Do the rules allow for a BLS ambulance to tier with an ALS service? The wording conflicts to allow the BLS ambulance to operate at an ALS unit.

Yes, a BLS transport can tier with an advanced program and should tier when appropriate based on the patient’s condition and needs. When a tier occurs with an advanced program and the patient remains in the BLS unit the advanced provider will bring sufficient equipment with them to provide ALS care and the ALS provider will be operating under the service program ALS protocols and medical direction.

How does a federally operated ambulance whom does less than 100 calls per year affiliate with a service whom is not even allowed on their property?

In this scenario the federally operated service program should apply to the Department for a variance to the proposed rule.

Services who are seeking CCT endorsement and are fully authorized 24-7 paramedic service, will they be required to staff the CCP 24-7 or only provide them if the take a CCT run or transfer?

Transporting service programs that are authorized at the paramedic level with a CCT endorsement will be staffed with paramedics with CCP endorsement (or other health care professionals in an appropriate specialty area) only when providing specialty care during transport.

So is the affiliate agreement kind of the same as a mutual aid agreement?

Yes, it could be. Multiple types of documents could be utilized to fulfill the affiliate agreement requirement. The agreement must be in writing and executed between one or more service programs or one or more management entities and filed with the department that clearly defines the responsibilities of each entity to ensure compliance with the rules in IAC 641-132.

You are forcing the service with less than 100 calls per year to affiliate with another service, what if that larger service doesn't want to take on the smaller service?

Nothing in the proposed rules will require a larger service program to accept an affiliation with a smaller service program. If a program needs to affiliate with another service and requires assistance in finding a suitable program to affiliate with, the Bureau’s EMS Field Coordinators will provide technical assistance as needed to assist with identifying possible service programs for affiliation.

Can a small service in Eastern Iowa affiliate with a larger service in Western Iowa?

Nothing in the rules will prevent an affiliation based on geographical location if the service program can provide the needed assistance of the other service program.
A small first responder service could affiliate with one or two other small first responder service(s) and add their calls together to get over 100 calls - or do they need to affiliate with a service that already has over 100 calls per year?

Multiple agencies could affiliate with each other to meet the 100 call requirements and share services to ensure compliance with IAC 641-132.

Why is the state no longer providing Protocol Updates? If we want the same or similar care throughout the state, should we not have a base set of protocols that each service can build off of? Similar to how we have been doing it.

The proposed move to EMS Clinical Guidelines instead of the current protocol process will require the Guidelines to serve as the minimum standards for all service programs throughout the state providing uniformity. Local protocols will be developed using the Guidelines as the base. One of the established EMSAC workgroups will be providing examples of local protocol based on the Guidelines for consideration and guidance that each local service could use.

When using department on this documentation, is that IDPH department forms or are each department to come up with the forms?

When the word department is used in the administrative rules it is in reference to the Iowa Department of Health.

Are personal vehicles used to respond to an emergency considered a rescue vehicle? If so, a new crew member cannot respond at all until they take the driver training?

Personal owned vehicles (POV) are not considered a first response vehicle.

How do we document that driver training has been completed?

Each service program should have all staff rostered in the service’s AMANDA folder. Within the AMANDA roster there is a place to identify the date of emergency vehicle driver training for each staff member.

If an ambulance is available to the non-transport, they would be transporting the patient anyway! Can other rescue vehicles be used to transport the patient in an emergency?

Patients will be transported in an ambulance (vehicle equipped with life-support systems and specifically designed to transport the sick or injured who require emergency medical care).

Does temperature control include central air to prevent garages from excessive heat during summer months?

The ambulance shall be housed in a temperature controlled garage to ensure the current Good Manufacture Practice recommendations for equipment and medications are maintained.
Can you describe a variance?

If a service program cannot meet or maintain compliance with any of the administrative rules the service can apply to the department for a variance to the rule. There is an outlined process for requesting a variance in IAC 641-178. As an example, a federally owned service program that operates on a closed facility that does not allow other agencies on-site. The service program will apply for a variance to the department indicating the rule, and request a variance to that rule. The department will review the request and if appropriate approve the variance request to that particular rule (service program will be required to have an executed transport agreement) and only for that service program.

Does this allow if a paramedic and basic crew taking care of a patient that is a basic level of care able to have the basic care for this patient or does all patients that have a paramedic on always have to care for that patient?

With the proposed changes if a paramedic and an EMT are on the same call and based on the patient assessment the patient only requires care within the EMT’s scope of practice and the service program’s medical director has approved a supporting protocol the EMT may provide the care.

Driver training such as EVOS? A national course or just something simpler?

No specific training program is required for emergency vehicle driver training. The only requirement is the training must include a review of Iowa laws regarding emergency vehicle operations (Iowa Code chapter 321.231), service program’s criteria for response with lights or sirens or both, speed limits, procedure for approaching intersections, behind-the-wheel driving and use of the service program’s communication equipment.

If a service is fully authorized 24-7 Paramedic and has a satellite, do both have to provide a first out ambulance with a paramedic or can the first response station have a paramedic, and the 2nd station only have a EMT?

The rule will only apply to the initial response to a 911 or emergency call so in the described scenario the first response station will respond with the paramedic and the satellite station could respond with an EMT.

Does the certified EMT have to physically be in the ambulance when responding to cover the rules or can they respond directly to the scene by POV? We have firefighters drive units (as a contracted service) directly to the scene but they are not on our roster. Can this practice continue under the new rules?

Nothing in the rules will require a certified EMS provider be physically in the ambulance when responding. However, a certified EMS provider, at the service program’s level of authorization, will be at the scene and with the patient during transport. The EMS provider could respond in a POV and another staff member with emergency vehicle driver training could bring the ambulance to the scene and meet the EMS provider(s).
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- How much time does a service have to address staffing shortages that take them out of service?
  
  A fully authorized service program should at all times be able to meet minimum staffing requirements for an initial response to 911 or emergency call. In the event that staffing shortages arise, in order to assure a response, the service program should have an executed transport agreement and simultaneous dispatching with another authorized service program to ensure a response.

- Will affiliates who are out of compliance keep the sponsor agency from renewing their authorization?

  No. Each affiliate service program will have an individual authorization, not a “sponsor” relationship. Only the service program that cannot meet renewal requirements will be effected.

- What would be a benefit of affiliating?

  Benefits from affiliating with one or more service programs or management entity could include: sharing services such common billing, data submission, staffing coverage, combined training, and common protocols.

- Can an affiliate agreement cross county lines?

  Nothing in the proposed administrative rules will prevent a service program from affiliating with a service in another county.

SCOPE OF PRACTICE QUESTIONS

- Why is aspirin and glucose paste no longer an optional skill of EMR’s when an EMD can tell the lay bystanders to provide aspirin to the patient? Also what about pulse oximeters?

  An Iowa EMR has not been allowed to administer oral glucose in previous versions of the Iowa Emergency Medical Care Provider Scope of Practice (June 2016 as example). The current 2018 National EMS Scope of Practice does not support EMR providing oral aspirin for chest pain of suspected ischemic origin.

- In review, I notice there are no areas for additional training and medical director approval required. Example: AEMT performing Central Line access.

  The current 2018 National Model Scope of Practice does not support AEMT accessing central lines.
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- What is the consideration for taking the supraglottic airway (King LT) out of the EMT scope?

  While the manufacture identifies the King LT® as a supraglottic airway, the FDA identified the King LT® as an oral airway. The use of that specific airway will be allowed within the oral airway skill/procedure.

- Is the EMT only MDI or does that include a nebulizer?

  The EMT will be allowed to use either aerosolized or nebulized beta agonist, bronchodilators, or anticholinergic for the treatment of dyspnea and wheezing if approved by the service’s medical director and service protocol.

- Clarify analgesia io/iv for AEMT

  With the proposed changes to the scope of practice an AEMT may provide IO or IV analgesia for pain. The service program’s medical director will indicate the specific medication based on the patient assessment. The EMS Clinical Guidelines under pain management suggest analgesics such as acetaminophen, ibuprofen, fentanyl, ketorolac, morphine sulfate, ketamine, or nitrous oxide.

- Does Legacy EMTD have all the same skills as the EMT B now?

  With the proposed changes individuals who hold a valid Iowa EMS certification at the EMT-D level will operate within the EMT scope of practice.

- Why are we taking away skills and procedures and not increasing the training to add skills and procedures? AMET can give epi during cardiac arrest, Nitro for chest pain but can't be trained to interpret a 3 or 4 lead EKG? With the proper level of training this one single added skill would significantly decrease the wait time at local hospitals trying to transport patients to a higher level of care waiting for Paramedic services to become available. Can the AEMT transport with cardiac monitor if they can transmit the rhythm to the receiving facility?

  The current National EMS Educational Standards for the AEMT does not include cognitive or psychomotor objectives for EKG interpretation. AEMT will be able to transport a patient on a cardiac monitor and transmit the ECG to the receiving facility.

- This computerized Clinical Guidelines is nice, but we have always had to have the Protocols on the rigs to use as a reference. Will the Clinical Guidelines be available to print out so it can be carried on the rig? Computer / internet access is not always available during a call.

  The Clinical Guidelines will be available for downloading and printing. As a reminder the EMS Clinical Guidelines should be utilized by the service programs’ medical director to develop service protocols. The Clinical Guidelines are NOT a protocol and are not designed as a quick reference guide for treatment.
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- Can we discuss ATV's? Specifically to utilizing complex ventilators?
  
  An end note describing ATVs approved by EMSAC has been added to proposed scope of practice.

- Other states have these guidelines and state protocols in app form, any chance of that happening?
  
  The department is currently looking into the ability to make some services available through apps.

- I know that you have said the use of guidelines to create protocols are in 132 which is still a draft when must medical directors have protocols in place or will we continue to use 2018 for 2019 year?
  
  The current 2018 state protocols can continued to be utilized.

- As changes are made to the drafts of both of these documents - could those changes be highlighted in the drafts?
  
  We will attempt to provide highlighted changes based on the documents discussed during the January 2019 webinars.