Board Meeting  
Dr. Joel Hornung - Chair  
AGENDA  
Friday, August 7, 2020 – 9:00 AM  
*****PLEASE NOTE CHANGE IN LOCATION*****  
KANSAS STATE CAPITOL  
300 SW 10th, Room 582-N; Topeka, Kansas  

Public Comment Note  
This meeting is open to the public with limited spacing due to social distancing requirements. Because of this, we are asking that if you do not have business before the Board, that you please consider attending through one of our virtual offerings. 

The Board strongly believes that transparency and open government are paramount and holds firm upon the importance of the public to have an ability to observe and comment upon the Board proceedings and to provide comment and insight upon items appearing on the agenda. 

To assist with ensuring a fair and consistent manner by which all public comment can be received for the purpose of assisting the Board with a potential decision at hand, we ask that public comment on an agenda item be submitted in writing at least eight (8) hours prior to the meeting to joseph.house@ks.gov. 

All public comment submitted will be provided as submitted to each Board member and will be read at the appropriate time by Board staff, if it can be done within 5 minutes. All public comment relating to and identifying a specific agenda item will be presented or read prior to a vote on that agenda item. 

I. CALL TO ORDER  
II. APPROVAL OF MINUTES – APRIL 3, 2020  
III. OLD BUSINESS  
   a. KRAF Award Follow-Up  
      i. Unable to fund grants 18 through 21, but full regional distribution  
   b. COVID-19 Related Topics/Updates  
      i. No decisions made requiring affirmation  
IV. COMMITTEE REPORTS  
   a. Planning and Operations  
      i. Possible Action Items  
         1. Voluntary EMS Recognition Program  
            Supporting Document – Brief – Voluntary EMS Recognition  
   b. Medical Advisory Council  

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 the donning of face masks while in public settings and the practice of social distancing where possible.
c. Education, Examination, Training, and Certification
   i. Possible Action Items
      1. Sponsoring Organization Regulations
         Supporting Document – Brief – Sponsoring Organization Regs

d. Executive
   i. Possible Action Items
      1. Medical Oversight Legislation
         Supporting Document – Brief – Medical Oversight
      2. KRAF Changes for FY2021
         Supporting Document – Brief – KRAF Changes
      3. AEMT Medication List
         Supporting Document – Brief – AEMT Med List
      4. EIG Study – Low-income, Military Families, and Separating Military Members.
         Supporting Document – Brief – EIG Study
      5. Inactive Certificate Regulation
         Supporting Document – Brief – Inactive Certification Regs
      6. Board Articles Revision
         a. Pursuant to Article 8 – Section 1 of the Board Articles, proposed amendments to these articles were provided to all Board members on March 9, 2020 and again on July 17, 2020.
         Supporting Document – Brief – Board Articles Amendment

e. Investigations
   i. Possible Action Items
      1. CE Audit Sanctioning Reference Points (SRP)
         Supporting Document – Brief – CE Audit SRP

V. OFFICE UPDATE

VI. NEW BUSINESS

VII. ADJOURNMENT
Board Meeting Minutes
April 3, 2020

Board Members Present
Dr. Gregory Faimon
Comm. Ricky James
Director Deb Kaufman
Chief Shane Pearson
Mr. Chad Pore
Director John Ralston
Comm. Bob Saueressig
Dr. Martin Sellberg
Director Jeri Smith
Mr. Dennis Shelby

Staff Present
Joseph House
Curt Shreckengaust
Suzette Smith

Call to Order
Vice-Chairman Pore called the Board Meeting to order on Friday, April 3, 2020 at 10:01 a.m. via teleconference call. A roll call by Director House found the above board members present.

Director Ralston made a motion to approve the February 7, 2020 and March 20, 2020 minutes. Dr. Faimon seconded the motion. No discussion. No opposition noted. The motion carried.

New Business

- The KRAF committee recommendation for this year’s awards was discussed. Vice-Chairman Pore gave an overview of the committee’s meeting held in early March in Salina. All applications were reviewed at that meeting. The Committee recommended the Board award 21 grants. Recently the FDA sent a letter out on AED’s they identified that would no longer be eligible to use or supported beginning in 2021. Many of this year’s KRAF
applications were to replace these monitors. The focus of the Committee was that each service would have at least one FDA approved monitor, and then the Committee looked at one per station. Director House gave an update on developments since the Committee met. The estimated ending balance of available funding has come into question. KRAF funding comes from fines and penalties from district courts. Most district courts are not hearing cases at this time so we anticipate a slowdown of funding. At the end of March there was $284,291 in funding. This is $70,080 short of the amount needed for all 21 awards. During the Committee’s process there were four applications they came back to. With the shortfall it is not anticipated that all 21 applications can be funded. Director House provided two options. The first would be to not award the last four items and cut the remaining shortfall from the direct payment of regional funding. If the balance grows, then the distribution to the regions could be put back in part or whole. The second option is to hold the last four awards and only award the first 17 and hold the regional distribution. On May 31st we would look to see if KRAF funding is greater than $325,000. If so, then the last four applications could be awarded but still eliminate all regional distribution. If no, then we do not award the last four applications and would pay each region proportionally then roll over any remaining funds for next year.

Vice-Chairman Pore made a motion to approve the recommendation from the KRAF Committee and go with option 2 based on a review of available funding thru May 31, 2020. Dr. Faimon seconded the motion. There was discussion including local match by all awardees and the uncertainty for the funding stream. No opposition noted. The motion carried.

• A COVID-19 update was provided by Director House. He provided a summary of world and state statistics that keep ratcheting up. The United States is up to 6,000 fatalities and Kansas has 44 counties with positive cases. Of the 552 cases in Kansas, 447 are attributed to the KC Metro area and Sedgwick County. He is monitoring Emergency Management teleconferences every day. A lot of time is being spent squashing rumors. The peak season in Kansas is projected to be within 18 days, which is the week of April 20. Guidance documents have been put out to services. These are to assist in guiding a service’s approach. Call volume and transporting trends were reviewed and are down 25% in comparison to 1 year ago. One service reported they were starting down the path of a staffing shortage, but it resolved itself. Director House reported receiving calls from the public that an ambulance service is in trouble, but contacts the service and they state they are not. Director House asked that if a service is having a staffing shortage or difficulty, to let him know.

• On examinations, the National Registry implemented provisional certifications for those that have passed a cognitive examination, but have not completed the skills testing – typically due to COVID reducing the availability of skills testing sites. Director House noted that Kansas does not currently have a mechanism to recognize a “provisional certification”. Vice-Chairman Pore asked how many people in Kansas have passed the cognitive, but not skills. Director House reported there are 55, but only 7 that had not been able to test skills, the remaining 48 had failed the skills test at least once. Director House also reported that Pearson Vue says cognitive testing is opened up to essential testing with a limited number of seats. EMS is considered essential. He also said Board staff can do mobile testing. He would need a large room to allow adequate distancing, but it is very possible. He would want to host testing at the same location as skills testing if possible. Mr. Shelby added that physicians are being allowed to crossover state lines and also that medical students and residents are being allowed to help out. While provisional certifications could be looked
into, Director House said testing has not stopped in Kansas so he is hesitant to work on this yet. He said there are a couple changes on ALS exams. Mannequins will be used instead of live patients and instead of a partner they will have a verbal assistant.

- For Agency Operations the office will be restoring back to limited staff on April 6, 2020. This will allow about 98% of functions, but inspections and audits are curtailed by travel restrictions. State office buildings will remain closed through April 19, 2020.
- Vice-Chairman Pore asked about any additional conference calls with service directors. Director House said he would have them as needed and probably next week.
- Vice-Chairman Pore said service renewals are due by the end of April and suggested services do not wait to renew.
- Director House was asked by Emergency Management to report the number of transport ventilators. He put out a survey and with 90% of the services reporting, there are 270. Vice-Chairman Pore stressed the importance of training in the proper use of ventilators.
- At this time only one person has put their name in for the 911 Coordinating Council.

**Director Ralston made a motion to recommend to the Governor that Nick Robbins be appointed to the 911 Coordinating Council. Dr. Sellberg seconded the motion. The motion carried.**

- Chief Pearson received a call from a small volunteer service regarding a screening process on calls for assistance to offer protection to law enforcement and others arriving on scene. He asked if there is another resource where a local dispatch center could transfer calls to ask questions on COVID-19. Vice-Chairman Pore suggested the 911 Coordinating Council might be contacted to see if these basic questions could be asked. Director House will bring it up to them and emphasize they should take this back home to local areas and give the information on why it needs done.
- Vice-Chairman Pore thanked everyone for the job they are going. He stressed that this is a time to keep working together and reach out to your neighbors. He also reminded board members that meetings may be called impromptu and to please respond quickly.

**Vice-Chairman Pore adjourned the meeting at 11:07 a.m.**
Agenda Item:  Voluntary EMS Recognition Program
Committee:  Planning and Operations

BACKGROUND
In 2014, an effort was established to assist with identifying a means to recognize the work and effort involved with continuous quality improvement measures being done by ambulance services. Through a collaborative process involving multiple associations, services, regions, and state associations, the EMS Voluntary Recognition Program (Enclosure 1) was developed and implemented by the Board in October 2016. The developed program was a collaborative effort from representatives of the EMS for Children program, the Kansas Trauma program, the Kansas Heart and Stroke Collaborative, the Kansas EMS Association, the Kansas Emergency Nurse’s Association, and others.

There are seven (7) categories for recognition: Cardiac Care; Stroke; Trauma; Pediatrics; EMS Safety; Compliance; and Community Outreach. There are three levels attainable within each category: Bronze, Silver, and Gold. There are specific criteria listed that must be met to achieve each level.

The program was designed to be voluntary in nature and to operate as independent categories allowing services to participate in whole or in part.

DISCUSSION
To date, no ambulance service has made application for this voluntary recognition program and some of the measures utilized, and resources identified, may need to be reviewed to determine continued applicability.

Maintaining the program does require the upkeep and maintenance of a method to receive applications, review those applications, and review the submissions prior to issuance.

FINANCING
The cost to operate this program is indirectly included with the Compliance sub-program. There is no specific identification or allocation of costs associated with this recognition program.

ALTERNATIVES
The Board has the following alternatives concerning the matter at hand. The Board may:
1. Adopt the committee’s recommendation.
2. Modify the committee’s recommendation.
3. Reject the committee’s recommendation.
4. Table the item.

RECOMMENDATION
To adopt the committee’s recommendation.

POSSIBLE MOTION(S)
To adopt the committee’s recommendation pertaining to the EMS Voluntary Recognition Program.

Enclosures:
1. EMS Voluntary Recognition Program
EMS Voluntary Recognition Program

The Kansas Board of Emergency Medical Services has established a voluntary program to recognize those EMS services going above and beyond to better serve the citizens of their community. This program was developed with collaboration from representatives of Emergency Medical Services for Children, The Kansas Trauma Program, The Kansas Heart and Stroke Collaborative, Emergency Nurses Association, and other interested parties. The board has endorsed seven categories of recognition, each of which will have levels of Bronze, Silver, and Gold, which are attainable by each participating EMS service. (Every level above Bronze requires completion of all requirements for all levels below the level being requested.) The seven areas and the requirements for each level are outlined in this document. This program is strictly voluntary, and services can elect to participate in only the areas that they desire.
Cardiac Care

About 610,000 people die of heart disease in the United States each year; equating to 1 in every 4 deaths. Therefore, it is imperative all Emergency Medical Services in Kansas plan and train for optimal response and management of the cardiac patient. Doing so enhances the chance of survival following a cardiac emergency.

**Bronze Level**

a) All advanced providers (AEMT, Paramedic) currently certified in ACLS, or KBEMS approved equivalent.

b) Destination protocols in place to transport to the most appropriate cardiac care center.

c) QI-QA policies in place to monitor compliance with cardiac protocols and guidelines.

**Silver Level**

a) Validation of performance improvement project, through the use of measured outcomes and improvement strategies.

b) Documentation of case reviews from tertiary cardiac care centers that include patient outcomes.

c) Provide opportunities for quarterly education directly related to emergency cardiac care.

**Gold Level**

a) Provide opportunities for monthly education directly related to emergency cardiac care.

b) Active participation in local/regional cardiac center multidisciplinary quality improvement meetings.

**Resources:**

Journal articles in the following publications:


Stormont Vail and University of Kansas Hospital on-line education offerings.

Bound Tree University
http://www.boundtreeuniversity.com/classroom/
Stroke

Each year, about 795,000 Americans have either a new or recurrent stroke. Every 40 seconds, someone in this country suffers a stroke. Stroke kills more than 137,000 people each year; every four minutes someone in the U.S. dies from a stroke. The longer a stroke goes untreated, the greater the chances for permanent neurological damage. Rapid recognition, and intervention is crucial in the treatment of strokes.

**Bronze Level**

a) All advanced providers (AEMT, Paramedic) currently certified in ASLS, or KBEMS approved equivalent.

b) Destination protocols in place to transport to the most appropriate stroke center.

c) QI-QA policies in place to monitor compliance with stroke protocols and guidelines.

**Silver Level**

a) Validation of performance improvement project, through the use of measured outcomes and improvement strategies.

b) Documentation of case reviews from tertiary stroke care centers that include patient outcomes.

c) Protocols in place implementing the use of a prehospital approved stroke assessment tool i.e., Cincinnati Stroke Scale, LA Stroke Scale, NIH or MENDS.

**Gold Level**

a) All advanced providers complete a Stroke Certification Course, i.e., Advanced Stroke Life Support or BEMS approved equivalent.

b) Provide opportunities for monthly education directly related to emergency stroke care.

c) Active participation in local/regional stroke center multidisciplinary quality improvement meetings.

d) Actively involved in public stroke awareness educational campaign.

**Resources:**

N.I.H course

Journal articles in the following publications:

Trauma

Traumatic injuries are one of the leading causes of death and disability among Kansans. In addition, injuries occur disproportionately among both younger and older people. During this century, trauma has replaced infectious disease as the greatest threat to children. In recent years, traumatic injury has begun to receive long overdue recognition as a major public health issue.

**Bronze Level**

a) Destination protocols in place to transport to the most appropriate facility.
b) 100% of service staff acquires a minimum of 8 hours of trauma education each year.
c) EMS service staff member(s) actively involved in the Regional Trauma Council. (participate in 50% of RTC meetings).

**Silver Level**

a) Centers for Disease Control and Prevention (CDC) Field triage guidelines written into policy and procedures.
b) 25% of service staff shows certification in PHTLS, ITLS, or other KBEMS approved equivalent.
c) Documentation of case reviews from tertiary trauma centers that include patient outcomes.

**Gold Level**

a) EMS service coordinates with a Trauma Medical Director in the development of trauma protocols.
b) Develop a Performance Improvement and Patient Safety (PIPS) QI/QA plan and show evidence of educational provisions associated with the QI/QA findings.
c) Active participation in the regional Trauma Council PIPS program.

**Resources:**

Advanced Trauma Life Support manual


KDHE Trauma

NAEMT

ITLS.org
Pediatrics

Pediatric patients constitute a small, but unique percentage of EMS transports. This is generally a good thing and demonstrates how rare pediatric emergencies are, as well as how injury prevention and vaccination programs have ensured a healthy pediatric population. An unintended consequence is that EMS does not have the same familiarity with pediatric emergency care as it does with adult emergency medical care. Even though 25 percent of the population is pediatric.

**Bronze level**
- a) 50% of service staff acquires a minimum of 4 hours of pediatric education each year.
- b) Identify a pediatric emergency care coordinator (PECC).
- c) Conduct education on the safe transport of pediatric patients.
- d) Develop policies and insure access of equipment for the safe transport of pediatric patients.

**Silver level**
- a) 50% of service staff acquires a minimum of 8 hours of pediatric education each year.
- b) PECC has attained instructor status by a nationally recognized pre-hospital pediatric course (EPC, PALS, PEPP, etc)

**Gold Level**
- a) 80% and above service staff acquire 8 hours of pediatric education each year
- b) Pediatric Education Coordinator is part of the QI/QA with receiving facilities/staff.
- c) Pediatric Education Coordinator is able to show evidence of implementation of injury prevention programming based on needs assessment of the community.

**Resources:**
2. EMSC National Resource Center – [www.emscnrc.org](http://www.emscnrc.org)
7. On-line Education - [http://www.emscnrc.org/emsc-resources/online-training](http://www.emscnrc.org/emsc-resources/online-training)
10. Educaton (PALS) -
http://cpr.heart.org/AHAECC/CPRAndECC/Training/HealthcareProfessional/Pediatric/UCM_476258_PALS.jsp
EMS Safety

Emergency Medical Services is a dangerous job. Every day we read about another EMS practitioner who have been hurt or killed in the line of duty. EMS providers work under unpredictable circumstances, at odd hours, with limited information, assistance, supervision and resources in the field. During a shift, pre-hospital care providers can be exposed to risks ranging from infectious diseases to stress, fatigue, violence, high speed responses and road/traffic conditions. We need to take action ourselves to make sure we go home at the end of the shift.

**Bronze level**

a) Conduct an EMS safety needs assessment, data related to injuries, call volume, accidents, seat belt use, response policies utilizing a survey and/or interview process.

b) Yearly provider education on lifting, Proper lifting, safe driving, infectious disease, equipment storage, and safety equipment usage.

c) Implementation of Safety Officer Program; designation of a person and implementation of a program.

**Silver level**

a) Verifiable health policies in place. (Plan for health awareness, CIS teams, gym membership, provider fatigue, healthy eating, etc)

b) Show evidence of safety culture in service.

**Gold Level**

a) 50% of service staff acquire NAEMT - EMS Safety or T.I.M.S certification or KBEMS approved equivalent.

**Resources:**

AAA Driver Improvement Program, EVOC, CEVO NAEMT
Provider fatigue articles
EMSA Fit Medic

NAEMT
Compliance

The Kansas Board of Emergency Medical Services exists, primarily, to ensure that quality out-of-hospital care is available throughout Kansas. This care is based on the optimal utilization of community resources that are consistent with the patient’s needs. The delivery of optimal care is supported through the adoption of standards; definition of scopes of practice; and provision of health, safety, and prevention education and information to the public, Emergency Medical Services, Emergency Medical Services providers/instructors, related health care professionals, and other public service and political entities.

Bronze level
a) Zero deficiencies in administrative inspection.
b) Zero program provider delinquent reporting deficiencies.

Silver level
a) Zero deficiencies on final inspection report (per inspection policy). b) Zero deficiencies in education audit.

Gold Level
a) Zero deficiencies (critical and non-critical), includes administrative and vehicle.

Resources:
KSBEMS.org
Community Outreach

Research has shown that the current Emergency Medical Services model saves countless lives. Through evidence based medicine and quality assurance programs, we continually update our protocols and practices to improve our effect on morbidity in our communities. We must now take into consideration how we can expand our services to the community and effect death and disability in another way. EMS services are addressing this is with injury-and illness prevention programs, and training lay persons in early CPR and defibrillation, early stroke recognition programs and education on EMS utilization.

Bronze level
a) EMS service staff coordinates and conducts two community CPR events.
b) Sponsor one community outreach program: Stop the Bleed, Friday Night lights, ATV safety, farm safety, geriatric fall prevention, bike helmets, etc.

Silver level
a) Provide one public presentation on proper EMS utilization. b) Conduct two or more community outreach programs: Stop the Bleed, Friday Night lights, ATV safety, farm safety, geriatric fall prevention, bike helmets, etc.

Gold level
a) Community Needs Assessment - Identifying and addressing local special populations through guidelines, policies, protocols and/or education (i.e. sepsis, LVAD, CWSHCN, Hemophilia, diabetes) bike helmets for kids, atv safety, farm safety, wind turbines, AED placement, refineries, care/transport of obese patients, etc – Documented actions.
b) Participate in the implementation of a community injury prevention program/initiative.

Resources:
Safe Kids Kansas

KDHE Injury prevention Poison control center

American Heart Association

American Red Cross

Stroke collaborative
Agenda Item:    Sponsoring Organization Regulations

Committee:     Education, Examination, Training, and Certification

BACKGROUND
Spawning from an April 2019 discussion and Board decision to institute a quality component for sponsoring organizations and their initial course offerings (discussion relevant to K.A.R. 109-11-1a), it was determined that there is little regulatory language that provides sponsoring organizations clear guidance on their functions, responsibilities, and oversight.

In June 2019, a draft set of regulations was developed with the following intent:

1) Clearly identify the role and responsibilities of the sponsoring organization;
2) Revise existing regulations to move all sponsoring organization requirements into a smaller grouping of regulations in an effort to not scatter responsibilities across all regulations;
3) Incorporate the requested changes to K.A.R. 109-11-1a; and
4) To ease the process upon sponsoring organizations by which courses (initial and continuing education) could receive approval while still requiring all necessary components.

A public meeting was held in Junction City on November 19, 2019, regarding these regulations. Comments/questions/suggestions were compiled and the EETC reviewed and discussed at their December meeting. The next revision based upon that meeting was made available for comment in December. Comments were submitted by the EDTF and reviewed at the February 2020 EETC Committee meeting with revisions made to address those comments. A 2nd public meeting was held in Wichita on February 28, 2020, with very slight modifications requested and a consensus thought that the regulations were ready for entering the process.

Since the April 2019 decision to look at a 70% pass rate following all attempts in initial courses over a rolling 3 year average, the EETC committee opted to modify that to a 70% pass rate over all attempts made during the previous calendar year (February 2020 decision).

The current packet of regulations (Enclosure 1) involves 4 new regulations, 4 revoked regulations, and 9 revised regulations.

These regulations do provide an operational deviation in practice for initial course submission, reducing the amount of paperwork being submitted for a course approval and relying heavily upon an audit method of ensuring that policies/procedures exist and are available to the students.

DISCUSSION
On 109-17-4, subsection (b) – The February 2020 public meeting supported a previous suggestion that these “training reports” be submitted within a certain time frame after the offering, not necessarily on a quarterly basis. The consensus on a suggested time frame was 30 days.

On 109-11-8, subsection (a)(4)(B) is a skill done through the EMT (nebulized breathing treatment). It was requested that this be a requirement under the EMT instead of the AEMT for successful course completion.

Also on 109-11-8, subsection (b) – Board staff had requested a section stating that written approval shall not only be done within 15 days of the final class, but shall also be done prior to the student challenging
the State examination for certification. February 2020 public meeting had no stated objection to its inclusion.

In that same area and after the Spring testing cohorts, Board staff is asking for additional consideration of the above submission to also occur no less than 7 days prior to the student challenging a state examination (for processing and preparation). This change is being requested due to a sharp increase in candidates that have not completed an application, or are not showing having successfully completed a course, yet are appearing on a scheduled skill’s examination or for whom we receive a NREMT cognitive result. Board staff believes that 7 days is consistent with other time frames regarding sponsoring organizations and provides an adequate amount of time for staff to complete quality control.

**FINANCING**

This change should have a net zero long-term fiscal effect. Due to the volume of this packet, we would expect there to be a slight increase in operational expenditures, but nothing that would require additional appropriation or income.

**ALTERNATIVES**

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

1. Adopt the committee’s recommendation.
2. Modify the committee’s recommendation.
3. Reject the committee’s recommendation.
4. Table the item.

**RECOMMENDATION**

To adopt the committee’s recommendation.

**POSSIBLE MOTION(S)**

To move forward with the regulatory revision process with the committee’s recommended changes.

Enclosures:

1. Sponsoring organization regulations
109-17-1. Sponsoring organization general requirements; program manager.

(a) Each sponsoring organization shall perform the following:

(1) Notify the board of any change in the program manager within seven days of change;

(2) designate a person as the program manager to serve as an agent of the sponsoring organization;

(3) designate a physician to serve as a medical director of the sponsoring organization;

(4) maintain training program records for at least three years from the last date of class;

(5) develop and maintain a quality management plan;

(6) ensure that EMS training equipment and supplies, including simulation models or empty pharmaceutical packages or containers for pharmaceutical training, necessary to facilitate the teaching of all psychomotor skills being provided are:

   (A) available for use with the class;

   (B) functional, clean, serviceable, and in sufficient quantity to maintain a ratio of no more than six students practicing together on one piece of equipment at any one time; and

   (C) functional, clean, and provided in sufficient quantity for each student to utilize without sharing if the equipment or supplies are for the purpose of protecting the student from exposure to bloodborne or airborne pathogens;
(7) select qualified instructors as determined by training and knowledge of subject matter as follows:

(A) Each didactic instructor and each instructor for medical skills shall possess certification, registration, or licensure in the subject matter or medical skills being taught;

(B) each instructor for nonmedical skills shall have technical training in and shall possess knowledge and expertise in the skill being taught;

(C) each instructor of clinical training being conducted in a clinical health care facility shall be a licensed physician or licensed professional nurse; and

(D) each instructor of field internship training being conducted with a prehospital emergency medical service shall be an EMS provider certified at or above the level of training being conducted; and

(8) maintain records of all individuals used as instructors or lab assistants to provide training for at least three years from the last date of class. These records shall include the following:

(A) The individual’s name and qualification;

(B) the subject matter that the individual taught, assisted in teaching, or evaluated;

(C) the dates on which the individual instructed, assisted, or evaluated; and

(D) the students’ evaluation of the individual.

(b) The program manager shall meet the following requirements:

(1) Be responsible for all EMS education provided by the sponsoring
organization;

(2) be available to the board regarding regulatory and emergency matters;

(3) be responsible for maintaining a current list of the sponsoring organization’s qualified instructors;

(4) notify the board of each addition or removal of a qualified instructor within 7 days of the addition or removal;

(5) submit written notification and the content of each change in the quality management plan no later than 7 days after the effective date of the change;

(6) submit written notification and the content of each change in the long-term provider continuing education program management plan no later than 7 days after the effective date of the change;

(7) notify the board of any known resignation, termination, incapacity, or death of a medical director once known and the plans for securing a new medical director; and

(8) submit written notification of each change in the medical director within 7 days of the change.
109-17-2. Application for sponsoring organization approval; approval renewal.

(a) Each applicant for sponsoring organization approval shall indicate the EMS education it requests to provide as one or both of the following:

(1) Initial course of instruction; and

(2) continuing education.

(b) All sponsoring organization approval applications and renewal forms shall be submitted in a format required by the executive director.

(c) If the board receives an insufficient initial or renewal application for a sponsoring organization approval, the applicant shall be notified in writing of any errors or omissions. If the applicant fails to correct the deficiencies and submit a sufficient application within 30 days from the date of written notification, the application may be considered by the board as withdrawn.

(d) Each initial application for sponsoring organization approval shall meet all of the following:

(1) Designate a program manager;

(2) designate a medical director;

(3) designate a physical address where all training program records shall be maintained; and

(4) provide a copy of the quality management plan.

(e) Each sponsoring organization’s quality management plan shall describe all processes utilized by the sponsoring organization to ensure that EMS education provided validates the community’s EMS training needs assessment or meets the training needs of the intended audience and shall, at a minimum, include a review and
analysis of completed course and instructor evaluations by the medical director and program manager.

(f) Each sponsoring organization approval shall expire on April 30 of each year and may be renewed annually in accordance with this regulation.

(g) Each renewal application for sponsoring organization approval shall affirm all the following are current and accurate:

(1) Personnel affiliated with the sponsoring organization; to include the program manager, medical director, and qualified instructors;

(2) EMS education the sponsoring organization requests approval to provide;

(3) physical address where all training program records shall be maintained;

(4) quality management plan; and

(5) all of the following that are applicable to the sponsoring organization:

(A) Initial course of instruction course policies;

(B) clinical and field training agreements; and

(C) long-term provider continuing education program management plan.
109-17-3. Sponsoring organization providing initial course of instruction standard and requirements. (a) Each sponsoring organization shall provide an enrollment roster listing each student enrolled in the course to the executive director within 20 days of the date of the first scheduled class session.

(b) Each sponsoring organization providing an initial course of instruction shall provide access at each scheduled class session for physical inspection of the course syllabus and all policies or documents addressing the following:

1. Student evaluation of program;
2. Student attendance;
3. Student discipline;
4. Student and participant safety;
5. Student requirements for successful course completion;
6. Kansas requirements for certification;
7. Student dress and hygiene;
8. Student progress conferences;
9. Equipment use;
10. Infection control; and
11. Acknowledgement of the commitment to provide the support as defined in the course curriculum from each of the following:

   A. Initial course of instruction medical director;
   B. Ambulance service director for each ambulance service utilized for field training; and
   C. Administrator of each medical facility utilized for clinical training.
(c) The course syllabus shall include at least the following information:

(1) A summary of course goals and objectives;

(2) student prerequisites, if any, for admission into the course;

(3) instructional and any other materials required to be purchased by the students;

(4) a description of the clinical and field training requirements, if applicable;

(5) instructor information, which shall include the following:

(A) Instructor name;

(B) office hours or hours available for consultation; and

(C) instructor electronic mail address.

(d) Each sponsoring organization providing an initial course of instruction shall validate each student’s successful course completion.

(e) Each sponsoring organization shall schedule a psychomotor skills examination for the student’s initial examination as specified in K.A.R. 109-8-2.

(f) Each sponsoring organization shall maintain the following course records for each initial course of instruction for at least three years from the last date of class:

(1) Course syllabus;

(2) all policies or documents addressing the listed items in subsection (b);

(3) student attendance;

(4) student grades;

(5) student conferences;

(6) course curriculum;

(7) lesson plans for all lessons;
(8) clinical training objectives;
(9) field training objectives;
(10) completed clinical and field training preceptor evaluations for each student;
(11) a copy of each student's psychomotor skills evaluations;
(12) completed copies of each student’s evaluations of each course, all instructors for the course, and all lab instructors for the course; and
(13) completed copies of the outcome assessment and outcome analyses tools used for the course that address at least the following:

(A) Each student’s ability to perform competently in a simulated or actual field situation, or both; and

(B) each student’s ability to integrate cognitive and psychomotor skills to appropriately care for sick and injured patients.

(g) Each sponsoring organization providing initial courses of instruction shall maintain an average pass rate of seventy-percent on the cognitive examination for certification at each level of certification the sponsoring organization instructs for all attempts made by their students in the preceding calendar year. A sponsoring organization that fails to meet or exceed this average pass rate shall submit to the board a plan for ensuring future cognitive examination pass rates meet or exceed this average no later than March 1.

(h) Each sponsoring organization may allow a student to enroll late into an initial course of instruction upon submitting a make-up schedule to the executive director within 7 days of the student’s enrollment that includes the provision of educational standards that the late enrollee missed.
(i) Each sponsoring organization shall provide any course documentation requested by the executive director within thirty (30) days of the request.

(j) Violation of any provision of this regulation may subject the sponsoring organization to a civil fine and may result in a suspension of sponsoring organization approval.
109-17-4. Sponsoring organization providing continuing education standards and requirements. (a) A sponsoring organization may provide prior-approved continuing education as a long-term provider or a single-program provider.

(b) Each sponsoring organization providing prior-approved continuing education shall submit a training report on a form provided by the board for each class within 30 days of the date of last class.

(c) The training report shall include:

(1) The date or dates, title, and location of the class;

(2) a list of all qualified instructors used in the class;

(3) the name and certification number of each attendee; and

(4) the amount of continuing education awarded to each attendee.

(d) Each sponsoring organization shall maintain the following course records for each prior-approved continuing education class for at least three years from the last date of class:

(1) Course educational objectives;

(2) completed course attendance sheet;

(3) completed copies of each student’s evaluations of the class and the instructors; and

(4) a copy of the submitted training report.

(e) Each completed course attendance sheet shall have the name and signature of each attendee of the prior-approved continuing education class.
(f) Each sponsoring organization providing prior-approved continuing education as a long-term provider shall develop and maintain a long-term continuing education program management plan.

(g) Each sponsoring organization shall provide any continuing education documentation requested by the executive director within thirty days of the request.

(h) Violation of any provision of this regulation may subject the sponsoring organization to a civil fine and may result in a suspension of sponsoring organization approval.
109-1-1. Definitions. Each of the following terms, as used in the board’s regulations, shall have the meaning specified in this regulation:

(a) “AEMT” means advanced emergency medical technician.

(b) “Advanced life support” and “ALS” mean the statutorily authorized activities and interventions that may be performed by an emergency medical technician-intermediate, emergency medical technician-defibrillator, emergency medical technician-intermediate/defibrillator, advanced emergency medical technician, or paramedic.

(c) “Air ambulance” means a fixed wing or rotor-wing aircraft that is specially designed, constructed or modified, maintained, and equipped to provide air medical transportation or emergency care of patients.

(d) “Air medical director” means a physician as defined by K.S.A. 65-6112 and amendments thereto, who meets the following requirements:

1) Is trained and experienced in care consistent with the air ambulance service’s mission statement, and

2) is knowledgeable in altitude physiology and the complications that can arise due to air medical transport.

(e) “Air medical personnel” means the attendants EMS providers listed on the attendant EMS provider roster, health care personnel identified on the service health care personnel roster of the air ambulance service, specialty patient care providers specific to the mission, and the pilot or pilots necessary for the operation of the aircraft.
(f) “Airway maintenance,” as used in K.S.A. 65-6121 and amendments thereto and as applied to the authorized activities of an advanced emergency medical technician, means the use of any invasive oral equipment and procedures necessary to ensure the adequacy and quality of ventilation and oxygenation.

(g) “Attendant” means an EMS provider.

(h) “Basic life support” and “BLS” mean the statutorily authorized activities and interventions that may be performed by an emergency medical responder or emergency medical technician.

(i) (j) “CAPCE” means the commission on accreditation for prehospital continuing education.

(j) (k) “Certified mechanic,” as used in K.A.R. 109-2-2, means an individual employed or contracted by the ambulance service, city or county, qualified to perform maintenance on licensed ambulances and inspect the vehicles and validate, by signature, that the vehicles meet both mechanical and safety considerations for use.

(k) “Class,” as used in these regulations means the period during which a group of students meets.

(l) “Clinical preceptor” means an individual who is responsible for the supervision and evaluation of students in clinical training in a health care facility.

(m) “Continuing education” means a formally organized learning experience that has education as its explicit principal intent and is oriented towards the enhancement of emergency medical services practice, values, skills, and knowledge.
(m) “Contrived experience,” as used in K.A.R. 109-11-3a, means a simulated ambulance call and shall include dispatch communications, responding to the scene, assessment and management of the scene and patient or patients, biomedical communications with medical control, ongoing assessment, care, and transportation of the patient or patients, transference of the patient or patients to the staff of the receiving facility, completion of records, and preparation of the ambulance for return to service.

(n) (l) “Coordination” means the submission of an application for approval of initial courses of instruction or continuing education courses and the oversight responsibility of those same courses and instructors once the courses are approved.

(o) (m) “Course of instruction” means a body of prescribed EMS studies approved by the board.

(p) (n) “Critical care transport” means the transport by an ambulance of a critically ill or injured patient who receives care commensurate with the care rendered by health care personnel as defined in this regulation or a paramedic with specialized training as approved by service protocols and the medical director.

(q) “Educator” means instructor-coordinator, as defined in K.S.A. 65-6112 and amendments thereto.

(r) (o) “Emergency” means a serious medical or traumatic situation or occurrence that demands immediate action.

(s) (p) “Emergency call” means an immediate response by an ambulance service to a medical or trauma incident that happens unexpectedly.
“Emergency care” means the services provided after the onset of a medical condition of sufficient severity that the absence of immediate medical attention could reasonably be expected to cause any of the following:

1. Place the patient’s health in serious jeopardy;
2. seriously impair bodily functions; or
3. result in serious dysfunction of any bodily organ or part.

“EMS” means emergency medical services.

“EMR” means emergency medical responder.

“EMS” means emergency medical services.

“EMS provider” means emergency medical service provider.

“EMT” means emergency medical technician.

“Field internship preceptor” means an individual who is responsible for the supervision and evaluation of students in field training with an ambulance service.

“Ground ambulance” means a ground-based vehicle that is specially designed and equipped for emergency medical care and transport of sick and injured persons and meets the requirements in K.A.R. 109-2-8.

“Health care personnel” and “health care provider” as used in these regulations means a physician, physician assistant, licensed professional nurse, advanced practice registered nurse, or respiratory therapist.

“Incompetence,” as applied to attendants EMS providers and as used in K.S.A. 65-6133 and amendments thereto, means a demonstrated lack of ability, knowledge, or fitness to perform patient care according to applicable medical protocols.
or as defined by the authorized activities of the attendant’s EMS provider’s level of certification.

(bb) Incompetence,” as applied to instructor-coordinators and training officers and as used in K.S.A. 65-6129b and K.S.A. 65-6129c and amendments thereto, means a pattern of practice or other behavior that demonstrates a manifest incapacity, inability, or failure to coordinate or to instruct attendant EMS provider training programs.

(cc) Incompetence,” as applied to an operator and as used in K.S.A. 65-6132 and amendments thereto, means either of the following:

(1) The operator’s inability or failure to provide the level of service required for the type of permit held, or

(2) the failure of the operator or agent or employee of the operator to comply with a statute or regulation pertaining to the operation of a licensed ambulance service.

(dd) “Instructor-coordinator” and “I-C” mean any of the following individuals who are certified to instruct and coordinate attendant EMS provider training programs:

(1) Emergency medical technician;

(2) physician;

(3) physician’s assistant;

(4) advanced practice registered nurse;

(5) licensed professional nurse;

(6) advanced emergency medical technician; or

(7) paramedic.
(ee) (bb) “Interoperable” means that one system has the ability to communicate or work with another.

(ff) (cc) “Lab assistant” means an individual who is assisting a primary instructor in the instruction and evaluation of students in classroom laboratory training sessions.

(gg) (dd) “Long-term provider approval” means that the sponsoring organization has been approved by the executive director to provide any continuing education program as prescribed in K.A.R. 109-5-3.

(hh) “Mentoring educator” means an instructor-coordinator, as defined in K.S.A. 65-6112 and amendments thereto, who has obtained additional credentials prescribed by the board.

(ii) (ee) “Out of service,” as used in K.A.R. 109-2-5, means that a licensed ambulance is not immediately available for use for patient care or transport.

(jj) (ff) “Primary instructor” means an instructor-coordinator who is listed by the sponsoring organization as the individual responsible for the competent delivery of cognitive, psychomotor, and affective objectives of an approved initial course of instruction or continuing education program and who is the person primarily responsible for evaluating student performance and developing student competency.

(kk) (gg) “Prior-approved continuing education” means material submitted by a sponsoring organization, to the board, that is reviewed and subsequently approved by the executive director, in accordance with criteria established by regulations, and that is assigned a course identification number.
(hh) “Program manager” means an individual who has been appointed, employed, or designated by a sponsoring organization to ensure that the sponsoring organization is in conformance with applicable regulations and to ensure that quality EMS education is provided by the sponsoring organization qualified instructors.

(II) “Public call” means the request for an ambulance to respond to the scene of a medical emergency or accident by an individual or agency other than any of the following:

(1) A ground ambulance service;

(2) the Kansas highway patrol or any law enforcement officer who is at the scene of an accident or medical emergency;

(3) a physician, as defined by K.S.A. 65-6112 and amendments thereto, who is at the scene of an accident or medical emergency; or

(4) an attendant EMS provider who has been dispatched to provide emergency first response and who is at the scene of an accident or medical emergency.

(JJ) “Retroactively approved continuing education” means credit issued to an attendant EMS provider after attending a program workshop, conference, seminar, or other offering that is reviewed and subsequently approved by the executive director, in accordance with criteria established by the board.

(NN) “Roster” means a document whose purpose is to validate attendance at an educational offering and includes the following information:

(1) Name of the sponsoring organization;

(2) location where the educational offering occurred;
(3) signature, time of arrival, and time of departure of each attendee;

(4) course identification number issued by the board;

(5) title of the educational offering;

(6) date of the educational offering; and

(7) printed name and signature of the program manager.

(kk) “Service director” means an individual who has been appointed, employed, or designated by the operator of an ambulance service to handle daily operations and to ensure that the ambulance service is in conformance with local, state, and federal laws and ensure that quality patient care is provided by the service attendants EMS providers.

(ll) “Service records” means the documents required to be maintained by state regulations and statutes pertaining to the operation and education within a licensed ambulance service.

(mm) “Single-program provider approval” means that the sponsoring organization has been granted approval approved by the executive director to offer provide a specific continuing education program as prescribed in K.A.R. 109-5-6.

(rr) “Site coordinator” means a person supervising, facilitating, or monitoring students, facilities, faculty, or equipment at a training site.

(ss) “Syllabus” means a summary of the content of a course of instruction that include the following:

(1) A summary of the course goals and objectives;

(2) student prerequisites, if any, for admission into the course;
(3) instructional and any other materials required to be purchased by the student;

(4) student attendance policies;

(5) student requirements for successful course completion;

(6) a description of the clinical and field training requirements, if applicable;

(7) student disciplines policies; and

(8) instructor, educator, or mentoring education information, which shall include the following:

(A) the name of the instructor, educator, or mentoring educator;

(B) the office hours of the instructor, educator, or mentoring educator or the hours during which the instructor, educator, or mentoring educator is available for consultation; and

(C) the electronic mail address of the instructor, educator, or mentoring educator.

“Sufficient application” means that the information requested on the application form is provided in full, any applicable fee has been paid, all information required by statute or regulation has been submitted to the board, and no additional information is required to complete the processing of the application.

“Teach” means instruct or coordinate training, or both.

“Unprofessional conduct,” as applied to attendants EMS providers and as used in K.S.A. 65-6133 and amendments thereto, means conduct that violates those standards of professional behavior that through professional experience have become established by the consensus of the expert opinion of the members of the emergency
medical services EMS profession a reasonably necessary for the protection of the public. This term shall include any of the following:

(1) Failing to take appropriate action to safeguard the patient;

(2) performing acts beyond the activities authorized for the level at which the individual is certified;

(3) falsifying a patient’s or an ambulance service’s records;

(4) verbally, sexually, or physically abusing a patient;

(5) violating statutes or regulations concerning the confidentiality of medical records or patient information obtained in the course of professional work;

(6) diverting drugs or any property belonging to a patient or an agency;

(7) making a false or misleading statement on an application for certification renewal or any agency record;

(8) engaging in any fraudulent or dishonest act that is related to the qualifications, functions, or duties of an attendant EMS provider; or

(9) failing to cooperate with the board and its agents in the investigation of complaints or possible violations of the emergency medical services statutes or board regulations including failing to furnish any documents or information legally requested by the board. Attendents EMS providers who fail to respond to requests for documents or requests for information within 30 days from the date of request shall have the burden of demonstrating that they have acted in a timely manner.
(ww) (qq) “Unprofessional conduct,” as applied to instructor-coordinators and as used in K.S.A. 65-6129b and K.S.A. 65-6129c and amendments thereto, means any of the following:

(1) Engaging in behavior that demeans a student. This behavior shall include ridiculing a student in front of other students or engaging in any inhumane or discriminatory treatment of any student or group of students;

(2) verbally or physically abusing student;

(3) failing to take appropriate action to safeguard a student;

(4) falsifying any document relating to a student or the sponsoring organization;

(5) violating any statutes or regulations concerning the confidentiality of student records;

(6) obtaining or seeking to obtain any benefit, including a sexual favor, from a student through duress, coercion, fraud, or misrepresentation, or creating an environment that subjects a student to unwelcome sexual advances, which shall include the physical touching or verbal expressions;

(7) an inability to instruct because of alcoholism, excessive use of drugs, controlled substances, or any physical or mental condition;

(8) reproducing or duplicating a state examination for certification without board authority;

(9) engaging in any fraudulent or dishonest act that is related to the qualifications, functions, or duties of an instructor-coordinator or training officer;

(10) willfully failing to adhere to the course syllabus; or
109-5-1. Continuing education. (a) As used in these regulations, “continuing education” means a formally organized learning experience that has education as its explicit principal intent and is oriented towards the enhancement of EMS practice, values, skills and knowledge.

(b) Continuing education credit shall be awarded in quarter-hour increments for instruction for which an individual meets the requirements in subsection (b) and shall not be issued for more than one hour of credit for a 60-minute period.

(b) Each individual seeking continuing education credit for a course shall submit either of the following:

(1) The individual’s certificate of attendance; or

(2) the individual’s certificate of completion.

(c) Each acceptable certificate of attendance or certificate of completion shall include the following:

(1) The name of the provider of the continuing education course;

(2) the name of the attendant being issued the certificate;

(3) the title of the course;

(4) the date or dates on which the course was conducted;

(5) the location where the course was conducted;

(6) the amount of approved continuing education credit issued to the individual for attending the course;

(7) the course identification number issued by the board, by CAPCE, or by another state’s emergency medical services regulatory or accrediting body; and
(8) the name of the person or entity authorized by the provider to issue the certificate.

(d)(1) Acceptable continuing education programs shall include the following:

(A) (1) Initial courses of instruction and prior-approved continuing education provided by a sponsoring organization and approved by the board;

(B) (2) programs approved or accredited by CAPCE, which shall be presumptively accepted by the board unless the board determines that a particular program does not meet board requirements; and

(C) (3) programs or courses approved by another state’s emergency medical services EMS regulatory or accrediting body, which shall be presumptively accepted by the board unless the board determines that a particular program does not meet board requirements.

(2) (d) Any program not addressed in this subsection (c) may be submitted for approval by the attendant EMS provider as specified in K.A.R. 109-5-5.

(e) The number of clock-hours received for amount of continuing education credit obtained in one calendar day shall not exceed 12.

(f) Each attendant EMS provider and instructor-coordinator sponsoring organization shall keep documentation of completion of approved continuing education for at least three years and shall provide this documentation to the board upon request by the executive director.

(g) Documentation of completion of approved continuing education shall verify the following for each continuing education course completed:

(1) The name of the provider of the continuing education course;
(2) the name of the individual being issued the continuing education credit;

(3) the title of the continuing education course;

(4) the date or dates on which the course was conducted;

(5) the location where the course was conducted;

(6) the amount of continuing education credit issued to the individual; and

109-5-3. Continuing education approval for long-term providers. (a) Any sponsoring organization may submit an application to the board requesting approval as a long-term provider of continuing education.

(b) Each sponsoring organization seeking long-term provider approval for continuing education courses shall meet the following requirements:

(1) submit a complete application packet to the executive director at least 30 calendar days before the first initial course to be offered as part of the long-term provider of continuing education training program management plan at least 30 calendar days before the first course offered as part of the long-term provider. A complete application packet shall include the following: (A) A complete application form provided by the executive director that includes the signatures of the training program manager and the medical director; and (B) a long-term continuing education training program management plan that describes how the applicant shall meet the requirements of subsection (b); (2) appoint a training program manager who will serve as the liaison to the board concerning continuing education training; (3) appoint a physician who will serve as the medical director for the training program; (4) provide a sufficient number of lab instructors to maintain a student-to-instructor ratio of 6:1 during laboratory training sessions; (5) provide a sufficient quantity of EMS training equipment to maintain a student-to-equipment ratio of 6:1 during laboratory training sessions; (6) provide to each student, upon request, the following: (A) A course schedule that includes the following: (i) The date and time of each class lesson; (ii) the title of each lesson; and (iii) the name of the qualified instructor and that individual’s qualifications, as specified in K.A.R. 109-11-9, to teach each lesson; and (B) a certificate of
attendance that includes the following: (i) The name of the training program; (ii) a statement that the training program has been approved by the board as a long-term provider of continuing education training; (iii) the title of the continuing education offering; (iv) the date and location of the continuing education offering; (v) the amount of continuing education credit awarded to each participant for the offering; (vi) the course identification number issued by the board; and (vii) the printed name and signature of the program manager; (7) maintain training program records and continuing education course records for at least three years. The following records shall be maintained: (A) A copy of the application form and all documents required to be submitted with the application for training program approval; (B) student attendance rosters; (C) course educational objectives; and (D) master copies and completed copies of each student’s evaluations of the educational offerings; (8) establish a continuing education program quality management plan that includes the following: (A) A description of the training needs assessment used to determine the continuing education courses to be conducted; (B) a description of the training program evaluations to be conducted and a description of how a review and analysis of the completed evaluations by the training program’s medical director and the training program manager shall be conducted; (C) equipment use, maintenance, and cleaning policies; and (D) training program infection-control policies; (9) submit quarterly reports to the executive director that include the following: (A) The date, title, and location of each EMS continuing education course offered; (B) the amount of EMS continuing education credit issued for each EMS course offered; and (C) the printed name and signature of the training program manager; and (10) a description of how the program will ensure that all education offered under the
auspices of the long-term provider approval meets the definition of continuing education as specified in K.A.R. 109-1-1. (c) Each approved long-term provider wanting to offer continuing education in a distance learning format shall incorporate the following items into the provider’s long-term continuing education training program management plan: (1) A definition of the process by which students can access the qualified instructor, as specified in K.A.R. 109-11-9, during any distance learning offerings; (2) a definition of the procedures used to ensure student participation in course offerings oriented towards the enhancement of EMS practice, values, skills, and knowledge; and (3) specification of each learning management system that will be used and how each system is to be used in the course issued continuing education credit as specified in K.A.R. 109-5-1. (d) Each long-term provider of continuing education courses shall submit any change of program manager or medical director and any change to the long-term continuing education program management plan to the board office no later than 30 calendar days after the change has occurred. Failure to submit any of these changes may result in suspension of approval as a long-term provider of continuing education issue a course identification number for each long-term provider approval. (e) Each approved long-term provider of continuing education training shall provide the executive director with a copy of all training program records and continuing education course records upon the executive director’s request. (Authorized by and implementing K.S.A. 2016 Supp. 65-6111;
P-_____________________________________.)
109-5-6. Single-program Continuing education approval for single-program providers of continuing education. (a) Any entity specified in K.A.R. 109-1-1(bb) sponsoring organization may submit an application to the executive director to conduct board requesting approval as a single-program continuing education provider.

(b) Each provider of sponsoring organization seeking single-program continuing education provider approval shall meet the following requirements:

(1) submit a complete application for single-program approval to the executive director at least 30 days before the requested offering. A complete application shall include that provides all of the following:

(A) The signatures of the program manager and the program medical advisor;

and

(B) (1) A course schedule that includes the date and time of each continuing education program, the title of each continuing education topic in the program, and the instructor;

(2) provide each student with a certificate of attendance that includes the following: course educational objectives;

(2) name of each qualified instructor for the course; and

(A) The name of the continuing education program;

(B) a statement that the continuing education program has been approved by the board;

(C) the title of the continuing education program;

(D) the (3) date, title, and location of the continuing education program course:
(E) the amount of continuing education credit completed by the attendant for the
continuing education program;

(F) the board-assigned course identification number; and

(G) the printed name and signature of the program coordinator; and

(3) maintain the following records for at least three years:

(A) A copy of all documents required to be submitted with the application for
single-program approval;

(B) a copy of the curriculum vitae or other documentation of the credentials for
each instructor and lab instructor;

(C) student attendance records;

(D) course educational objectives; and

(E) completed copies of student evaluations of the educational offering.

(c) Upon request by the executive director, each provider of single-program
continuing education shall provide a copy of all continuing education program records
and continuing education course records. The board shall issue a course identification
number for each single-program provider approval where the course educational
objectives submitted are oriented towards the enhancement of EMS practice, values,
skills, and knowledge. (Authorized by and implementing K.S.A. 65-6111, as amended
by L. 2008, ch. 47, sec. 1; effective May 15, 2009; P-___________________________.)
109-10-3. Late enrollment. (Authorized by and implementing K.S.A. 2016 Supp. 65-
revoked P-_______________________________________.)
109-11-1a. **Emergency medical responder (EMR) course approval.** (a) Emergency medical responder EMR initial courses of instruction pursuant to K.S.A. 65-6144, and amendments thereto, may be approved by the executive director and shall be conducted only by sponsoring organizations.

(b) Each sponsoring organization requesting approval to conduct an EMR initial course of instruction shall submit a complete application packet to the executive director, including all required signatures, and the following documents: not later than 30 calendar days before the first scheduled course session

1. A course syllabus that includes at least the following information:
   (A) A summary of the course goals and objectives;
   (B) instructional and any other materials required to be purchased by the student;
   (C) student attendance policies;
   (D) student requirements for successful course completion;
   (E) a description of the clinical and field training requirements, if applicable;
   (F) student discipline policies; and
   (G) instructor information, which shall include the following:
      (i) Instructor name;
      (ii) office hours or hours available for consultation; and
      (iii) instructor electronic-mail address;

2. course policies that include at least the following information:
   (A) Student evaluation of program policies;
   (B) student and participant safety policies;
   (C) Kansas requirements for certification;
(D) student dress and hygiene policies;
(E) student progress conferences; and
(F) equipment use policies;

(3) a course schedule that identifies the following:

(A) The date and time of each class session, unless stated in the syllabus;
(B) the title of the subject matter of each class session;
(C) the instructor of each class session; and
(D) the number of psychomotor skills laboratory hours for each session; and

(4) letters or contracts from the ambulance service director of the ambulance service that will provide field training to the students, if applicable, and the administrator of the medical facility in which the clinical rotation is provided, if applicable, indicating their commitment to provide the support as defined in the curriculum.

(c) Each **complete** application shall be received in the board office not later than 30 calendar days before the first scheduled course session.

(d) Each approved initial course shall meet include all of the following conditions:

(1) Meet or exceed the course requirements described in the board’s regulations

Name of the primary instructor; and

(2) be approved by the sponsoring organization’s medical director name of all ambulance services and medical facilities utilized for field or clinical training, if applicable; and

(3) maintain course records for at least three years. The following records shall be maintained a course schedule that identifies the following:

(A) A copy of all documents required to be submitted with the application for
course approval The date and time of each class session;

(B) student attendance the title of the subject matter of each class session;

(C) student grades the qualified instructor for each class session; and

(D) student conferences the number of psychomotor skills laboratory hours for each class session;

(E) course curriculum;

(F) lesson plans for all lessons;

(G) clinical training objectives; if applicable;

(H) field training objectives; if applicable;

(I) completed clinical and field training preceptor evaluations for each student;

(J) master copies and completed copies of the outcome assessment and outcome analyses tools used for the course that address at least the following:

(i) Each student’s ability to perform competently in a simulated or actual field situation, or both; and

(ii) each student’s ability to integrate cognitive and psychomotor skills to appropriately care for sick and injured patients;

(K) a copy of each student’s psychomotor skills evaluations as specified in the course syllabus;

(L) completed copies of each student’s evaluations of each course, all instructors for the course, and all lab instructors for the course; and

(M) a copy of the course syllabus.

(e) (d) Each primary instructor shall provide the executive director with a student registration form from each student within 20 days of the date of the first class session
approved EMR initial course shall meet or exceed each of the educational standards referenced in K.A.R. 109-10-1a.

(f) Each sponsoring organization shall provide any course documentation requested by the executive director.

(g) Any approved course may be monitored by the executive director.

(h) The board shall issue a course identification number for each EMR initial course of instruction approval.

(g) Program Course approval may be withdrawn by the board if the sponsoring organization fails to comply with or violates any regulation or statute that governs sponsoring organizations. (Authorized by K.S.A. 65-6110, 65-6111; implementing K.S.A. 65-6110, 65-6111, 65-6129, and 65-6144; effective, T-109-2-7-11, Feb. 7, 2011; effective June 3, 2011; amended Dec. 29, 2017; amended P-_______________________________.)
109-11-3a. Emergency medical technician (EMT) course approval. (a) Emergency medical technician (EMT) initial courses of instruction pursuant to K.S.A. 65-6121, and amendments thereto, may be approved by the executive director and shall be conducted only by sponsoring organizations. (b) Each sponsoring organization requesting approval to conduct an EMT initial course of instruction shall meet the following requirements:

(1) Meet the course requirements specified in K.A.R. 109-11-1a (b)-(e); and

(2) in each initial course of instruction, include hospital clinical training and ambulance field training that provide the following:

(A) An orientation to the hospital and to the ambulance service; and

(B) supervised participation in patient care and assessment, including the

performance of submit a complete patient assessment on at least one patient in compliance with K.S.A. 65-6129a and amendments thereto. In the absence of participatory clinical or field training, contrived experiences may be substituted

application not later than 30 calendar days before the first scheduled course session.

(c) Each sponsoring organization shall ensure that the instructor-coordinator provides any course documentation requested by the executive director. complete application shall include all of the following:

(1) Name of the primary instructor;

(2) name of all ambulance services and medical facilities utilized for field or clinical training; and

(3) a course schedule that identifies the following:

(A) The date and time of each class session;
(B) the title of the subject matter of each class session;

(C) the qualified instructor for each class session; and

(D) the number of psychomotor skills laboratory hours for each class session.

d) Each approved EMT initial course shall meet or exceed each of the educational standards referenced in K.A.R. 109-10-1b.

e) Any approved course may be monitored by the executive director.

(f) The board shall issue a course identification number for each EMT initial course of instruction approval.

g) Program Course approval may be withdrawn by the board if the sponsoring organization fails to comply with or violates any regulation or statute that governs sponsoring organizations. (Authorized by K.S.A. 2014 Supp. 65-6110 and 65-6111; implementing K.S.A. 2014 Supp. 65-6110, 65-6111, and 65-6121; effective T-109-2-7-11, Feb. 7, 2011; effective June 3, 2011; amended May 1, 2015; P-____________________________.)
109-11-4a. Advanced emergency medical technician (AEMT) course approval.

(a) AEMT initial courses of instruction pursuant to K.S.A. 65-6120, and amendments thereto, may be approved by the executive director to and shall be conducted only by sponsoring organizations.

(b) Each sponsoring organization requesting approval to conduct an AEMT initial course of instruction shall meet the course requirements in K.A.R. 109-11-1a (b)-(e) submit a complete application not later than 30 calendar days before the first scheduled course session.

(c) Each approved AEMT course shall ensure, and shall establish in writing, how each student is provided with experiences, which complete application shall include at a minimum all of the following:

1. Successfully perform 20 venipunctures, of which 10 shall be for the purpose of initiating intravenous infusions; Name of the primary instructor;

2. Administer one nebulized breathing treatment during name of all ambulance services and medical facilities utilized for field or clinical training; and

3. Successfully perform five intraosseous infusions; a course schedule that identifies the following:

   (A) The date and time of each class session;
   (B) the title of the subject matter of each class session;
   (C) the qualified instructor for each class session; and
   (D) the number of psychomotor skills laboratory hours for each class session.

(4) perform a complete patient assessment on each of 15 patients, of which at least 10 shall be accomplished during field internship training;
(5) while directly supervised by an AEMT, a paramedic, a physician, an advanced practice registered nurse, or a professional nurse, respond to 10 ambulance calls;

(6) perform 10 intramuscular or subcutaneous injection procedures;

(7) complete 10 patient charts or patient care reports, or both; and

(8) perform the application and interpretation of the electrocardiogram on eight patients during clinical training and field internship training.

(d) Each approved AEMT initial course shall meet or exceed each of the educational standards referenced in K.A.R. 109-10-1c.

(e) Any approved course may be monitored by the executive director.

(e) Each sponsoring organization shall ensure that the instructor-coordinator provides any course documentation requested by the executive director.

(f) The board shall issue a course identification number for each AEMT initial course of instruction approval.

(g) Program Course approval may be withdrawn by the board if the sponsoring organization fails to comply with or violates any regulation or statute that governs sponsoring organizations. (Authorized by K.S.A. 2014 Supp. 65-6110 and 65-6111, implementing K.S.A. 2014 Supp. 65-6110 and 65-6111 and K.S.A. 65-6129a; effective March 2, 2012; amended May 1, 2015.)
109-11-7. Instructor-coordinator course approval. (a) Each Instructor-coordinator initial courses of instruction pursuant to K.S.A. 65-6129a, and amendments thereto, may be approved by the executive director and shall be provided conducted only by the board or by an agency with which the board contracts sponsoring organizations.

(b) Each sponsoring organization requesting approval to conduct approved an instructor-coordinator initial course of instruction shall submit a complete application packet not later than 30 calendar days before the first scheduled course session:

1. meet or exceed the curriculum described in K.A.R. 109-10-1(g);
2. consists of a minimum of 90 hours of training; and
3. use a text or texts approved by the board.

(c) Each complete application shall include all of the following:

1. Name of the primary instructor;
2. a course schedule that identifies the following:
   A. the date and time of each class session;
   B. the title of the subject matter of each class session;
   C. the qualified instructor for each class session; and
   D. the number of psychomotor skills laboratory hours for each class session.
3. Each approved instructor-coordinator course shall meet or exceed each of the standards described in K.A.R. 109-10-1e.

(e) Any approved course may be monitored by the executive director.

(f) The board shall issue a course identification number for each instructor-coordinator initial course of instruction approval.
(g) Course approval may be withdrawn by the board if the sponsoring organization fails to comply with or violates any regulation or statute that governs sponsoring organizations. (Authorized by K.S.A. 1988 Supp. 65-6110; implementing K.S.A. 1988 Supp. 65-6110 and 65-6111; effective T-109-1-19-89, Jan. 19, 1989; effective July 17, 1989.)
109-11-8. Successful completion of a course of instruction. (a) To successfully complete a course of instruction as an attendant EMS provider or instructor-coordinator, each student shall:

(1) Attend at least 90% Demonstrated application of the class sessions as described in the course syllabus a cognitive understanding of each EMS educational standard;

(2) maintain an average grade of at least 70% for all examinations given during the program; and

(3) demonstrate all practical skills to the satisfaction of the course coordinator primary instructor; and

(3) demonstrate successful completion of each of the following:

(A) for an EMR initial course of instruction, 10 intramuscular injection procedures;

(B) for an EMT initial course of instruction:

(i) one complete patient assessment;

(ii) one nebulized breathing treatment; and

(iii) 10 intramuscular injection procedures; and

(C) for an AEMT initial course of instruction:

(i) 20 venipunctures, of which at least 10 shall be for the purpose of initiating intravenous infusions;

(ii) five intraosseous infusions;

(iii) 15 complete patient assessments, of which at least 10 shall be accomplished during field internship training;

(iv) 10 ambulance calls while being directly supervised by an AEMT, a paramedic, a physician, an advanced practice registered nurse, or a professional nurse;
(v) 10 completed patient charts or patient care reports, or both; and
(vi) 8 electrocardiogram applications and interpretations during clinical training and field internship training.

(b) The course coordinator, primary instructor shall provide written approval, within 15 days of the final class and at least 7 days prior to the student challenging the State examination for certification, that the requirements of subsection (a) of this regulation have been met. Evidence of a grade of C or better on a course of instruction given by an accredited post-secondary school shall substitute for written approval. (Authorized by K.S.A. 65-6110, as amended by L. 1993, Chap. 71, Sec. 1; implementing K.S.A. 65-6111, as amended by L. 1993, Chap. 71, Sec. 2, and K.S.A. 65-6129, as amended by L. 1993, Chap. 71, Sec. 5, and K.S.A. 65-6142; effective, T-109-1-19-89, Jan. 19, 1989; effective July 17, 1989, amended Jan. 31, 1994; amended P-____________.)
Agenda Item: Medical Oversight Legislation
Committee: Executive

BACKGROUND
Multiple ambulance services have reported an increasingly difficult time in obtaining medical protocol approval through one of the three statutorily established methods of gaining medical protocol approval. The 3 approved methods currently dictated within statute are:

1. A county medical society;
2. The medical staff of a hospital to which the ambulance service primarily transports patients; or
3. If neither 1 or 2 are able or available to approve the medical protocols, the medical advisory council of the Board.

The number of functioning county medical societies has been a slow, but consistent decline over the past 15-20 years. Today, there are very few county medical societies that are robust enough to be able to make the time and effort necessary to provide a well vetted decision on medical protocol approval.

Having the medical staff of a hospital provide approval has led to a perception and some isolated instances of that decision being made to drive care towards a specific facility rather than for the best interest of patient care. The best example of this would be an active heart attack patient bypassing a closer facility for a longer transport time, but going to a facility that has the capability of providing interventional cardiology services necessary for the appropriate care of that patient’s condition.

The Medical Advisory Council of the Board has had 8 sets of medical protocols submitted for their approval. Most have been due to the statewide footprint of the submitting service. The Medical Advisory Council has been appropriately reluctant to approve medical protocols without the ability to completely understand the capacity of the service, its personnel, and its available resources. Also, there is a question as to the complete coverage of liability for medical care being directed through the use of medical protocols without the responsibility of direct oversight.

DISCUSSION
Discussion of this topic has been ongoing for the past several years. In late-2018, Dr. Joel Hornung, Board Chair, put forth a proposal to reignite the conversation (Enclosure 3). This led to multiple meetings involving physician subgroupings, the Kansas Medical Society, the Kansas EMS Association, the Board of EMS, and the Medical Advisory Council of the Board.

It was recognized that the solution needed to be flexible and representative of the diversity of Kansas as well as to provide the most basic and essential standard of care. It was also noted that any solution would require active participation by an ambulance service’s medical director.

Discussion from these meetings led to the development of a plan that involves 1) changing the medical protocol approval process to be able to be done by the physician responsible for medical oversight of the ambulance service; 2) establishing a statewide minimum standard of care; 3) monitoring of quality measures; and 4) providing or recognizing evidence based medical guidelines for use in the prehospital setting.

During the 2020 Legislative Session, HB 2723 was introduced to authorize the 1st step in the plan which would allow for the further development of steps 2 through 4 while providing a solution to the problems...
existing within the current medical protocol approval process. HB2723 received a public hearing with no noted opposition and 2 conferees in support. Slight modifications were made to HB2723 to better capture the intent and the bill was set to be deliberated at the committee level. Due to a global pandemic, most legislative issues in the 2020 Session were set aside and this bill became one of them.

**FINANCING**

There is no anticipated fiscal effect for pursuing HB2723 as revised in future legislative sessions. The system to be used for monitoring quality measures is already financially supported through the EMS operating fund and the remainder of the plan steps are policy decisions that should not require any additional funding or financing beyond normal operational expenditures.

**ALTERNATIVES**

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

1. Propose HB2723 as modified after the hearing (Enclosure 1) in the 2021 Legislative session.
2. Propose legislation as originally introduced (Enclosure 2) in the 2021 Legislative session.
3. Decline to pursue changes in the 2021 Legislative session specific to this topic.
4. Modify language.
5. Table the item.

**RECOMMENDATION**

To propose HB2723 as modified after the hearing (Enclosure 1) in the 2021 Legislative session.

**POSSIBLE MOTION**

To pursue enactment of HB2723 as presented with the balloon amendment (Enclosure 1).

Enclosures:
1. HB2723 with the balloon amendment proposed post-hearing
2. HB2723 as introduced
3. Initial Proposal for Protocol Approval in Kansas
65-6126. Medical director. (a) Except as provided in subsection (b), each emergency medical service operator shall have designate a medical director appointed by the operator of the service to review and implement medical protocols, approve and monitor the activities, competency and education of the emergency medical service providers to provide medical oversight.

(b) The board may approve an alternative procedure for medical oversight by a physician if no medical director is available to be designated by the operator.

65-6124. Limitations on liability. (a) No physician, physician assistant, advanced practice registered nurse or licensed professional nurse, who gives emergency instructions to an emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto, during an emergency, shall be liable for any civil damages as a result of issuing the instructions, except such damages that may result from gross negligence in giving such instructions.

(b) No emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto, who renders emergency care during an emergency pursuant to instructions given by a physician, the supervising physician for a physician assistant, advanced practice registered nurse or licensed professional nurse shall be liable for civil damages as a result of implementing such instructions, except such damages that may result from gross negligence or by willful or wanton acts or omissions on the part of such emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto.

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

(d) No medical director who reviews, approves and monitors the activities of emergency medical service providers provides medical oversight shall be liable for any civil damages as a result of such review, approval or monitoring medical oversight, except such damages that may result from gross negligence in the provision of such review, approval or monitoring medical oversight.
65-6112. Definitions. As used in this act article 61 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto:

(a) "Administrator" means the executive director of the emergency medical services board.

(b) "Advanced emergency medical technician" means a person who holds an advanced emergency medical technician certificate issued pursuant to this act.

(c) "Advanced practice registered nurse" means an advanced practice registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

(d) "Ambulance" means any privately or publicly owned motor vehicle, airplane or helicopter designed, constructed, prepared, staffed and equipped for use in transporting and providing emergency care for individuals who are ill or injured.

(e) "Ambulance service" means any organization operated for the purpose of transporting sick or injured persons to or from a place where medical care is furnished, whether or not such persons may be in need of emergency or medical care in transit.

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

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

(h) "Emergency medical service provider" means an emergency medical responder, advanced emergency medical technician, emergency medical technician or paramedic certified by the emergency medical services board.
(i) "Emergency medical technician" means a person who holds an emergency medical technician certificate issued pursuant to this act.

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

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

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

(m) "Medical director" means a physician.

(n) “Medical oversight” means to review, approve and implement medical protocols and to approve and monitor the activities, competency and education of emergency medical service providers.

(o) "Medical protocols" mean written guidelines that authorize emergency medical service providers to perform certain medical procedures prior to contacting a physician, physician assistant authorized by a physician, advanced practice registered nurse authorized by a physician or professional nurse authorized by a physician. The medical protocols shall be approved by a county medical society or the medical staff of a hospital to which the ambulance service primarily transports patients, or if neither of the above are able or available to approve the medical protocols, then the medical protocols shall be submitted to the medical advisory council for approval.

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

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

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

(s) "Paramedic" means a person who holds a paramedic certificate issued pursuant to this act.

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

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

(v) "Physician assistant" means a physician assistant as defined in K.S.A. 65-28a02, and amendments thereto.

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

(x) "Sponsoring organization" means any professional association, accredited postsecondary educational institution, ambulance service that holds a permit to operate in this state, fire department, other officially organized public safety agency, hospital, corporation, governmental entity or emergency medical services regional council, as approved by the executive director, to offer initial courses of instruction or continuing education programs.

AN ACT concerning emergency medical services; relating to medical
 directors; requiring provision of medical oversight; amending K.S.A.
 2019 Supp. 65-6112, 65-6124 and 65-6126 and repealing the existing
 sections.

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

Section 1. K.S.A. 2019 Supp. 65-6112 is hereby amended to read as
follows: 65-6112. As used in this act article 61 of chapter 65 of the Kansas
Statutes Annotated, and amendments thereto:

(a) "Administrator" means the executive director of the emergency
medical services board.

(b) "Advanced emergency medical technician" means a person who
holds an advanced emergency medical technician certificate issued
pursuant to this act.

(c) "Advanced practice registered nurse" means an advanced practice
registered nurse as defined in K.S.A. 65-1113, and amendments thereto.

(d) "Ambulance" means any privately or publicly owned motor
vehicle, airplane or helicopter designed, constructed, prepared, staffed and
equipped for use in transporting and providing emergency care for
individuals who are ill or injured.

(e) "Ambulance service" means any organization operated for the
purpose of transporting sick or injured persons to or from a place where
medical care is furnished, whether or not such persons may be in need of
emergency or medical care in transit.

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

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

(h) "Emergency medical service provider" means an emergency
medical responder, advanced emergency medical technician, emergency
medical technician or paramedic certified by the emergency medical
services board.
(i) "Emergency medical technician" means a person who holds an emergency medical technician certificate issued pursuant to this act.

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

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

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

(m) "Medical director" means a physician.

(n) "Medical oversight" means to review, approve and implement medical protocols and to approve and monitor the activities, competency and education of emergency medical service providers.

(o) "Medical protocols" mean written guidelines that authorize emergency medical service providers to perform certain medical procedures prior to contacting a physician, physician assistant authorized by a physician, advanced practice registered nurse authorized by a physician or professional nurse authorized by a physician. The medical protocols shall be approved by a county medical society or the medical staff of a hospital to which the ambulance service primarily transports patients, or if neither of the above are able or available to approve the medical protocols, then the medical protocols shall be submitted to the medical advisory council for approval.

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

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

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

(r) "Paramedic" means a person who holds a paramedic certificate issued pursuant to this act.

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

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

(u) "Physician assistant" means a physician assistant as defined in K.S.A. 65-28a02, and amendments thereto.

(v) "Professional nurse" means a licensed professional nurse as defined by K.S.A. 65-1113, and amendments thereto.
(w) "Sponsoring organization" means any professional association, accredited postsecondary educational institution, ambulance service that holds a permit to operate in this state, fire department, other officially organized public safety agency, hospital, corporation, governmental entity or emergency medical services regional council, as approved by the executive director, to offer initial courses of instruction or continuing education programs.

Sec. 2. K.S.A. 2019 Supp. 65-6124 is hereby amended to read as follows: 65-6124. (a) No physician, physician assistant, advanced practice registered nurse or licensed professional nurse, who gives emergency instructions to an emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto, during an emergency, shall be liable for any civil damages as a result of issuing the instructions, except such damages that may result from gross negligence in giving such instructions.

(b) No emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto, who renders emergency care during an emergency pursuant to instructions given by a physician, the supervising physician for a physician assistant, advanced practice registered nurse or licensed professional nurse shall be liable for civil damages as a result of implementing such instructions, except such damages that may result from gross negligence or by willful or wanton acts or omissions on the part of such emergency medical service provider as defined by K.S.A. 65-6112, and amendments thereto.

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

(d) No medical director who reviews, approves and monitors the activities of emergency medical service providers provides medical oversight shall be liable for any civil damages as a result of such review, approval or monitoring medical oversight, except such damages that may result from gross negligence in the provision of such review, approval or monitoring medical oversight.

Sec. 3. K.S.A. 2019 Supp. 65-6126 is hereby amended to read as follows: 65-6126. (a) Except as provided in subsection (b), each emergency medical service operator shall have designate a medical director appointed by the operator of the service to review and implement medical protocols, approve and monitor the activities, competency and education of the emergency medical service providers to provide medical oversight.

(b) The board may approve an alternative procedure for medical
oversight if no medical director is available.

Sec. 4. K.S.A. 2019 Supp. 65-6112, 65-6124 and 65-6126 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the Kansas register.
Proposal for Protocol Approval in Kansas

The current protocol approval process in Kansas is problematic. After reviewing the problems, looking to other States for their solutions, and recognizing the diversity of Kansas; the following solution is brought for consideration. The choices should be a good fit for Kansas. If additional training or equipment is required, it is only so much as to provide the most basic and essential standard of care. It will allow for care that is proven and effective. Choice #2 will allow for the continuation of established protocols in services that have an ongoing protocol development system with experienced Medical Directors. This proposal requires active participation by the Service Medical Director, no matter the choice.

The choices also include reminders that training of staff and involvement of the Medical Directors are necessary.

Protocol choice #1 (State Developed Protocol):

1. This is a protocol developed by a team of professionals (defined below).
2. The Protocol is comprehensive and it is based on the NASEMSO Clinical Guidelines. Protocols may include additional best practices as determined by the Kansas EMS Protocol Development Team.
3. The Service adopting choice #1 cannot amend or add protocols.
4. The Medical Director is required to affirm the protocols. This means he or she is comfortable with:
   a. The medical content of the protocols
   b. The training of the EMS providers performing the duties outlined in the protocols
   c. actively taking part in a quality improvement process for the service.
5. These protocols will be updated yearly. Services will have four (4) months to apply updates.
6. The protocol should delineate allowed activities for all levels of EMS Provider scope of practice.
7. The Service can immediately implement the protocols with the affirmation of their medical director.

Protocol choice #2 (Medical Director Developed Protocol): In this situation, the local Medical Director creates the medical protocols for his service. In these protocols, the following points must be met:

1. The base level of care must be consistent with the NASEMSO Clinical Guidelines.
2. The Medical Director understands that he or she is responsible for the content of the protocols. If creation of the protocols is shared with other individuals, it must be clearly stated in an introduction to the protocols.
3. The Medical Director must affirm that he/she is aware and satisfied with protocol and procedural training.

4. The Medical Director must be credentialed in some way (e.g. NAEMSP Course Graduate, Active Practice of Emergency Medicine, five (5) years of experience as an EMS Medical Director, or other Method as deemed by the Kansas Medical Society)

5. A copy of the protocol must be on file with the Board of EMS.

6. The Service Medical Director should update and reaffirm the protocol at least every two (2) years.

7. In the case of a change of Medical Directors, the Service has six (6) months to file a change, credential the Medical Director, and affirm the protocols.

8. Verification that the protocols meet minimum standard would be the responsibility of the Board of EMS. Most likely, this would be carried out by periodic audit of the protocols.

**Kansas EMS Protocol Development Team**

This group would direct protocol review, modification and formatting. Initially, the group would review the NASEMSO Clinical Guidelines. They would then make suggestions for additional protocols that aren’t part of the guidelines and discuss:

- Is there adequate evidence for their use?
- Would it cause undo additional expense for the service?
- Are training materials readily available for the implementation of the protocols?

Funding for the time spent working in this team should be sought. The amount of time, effort and expertise needed for this project is extensive. This will take more time than a team member can reasonably volunteer.

The Team would be made up of the following:

- Four (4) EMS Medical Directors,
  - two (2) selected by BEMS, two (2) selected by KMS
- One (1) Pediatrician familiar with emergency care selected by KMS
- One (1) Trauma surgeon selected by KMS
- One (1) EMS provider selected by KEMSA
- One (1) service director selected by KEMSA
- One (1) EMS instructor selected by BEMS
- One (1) nonvoting coordinator, that manages the logistics of the Team.

The EMS providers must have at least ten (10) years of in field experience. When voting on approval of a protocol, a two-thirds (2/3) majority is required to pass.

The Team would meet initially for creation of the protocols. They would meet yearly after that to review new material and discuss changes. If significant care changing breakthroughs occur, a member of the team may request an interim meeting to discuss an early update or addendum.
Agenda Item:       KRAF Changes for FY2021 Process
Committee:        Executive

BACKGROUND
The EMS Revolving Grant Fund, known as KRAF, is a state funded grant program designed to provide financial assistance based upon demonstrated financial need to Kansas EMS agencies and organizations. The funding is provided through a percentage disbursed from remitted fines, penalties, and forfeitures associated with K.S.A. 74-7336, and was established by the passage of 2007 SB 8. The primary goal of this program is to financially assist EMS agencies and organizations to purchase EMS equipment and assist in regional education and training. Funding is granted based on the documented need of the specific item being requested.

Distribution of the funding is a two-fold process: Direct distribution and Individual distribution. Direct distribution goes directly to each of the six (6) EMS Regional Councils to maintain an overall Regional preparation and education in EMS, homeland security, and education and training opportunities that benefit that geographical area. Individual distribution is to a service and prioritized based upon information submitted during the application process. The requested information on the application is designed to demonstrate the current capacity, to demonstrate the need, and to identify the benefits to the community for receiving the disbursement. The grant application period opens each year approximately December 1st and runs through the 1st of January.

Each year, the Board convenes a committee of regional representatives to assist in the prioritization of grants. Each of the six regions has representation upon this committee as well as the Board.

We have continued to see a decreased amount remitted into this fund each fiscal year. In 2009, the fund received $536,961 from a 2.5% disbursement of the $21.478M remitted. In 2019, the fund received $392,271 from a 2.23% disbursement of the $17.591M remitted.

DISCUSSION
Prior to the committee ending their work for recommendations and prioritization, they are asked if there are any changes necessary for the upcoming grant cycle to assist in making their job easier or that would assist in spreading these funds further. The following are their recommendations for consideration for the FY2021 grant period.

1. Applications that have not been filled out completely or have been filled out inaccurately be presumptively denied without consideration.
   This has been described as one of the easiest grant applications to fill out and the committee felt that it was not an appropriate use of Board staff’s time, or anyone else, to track down an applicant for omitted or inaccurate information.

2. Consideration of reducing the cap of state funding on an ECG monitor from $20,000 to $15,000.
   The committee recognized that monitors are one of the most commonly requested items, but in an effort to spread the funding to more recipients, thought that the reduction would allow greater opportunity to fund more services.

3. Board consider issuing a request to ambulance service operators to consider including durable medical equipment (ECG monitors, cots, ventilators, etc.) with the specifications in their
ambulance vehicle bids. 
Most ambulance manufacturers are comfortable including these items as part of the ambulance and including these items with the ambulance may help the service defer the cost over a period of time rather than having a large one-time expense. The committee did note that it will cause an appearance of an increase in bid amounts from previous years.

4. **Board consider a single year, or two, of funding solely monitors or seeking out additional funding/assistance opportunities due to the final order issued by the FDA in 2015 requiring premarket approval for all new and existing AEDs and necessary AED accessories.**

This final order renders some EMS ECG monitors obsolete on and after February 3, 2021 due to not being able to purchase accessories such as batteries, pad electrodes, and adapters or to have the device maintained.

**FINANCING**
As mentioned in the overview, it is anticipated that funding for FY2021 will be lower than normal. Each year, we expend as close to all as we can, but with deposits coming in up to the end of our fiscal year, it is impossible to expend 100%. The amount not expended each year is rolled over and expended as part of the next. The recommended changes have no budgeting impact upon the Board, they simply provide guidance for prioritization and eligibility.

**ALTERNATIVES**
The Board has the following alternatives concerning the matter at hand. The Board may:
1. Adopt committee recommendation in whole
2. Adopt committee recommendation in part
3. Modify committee recommendation
4. Table the item.

**RECOMMENDATION**
To adopt the committee recommendation in whole and as presented.

**POSSIBLE MOTION**
To adopt the committee’s recommendations for changes beginning with the FY2021 KRAF Grant.

Enclosures:
None
Agenda Item: Advanced EMT Medication List
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.

DISCUSSION
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.

The AEMT excellence committee believes this is a multiple step process and that the first step is placing the medication list into effect while the further steps are developed and addressed.
The AEMT excellence committee recommends that the Board proceed with the adoption of the medication list and pursue the necessary regulatory changes to place that medication list into effect.

**FINANCING**

This item has no anticipated fiscal effect upon the Board.

**ALTERNATIVES**

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

1. Adopt the Executive committee’s recommendation in whole
2. Adopt the Executive committee’s recommendation in part
3. Modify the Executive committee’s recommendation
4. Table the item.

**RECOMMENDATION**

That the Board adopt the Medication List as presented and that the regulatory revision process be initiated to make this change.

**POSSIBLE MOTION(S)**

1. To adopt the medication list as presented.
2. To initiate the regulatory revision process to implement the adopted medication list.

Enclosures:

1. **DRAFT – Medication List – 2020-08**
2. **DRAFT – AEMT Medication List Regulation Changes – Proposed Language**
Approved Medication List
Kansas Board of EMS

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

**Abbreviations:**

<table>
<thead>
<tr>
<th>MDI = Metered Dose Inhaler</th>
<th>IN = Intranasal</th>
<th>IV/IO = Intravenous/Intraosseous</th>
</tr>
</thead>
</table>
| INH = Inhalation           | IM = Intramuscular | SL = Sublingual
| NEB = Nebulized            |

<table>
<thead>
<tr>
<th>Medication</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activated Charcoal</td>
<td>Not Approved</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>B2-agonist and/or anticholinergic bronchodilator*</td>
<td>MDI</td>
<td>MDI; Neb</td>
<td>MDI; Neb</td>
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<tr>
<td>Amiodarone</td>
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<td>Not Approved</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Antidote*</td>
<td>Oral; Autoinjector; IN</td>
<td>Oral; Autoinjector; IN</td>
<td>Oral; Autoinjector; IN; IV/IO</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Oral</td>
<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>Benzodiazepine*</td>
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<td>Not Approved</td>
<td>IM; IV/IO; IN; Rectal</td>
</tr>
<tr>
<td>Corticosteroids*</td>
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<td>Not Approved</td>
<td>Oral; IM; IV/IO</td>
</tr>
<tr>
<td>Dextrose</td>
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<td>Not Approved</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Diphenhydramine</td>
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<tr>
<td>Epinephrine (1:1,000)</td>
<td>Autoinjector; IM</td>
<td>Autoinjector; IM</td>
<td>Autoinjector; IM</td>
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<tr>
<td>Epinephrine (1:10,000)</td>
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<td>IV/IO</td>
</tr>
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<td>Glucagon</td>
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<td>IM</td>
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<tr>
<td>Glucose</td>
<td>Oral</td>
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<td>Oral</td>
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<td>Isotonic Crystalloid IV Fluids*</td>
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<td>IV/IO</td>
</tr>
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<td>Not Approved</td>
<td>IV/IO</td>
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<td>IV fluids with antibiotic additives*</td>
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<td>IV/IO</td>
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<td>IV/IO</td>
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<td>Autoinjector; IN; IM; IV/IO</td>
</tr>
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<td>SL; Transdermal</td>
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<td>INH</td>
</tr>
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<td>Opioid*</td>
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<td>Oral; IM; IN; IV/IO</td>
</tr>
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<td>Over the Counter Antipyretics*</td>
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<td>Oral</td>
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<td>Over the Counter Non-opioid analgesics*</td>
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<td>Oral</td>
<td>Oral</td>
</tr>
<tr>
<td>Oxygen</td>
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<td>INH</td>
<td>INH</td>
</tr>
<tr>
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<td>IV/IO</td>
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<td>Patient Assisted Medications*</td>
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<td>Prescribed Route ONLY</td>
</tr>
</tbody>
</table>

*Where a drug class, type, or category is listed, specific agents shall be selected and approved through local medical protocols.
109-3. 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;

(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;
(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

(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;

(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 August 7, 2020, 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
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 Supp. 65-6111; implementing K.S.A. 2013 Supp. 65-6120; effective March 9, 2012; amended Nov. 2, 2012; amended Aug. 29, 2014; amended P-___________.)
**Agenda Item:** Education Incentive Grant Study Follow-Up  
**Committee:** Executive

**BACKGROUND**

The Education Incentive Grant (EIG) program was established to finance the recruitment and retention of volunteers primarily in underserved, rural areas of Kansas. This funding is available through an application process with criteria established from the three priorities set forth in the enabling legislation. Those priorities are to assist with the cost of 1) initial courses of training for EMS providers and instructor-coordinators; 2) continuing education; and 3) education for EMS providers and instructor-coordinators who are obtaining a post-secondary education degree.

EIG is funded through our EMS operating fund as we are budgeted to transfer $300,000 from our operating fund to the EIG fund each year.

The funds are disbursed to services to assist individuals. In return, the individual must meet certain obligations in order to receive the funding (such as working 20 hours a month for the service providing the funding for a set period of time). In certain circumstances, an individual does not meet the grant obligations and is responsible to repay the grant for a percentage of, or all, expenditures (as per their signed agreement to receive the funds).

In April 2018, the Board approved a study (Enclosure 1) to utilize a portion of the funds that had already been expended for their primary purpose and had been collected from those that failed to meet the current grant requirements to fund an alternate proposal. This alternate would be to provide low income individuals, separating military members, and military families’ assistance with certification and examination costs associated with gaining Kansas EMS Certification and to incentivize them to enter the Kansas EMS Workforce.

In FY2019, the Board received $82,778 in repayments for the grant and in FY2020, $80,376.

The approved study ended on June 30, 2020 (end of FY2020).

**DISCUSSION**

During the 2 year study, 3 applications were made specific to this study offering. 2 of the 3 applications met the qualifications to receive funding. One submitted a military application, but separated from service 7 years prior. Neither of the two recipients are affiliated with an ambulance service at this time, but one has a prospective offer from a fire service that provides emergency medical response.

This study and the lack of active applicants was discussed during legislative hearings on HB2506 in both the House and the Senate (a bill to expedite licensing for military spouses and servicemembers and expanded to all applicants) and we have attempted to market to the 3 major military installations – Fort Leavenworth, Fort Riley, and McConnell Air Force Base.

Although there were very minimal applications for the funding, offering the funds does not hinder availability or prevent others from having access to that funding.

**FINANCING**

This item has no anticipated fiscal effect upon the Board. Funding not used for this purpose continues to be expended upon the priorities set forth in the EIG program.
ALTERNATIVES
The Board has the following alternatives concerning the matter at hand. The Board may:
1. Continue providing the opportunity.
2. Cease providing the grant opportunity.
3. Modify the grant opportunity.
4. Table the item.

RECOMMENDATION
That the grant continue to be offered under the auspices set forth in the study (funds collected from those that failed to meet the grant obligations and for the populations listed).

POSSIBLE MOTION(S)
To make permanent the changes to the EIG offering pertaining to the low-income and military provisions as was studied in FY2019 and FY2020.

Enclosures:
1. EIG Study Proposal – 201804
Education Incentive Grant Study Proposal

**Intent:** To incentivize an opportunity for low income individuals, separating military members, and military families to obtain Kansas EMS certification and to enter the Kansas EMS Workforce by reducing certification and examination costs.

**Desired Effect:** Increased opportunity for recruitment of individuals by ambulance services and first response agencies.

- We are seeing more EMS courses (EMR and EMT) being provided through high schools and utilizing the technical professions grant afforded by the Kansas Legislature. In most instances, this covers the cost of books and tuition for the student to complete the course. Some of the students in these courses are from lower-income families and the only obstacle to making the attempt for certification is the cost of the examination being too much for the student, or their family, to incur.
- We are seeing more members of our military separating from service and looking for gainful employment.
- Military spouses and families are moving to military installations in Kansas. Some of these spouses and families have EMS certification and are looking for gainful employment within the state.

**PROPOSED ADDITIONAL INCENTIVE**

The Board utilize a portion of the EIG funds that were expended and have been collected from those that failed to meet the current grant requirements.

Individuals that meet low-income requirements may request to receive assistance for the fees of a first attempt at certification examinations and the application fee. The individual will be required to cover 20% of those costs with the grant covering the remaining 80%.

- EMR – utilizing current costs - $190 total cost ($152 State - $38 Individual)
- EMT – utilizing current costs - $255 total cost ($204 State - $51 Individual)

Military members separating from service as well as active military members’ spouses and dependents may request to receive assistance for the fees associated with application for certification. The grant would provide 75% of the application fee if the individual currently resides in Kansas or the active military member can provide orders demonstrating relocation to Kansas and 100% of the application fee if the individual has a conditional offer of employment from a Kansas entity that provides EMS response (where the condition is gaining Kansas certification).

- EMR – 75% = $11.25 (State)
- EMT and AEMT – 75% = $37.50 (State)
- Paramedic – 75% = $48.75 (State)

This would be proposed to go into effect on July 1, 2018 and continue through June 30, 2020 (FY2019 and FY2020).
Agenda Item: Inactive Certificate Regulation
Committee: Executive

BACKGROUND
An item appearing multiple times through the Board’s annual legislative meetings was the creation of an inactive certificate. On June 6, 2019, the Kansas Legislature granted the Board the authority to issue and renew an inactive certificate.

Pursuant to discussion at the October 2018 meeting, it was the desire that the inactive certificate would have no change in renewal fee; no continuing education requirement for renewal while inactive; and cannot engage in direct patient care (but may remain in an administrative role that has oversight of patient care). A pathway to convert from inactive to active was also created.

That pathway to convert involves making an application; demonstrating completed training for any scope of practice changes that occurred since last active; and challenging the certification examinations or demonstrating completion of continuing education hours in sufficient quantity to reinstate an expired certificate of similar duration.

DISCUSSION
A draft of the proposed regulatory changes necessary to issue an inactive certificate are included (Enclosure 1). This involves the regulation specific to the issuance process and the regulation specific to fees.

Discussion should be had to clearly identify the intent of whether there are scenarios where an “inactive” certificate holder may function as one of the two required EMS providers during transport. (Example: an “inactive” certificate holder being a driver for interfacility transports). The statute is clear that an inactive certificate shall not entitle the holder to engage in the practice of emergency medical services and restricts the Board to issuing an inactive certificate “only to a person who is not directly engaged in the provision of emergency medical services for which certification is required.”

FINANCING
We estimate that implementation of these regulations will have a negligible fiscal effect, if any. There may be a very slight increase in revenue related to licensing as it may lead individuals to remaining certified in an “inactive” status rather than let their certification lapse.

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

1. Proceed with the committee’s recommendation.
2. Modify the committee’s recommendation.
3. Appoint a subcommittee to review and draft an alternative.
4. Table the item.

RECOMMENDATION
To proceed with committee’s recommendation.
POSSIBLE MOTION(S)

To initiate the regulatory process for the regulations necessary to implement the Inactive Status for certification.

Enclosures:

1. DRAFT - Inactive Status Regulations (NEW and KAR 109-7-1)
NEW 109-6-4. Inactive Certificate. (a) Before expiration of an active certificate, an emergency medical service provider may apply for an inactive certificate on a form provided by the board.

(b) The application shall be accompanied by the inactive certificate fee specified in K.A.R. 109-7-1.

(c) An inactive certificate may be renewed upon submission of a sufficient renewal application and the inactive certificate renewal fee specified in K.A.R. 109-7-1.

(d) The inactive certificate of a person may be reinstated to an active certificate by the board if the person meets the following requirements:

1. Submits a completed application to the board on forms provided by the executive director;

2. pays the applicable fee specified in K.A.R. 109-7-1;

3. completed training upon scope of practice changes specific to level of certification that occurred after issuance of the inactive certificate; and

4. either of the following:

   (A) completed continuing education in an amount to meet or exceed the number of clock-hours specified for renewal of a certificate in K.A.R. 109-5-1a for EMR, K.A.R. 109-5-1b for EMT, K.A.R. 109-5-1c for AEMT, or K.A.R. 109-5-1d for paramedic for each two year period after issuance of the inactive certificate; or

   (B) successfully completed the cognitive and psychomotor assessment for the person’s level of certification, within 3 attempts.
109-7-1. Schedule of fees. (a) Attendant, I-C, and ambulance service application fees shall be nonrefundable.

(b) Emergency medical responder fees:

(1) Application for certification fee ................................................................. $15.00

(2) certification renewal application fee for a renewal that expires on a biennial basis if received before certificate expiration ................................................................. $20.00

(3) certification renewal reinstatement application fee if received within 31 calendar days after certificate expiration ................................................................. $40.00

(4) certification renewal application fee if received on or after the 32nd calendar day after certificate expiration ................................................................. $80.00

(c) Paramedic fees:

(1) Application for certification fee ................................................................. $65.00

(2) certification renewal application fee if received before certificate expiration ... $50.00

(3) certification renewal application fee if received within 31 calendar days after certificate expiration ................................................................. $100.00

(4) certification renewal application fee if received on or after the 32nd calendar day after certificate expiration ................................................................. $200.00

(d) EMT and AEMT fees:

(1) Application for certification fee ................................................................. $50.00

(2) certification renewal application fee if received before certificate expiration ... $30.00

(3) certification renewal application fee if received within 31 calendar days after certificate expiration ................................................................. $60.00
(4) certification renewal application fee if received on or after the 32nd calendar day after certificate expiration .................................................................$120.00

(e) Inactive certificate fees:

(1) Application for inactive certificate ..........................................................$10.00

(2) inactive certificate renewal fee .................................................................$25.00

(3) application fee for reinstatement of inactive certificate .........................$20.00

(f) Instructor-coordinator fees:

(1) Application for certification fee ...............................................................$65.00

(2) certification renewal application fee if received before certificate expiration .................................................................$30.00

(3) certification renewal application fee if received within 31 calendar days after certificate expiration .................................................................$60.00

(4) certification renewal application fee if received on or after the 32nd calendar day after certificate expiration .................................................................$120.00

(f) (g) Ambulance service fees:

(1) Service permit application fee ...............................................................$100.00

(2) service permit renewal fee if received on or before permit expiration ..........$100.00

(3) service permit renewal fee if received after permit expiration .................$200.00

(4) vehicle license application fee .................................................................$40.00

(5) Temporary license for an ambulance .......................................................$10.00

(g) (h) Each application for certification shall include payment of the prescribed application for certification fee to the board.

(h) (i) Payment of fees may be made by either of the following:
(1) An individual using a personal, certified, or cashier’s check, a money order, a credit card, or a debit card; or

(2) an ambulance service, fire department, or municipality using warrants, payment vouchers, purchase orders, credit cards, or debit cards.

(i) (i) Payment submitted to the board for application for certification fee or renewal fee for more than one attendant or I-C shall not be accepted, unless the fee amount is correct.
**Agenda Item:** Board Articles Revision  

**Committee:** Executive

**BACKGROUND**

In June 2014, the Executive Committee of the Board was reintroduced to the creation and adoption of Board Bylaws/Articles. These bylaws would assist the committees and the Board with an understanding of the function and role of each part of the Board of EMS.

In December 2014, the Board adopted the current bylaws. They have not been revised since adoption.

**DISCUSSION**

Statutory changes since December 2014, an organization name change, and an update to the Board’s Purpose have led to the following six recommended changes to the Articles:

1. Change reference of “attendant” to “EMS provider” – pursuant to statutory change effective June 6, 2019.
2. Remove training officer – pursuant to statutory change effective June 6, 2019.
3. Change reference the minimum annual meeting number (from six to four) – pursuant to statutory change effective June 6, 2019.
4. Update the MAC membership – pursuant to statutory change effective July 1, 2016.
5. Change “KanAAMS” to “KAMTS” – organization changed names shortly after adoption of the Articles.

Article 8 – Section 1 of the Board Articles states that proposed amendments to these articles shall be sent to each member of the Board at least two weeks prior to the meeting of the Board. These proposed amendments (Enclosure 1) were sent on March 9, 2020 and again on July 17, 2020.

**FINANCING**

There is no fiscal effect for these changes.

**ALTERNATIVES**

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

1. Adopt the amendments to the Articles as presented.
2. Modify the Articles further.
3. Appoint a subcommittee to review and draft an alternative.
4. Table the item.

**RECOMMENDATION**

Adopt the amendments to the Articles as presented.

**POSSIBLE MOTION(S)**

To amend the Board Articles as proposed.

Enclosures:

1. Bylaws Draft Amended Version
KANSAS BOARD OF EMERGENCY MEDICAL SERVICES

ARTICLES

Insofar as these articles conflict with or limit any federal or state statute or regulation, the statute or regulation controls. These articles are not intended to create any rights, contractual or otherwise, for any person.

ARTICLE I – NAME AND LOCATION

Section 1. The name of the agency shall be the Kansas Board of Emergency Medical Services, hereinafter referred to as the Board.

Section 2. The Board is located in the Landon State Office Building, 900 SW Jackson, Suite 1031, Topeka, Kansas 66612-1228.

ARTICLE II – PURPOSE AND FUNCTIONS

Section 1. Purpose. The purpose of the Board is to protect and promote the welfare of the citizens of Kansas through the efficient and effective regulation of emergency medical services (EMS) and to ensure that quality out-of-hospital care is available throughout the state. This purpose supersedes the interest of any individual, the emergency medical services (EMS) profession, or any special interest group. This is accomplished through the regulation of standards for the effective and coordinated delivery of care which includes the care and transportation of individuals by ambulance services and the performance of authorized emergency care by attendants EMS providers.

Section 2. Functions. The Board performs the functions set forth in K.S.A. 65-6111.

ARTICLE III – MEMBERSHIP

Section 1. Members, Qualifications, and Reimbursement. The Board composition, qualifications, and reimbursement are set forth in K.S.A. 65-6102.
Section 2. Privileges of Membership. Each member of the Board has the privilege of voting, of holding office, and of serving on committees.

Section 3. Resignation. The Board may request voluntary resignation of any of its members for neglect of duty or other conduct which shall mean:

a. failure to attend two consecutive meetings without justification;

b. failure to participate in committees to which appointment was accepted without justification;

c. abuse of position.

Any member wishing to resign shall submit resignation in writing to the Governor and Board Chairperson who shall present it to the Board.

Section 4. Disqualification. In keeping with the Board’s Purpose as stated above in Article II, Section 1, Board members are disqualified and will recuse themselves from chairing or voting in any proceeding before the Board or a Board committee if:

a. The Board member has a substantial economical interest in a subject matter;

b. the Board member or the Board member’s spouse, parent, or child is an officer or director of a professional association that is actively promoting or representing a particular subject matter or issue on behalf of the association; or

c. the Board member has prior knowledge of the allegations in a disciplinary case or may have a personal bias with a party who is the subject in the disciplinary case.

ARTICLE IV – OFFICERS

Section 1. Officers. The officers shall consist of a Chairperson and Vice-chairperson.

Section 2. Election. The officers shall be elected annually at the first meeting of the board after January 1, and shall serve until the next election.
Section 3. Vacancy. In the event of the vacancy of one of the offices, a new election will be held at the next meeting to fill the vacancy.

Section 4. Chairperson duties. The Chairperson shall:

a. preside over all meetings of the Board;

b. establish a proposed agenda in consultation with the Executive Director for meetings of the Board;

c. gain consent and appoint all members of standing committees, including chair and vice chair of each committee;

d. serve as an ex-officio member of all standing committees with a voice, but shall not vote except when needed as a member to establish a majority;

e. remove any committee member not fulfilling obligation to a committee;

f. have the right to vote on all Board issues;

g. sign appropriate legal documents;

h. advise the Executive Director;

i. oversee the annual evaluation of the Executive Director; and

j. be responsible for the proper functioning of the work of the Board

Section 5. Vice-Chairperson duties. The Vice-Chairperson shall:

a. serve in the absence of the Chairperson;

b. assume all such functions or responsibilities as may be delegated by the Chairperson;

c. assist the Chairperson and the Executive Director with appointments to committees.

ARTICLE V – EXECUTIVE DIRECTOR

Section 1. Executive Director duties. The Executive Director shall:

a. administer agency operations by the following:
1. evaluate staffing patterns to enhance operation of the organization;
2. direct professional and clerical staff for efficient functioning;
3. solve administrative problems;
4. evaluate agency staff; and
5. assist professional staff to review investigative cases;

b. Manage board activities by the following:
1. develop a proposed agenda for meetings of the Board with the Chairperson;
2. research and prepare informational materials for Board meetings;
3. assist staff in completing work of standing committees;
4. serve as professional staff to standing committees; and
5. report on national and state issues to the Board;

c. manage agency budget by the following:
1. develop agency budget based on current agency expenditures, trends, and issues;
2. present budget to legislature and appropriate others; and
3. evaluate on-going expenditures and revenues to maintain balanced budget;

d. participate in legislative and regulatory activities by the following:
1. evaluate current statutes and regulations as to changing needs of EMS and health care as directed by the Board;
2. prepare drafts of changes in statutes and regulations for Board approval;
3. present testimony on proposed changes in statutes before the legislature; and
4. prepare statistical and technical reports for the legislature;

e. participate in professional activities by the following:
1. provide information on EMS issues to EMS providers, ambulance service owners/operators, service directors, sponsoring organizations, hospitals, and medical directors;

2. facilitate joint activities with EMS organizations, Attorney General’s office, and other state agencies;

3. represent the Board at local, state, and national meetings;

4. lecture on EMS issues; and

5. compile an annual report; and

f. perform such other duties as directed by the Board.

ARTICLE VI – MEETINGS

Section 1. Kansas Open Meetings Act. The Board adheres to the provisions of the Open Meetings Act. Regular meetings of the Board shall be held at a place and time designated by the Board.

Section 2. Board Meetings. The Board shall meet at least six four times annually and at least once each quarter. Scheduled Board meetings occur in February, April, June, August, October, and December.

a. Scheduled Board meetings occur on the first Friday of the listed months. In the case of unusual circumstances and the Board cannot meet at a regularly scheduled time, then notice shall be given and the meeting shall be rescheduled.

b. Notice shall be given to the public at least fourteen (14) days prior to the date of the meeting except in cases of special or emergency meetings when notice will be given as soon as possible. The purpose of the meeting shall be stated in the meeting notice.
c. There shall be a majority of the Board. For the purposes of a majority, one or more
members may participate by telephone conference call, video conference or other
interactive means of conducting conference communications.

d. Minutes of each meeting shall include the names of participating members, by what
means they were participating (if not physically present), and a record of each vote
taken.

Section 3. Special Meetings. Special meetings shall be called by the Executive
Director at the request of the Chairperson, at the request of the Executive Director, or at
the request of any six members of the Board.

Section 4. Consent Agenda. The Board may use a consent agenda, whereby those
items that require no discussion, no action, or action but no anticipated discussion can be
adopted in one motion. A Board member, after reviewing the agenda, may request the
removal of an item from the consent agenda for purpose of discussion.

Section 5. Notice of Meetings. Request for notice of meetings pursuant to the
Kansas Open Meetings Act should be directed to: Executive Director, Board of
Emergency Medical Services; Landon State Office Building; 900 SW Jackson, Rm 1031;
Topeka, KS 66612-1228. Written requests are preferred, but not required. Requests
should be renewed annually.

Section 6. Members of the public may participate at Board or committee meetings
only at the discretion of the respective Chairperson.

ARTICLE VII – COMMITTEES

Section 1. General Committee Information. Unless otherwise noted, each committee
serves as an advisory body to the Board.
a. Standing committees shall be Planning and Operations; Education, Examination, Training, and Certification; Investigations; and Executive;

b. committees may submit recommendations to the Board. A Board member will need to make the recommendation in a motion which would then be subject to approval by the entire Board;

c. committee meetings shall conform to the law regarding open meetings. The dates, times, and places of all committee meetings shall be listed with their agenda;

d. members of the Board on standing committees shall be appointed by the Board Chairperson in consultation with the Executive Director and Vice-Chairperson;

e. chairperson and vice-chairperson of each committee shall be appointed by the Board Chairperson in consultation with the Executive Director and Board Vice-Chairperson;

f. appropriate Board staff shall serve as non-voting members of all committees. Board staff or designees shall provide support services to each committee and prepare and distribute agendas and supporting documentation of each meeting to committee members;

g. a quorum of the committees shall consist of a majority of the members appointed by the Board Chairperson. Only committee members appointed by the Board Chairperson shall be entitled to vote within the committee. The Board Chairperson may serve as a voting member of any committee in order to establish a majority. Other Board members may participate, but have no vote;

h. in the sustained absence or temporary inability to serve by one committee member, the Board Chairperson may appoint a new member; and
i. scheduled meetings of the committees shall be held the day prior to the scheduled Board meeting and whenever deemed necessary by the Committee Chairperson or the Board Chairperson.

**Section 2.** Planning and Operations (P & O) Committee.

a. Membership: A minimum of 5 Board members and no more than seven, including at least one attendant EMS provider involved in EMS.

b. Ad hoc Membership: In addition to each EMS Region being allowed one (1) representative; each of the following organizations/entities are allowed one (1) representative to act as an ad hoc member of the committee:

1. Kansas Emergency Medical Services Association (KEMSA)
2. Kansas Emergency Medical Technicians Association (KEMTA)
3. Mid-America Regional Council Emergency Rescue Committee (MARCER)
4. Kansas Association of Air Medical Services (KanAAMS) Air Medical Transport Society (KAMTS)
5. Fire Services
6. Kansas Department of Health and Environment (KDHE)

Each ad hoc member shall not be a voting member of the committee and shall be appointed by their respective EMS region/organization/entity.

c. Purpose: To review and recommend revisions in statutes and regulations as they pertain to operational functions of ambulance services and attendants EMS providers. To make recommendations upon issues that may affect the operation of ambulance services. To review and recommend changes in attendant EMS provider authorized activities. To review and recommend changes based upon statistical
information regarding the operations of ambulance services. To review and recommend changes to operational policies and procedures. To make recommendations to assist the development of a state plan for delivery of EMS. To make recommendations for statewide education of operational functions of ambulance services and attendants EMS providers.

Section 3. Education, Examination, Training and Certification (EETC) Committee.

a. Membership: A minimum of five Board members and no more than seven, including at least one attendant EMS provider and an instructor-coordinator.

b. Purpose: To review and recommend revisions in statutes and regulations as they pertain to educational programs, examination, training, and certification. To make recommendations to changes in educational standards for the EMR, EMT, AEMT, and Paramedic levels of attendant EMS provider certification. To make recommendations to changes in educational standards for the Training Officer and Instructor-Coordinator levels level of certification. To make recommendations for changes in the examination for each level of certification. To make recommendation for changes pertaining to EMS continuing education. To review and recommend changes based upon statistical information regarding education, examination, training, and certification. To review and recommend changes to educational standards in collaboration with the P & O committee review and recommendations for changes in attendant EMS provider authorized activities. To make recommendations for statewide education of certification, training, examination, and education processes for educators and attendants EMS providers. To make
recommendations upon issues that may affect EMS education, examination, training, and/or certification.

**Section 4.** Investigations Committee.

a. Membership: A minimum of five Board members and no more than seven, including at least one attendant EMS provider involved in EMS and one physician.

b. Binding Authority: The Investigations Committee has binding authority of the Board in all disciplinary issues and actions.

c. Purpose: To review and recommend revisions in investigative and discipline statutes and regulations. To conduct a review of opened cases, determine what type of disciplinary proceeding, and recommend proceedings be initiated. To review and recommend changes to investigative and discipline policies and procedures.

**Section 5.** Executive Committee

a. Membership: A minimum of five Board members and no more than seven, including each of the other Committee Chairpersons, the Board Chairperson, and the Board Vice-Chairperson.

b. Purpose: To review and project budgetary needs to support agency. To develop and review grant programs to support EMS in Kansas. To assist with the delegation and coordination of board tasks to each of the committees. To assist in the development and implementation of the Board’s strategic plan. To review all recommendations for changes in EMS statutes. To assist in the development of a legislative packet. To review and recommend changes to Board policies and procedures. To review and recommend clinical changes in EMS.
Section 6. Other Committees. Such other committees, standing or ad hoc, shall be appointed by the Board Chairperson as deemed necessary to carry on the work of the Board. The Board Chairperson shall provide any such committee with a stated purpose or mission.

a. Medical Advisory Council

1. Membership: A minimum of six members and shall include two including one Board members, one of whom member who shall be a physician, and not less than four five other physicians not members of the Board.

2. Officers: The Medical Advisory Council elects a chairperson and vice-chairperson from their membership.

3. Purpose: To advise and assist the Board in medical standards and practices.

ARTICLE VIII – AMENDMENTS TO THE ARTICLES

Section 1. Proposals

a. Proposed amendments to these articles shall be submitted to the Executive Director and sent to each member of the Board by the Executive Director at least two weeks prior to the meeting of the Board and shall be included in the agenda of that meeting.

b. The Board Chairperson will form an ad hoc committee of Board members as needed to review the articles.

c. Changes in the articles require a majority vote of the membership.

Adopted: December 5, 2014

Amended:
Agenda Item: Sanctioning Reference Points (SRP) – CE Audits

Committee: Investigations

BACKGROUND

The Board desires to provide a fair and consistent method of adjudication through the process of enforcement of its statutes, rules, and regulations.

Sanctioning reference points are a means to determine the severity of the infraction based upon the facts identified in the case. These points can be applied to the already established graduated sanctions and provide the Board with a consistent approach.

On April 7, 2017, the Board adopted and put into effect a Provider Continuing Education Audit Policy. Within that policy, the Board directed that any audit where it was determined that the individual did not have approved hours of continuing education and in sufficient quantity and distribution to renew certification would be forwarded to the Board’s Investigation Committee with a recommendation to suspend the provider’s certification until further notice of the Board. It also stated that if a person did not respond after 2 requests and within 30 days, that would be forwarded to the Board’s Investigation Committee with a recommendation to revoke the provider’s certification.

There are primarily two (2) regulations violated through continuing education audits – Failure to Comply and Falsification of a Renewal Application. Failure to comply occurs when an individual does not respond to the lawful requests of the Board. Falsification of a renewal application occurs when an individual attests that they have completed all of their continuing education in sufficient quantity and distribution at the time the application is submitted and that has not been done.

DISCUSSION

A copy of the developed SRP for Continuing Education Audits is attached (Enclosure 1). Specific points are applied based upon the answers for each question. This SRP was applied to the 34 continuing education audits on the Investigations Committee docket.

It should be noted that the sub-categories do appear on this SRP and this line will need to be removed for those with a certification expiration date on and after December 31, 2020. All renewals submitted prior to January 2020 still had a requirement to adhere to subcategories of continuing education.

Discussion may want to address:

- Applicability
- Weights on scoring.
- Standardizing fine amounts and usage of a fine vs. suspension.
- Consideration of future delegation of the use of this tool to the Executive Director (with a report provided to the Investigations Committee and/or Board of each use).

FINANCING

Usage of this tool will have no fiscal effect upon the Board.

ALTERNATIVES

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

1. Proceed with the committee recommendation.
2. Modify the committee recommendation.
3. Reject the committee recommendation.
4. Table the item.

**RECOMMENDATION**
To proceed with the committee’s recommendation in utilizing the SRP for CE Audits.

**POSSIBLE MOTION(S)**
That the Investigations Committee utilize the SRP for CE Audit cases to assist in determining the applicable sanction for the identified violation in statute and/or regulation.

Enclosures:
1. SRP – CE Audit
### Case Number

<table>
<thead>
<tr>
<th>Level of Certification (EMR, EMT, AEMT, Paramedic)</th>
<th>Hours Needed (EMR - 16; EMT - 28; AEMT - 44; Paramedic - 60)</th>
<th>Did Individual Respond to 1st Notice of Audit</th>
<th>Did Individual Respond to 2nd Notice of Audit</th>
<th>Did Individual Respond to 1st Notice of Audit Request for Additional Information</th>
<th>Did Individual Respond to 2nd Notice of Audit Request for Additional Information</th>
<th>Did Individual Respond to 3rd Notice of Audit Request for Additional Information</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>[NA = 0; Yes = 5; No = 10]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

If any of Lines 4 through 8 are answered "No", enter "150"; otherwise add Lines 4 through 8 and enter here:

<table>
<thead>
<tr>
<th>Did Individual Respond to Investigator 1st Request</th>
<th>Did Individual Respond to Investigator 2nd Request</th>
<th>If any of Lines 4 through 8, 10, or 11 are answered &quot;Yes&quot;, based upon the date the renewal application was submitted:</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>[NA = 0; Yes = 10; No = 20]</td>
<td>[NA = 0; Yes = 20; No = 80]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Line 13, 14, or 15 is "No":

<table>
<thead>
<tr>
<th>Were all hours approved (prior, retroactive, or presumptive)</th>
<th>Were approved hours in sufficient quantity to renew at the level requested</th>
<th>Were approved hours in sufficient distribution to renew at the level requested</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>[NA = 0; Yes = 0; No = 5]</td>
<td>[NA = 0; Yes = 0; No = 5]</td>
<td>[NA = 0; Yes = 0; No = 5]</td>
<td></td>
</tr>
</tbody>
</table>

If Line 13 is "No":

<table>
<thead>
<tr>
<th>How many additional approved hours completed on or before expiration (December 31)</th>
<th>How many hours were submitted</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>[NA = 0; Yes = 5; No = 150]</td>
<td>[NA = 100; Hours Submitted = Hours Needed = -10; Hours Submitted &lt; Hours Needed = (Number of Hours short / Number of Hours needed) * 100]</td>
<td></td>
</tr>
</tbody>
</table>

If Line 15 is "No":

<table>
<thead>
<tr>
<th>How many categories were missing</th>
<th>How many subcategories were missing</th>
<th>Affiliated with a Service or EMS Providing Organization</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Number missing x 80)</td>
<td>(Number missing x 5,4347)</td>
<td>If affiliated, any local discipline</td>
<td></td>
</tr>
</tbody>
</table>

### Special Recommendations:

#N/A

### Sanction Score

| 0.00 | No Action |

### Sanctioning Reference Points

<table>
<thead>
<tr>
<th>Level</th>
<th>Action</th>
<th>Score</th>
<th>1st Violation</th>
<th>2nd Violation</th>
<th>3rd or Subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Sanction</td>
<td>No Action</td>
<td>Less than 5</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Sanction Level 1</td>
<td>Local Action Approved, if done</td>
<td>5 to 20</td>
<td>$25</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td>Sanction Level 2</td>
<td>Modification of Certificate</td>
<td>21 to 80</td>
<td>$50</td>
<td>$125</td>
<td>$225</td>
</tr>
<tr>
<td>Sanction Level 3</td>
<td>Limitation of Certificate</td>
<td>81 to 150</td>
<td>$75</td>
<td>$150</td>
<td>$250</td>
</tr>
<tr>
<td>Sanction Level 4</td>
<td>Suspension of Certificate for less than 3 months</td>
<td>151 to 400</td>
<td>$150</td>
<td>$225</td>
<td>$325</td>
</tr>
<tr>
<td>Sanction Level 5</td>
<td>Suspension of Certificate for 3 or more months</td>
<td>401 to 750</td>
<td>$300</td>
<td>$375</td>
<td>$475</td>
</tr>
<tr>
<td>Sanction Level 6</td>
<td>Revocation of Certificate</td>
<td>751 or more</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

CE Audit Sanctioning Reference Points (SRP)