 109-3-3 and 109-3-5

Infusion comment – ability to prepare and administer the maintenance drip for certain medications:
Amiodarone, TXA, Lidocaine, and Nitroglycerin.

Board Response – the proposed regulation allows for IV/IO administration of Amiodarone, TXA, and Lidocaine – bolus or maintenance drip, both would be IV/IO administration and allowed under this list. Nitroglycerin is specifically not included for IV administration at the AEMT level as IV administration of nitroglycerin has significantly different pharmacokinetics than sublingual or transdermal administration and the AEMT is not trained to the level of having a comprehensive knowledge of pharmacology sufficient to safely formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient. The AEMT, by educational standards, is trained to a fundamental knowledge of medications. IV Nitroglycerin requires a complex depth of medication knowledge at a minimum.

Dextrose comment – ability to administer D10 for treatment of hypoglycemia as 100mL of a 250mL bag being administered, followed by the remaining 150mL if no improvement seen after 10 minutes.

Board Response – the proposed regulation allows for the IV/IO administration of Dextrose. The proposed practice would be the IV administration of Dextrose and therefore would be allowed under this list.

Transfer comment – ability to administer any premixed medication or medication started by a transferring facility.

Board Response – as earlier stated, the AEMT, by educational standards, is trained to a fundamental knowledge of specific medications carried by AEMTs that may be administered to a patient during an emergency. Without a comprehensive knowledge of pharmacology, it would be unsafe for the Board to potentially authorize an AEMT to administer any medication without ensuring at least a fundamental knowledge of the specific medication.

Missing medications comment – medications missing from list, one to address bradycardia and one to address tachycardia.

Board Response – Without a comprehensive knowledge of pharmacology, it would be unsafe for the Board to potentially authorize an AEMT to administer any medication without ensuring at least a fundamental knowledge of the specific medication. Administration of any medication intended to speed up or slow down the heart rate of a perfusing patient requires a complex depth and comprehensive knowledge of both pharmacology and cardiology in order to formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient.

The AEMT medication list was never meant to allow AEMTs to take all transfers. Transfers require a crew with the knowledge, expertise, and skill set to perform care commensurate to the patient's needs, known and unknown. In some cases, this requires a paramedic and/or critical care team.