



# New York State Volunteer Ambulance and Rescue Association, Inc.

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January 29, 2008

Debra Cason, Project Director  
National EMS Education Standards Project Team  
UT Southwestern Medical Center  
5323 Harry Hines  
Dallas, Texas 75390-9134

Re: NYS Volunteer Ambulance and Rescue Association  
Comments on Draft 2.0 National EMS Education Standards

Dear Ms Cason:

I am writing on behalf of the New York State Volunteer Ambulance and Rescue Association with comments on the second draft of the National EMS Education Standards for the Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic levels ("Draft 2.0").

New York State relies heavily on EMT – Basic certification for community-based, volunteer driven agencies. Like many states, New York would face significant fiscal and service-level challenges if community volunteers were not available for EMS services, especially in our suburban and rural regions.

Based on data supplied by the New York State Bureau of EMS in December, 2007 there are:

All levels of EMT	53,546 providers
EMT / Basic	43,065 providers or 80% of all providers
EMT / Intermediate	1,222 providers or 2.2% of all providers (Not DOT Intermediate)
EMT/Critical Care	2,426 providers or 4.53% of all providers (NYS level of certification)
EMT/Paramedic	6,833 providers or 12.76% of all providers

Recruitment and retention of volunteers is a critical issue to our agencies. A recent report by the NYS Association of Towns and Villages highlighted this critical issue and its impact on local communities. Training time for original certification and periodic re-certification is already a major challenge to staffing our agencies and providing our communities with adequate levels of service.

Typically an EMT course in a rural area is held in two (2) sessions per week, over the course of a few months. It is not unusual for one way travel time to be in the area of 45 minutes. As a result the impact of the added training time is magnified by added sessions (a dozen or more) and added travel time (at least an additional 18 hours).

### General Comments

The additional training time incorporated into Draft 2.0 of the National EMS Education Standards, if implemented, would likely have significant impacts and could easily decimate the volunteer-driven EMS system in New York State.

By raising the training hours expected of volunteer EMS providers to certify at the EMT-Basic level to 150 – 186 hours (an increase in hours of 35 – 70 percent), the message sent by Draft 2.0 to community volunteers is “need not apply”. It is simply not reasonable to ask that community volunteers commit to over 200 hours of training in order to perform EMT-Basic level services for their neighbors. Remember, in addition to their EMT-Basic certification, all community volunteers must undergo additional training required by their agencies. Local communications protocols, interagency training, state medical protocols, and other state/local requirements add to the minimum training times required of community volunteers. Certifying as an EMT-Basic is only the beginning of a long training process.

NYS relies upon tens of thousands of EMT-Basic level providers. Rather than raising the barriers to volunteerism, we encourage a revision of the draft Standards to provide for realistic, appropriate training for EMS providers to deliver community-based care.

### Specific Recommendations

We suggest the Project Team revise Draft 2.0 to both reduce certain content areas and increase others, to more accurately reflect field conditions encountered by community-based EMT-Basic personnel, as follows:

- (1) Add “Patient Movement and Transportation” to the EMT-Basic curriculum, including methods of extraction, C-Spine immobilization and field techniques for patient movement. Although local, agency-specific training is required in this area due to equipment availability and environmental conditions, the practical, field-based issues arising from patient movement, motor vehicle extraction and building (stairways, etc.) obstacles are key to successful EMS operations.
- (2) Add “Mental Health Patients and EMS” to the EMT-Basic curriculum, acknowledging the high number of EMS patients who suffer from mental health disabilities and the special considerations for both patients and EMS providers in dealing with mental health issues. This is especially important in light of the potential for harm to the patient and the EMS provider with mentally impaired or altered mental state patients.
- (3) Reduce the training requirements for airway management, patient assessment, medicine, shock and resuscitation, trauma, and special patient populations to be consistent with what EMT-Basic level providers require. These categories all demonstrate differences between “need to know” and “nice to know” for the EMT-Basic provider. There are significant drops in training hours if the knowledge required by EMT-Basic providers is matched with the skills required to deliver Basic-level EMS patient services.

The most significant reduction in recommended training hours from Draft 2.0 are in the “medicine”, “shock” and “trauma” content areas. We believe this is justified because a distinction must be made between the role of EMT-Basic responders and that of medical personnel who will diagnose and treat patients. There is a temptation, in some quarters, to push EMT-Basic training toward the level of AEMT or Paramedic. We strongly recommend the Project Team recognize the distinction between these levels and allow community-based, volunteer agencies to provide an appropriate level of care within the “Basic” level of EMS response.

Our concerns in this area can be summarized by noting it is better to have a Basic crew in service than a more highly trained crew that is not there or that is not available with a reasonable response time.

(4) We believe that some modest increase in training time can be added to augment the Pharmacology program with important skills such as Albuterol & Aspirin Administration, Epi-pen for Anaphylaxis, and assisted medications.

(5) *Overall, cap EMT-Basic training requirements at a maximum 120 – 125 hours.* We feel strongly that moving beyond 120-125 hours for an EMT-Basic curriculum will place an unbearable “last straw” upon the ability of volunteer agencies to recruit and retain from most suburban and rural communities.

(6) Make alternative-learning technologies and techniques more accessible to students, specifically Internet-based training, supplemented with local, field-training for specific skills such as patient movement, CPR/AED.

We have attached as Exhibit A a list of the EMT-Basic content categories with a comparison of Draft 2.0 Minimum and Maximum training hours, and our recommended training hours in each category.


#### Consider a Two-Tier EMT-Basic Certification

It may be advisable to consider two levels of basic EMT-Basic certification. An EMT-Basic/Level 1 certification at the level we have suggested above could be the basic level for patient care by community-based Basic transport agencies, rescue squads and most fire agencies. EMT-Basic/Level 2 could be closer to the level in the National Scope of Practice draft document and could be adopted for agencies operating in high call volume and urban environments, or rural/isolated regions where advanced life support personnel (AEMT or Paramedic) may not be available within appropriate time frames. It may also be advisable to establish a modular training curriculum where EMT Basic/Level 1 could easily advance via a Continuing Medical Education type program to EMT/Level 2.

Thank you for the opportunity to comment on Draft 2.0. We hope you can revise the draft to roll-back the dramatic increase in time that appears to be proposed for EMT-Basic certification, which would have a devastating and negative impact on the community-based EMS system in New York State.

Please let us know if we can provide further information or comment as you consider a final version of the National EMS Education Standards.

Sincerely,



Michael J. Mastrianni, Jr.  
President

Cc: NYS EMS Council  
Bureau of EMS, NYS DOH  
Officers & Directors, NYSVARA,  
FASNY, NYSAPC

New York State  
 Volunteer Ambulance and Rescue Association  
 Comments on Draft 2.0 / National EMS Standards - Exhibit A

	<u>Draft 2.0 Minimum</u>	<u>Draft 2.0 Maximum</u>	NYSVARA <u>Recommended Maximum</u>
Preparatory (EMS systems, Research, Provider Wellness, Documentation and EMS System Communication, Therapeutic Communication, Medical and Legal Ethics)	6	7	6
Anatomy and Physiology	3	4	3
Medical Terminology	1.5	2.5	1.5
Pathophysiology	1	2	1
Life Span Development	0.5	0.5	0.5
Pharmacology (Principles of Pharmacology, Medication Administration, Emergency Medications, includes Epi-pen, aspirin admin, practical lab)	4	6	8
Airway Management, Ventilation & Respiration (Anatomy & Physiology, Airway Management, Ventilation, includes practical lab)	6	10	4
Patient Assessment (Scene Size-up, Primary Assessment, History Taking, Secondary Assessment, Monitoring Devices, Reassessment)	21	23	16
Medicine (Medical Overview, Neurology, Abdominal & Gastrointestinal Disorders, Immunology, Infectious Diseases, Endocrine Disorders, Psychiatric, Cardiovascular, Toxicology, Respiratory, Hermatology, Renal, Gynecology, Non-Traumatic Musculoskeletal Disorders, Diseases of the Eyes, Ears, Nose & Throat, includes labs)	26	28	8
Shock and Resuscitation (includes CPR for Health Care Providers)	16	20	10
Trauma (Trauma Overview, Bleeding and Shock, Chest Trauma, Abdominal and Genitourinary Trauma, Orthopedic Trauma, Soft Tissue Trauma, Head, Face, Neck and Spine Trauma, Central Nervous System Trauma, Special Considerations in Trauma, Environmental Emergencies, Multi-System Trauma, includes labs)	26	28	15
Special Patient Populations (Obstetrics, Neonatal Care, Pediatrics, Geriatrics, and Special Challenges)	13	15	12
Patient Movement, Transportation (extraction, placement on gurney, stair chair, spinal immobilization)	0	0	6
Mental Health Patients and EMS (the mentally unstable patient, mental health arrests, safety)	0	0	3
EMS Operations (Incident Management, Air Medical, Hazardous Materials, Special Operations, MCI, Terrorism and Disasters)	6	8	6
Student Evaluation in all Domains	8	10	8
Patient Contacts (clinical and field settings)	12	22	12
<b>TOTAL</b>	<b>150</b>	<b>186</b>	<b>120</b>