

EMS Draft Rules Comments As of December 31, 2012

Sun, Dec 30, 2012

My comments are related to R9-25-406 EMT Certification

The title of Article 4 needs to be changed to EMCT Certification, if not already considered, to be consistent with HB2261 and the definitions.

Section C.3.b.- Requirement for an AEMT to document current certification in advanced emergency cardiac life support. AEMT education and certification does not require certification or knowledge in advanced emergency cardiac life support. They are not trained in ECG monitoring and do not have any emergency medications applicable to that level of training. This requirement is not appropriate for the AEMT.

Section C.3.c.- I am concerned with how specific or general this may be interpreted as requiring "topics that are consistent with the content of the applicable refresher course." Does this mean attendance at my base hospitals run reviews would no longer be applicable if they didn't cover a topic specifically noted in the refresher course? Does this mean that if I attend a conference on how to build a regional STEMI system (which I recently did) and CE's are given that this would no longer count towards my recertification because I doubt that this is specifically consistent with a paramedic refresher course? On the surface this seems to be written so that agencies could conduct their own education without having to pay for providers to attend an applicable refresher but does not allow for those of us who want to, perhaps, participate in other types of education available to us to increase our knowledge of emergency medicine and not be able to count the expense we incur and the available CE's towards our recertification. I would ask that the Bureau consider adding more generalized terminology, as in the current rules, on allowable CE for recertification.

C.3.c.ii.- The requirement for 6 hours of pediatric training for an EMT out of 24 hours seems an excessive amount of time given the total time. Prior to initiation of this requirement I would ask that it be determined that this is the amount of time that would be dedicated to pediatric training in an EMT refresher course.

Thank you for taking the time to consider my comments and concerns related to this rulemaking.

Fri, Dec 28, 2012

Comments related to R9-25-502 Scope of Practice for EMCT's

1. Paragraph C.1.a.i- This is an onerous requirement on a medical director. It essentially would require a medical director to test every EMCT for each level on every ALS skill in the scope of practice table. Medical directors rely that a certified individual has had these skills verified by a training program prior to certification by the state. The way this is worded would require an immense amount of work on the medical direction system to "ensure competency in every ALS skill prior to performing a skill." It might also cause an increase in the cost to agencies to provide medical direction to be in compliance with this rule. It would substantially increase the cost by this base hospital to provide medical direction.

It is reasonable for the items marked with an STR to have this provision as in C.1.b.

The following refers to Table 5.1 EMT-I(99)- there are some skills marked with a check mark that are not in the USDOT Curriculum and should either be removed or made an STR to include:

cardiac monitoring multiple lead- interpretive

cardioversion- electrical

These skills may have been identified in the rule for the EMT-I(85) to EMT-I (99) upgrade but for new certification classes there is no guarantee that they were verified skills since they are not in the DOT curriculum package.

The following is a general comment on Table 5.1 related to EMT scope of practice and STR's. A number of advanced procedures are noted for this level of certification as STR's, e.g., blind airway insertion devices- supraglottic and esophageal, oral intubation, administration of beta agonists via SVN not related to a pts. own medication, and IV initiation when they have no medications that can be administered via this method. While the rule structure previously included some of these additions that were developed partially because of the increased level of training required to obtain the EMT-I(99) level there is now a new level that is much closer to the EMT that is an AEMT with an estimated time of around 150-250 hours to complete with an increase level of depth and breadth of education in certain areas such as physiology. To continue to add STR's to the

EMT level given the new AEMT level is in direct conflict with the Agenda on the Future of EMS Education. I believe that due to these reasons the ALS skills noted as STR's at the EMT level should be removed. It is interesting to note also, that at the Paramedic level, a number of skills noted in the National Scope of Practice Model were turned into STR's even with the increased level of paramedic education and there were very few additions of new skills. Thank you for taking the time to consider my comments.

Wed, Dec 26, 2012

In regards to 302 (D3), the requirement for 2 hour response time for records requests is not feasible due to the fact of what time of day the call might come in. Allowing us 1 business day to process the request would greatly help all of us.

In regards to 304 (B2), the preventing of instructors and program directors from proctoring exams. A more feasible solution would be to remove that restriction due to the financial and logistical constraints that it puts on programs, especially those from rural or super rural communities.

In regards to 304 (B2), the mandate of a 150 question exam. The computer adaptive tests endorsed by NREMT and CoAEMSEP could be more beneficial and cost effective for programs. If this were rule were to go into effect, it could make it harder for them to achieve their programmatic accreditation standards.

In regards to 305 (C2), the AHA-specific proprietary language. Changing the verbiage to read, "current national standards for CPR and ECC," not specifically the American Heart Association would allow training centers to continue using the program that they currently have that is up to the national standards and not incur the financial stress of having to become an AHA training center.

In regards to 305 (E2), it appears that an AEMT must have an ACLS certification. If we could get some clarification as to the reasoning behind this considering that it would be out of their scope of practice anyway.

In regards to 306 (A12), Chief Admin Officer or designee must submit course notifications. We would like to see the verbiage changed to, Training Program Director due to the fact that the Chief Administration Officer may not be available or may have other concerns other than course notifications. Also, they may not want to designate someone to do the course notifications for them because it would have their name attached to it. Finally, throughout Article 3, it is ambiguous if items have an "AND" relationship or an "OR" relationship. For example, 305 (E1); does a student need one of the qualifications (a-d) or all of them?

Fri, Dec 21, 2012

302 D3, 2 hr response time for records request. Recommend changing to one business day to respond.

304 A4, No instructional methodology requirement for instructors. Recommend changing to some sort of non-proprietary instructional methodology for EMS instructors.

304 B2. Not authorizing instructors and program directors to monitor exams. Recommend removal.

Unnecessary requirement. I can monitor/my instructors monitor testing for other courses taught, why not EMT? My spin would be the state believes there is some sort of integrity issue with me? If this logic is accurate how can the state trust me to manage an EMT program?

304 B2. 150 question requirement for final exams. Recommend removal. We are dealing with a 24 hour course or challenge examination . 80-100 questions would be appropriate to determine the students level of knowledge.

306 A12. Chief Admin Officer or designee must submit course notifications. Recommendation, change to is the responsibility of the program director. I manage all aspects of the program, surely I can handle this.

Throughout Article 3. Ambiguous if items have an "AND" relationship or "OR" relationship. For reference, 305 E1; does a student need one of the qualification 'a-d' or all of them?

Thurs, Dec 20, 2012

First and foremost thank you for the opportunity to offer feedback on the proposed rule changes. The following are several proposed rule changes that I would like to offer comment on:

- 302 (D3): (In reference to policies and procedures) 'maintained on premises and available to the department within two hours after the department's request.

I am supportive of maintaining all documents on premises (campus) and available to the department – however within two hours after request can present obstacles. How will this request be made (electronically, certified mail, in person?). I believe a better practice would be to require program directors to have copies on premises and to submit copies of current policies and procedure to ADHS with every course request. Furthermore at any time there is a change to the policies and procedure ADHS be sent a new document with the changes highlighted – as has previously been required (R9-25-313 and 314). I welcome ADHS or any other governing body on campus at any time (announced or un announced) however if I am away from the office will I be able to meet the ‘2 hour’ timeline. Our campus is breaking for winter session, while I will be addressing all emails/phone calls – our program staff will be un-available.

- 304 (A4): instructional methodology requirement for instructors has been removed.

I believe some type of non-proprietary instructional methodology requirement for EMS instructors should be a requirement for program directors and lead instructors. While many individuals can be the most compassionate/efficient EMS providers – do they have the ability to teach? Understanding the learning domains and methodology practices of teaching is imperative to provide academic education, and will provide many the opportunities to develop these skills.

- 304 (B2): Proctoring of exams cannot be done by the program director or instructor.

While I understand neither of the above can proctor a skills station component I am concerned why the program director or instructor for the course is being restricted from doing this? These are the people who are most accountable for the entire program and have been delegated the responsibility for the day to day operations of the course. Furthermore it is the responsibility of these people to maintain the integrity of the program. We are not only governed by ADHS but by our academic institutions as well, to jeopardize either would be immediate grounds for dismissal by both bodies.

- 304 (B2): 150 question final exam

While I am in absolute agreement that there needs to be a minimum set standard I also believe that consideration needs to be available for those training institutions that chose to use Nationally Accredited CBT testing software – a recommendation by NREMT as well as CoAEMSP.

- 304 (C2): Why are there programmatic differences for state certification courses versus accredited institutions? This rule gives state certification programs the autonomy to attest to a student’s practical skills competence where as an accredited program must still proctor the stations? I understand from discussions at the statutory meetings medical directors can attest to certain practices, but this rule is written to apply to initial and recertification courses. There should be no differences between an accredited program and a state certification course – the same people are delivering the content and should be held to equal standards.

-305 (A1): Covers knowledge, skills, and competencies comparable to the national education standards.

A recommendation to change the word comparable to consistent.

-305 (A3): Has no more than 24 students enrolled in each session of the course

Prior rule allowed training programs the ability to combine didactic sessions, as long as the **instructor to student ratio of 10:1 is maintained in lab session.**

- 306 (A12): Chief Admin Officer required signature on course notification forms

Has always been a responsibility of the Program Director who is acting on behalf of the medical director as well as their training institutions administration. A recommendation would be to include the administrative designee on all correspondences. If electronic devices are not in use than a signature from this person can be a requirement.

Wed, Dec 19, 2012

- 302 (D3): 2 hr response time for records request (changing the language to allow programs "one business day" to respond)

- 304 (A4): No instructional methodology requirement for instructors (some type of non-proprietary instructional methodology requirement for EMS instructors)

- 304 (B2): Proctoring of exams (mandate that was particularly burdensome most rural training programs)

- 304 (B2): 150 question final exam (this verbiage may prevent use of computer adaptive testing options endorsed by NREMT and CoAEMSEP)

- 305 (C2): AHA proprietary language (this should reference "current national standards for CPR and ECC",

not specifically the American Heart Association)

- 306 (A12): Chief Admin Officer or "designee" for course notifications (the group felt course notifications are the responsibility of the program director, NOT the "chief admin officer").

- Throughout Article 3, it is ambiguous if items have an "AND" relationship or an "OR" relationship. For example, 305 (E1); does student need one of the qualifications (a-d) or all of them?

Tues, Dec 18, 2012

My questions are related to Article 3.

R9-25-304 (B. 2. a. i) is related to the 150 question final examination. In relation to an ALS refresher (this has been an ongoing debate); there is nothing to actually indicate how to interpret this. If I am providing a refresher with ACLS, PALS, PEPP, CPR, ITLS, all of these courses have exams associated with them. The final exam should allow use of these individual exams that will total 150 or more questions to comprise a final exam.

R9-25-304 (B. 2. a. iv) has the statement regarding proctoring of an exam by an individual who is not the program director or instructor. I was under the impression that this was going away. Really, if we are concerned with "cheating" as this seems to imply, then should DHS not deal with each program individually instead of creating a need to pay and provide another proctor.

R9-25-305 (C. 1. b) and (E. 1. b) relates to getting documentation from students attending both BLS and ALS refreshers that they finished a qualified training program. Is not their state certification sufficient? Does that also mean I have to make a copy of this "proof" and keep on file? Along with this is (C. 2 and E. 2) regarding having CPR and ACLS current – if we offer this as part of the course, it should not matter if it is expired as it will be renewed. Also the CPR is listed as by American Heart Association, so the rule is that specific that it will not allow for ASHI or American Red Cross training?

Exhibit C is gone. The state is no longer going to mandate how many and what types of patients will constitute the minimum requirements for ALS training?

Fri, Dec 14, 2012

Upon reviewing the proposed changes, it is in my opinion that the AEMT, and I-99 should be combined and the EMT basic should be eliminated. This will disallow agencies from further demeaning the EMT's that already exist in the system and provide them the ability to do more in the field as providers. AZ should step and equate their changes to that of other agencies around the country and allow EMT's to do more.

Thurs, Dec 13, 2012

Notice of opportunity to provide public comment was emailed on Nov. 29. This email did not identify when the public comment period would close. BEMS officials stated the public would have 30 days to comment. Did public comment close prior to the 30 period?

The proposed rules state training programs cannot use an instructor or program director to proctor final exams. This is a logistical problem since all qualified proctors are instructors and/or program director.

The proposed rules require training programs to respond to BEMS requests to provide policies and procedures within 2 hrs. This is an unreasonable time frame and the rules do not clarify what is considered a suitable form of request. Does an email or voice mail from BEMS start the arbitrary 2 hour time limit?

The proposed rules require the comprehensive final exam for initial and refresher courses to be 150 questions. This would prevent training programs from utilizing computer adaptive testing, which is encouraged by NREMT and CoAEMSEP.

Thank you for taking comments on this EMS Rulemaking. In review, I have some concern regarding R9-25-304 requiring a test proctor that is not the training program director or a course instructor. As you probably

know, we pull from a limited number of instructors to teach their specialties in our Paramedic programs. I completely understand this type of rule for a skills evaluation that allows for some judgement to be used and could be swayed by someone who is familiar with the student's abilities. A written test, on the other hand, is very different. Each question has one right answer and three wrong answers. The student either gets the answer correct or misses it. Not allowing the program director or a program manager or instructor to proctor a test for their class implies a lack of trust in the program. If there is a lack of trust for a program to test properly, then it should be handled with that program. Other programs, that are outstanding and uphold all the standards and rules, I believe, should be allowed the convenience of having one of their instructors or the program director to proctor the exams.

My concerns:

For R9-25-406 under C. 3. a, and R9-25-305 under C. 2. and E. 2. a. Use of a proprietary name such as "American Heart Association" could be construed to dictate an unfunded mandate to use only American Heart Association curricula and training materials. Not all EMS agencies use the "AHA" format but all adhere to national standards taught by not only "AHA" but also "ASHI" and the Red Cross. Would it not be better to substitute "national standards" rather than the American Heart Association?

For R9-25-304 under B. 2. a. iv. Dictating that an exam "That is proctored by an individual who is neither the training program director nor an instructor for the course" again suggests an unfunded mandate that a training program hire a third party from other than the training program certificate holder to proctor the exam. And does this prevent the training program director or any of the instructors from being present during the exam to answer any questions not related to the exam content.

Wed, Dec 12, 2012

For R9-25-502, under B. 3. Will skills indicated by "STR" that are parts of the national curricula require separate documentation to be maintained other than a training course certificate of completion issued by the educational program?

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R9-25-406 C.3 a and R9-25-305 under C 2 and E 2 a, I am concerned about the use of the proprietary name of American Heart Association. This is being interpreted by some people as meaning they should only teach AHA classes and utilize AHA training materials. There are other national organizations that also teach and offer training materials very similar to AHA materials, such as ASHI and the American Red Cross. I believe the language should read "a program which is nationally recognized and uses the most current national evidence-based Emergency Cardiovascular Care guidelines and incorporates psychomotor skills development into the instruction." This language is actually recommended by AHA!

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Sun, Dec 9, 2012

In regards to the recertification process proposed rules, the Sun City Fire Department has CPR instructors who are ASHI certified. We are requesting that the wording be more specific to include ASHI or American Heart Association emergency cardiovascular care by EMCTs. The draft only addresses AHA.

R9-25-406

3. Attestation on a Department-provided form that the applicant:

a. Has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through a course or courses consistent with recommendations for emergency cardiovascular care by EMCTs from the American Heart Association;

Thu, Dec 6, 2012

The Sun Lakes Fire District has reviewed the EMS Rulemaking document and supports the proposed changes with one clarification; Article 4. EMT Certification R9-25-406. Application Requirements For EMCT Recertification C. 3. Attestation on a Department provided form that the applicant: The EMCT(s) has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through a course or courses consistent with recommendations from the "Guidelines for CPR and ECC" published by the American Heart Association.

Article 4 Section C3 needs to be clearer. It states American Heart, but not everyone uses American Heart. I understand that it says consistent with, but are we pushing American Heart?

Tue, Dec 4, 2012

is the American Heart Association the only card that will be accepted for emergency cardiovascular care?

Mon, Dec 3, 2012

Article 3. R9-25-317. B. 2. I see no mention of emergency proceedings in ARS Title 41, Chapter 6, Article 10. Does the Department have no ability to take emergency action to stop a course which may be placing students or patients at risk of bodily harm? I would think the nature of the profession being regulated by BEMS would necessitate the ability to issue an emergency order. Administrative hearings are all well and good, but if a student or patient is harmed in the 30- to 60-day waiting period for an administrative law judge to rule on the issue, the student, patient, or family thereof will receive little comfort from the judge's ruling.

Article 3. R9-25-316. C. 5. Two hours does not seem like an adequate amount of time for a training program to produce requested documents, particularly for programs which do not maintain electronic records. Since failure to comply with regulations puts the Department in a position where they should censure a non-compliant certificate holder, this would seem to cause unnecessary work for the Department. I would think two business days or some other reasonable period of time would be much more sensible than two hours.

Article 3. R9-25-316. C. 2. This section requires training program certificate holders to maintain records for three years after the START of a student's course session. If the student in question is enrolled in a typical two year paramedic training program, this would only require the program to maintain records for less than a year (since students have up to six-months after the completion of their course sessions to meet the requirements for licensure) after completion of the course. My recommendation, as a former state EMS office administrator, would be to change "start date of a student's course session" to "student's final course session."

Article 3. R9-25-305. C. 1. b. (also used in other locations in the proposed regulations) "registration in a national certification organization." The National REGISTRY is holding themselves out to be a certification agency. I presume this is from whence the term "national certification organization" arises. If the Department is going to use the term "national certification organization," then the term "registration" should be changed as well to "certification" since certification is how the actions of the NREMT and other "national certification organizations" is being classified. Keeping the registration term is technically incorrect and confusing.

Article 3. R9-25-304. B. 2. a. i. "two incorrect answers, and one distractor." Without extensive direction as to the subtle differences between and incorrect answer and a distractor, this regulation is without value. If you were to place a dozen EMS educators in a room with a sample exam and instruct them to evaluate compliance with this regulation, I would offer that you would likely have twelve very different views on nearly every question. The strict verbiage of this section precisely limits every question on the examination to four questions. Not only are "all of the above" and "none of the above" options eliminated, but questions with answers such as "a, b, and d are correct" would also be a violation. If this is the intent of the regulation, on what basis are "all of the above," "none of the above," and similar type questions being forbidden?

Article 3. R9-25-304. A. 5. b. This section is indented too far. The indent should be reduced to match a.

Article 3. R9-25-301. F. "may not be transferred to another person."

Yet, in R9-25-303. A. 3 and 4 and C. the option is given to provide a new name. One or the other should be amended. Either a change is allowed or it is not. If it is not, as is implied in 301 F, then the option of changing names in 303 should be removed.

Article 5. R9-25-502. Scope of Practice for EMCTs

Table 5.1

BiPAP/CPAP is restricted to Paramedics. End Tidal CO2 monitoring / capnography is limited to EMT-I (99)s and Paramedics. These two skills are non-invasive. BiPAP/CPAP has virtually no risk and has the capacity to drastically improve a patient's cardiorespiratory status and potentially eliminate the subsequent need to intubate the patient upon arrival at a definitive care facility. It is not possible to harm a patient with ET/CO2, but valuable information can be gained by minimally-trained EMCTs who are authorized to provide oxygen therapy. I implore the Department to reconsider the risk-benefit analysis of these two interventions and either authorize their use by BLS providers or, at a minimum, place them in the STR category.

Thu, Nov 29, 2012

"Automatic Transport Ventilator"

Listed as "STR" for EMT, AEMT, and Paramedic. But listed as normal skill for IEMT (99)?

Is this a "typo"? I'm curious why an IEMT would be expected to utilize a ventilator but a paramedic requires special training?

Why is an EMR not considered to be able to utilize pulse oximetry? Is there a specific reason?

EMR is listed to be able to utilize manual blood pressure measurement, but not automated? Why?

R9-25-502, Page 3, Automated Transport Ventilator is listed as qualified for EMT-I/99, but as STR for Paramedic. I would contest that a qualified Paramedic should be identified as equally qualified as an EMT-I/99 to operate, maintain and administer oxygen via Automated Transport Ventilators.