IOWA EMS SYSTEM STANDARDS

"What every Iowan can expect from Emergency Medical Services"

Public Comments—Draft Version 2.0

From July 12, 2007 through September 21, 2007

IOWA EMS SYSTEM STANDARDS
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System Organization and Management

7-12-07

Your email certainly got the phone lines burning. It appears this is taking local control away from community services and putting control under a county authority. This puts politics into play which is rarely good. Is our current system or "way of doing business" failing? If it is mandated that EMS be county controlled, is the county going to start funding all the services that provide EMS? Do you honestly think this is going to force some current EMS services to close or stop providing EMS response? Or, will some be forced to stop EMS response by a county mandate? I'm sure you braced yourself before hitting the send button. If this is an answer to a question or problem, what was the original question/problem?

I'm sure I will have additional comments. My main concern right now is the question, is this establishing a county authority to take control away from local services who have worked hard to provide quality EMS to their response area, and do it with pride? It appears from the draft, the county could even change our response territory. Under what legal authority can that be done? What problems would that create with all of the taxation authorities that go by district, township, and city boundaries?

You've got my attention! I'll be listening and watching for more information.

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I finally read through the IOWA SYSTEMS STANDARDS. I think that the idea is good. I like the promotion of a single medical director/committee.

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I am unclear in 1.01. By saying "county" does this refer to the Board of Supervisors as being mandated to provide for EMS in their counties and in charge of setting up the system. If that is the case then will they also assume some of the regulatory functions referred to in the standards? Will all certified services in a county be required to participate in the system and will the system be able to determine who will be able to be certified in their county?

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I have a "quickly" scanned the document you sent, and will further digest it at a later time. I have however noticed that the County EMS System appears to have considerable control over all EMS in it's particular county? Am I understanding correctly, or will further study the document clear up this concern?

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I hate to be one of the complainers—but 1.23 On-line Medical Direction states—"provided by a hospital physician or physician designee or supervising physician." I suggest that we drop the "hospital" and just say physician because we have just taken out

clinic, medical directors, and/or other qualified physicians who are capable of providing on-line medical direction.

7-13-07

Wow-the committee has done a lot more than I expected. I'm still absorbing it all, but do have a question (or a few). Who is the authority in all this? Saying the county EMS system shall….implies that this would be passes as code, and someone has to have authority over it. Will this fall onto the county EMS associations, who currently don't really have any authority, or the county supervisors who wouldn't have a clue how to run an EMS system? Does "county EMS system" include everyone, from dispatchers to hospitals?

7-16-07

I was reviewing the System Standards, and I do believe they will be a positive step. Implementation will be a big task, but worth it. What kind of time frame will be given for implementation?

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Thank you for the opportunity to comment. I thought it would be helpful to structure my comments in the order of the document. The overall organization; roles and responsibility—the "EMS system" seems to extend to the County level. Can you describe the relationship between the individual rural and urban EMS organizations and the county "EMS system"? Can you descry be the whether(?) and how the relationship will change between the local EMS organization? Do you foresee the EMS system being larger than county wide in some areas of the state?

1.01 Minimum Standards "Emergency medical services treatment and transport for all within the county…." Does this standard refer to treatment and transport as one action or is it two separate actions? Can I treat without transporting or must I treat and transport by whatever means necessary? If so, can a patient no longer provide refusals? Can I transport without treating and if so, must I obey the proposed standards in this document? E.g. picking up someone who has passed away at a nursing home.

1.14 System finances "maximize use of its fiscal resources" Some rural, volunteer EMS organizations operate without gov't funding. Why would Bureau of EMS want to change that? (The operative word here is fiscal, which refers to gov't funding

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7-17-07

I have reviewed the proposal and would like to present the following comments. I have been in EMS for 31 years. I could not believe what I was reading.

By what legislative authority does the IDPH possess to attempt to impose this action on each county?

Do you really want 99 different mission statements, 99 different inventory lists, 99 different CQI programs, etc?

I thought that we had standards. If some services need attention/discipline, do it. If some of your policies/procedures need modified, then modify them.
I did not think our system was broke. Why try to reinvent it!
System direction needs to stay at the state level and not be farmed out to the county level.

7-19-2007

Craig..after review of these Standards…I am a little confused….when they talk of "each county EMS system" who are they referring to"? Each individual service? In some standards it reads like there should be an entity "County EMS: like in Standard 1.05.. "each county system will develop an EMS system plan on community need….I quess I am wondering who these county EMS people are….?? That will be responsible for these standards? Thanks Craig

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1.04 May consider consulting present medical Directors for input.
1.14 May be unfunded mandate. State policy conflicts?

7-24-07

Can you help with a couple of questions? I am trying to understand the context for this. Is this shifting many responsibilities from the Regional coordinators and the state to the County systems (or larger systems)? Is this intended for law, administrative rule, legislative support…what? I didn't see anything about larger regional oversight or state medical director.

7-25-07

The term county is used through out the draft. Does this mean a "county EMS board" will oversee each EMS service in the county?

8-09-07

I have reviewed DRAFT Version 1.0 of the Iowa EMS System Standards. These standards cause me grave concern.
The standards appear to be quite applicable to individual agencies, listing processes and procedures that a professionally ran EMS system should adhere to.
The problem is that proposed standards place all control at the county level. It is not in the best interest of the citizens of Clive to remove the control and responsibility of EMS care from the local level to the county level. A new and much larger level of bureaucracy will provide no gain for our community. I would also argue that this is true for most communities in Iowa…..new and larger bureaucracy is not better.
Notwithstanding the operational and service delivery concerns of forced migration to county control, there are two additional concerns:

1. I suspect counties may view this as an unfunded mandate (at least the initial investment in time, resources, and personnel it will take to adhere to the standards you have suggested).
2. Once the counties figure out that they can control the EMS system, the revenue games will begin. Every city and county in the state is struggling with revenue. If the county is given immediate or optional control of a revenue producing service, they will likely take the opportunity regardless of the impact on local service delivery.
I suggest tat the proposed standards be changed to place responsibility at the county level for any unincorporated area and at the city/town level for any incorporated area.
The rule as drafted have serious patient care and financial impacts.
As Chief of the Clive Fire Department, I strongly oppose the draft as written.

8-16-07

The statement of "by whatever means necessary" incorporated into the paragraph. This raises concerns on my part. Are the county administrators going to be dictators? How are the county administrators going to be chosen? How long is their term? Is this a paid position or volunteer? Statistics will agree that with 99 counties in the state, the odds of getting at least one bad administrator is very high. How will a bad administrator be handled? What are the penalties of non compliance? How will this be resolved? Our fire district and response area involves three counties. If there are differences in county rules which one do we follow? If there is a dispute between county administrators over procedure differences who and how will this be settled?

8-17-07

Will there be statutory authority to mandate this?
1.01 A service whose primary response is a multi-county based/ Why not take a snapshot of current system and compare. Who is going to fund this position? Will there be a planning assessment template?
1.02 Should these be review strategic planning every year and formulate a strategic plan every 3 or 5 years? Will there be a strategic planning template?
1.03 Provide examples of recommended input.
1.05 Does this relate to the strategic planning process?
1.06 Should this report be presented to the stakeholders of the county?
1.12 Will there be a set time line for completion? Will there be a template or core criteria available?
1.15 Scott County Physician Advisory Board(PAB)to review and discuss.
1.17 On –scene treatment times—Clarification--Why?
Transfer of emergency patients—Clarification—Intra-facility, inter-facility, scene, transfer of emergent patients

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8-20-07

I just finished reading the Iowa EMS System Standards, "What every Iowan can expect from Emergency Medical Services," Overall, I thought it way very well written. I guess before I waste any of our time with questions and comments, I have one question for you: Is this going to be a standard that you will encourage the EMS services to use, or is this going to be an enforced set of operating guidelines? And if it is the latter, who will be the individual or board that is in charge of making sure tat these regulations are followed?

8-24-2007

Dear Sirs, I have received and reviewed DRAFT Version 1.0 of the Iowa System Standards. I appreciate the opportunity to comment as I am very concerned with this original proposal.

I agree with and appreciate the desire to establish and maintain minimum EMS standards and recognize that there are likely many regions within the State that have EMS systems that need attention. My concern is that this document proposes to establish a new layer of EMS oversight at the county level that would have full authority over both incorporated and unincorporated jurisdictions effectively removing all local control. There are many agencies across the State that already meet or exceed the minimums as proposed. These successful EMS systems are driven by local authorities who recognize the value of a strong EMS program and taxpayers that are willing to support it.

The goal of this standard should be to fix only what is in need of attention and should not disrupt those systems that are functioning well at a level equal to or above the proposed minimums and meet the needs and desires of their community. The responsibility for EMS delivery in incorporated areas aw well as those areas that are formally contracted to a municipality should remain under local control.

8-28-07

Referring to the document published by the Bureau of EMS, these are some of the areas I have comments on.

1.01 Each city ambulance service already has policy and procedure in place to treat and transport within the county. The communications center has protocol to handle the calls for service it receives.

1.14 Where is the funding from the Bureau of EMS?

8-29-07

Comments on the proposed changes to the Iowa EMS System Standards as discussed at Trauma & ED Function:

Standards 1.22 and 1.23 require the development and utilization of a hospital-based medical control by a hospital physician or their design: medical control for EMS providers in the field should come from a higher level of expertise and care, i.e. the hospital. Standard 5.06 allows the EMS provider in the field to follow the out of hospital trauma triage destination protocol without in-put from medical control: the determination of patient destination should be determined by medical control in conjunction with the

EMS provider, not by the EMS provider alone. This standard contradicts standards 1.22 and 1.23. 8-29-07

8-30-07

Can the committee please define "County" ? Does the "County" have to be the 99 existing counties or can counties split and make up, for EMS purpose only, a "County" that is better suited for the EMS need in the rural setting?

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There are few sections we have concerns about:
Section 1.04 System Administration: Medical Director PCEMSA is concerned about retaining a single medical director or being able to create an advisory board. Several of the current Medical Director's are not willing to be the medical director for several squads or sit on an advisory board. If the County EMS Structure requires the use of state protocols with no variances for each squad, there should be no need to have one Medical Director or advisory board. It should be a recommendation, not a standard.

9-06-07

Section 1.03 Is the state going to develop the survey so each county gets the same input and how is this going to be funded? I have spoken with my local Board of Supervisors, about these standards and their comment was who is going to fund all of these mandates?
Section 1.05 & 1.06 How is this position going to be funded and is there going to be a template from the state so every county is the same?
Section 1.08 Are you going to get the code of Iowa changed to mandate that every county have an ALS service?
Section 1.10, 1.11, & 1.12 These are all great ideas but with out funding to create a position with in the county to do these task. I do not see how they will get done. You cannot expect the paid service in the county to do this.
Section 1.14 First I think we should work on getting the Iowa Code changed to mandate every county provide EMS and include some type of permanent funding for EMS like fire and law has. Without a code change do you think any local Board of Supervisors is going to fund any new mandates?
Section 1.17 Is there going to be a template from the state so every county has the same policies and procedures and are you going to mandate every county have the same protocols?
Section 1.18 Is the state going to fund the training and make it mandatory to every Doctor, Hospital personnel and Attorneys attend the training?
Section 1.22 & 1.23 I think to make this work you will have to mandate hospitals by code or rule that they have to do this.

9-11-07

1.01 Comment: The development of a functional organizational structure is paramount. Given the multiple organizations and interests that comprise and EMS system, it would be beneficial to have a discussion in the report that offered some suggestions as to how such a system should be organized and, more importantly, governed to insure that the multiple interests were represented (e.g. designated lead-agency, coalition/consortium). Implicit in such a discussion would be a definition that describes the scope of responsibility, authority and accountability that would accompany an EMS organizational structure. Whether this term is intended to by synonymous with a county EMS association is unclear and further clarification is recommended. Perhaps, of greatest concern is emphasis given to an organizational structure that is focused at the county level. Given the rural nature of Iowa and the strength of the literature giving emphasis to the regional design and development of EMS, there would seem to be value in formatting the standards around the six Iowa EMS planning regions. Another consideration that probably should be addressed is that of local/municipal regulation of ambulance services and how such regulation should relate to state regulation. The standard recognized an approval process based on a need assessment. How such an assessment would be conducted would be of vital concern to insure that due process and relevancy are tied to established and published criteria. Too, lacking a regional perspective, a risk exists that could promote parochial interests that would be counterproductive to system performance, both clinical and financial.

9-17-07

Specifically here are the sections I feel need revised and the reasons for those suggestions:

1.01 As a whole, this is an unfunded mandate to require the County System to find the funds to do what ever is necessary.

1.02 Agreed

1.03 Ideal, but may require funds without any funding mechanism provided by the State.

1.04 I don't know of any medical directors that would have the time to take on a project like oversight of an entire county without it becoming a part or full time job. Once again this would become an unfunded mandate if a medical director had to be paid.

1.05 Is this not the Bureau's job? This would be a very time consuming process and once again an unfunded mandate.

1.06 Good ideas but very time consuming.

1.07 Agreed

1.08 Good goal

1.09 Good goal and achievable

1.10 Agreed

1.11 Would this be done by the board and the medical director? How much time would this take and who would have the time to do it properly if they were not paid?

1.12 Good goal, but very time consuming.

1.13 Good goal, but is this not the Bureau's responsibility?

1.14 This is again the crux of the problem. Why should the County have to identify a funding mechanism? The State should provide the funds.

1.15 Good goal but not practical without paying one or more people to do this function.
1.16 Good goal
1.17 Good goal
1.18 OK, currently done
1.19 OK, currently done
1.20 OK, currently done
1.21 OK
1.22 OK
1.23 OK

9-18-07

Questions/comments regarding the system standards proposal:
My biggest question is "Who oversees the system?" Are you thinking the county Board of Health, County Supervisors, County EMS Association? It is concerning to think that people who have very little knowledge or understanding of EMS may suddenly have this authoritative role. Part of my concern is that I live in a county with no hospital, and no county EMS services (local municipals only).
1.14 I am assuming that with imposing a funding requirement there will be some support from the State. I am concerned about how these funds will be dispersed and if this is a method of forcing counties to form county departments rather than utilizing existing municipal departments. I'm not being closed-minded, as it may be beneficial to merge, have paid staff and make better use of financial sources, but it's going to be very difficult for towns to give up their services, and I have no idea how the departments would physically and financially be merged if the decision was made to do that.
1.15 – 1.20 If there is going to be a system, it should have a medical director. Taylor County has no doctors that reside in the county, 6 EMS services, and several medical directors. I am concerned about the strain of finding a medical director to oversee the system AND get the MDs of all of the services to meet regularly, when they are voluntarily serving as medical directors and are already pushed to find the time to perform duties already required. Then to get all the medical directors to agree on each protocol and policy seems even more difficult. I know there has been a push to go to one medical director per county, and I believe that may work great in some counties, but in Taylor County, with no hospital, and services regularly transporting to 5 different hospitals in 5 different counties, I am worried this is going to put a strain on our physicians.

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How does the state propose to determine services on boundries of multiple counties to comply with which county? Do they have to answer to both? ie, Cascade, Dyersville, Hopkinton…
Many services are aligned with Hospitals / Doctors of which the community in majority utilizes- there is no provision to encourage or include local hospitals in the processes proposed.

Does 1.01 mean to state that the county itself will determine who remains in business of running an ambulance service in which location? What authority does it have to "shut down squad A because it is redundant? And what about 3rd party providers such as Heartland of SE Iowa? They have no set boundry or response area-what is their role in these standards?
In 1.04, Is it the state's proposal to force present medical directors out of the services they are associated with?
1.10, 1.13, 6.07 (…system shall ensure…participants conform…shall have the resources to require…) IF a service does not what will the state bureau's reponse be. IF a service doesn't because of a territorial conflict where does the ultimate fault of failure to comply lie?
1.17 Isn't this what this document is trying to eliminate in the first place? Each county establishing it's ***own*** set of protocols? Isn't that why one service in Jones County lost its medical director in the 1st place – now you are setting up to empower this repeat kind of "problem" via this document. Case in point the service covers 2 counties – does it conform to county J or County D?

9-20-07
I wonder why some items are in this document or have comments:
1.14 each county shall identify funding mechanisms to ensure continued operations… the money pot is only so big, so why is the state not contributing funding to their project? Yes, it would be great to have funding, you didn't have to have a soup supper for. Government will make it so difficult to get money, it won't be worth having. Since we are private service will we get any funding at all?
1.18 do physician's and patient's not have the right to change the DNR status? Is there a problem with the current plan?
1.19 are there problems with EMS determining death and working with the medical examiner?
1.21 interfacility transfers won't be driven by a county system as long as we need physicians to admit/transfer/discharge patients in a hospital.

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Section 1.01-Ultimately it is the county's responsibility for the provision of EMS services. We think this language could even be strengthened a bit. We think that there needs to be some clarification as to who would be included in the formal organizational chart of the EMS Systems committee. It needs to be assured that one body has the taxing authority, legal authority to implement the plan and also be held accountable to enforce these Standards.
Section 1.10-Responsibility has to e followed with authority.
Section 1.14-specific funding mechanisms would need to be identified by the EMS bureau. It should not be left up to the local organizations to identify funding streams. This would appear to be an unfunded mandate to the local level.

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I am writing to you to officially comment of the Iowa EMS System Standards document.
1.01 I feel that this is being listed as an unfunded mandate.
1.04 I am not sure how a doctor would be able to take on this job without being paid. Again, this seems to lead to an unfunded mandate.
1.05 In a state where the majority of towns and cities are staffed by volunteer EMS providers I feel this places a large and time consuming process on the member of an EMS squad. If this were done by a paid person, it would need to have funding provided, and that funding doesn't appear to come with this mandate.
1.07 ok
1.09 This sounds like something that can be done. Who is the list for though?
1.13 I thought that is was the EMS Bureau that was responsible for regulation.
1.14 This appears to be another unfunded mandate.
1.18 This is already done with the direction of our medical director.
1.20 this is already in place and it is set through DHS. Why is EMS making rules and/or regulations about another departments functions:
1.23 This sounds very achievable and I believe it is already being done in our area.

****

A subcommittee of the Plymouth County EMS Association (PCEMSA) has reviewed the Proposed Iowa EMS System Standards, draft for public comment.
Below is a summary of what Plymouth County EMS local squads are currently doing, what we are not currently doing, and comments about the proposed EMS System Standards.
1.01 The current Plymouth County EMS Association is an advisory board and not an administrative board. *In order to administer the Proposed EMS System Standard, more funding, staffing and time is needed.
1.02 PCEMSA has this in place, but may need to be updated with a new system.
1.03 Not being completed at this time due to lack of funding, staffing and time.
1.04 Each squad had their own Medical Director. This will completely change our Medical Direction and cause problems due to lack of Doctor's having the time to direct one squad much less 8.
1.05, 106 Not being completed at this time due to lack of funding, staffing and time.
1.07 State system Guidelines are already being followed by each squad.
1.08 Already being followed by each squad.
1.09 Already being followed by each squad and individual reports are given to the County Emergency Manager.
1.10 Already being followed by each squad.
1.11, 1.12, 1.13 Not being completed at this time due to lack of funding, staffing and time.
1.14 There is no current funding available through the Bureau of EMS. The assumption is each county will need to find additional funding sources to pay for the new County EMS Structure. *No mandates should be made without any funding coming from the Bureau of EMS.
1.15 through 1.23 Already being done at the local level.

9-21-07

1.01 Will the state provide financial assistance to ensure this?
1.04 Will there be state rules to encourage participation in such?
1.14 Again wonderful plan but is there financial support from the state?

****

I would like to thank you for the opportunity to comment on the Iowa EMS System Standards. We are all for improving the EMS system within our state to provide for better care for our citizens, but need to comment on the proposed standards as they are written.

1.01 **Comment:** Because of the different ways in which EMS is provided both public and private it would be difficult to mandate that all providers fall under county control. As a city, I would question the legality of giving control of municipal resources to another political subdivision.

1.04 **Comment:** The availability of Medical Directors is already difficult in the rural area but is even harder to have one that will take an active role. With the limited availability of Medical Directors especially those willing to take an active role in their local services the likely hood of finding 99 more physicians seems dismal at best. Add to this the fact that the Iowa Department of Public Health has been unable to fund a full-time Medical Director for some time.

1.14 **Comment:** This is an unfunded mandate, which creates another level of oversight that really seems unnecessary.

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Please accept this as my official comments on the proposed change to the Iowa EMS. First of all, were there any scheduled presentations as descried in the "next steps"? I did not receive notice from my regional EMS coordinator of when and where these meeting would take place. Another general comment is that it appears that the counties are being created b/c the regional coordinators can't keep up with their paid workload. You are creating a bunch of work for volunteers; which by the way, according the EVERY article lately volunteer are a dieing breed? I have made a few notes on some of these.

1.01 Who make up the "county"? How are the organizational charts set? How many members are there? Are they paid? Are they elected? How long of a term is it? Can you run for consecutive terms? How do you get removed from the position? Will there be volunteers on this chart?

1.02 Seems like a waste of time for a volunteer department to come up with a Vision and Mission Statement – I would rather spend this time saving lives or helping the sick.

1.05 "Community need" but you want a plan at the county level that will work for all communities. Let the individual communities decide what is right for them. We know our communities better than anyone and I would hate to have to live with a county plan that does not fit our community.

1.09 already done and on your web site.

1.10 Is this not the job of the regional coordinator
1.13 coordinator is already doing this
1.16 Agree with having a CQI

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The following are sections that we did not understand, need clarification or were of concern:
1.01 Feels like an unfunded mandate. "by whatever means necessary" almost sounds criminal.
1.03 Clarify, what do you mean by mechanism and appropriate?
1.04 Not sure why you would allow multiple medical directors within an ems system when you are striving for same level of care.
1.05 This would take a lot of time and money. Would the Regional EMS coordinator assist with this?
1.06 Same comment as 1.05
1.09 System Registry?
1.10 Clarify
1.11 Clarify, who is doing this?
1.12 Time and money would be an issue
1.13 Clarify, would this be the EMS Regional Coordinator?
1.14 Where does the money come from and will something have to be cut along the way?
1.15 Clarify
1.17 Concur, with Bureau guidance
1.21 Clarify, is the county EMS medical direction the medical director?
1.22 Clarify, what do you mean by medical control plan?
1.23 Clarify, many people interpreted this as to mean internet. What do you mean?

Staffing and Training

7-12-07
In 2.03 Medical Dispatch I would like to require EMD, I know that this will be financially controversial but the benefit to the rural communities will be great.

7-13-07
2.03 Dispatchers: Dispatch Training-- I have been provided a copy of the system organization and management standards by the Communications Director for Story County. My role as training coordinator for the Story County Sheriff's Office requires I understand the training requirements and proposed changes for telecommunicators.
In reviewing the document, I see the recommended minimum standard is that " medical dispatch personnel shall be trained/certified using an approved program and maintain certification with continuing education in accordance with the EMS Bureau's Emergency Medical Dispatch guidelines".
So that I can be prepared to discuss this document with our Communications Director, and describe the intended action directed by the language contained in this passage, can you a) identify what programs have/are approved for dispatcher training and b) provide a link/copy of the EMS Bureau's Emergency Medical Dispatch guidelines so I can compare them to our current training program. Out telecommunicators are certified through the 40 hour ILEA basic telecomminicator course, and in-house APCO Communications Training program, and 40 hours APCO EMD training. Staff receive 48 hours of in-house training compatible with ILEA and APCO requirements.

7-16-07
2.03 Dispatch training Some organizations have a primary and secondary PSAP. Is the intent to have both the primary and secondary PSAP have EMD training?
2.08 Trauma Care Facility Verification "county EMS system shall participate in the trauma verification process." What is envisioned here?
2.09 Hospitals: Communication "personnel shall be knowledgeable about county EMS system policies and procedures." The proposed minimum standards should be measurable. How will this be measured?

7-19-07
2.03 Setting policy for other agencies. Another unfunded mandate.

7-25-07
2.03 Dispatchers: Mandating EMD training is good but we do need to assist in funding in some way. This is very costly to educate and keep the staff current.

8-17-07

2.02 *"with in"* within

2.04 First Responders(non-transport): First Responder Staffing----Clarification—call or vehicle?

2.05 Are we mandating private industries to adopt county policies and procedures? Will legislation need changing? In 2.04 states that a certified EMS provider must response, though in 2.05 states first-aid teams.

8-28-07

2.02 It is my understanding that the Bureau of EMS is already doing this. Why should it be done locally with no funding support?

2.03 Who is going to train the dispatchers? Who is going to absorb the cost for training and compensate for the time dispatchers are away from their normal duties? We currently work with a minimal staff, 4 full time and 2 part time dispatchers. This is barely enough to cover the shifts 24/7. There are times when a second dispatcher would be necessary, but because of funding it is not available. The last thing we need is to dump additional responsibilities on the dispatchers. It is just simply not acceptable, having one dispatcher to handle ALL calls into the Plymouth County Comm Center is all we handle at this time. The additional liability issues for the county also needs to be addressed. I find it difficult to believe the Bureau of EMS can dictate how the dispatchers will be trained.

8-29-07

Standard 2.08 provides for EMS in-put into the trauma verification process of the local hospital: EMS does not have the expertise to determine the trauma capabilities of the local hospitals.

8-30-07

2.03 Dispatchers: Dispatch Training EMS does not have any authority of what training dispatchers receive. If the Plymouth County Communication Center decides the dispatchers are not going to receive this training, there is nothing EMS can do to meet this standard. The training should be a recommendation, not a standard.

9-06-07

Section 2.03 How can we tell a county or city that their dispatchers have to do EMD without it being in the Iowa Code? I have been trying to get this done in Washington County for 9 years and with out it being in the code they are not going to do it.

9-11-07

2.08 Comment: The lack of specificity regarding the scope and associated activities of *participation* in the trauma verification activities would probably benefit from further delineation. The definition offered in the document for EMS system (i.e. a coordinated delivery model) does not offer much if any clarification to how the verification process will be impacted by a *county EMS system.* It would seem appropriate for any participation by an EMS agency in a hospital verification process to be quantitative and consistent throughout the state. In those EMS service areas where multiple hospitals are located, it would be especially important to structure any EMS participation in the verification process to avoid subjectivity.

2.09 Comment: On the surface, this standard appears reasonable and consistent with past federal guidelines. An issue may be a determination of what constitutes the scope and level of knowledge that hospital personnel must possess regarding EMS system policies and procedures. It may be beneficial to insert *"and competent"* as part of the expectation in order to establish a measurable expectation.

9-17-07

2.01 OK

2.02 OK, IDPH web site aids in this

2.03 NO, PSAP's are not going to change their makeup to allow EMS to have a seat when they are currently run by the Sheriff's department, Police Department or by both.

2.04 OK

2.05 OK

2.06 OK

2.07 OK

2.08 OK

2.09 Good goal but EMS does not have control over training at the hospitals.

9-18-07

2.03, 3.09 – I fully agree we need to require EMD. Only one county in our several county area has EMDs. In at least two of the counties that don't, including Taylor county, I have been told that to provide EMD, they would need to increase funds to allow for two dispatchers so one is still available if the other is tied up on the line with a caller. The sheriff in our county also is against it citing liability (I disagree and think it's more of a liability not providing it).

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2.02 Isn't this the state's job? What if director A looses people because director B was in charge year 20XX and in 200XY director A now is the county director and may retaliate on director B's service? What mechanism or authority is in place to prevent this kind of scenario. Shouldn 't this be up to the state to credential and regulate? This opens up a very large can of worms at a local level, especially where territorialism is reif and rampant.

9-20-07

2.03 dispatcher training – has been a hot topic with our sheriff and police department PSAP's for many years. They will be glad to provide EMD if someone funds the extra person/FTE it will take. In an era of their budgets constantly being cut and not being allowed to replace staff or layoff staff, this is not realistic without substantial funding that can not be diverted. Dispatchers also have a minimum standard which they are not allowed to staff.

****

2.03 This is not an area directly controlled by EMS and should have input from those that direct PSAP operations. I don't believe that they would regularly check the EMS website to find a document such as this to review.
2.04 ok
2.05 I don't believe that I or any other member of my squad has any right to tell a business how they will operate in reference to their employee's health care.
2.07 good, but this is a service issue and not a county issue
2.09 I am not sure how we will dictate what the hospitals do.

****

2.01 Already being done at the local level.
2.02 Bureau of EMS is currently doing this. * If this is done locally, what is the need for the Bureau of EMS?
2.03 Not being completed at this time. *PCEMSA does not believe the Bureau of EMS can dictate how the Communication Center trains their staff.
2.04 Already being done at the local level.
2.05 None that PCEMSA is aware of at this time. The local industrial first-aid teams would work with the Bureau of EMS but not take part in PCEMSA. *If this is done locally, what is the need for the Bureau of EMS?
2.06 through 2.08 Already being done at the local level.
2.09 Already being followed during PCEMSA monthly meetings with Floyd Valley Hospital representative in attendance.

9-21-07

2.03 EXCELLENT!

****

2.01 Is this not the responsibility of the IDPH Regional Coordinators. We are not against improving the standards for EMS care but why not have those standards overseen by the Regional coordinators.

2.05 This could create a negative impact between private industry and local EMS responders placed in a role to oversee those private entities. Additionally, the likelihood of local responders working for those industries could create a conflict of interest.

****

2.09 In a hospital setting the likelihood of having base station personnel serve in an online medical direction capacity that do not routinely do so (ie. float nursing staff, hospital charge staff etc.) is likely especially during times of increased emergency call volume. If a regional medical center is taking patients from multiple counties who's policies and procedures are they expected to utilize, those of the local providers or those of the region?

****

2.03 How do we enforce?
2.05 Could be good to make sure all are playing by the same rules, however, how do we enforce this?
2.09 How do we "ensure" this?

Communications

7-19-07
3.07 Changes other agencies or commissions policy. Exceeding your authority?

7-20-07
On 3.07 regarding EMS voting on E911 boards on the proposed EMS standards document, that will open up a whole can of worms. Currently, only political jurisdictions get a voting membership. If this goes through, then EVERY first responder agency organization will most likely want to be represented along with every city and the county. Maybe the hospitals and public health would then want to join as voting members. This could turn these boards into congresses and I believe get away from the original intent of Iowa Code 34A which was to give the elected officials of the counties and municipalities the ultimate decision how to oversee the funds. I just think that this could really become a mess at the statehouse if it is proposed.

7-26-07
I suggest that you remove the bulleted item: *Dispatching of EMS aircraft* from the draft for Iowa EMS System Standards. FAA regulations allow only the holder of an air carrier certificate to dispatch aircraft. This authority is delegated directly to the pilot in command by the certificate holder. Virtually all EMS aircraft providers hold an air carrier certificate issued by the FAA. EMS operations are conducted as "on demand" charters. Less than a dozen hospitals or public entities hold an air carrier certificate. The FAA has been focusing on the issue of operational control and is increasing surveillance of EMS operations. The rules are very clear. Only the certificate holder may exercise operational control and dispatch an aircraft. Thanks for your consideration.

8-17-07
3.07 Current Iowa Code does not allow this.

8-28-07
3.07 Each city in the county currently has a vote on the 911 commission. Those city mayor's or their representatives speak for the entire communities' public safety agencies. If the county EMS group have an additional vote, what about the law enforcement and fire departments? This is not necessary and only adds confusion to the 911 commission.
3.09 I am not sure if this pertains to on-scene triage or somehow involves the communications center. The Plymouth County Comm-Center can not accept additional responsibilities during a crisis or major event.

8-29-07

Standard 3.05 requires two-way communication capabilities between EMS and the hospital: This would appear to be an unfunded mandate without specification as to who is responsible for the purchase and upkeep of the equipment, EMS or the hospital. Also, what happens to hospitals who receive patients from multiple EMS services??

9-06-07

Section 3.07 This will take a change of the Iowa Code to make us voting member of the 911 commission. I know in our county that is the only way this will get done, to many politicians on the board.

Section 3.09 with out this being a mandate in the Iowa Code, counties are going to say how are the extra dispatchers going to be funded?

9-11-07

3.05 Comment: While this is not an unreasonable standard, it could be interpreted that the county EMS system, by having to ensure the ability to communicate, will then also assume the fiduciary responsibility implicit in meeting and sustaining this performance expectation. If such was the case, this may serve of another example where the structure and organization of an EMS system needs to be clarified as it relates to issues implying organizational accountability (see 1.01).

3.07 Comment: On surface, this standard appears worthy of support. EMS is a significant and important component of a community's 9-1-1 system (see 1.01).

3.09 Comment: This standard is widely touted as a key ingredient to a modern and efficient EMS system. Challenges often surface when the EMS call-taking and dispatching functions are embedded in a non-EMS organization that may produce conflicting priorities for limited resources (e.g. dispatchers). Defining the structure and authority of an EMS system (see 1.01) will help mitigate such conflicts.

3.10 Comment: See 1.01

9-17-07

3.01 OK

3.02 OK

3.03 OK

3.04 OK

3.05 Unfunded mandate, if the hospitals do not want to purchase the equipment then it would be left to the EMS System to purchase with no funding supplied by the State.

3.06 OK

3.07 This is not going to happen, refer to answer for 2.03

3.08 OK

3.09 Once again, good idea, but system will not have control over PSAP.

3.10 If this does not already exist, where will the funds come from to make this happen?

9-18-07

3.09 POSITIVE NOTE: I agree – we have not been able to get the sheriff to even auto-dispatch ALS to a CP call in the adjacent BLS service district per the Medical Directors request- based on the callers complaint of CP alone.

9-20-07

Thanks for sending that. I see a large problem with this first off as it seems to push a large number of unfunded mandates. Also, in 3.07 where they think they're becoming a voting member of the 911 board? As I read the law, they'd have to change code 34A to do this, as it states only political subdivisions can have voting members on the 911 commission.

1. Joint E911 service boards – plans.

a. The board of supervisors of each county shall maintain a joint E911 service board.

(1) Each political subdivision of the state having a public safety agency serving territory within the county is entitled to voting membership on the joint E911 service board. Each private safety agency operating within the area is entitled to nonvoting membership on the board.

Also I know in my county, with dispatch being under the Sheriff, they will not have the ability to dictate what goes on in there. They can make suggestions, but the final say will be by the Sheriff.

Those are the things that caught my attention. Not being an EMS person, I'll leave the rest up to the EMS folks to review.

****

3.07 communications need to start with EMS having a seat at the 911 board level, instead of 9 fire departments & 2 law enforcement, & 0 EMS, which is state dictated. Our county auditor is quick to remind me we can attend, but are not a voting member.

****

Section 3.09-Due to funding and staffing issues that face a rural system on a daily basis, the need to outsource dispatching of this nature might be necessary. This type of outsourcing may not be available.

****

3.02 ok

3.03 ok

3.04 ok

3.05 Again, I don't know how we can dictate what the hospitals do or how they Allocate their money and resources.

3.07 We already have an established governing body for this with representation from the communities in our county. I don't see them changing something that isn't broken

3.08 Not a bad idea, but is someone going to be paid for the extra time and/or materials that are needed?
3.09 This needs to be addressed with the people that do the dispatching.

****

3.01 Already in place with the Mass Casualty Incident Plan and NIMS.
3.02 through 3.05 Already being done at the county level.
3.06 Addressed in Mass Casualty Incident Plan and reviewed yearly with Emergency Manager. PCEMSA hold yearly drill.
3.07 through 3.10 Already being done at the local and county level.

9-21-07
3.01 Could a copy of this plan be posted on the bureau's website for reference?
3.07 EXCELLENT!
3.09 EXCELLENT!

****

3.05 How do we "ensure" this?
3.07 How do we actively participate when State Code dictates differently?
3.08 Clarify, in what capacity?
3.09 We could establish but can't guarantee they would be used.

Response & Transportation

7-12-07
In 4.04 Where did the response time number come from?

7-16-07
4.01 Service area "..County EMS systems shall in coordination with neighboring EMS systems determine the emergency medical service
response areas…. Some EMS systems operate on a 28E agreement and serve multi county areas. In the unlikely event of a multi county dispute as to whether the service area should be reallocated, how is this escalated? What is the measurement for "most appropriate"?
4.04 Response time standards "response zones shall be designated so that for 80% of the emergent responses…" What is definition of a response? For instance, if a unit is dispatched but discontinued enrooted , does that count as a response?

7-17-07
I do not think the IDPH should designate response times. Nice goal but not always realistic and would give great incentive for a lawyer to demolish an ambulance service. What about inclement weather conditions?

****

I totally understand the need for the response times section but would love it if you could have a packet of references you used to derive those times and statistics. If those are ready to go—could they be placed on the website? As a consumer—I love them. As an old manager (I say old with tongue in cheek) I know that some areas of Iowa do not qualify for "wilderness" but would be difficult for ALS to get to within 20 minutes.

7-19-07
4.04 Review data and receive feedback from county EMS associations. This is one that could create many future problems without feedback from units and counties.

8-03-07
Second, it was interesting to see the difference in the response times in the urban vs rural area (Section 4.04). As a county Zoning Administrator, we are charged with the responsibility of protecting agricultural areas in the county from the encroachment of conflicting uses such as residential and commercial/industrial uses of the land. We try to not only protect the prime agricultural areas in our county but we promote growth within or near cities where services, such as fire and ambulance, can be more easily provided. Many people like living in the county. They want to get away from noise, people etc.

But they fail to understand the drawbacks in living in rural areas. Some people even build in areas that are not easily accessible, where fire trucks and ambulances cannot safely travel. That is why I find the difference in response times in the urban vs rural areas very beneficial to know. If people understood the differences between urban amenities and rural amenities, maybe not as many people would be looking for more and more remote places to live.

8-16-07

4.04 In this section you use the 80% rule for response time yet the title is: "What Every Iowan Can Expect From Emergency Medical Services", which is it 80% or every Iowan? In rural Iowa the farthest point in the response area is always a challenge for response time. I am aware that the 80% rule is to allow latitude to the responding agencies to meet the response time requirements. In reality this response area will always e in that 20%. In our particular case this is where three fire department's districts meet. All of the responding departments have at least a 15 minute drive time, plus the response time to get to the station. That puts us in violation of section 4.04 with no way to comply. My fear is that we will be held liable if the patron wants to sue?

8-17-07

4.02 How $$

4.04 Frequency of measurement (Daily, weekly, monthly….)? When does the clock start(phone pickup)? National Standard (AAA) for urban ALS response is 8:59.
What is "not functioning as the first responder"?

4.05 Orientation of pilots and medical flight crews to the county EMS system---Do they need to know all the county systems they may respond to?

8-23-07

There is a specific reason that I was asking if these minimum standards are going to be enforced, or if they are just suggestions to EMS providers. If they are to be enforced, even if it is several years into the future as you say, I would expect that they will be enforced fully and completely, regardless of what service or what location is out of compliance. I am specifically referring to section **4.01** in the Response and Transportation chapter. The minimum standard for this section says "The county EMS system shall, in coordination with neighboring EMS Systems, determine the emergency medical service response areas, to ensure the most appropriate response." There are places in Dubuque County where one service will drive right past another service on their way to an emergency call. Does this meet the minimum standard? Will this be allowed to continue? When you come out for your on site inspection, there are always a few little things that we need to do differently to comply with the state standards. And that's fine, we're not complaining, we want to be doing things properly. The point that I am trying to make is that it seems like those little things get a lot more attention than a big issue like an ambulance coming from a lot farther away than it should. I believe that the IDPH not only needs to address the little problems, but the big fundamental ones as well. Miles are

minutes, and as you know, minutes have a huge impact on the outcome of the patient. This situation has been political for too long. It's time to start thinking about the patient again. Thanks for all you do for Iowa.

8-28-07

4.04 I don't know how these times can be implemented in Plymouth County. We are the 4th largest county in the state in square miles. The only way this can be met is by relocating ambulance vehicles or adding to what we have; an expense that is totally unacceptable or realistic. Having personnel available to respond to these calls in this time frame would be difficult at best.

4.06 Currently being done through the Plymouth County Emergency Management Commission.

8-29-07

Standard 4.04 determines response time standards: While these standards would improve patient outcome potentially significantly, these standards also provide lawyers with ready-made evidence of breach of standards.

****

Standard 4.05 provides a process for developing policies and procedures regarding medical aircraft: how, when and why the aircraft is dispatched as well as the patient's destination: This should be determined by medical control, not by EMS providers.

8-30-07

Section 4.04 Response & Transportation Response Time Standards PCEMSA feels the times stated "Not to exceed" for rural areas allows for longer response time. The time standards could have an average response time, with individual calls not to exceed 20 minutes. Those 20 minute calls are the exception and should not set the standard. The county should set an average response time.

9-06-07

Section 4.01 Good luck on this one, this would have to be mandated by code or rule. The idea is great but you know how territorial some people are.

9-11-07

4.01 Comment: This standard is absolutely necessary to maximize the performance and efficiency of any EMS system. The challenge, in part, may lie within the previous discussion of organizational structure, governance and accountability. In this regard, the Standards, as published, appear to focus on system s development at the county-level. It

should be argued that EMS development should reflect a regional orientation and that a county orientation falls short of a regional approach. Regional systems development for trauma has been strongly encouraged by a variety of organizations, including the American College of Surgeons, Committee on Trauma. Increasingly, other definitive care advocates (e.g. stroke and cardiac) are also pushing for regional delivery systems. To maintain a county-wide perspective and not advocate the planning and development of a more regional approach does not seem consistent with current thought and developments within the EMS industry.

4.04 Comment: Measurable response time performance standards are absolutely necessary if an EMS system is to be accountable and committed to a plan of continuous performance improvement. As published, the response time standards may not be consistent with national standards. In some reports, the threshold of performance reflects 90% compliance for having a defibrillator on-scene for cardiac-related cases. Increasingly, it appears that response deliberations are framed by a variety of clinical conditions and circumstances that may not be fully reflected in the proposed standard for Iowa. *"Systems should be driven to optimize response intervals for cardiac arrest and critically ill and injured patients. This includes optimizing the dispatch process and first-responder resources as well as assessing the resuscitation process using a uniform template. Shorter response intervals are not without costs. Beyond monetary costs are inappropriate use of lights and sirens carry established, significant safety risks for EMS providers and the public alike".(*Position Paper, National Association of EMS Physicians, *Considerations in Establishing Emergency Medical Services Response Time Goals*, E. David Bailey, M.D. and Thomas Sweeney, M.D., Prehospital Emergency Care, July-September 2003, Volume 7, Number 3. page 399) It would seem advisable to explore the response time parameters further before final adoption.

4.05 Comment: The role and function of air medical resources within an EMS system continues to be an evolving undertaking. While it is incumbent upon an EMS system to factor in all appropriate resources, including air medical, both rotor and fixed wing, such an undertaking extends beyond a county perspective. There has long been an argument in Iowa that a state-wide plan should be developed for EMS, including both ground and air resources, that empirically sets forth guidelines for matching demand considerations (e.g., geography, population, weather, situational) to the supply and location of resources to achieve optimal performance and operational efficiency. The bulleted issues identified in this standard could also apply to ground services. Moreover, the recent proliferation of rotorcraft operating in Iowa would appear to suggest a more global approach is needed to explore issues related specifically to air medical operations. To remand this discussion to a county-level venue may invite a tendency for parochial considerations to be unnecessarily emphasized (see 1.01).

4.09 Comment: While accountability is necessary in insure efficacy and effective performance, this standard implies a regulatory function that is not clearly defined and may have a deleterious impact on performance improvement processes. It could be argued that local agencies and coalitions are better served by promoting collaboration and cooperation than enforcing regulations promulgated by the Bureau of EMS. A conclusion on "failure-to-comply" should probably be left to a designated regulatory body.

9-17-07

4.01 This is a good goal, but will unpaid board have time to do tis correctly?
4.02 OK, part of current standards.
4.03 While this is an admirable goal, this is not achievable without considerable funding. Where is the money going to come from to make this achievable?
4.04 OK
4.05 OK
4.06 OK
4.07 Desirable but may be difficult in some areas.
4.08 Who is going to do this? Too much for volunteers to monitor everyone in the County.

9-20-07

4.04 with a time designation in minutes as a standard, it will not be cost effective for the call volume in our county to have transporting ambulances on 2 sides of the county within 20 min. Time means you get held accountable to it and sued for failing!

****

4.05 already in place
4.06 ok
4.09 Isn't this what the Bureau is paid to do already? Where is the funding to pay someone else to do this coming from? Why do we need someone else to replicate a job that is already being done?

****

4.01 already being done at the local and county level.
4.02 Not being completed at this time. *If this done locally, what is the need for the Bureau of EMS?
4.03 Already being done at the local and county level.
4.04 The current Mutual Aid Agreement includes a policy stating a squad had 3 pages and/or 6 minutes to respond or the communication Center will dispatch another unit. *PCEMSA feels the times stated for rural areas are unacceptable.
4.05 through 4.09 Already being done at the local and county level.

9-21-07

4.01 **Comment:** So the county EMS system will supersede county Supervisors, Township Trustees and Municipally elected officials in determining geographical boundaries for EMS response.
4.02 **Comment:** Is this not a redundancy to the duties of the IDPH Regional Coordinators?

****

4.01 We could determine the most appropriate response areas, but these are political boundaries. How do we enforce?
4.04 Good Goal, what happens if you cannot obtain?

Facilities/Critical Care

7-16-07

5.01 Facilities: Assessment of capabilities "….shall assess at least annually, the EMS related capabilities of acute care facilities in its service area?" What is the intent and how thorough/disruptive will this be for the hospital? This info would seem to be available from the hospitals or their accrediting organization without having to independently assess their capabilities?

5.07 Pediatric Emergency Medical and Critical Care "County EMS agencies that develop pediatric emergency medical and critical care systems share(shall)determine he(the)optimal system" Simply do not understand what this means or how it well be measured.

8-17-07

5.01 Will there be a template?

5.03 Recommended Guideline:--Provide suggested Criteria? i.e. what classifies a stroke center, cardiac, pediatric center, OB, NICU, mental health.

5.05 Should this include extended care facilities?

5.06 Clarify what is "design area".

5.07 Is this EMS providers or hospital providers of this critical care?

5.08 Should this be under 5.07? "it's"---its

8-29-07

Standard 5.01 allows for an annual assessment of acute care facilities by EMS: EMS does not have the training nor expertise to determine the capabilities of the hospital.

****

Standard 5.04 allows EMS to participation in the preparation of mass casualty management i.e. hospital communication and patient flow at the hospital: while EMS knowledge of the hospital plan is worthwhile, EMS should be preparing for pre-hospital events rather than attempting to manage the local hospital.

9-06-07

Section 5.01 Is this going to be mandate by code or rule to the acute care facilities.

9-11-07

5.01 Comment: The standard appears to conclude that the EMS system has the knowledge and capacity to evaluate a hospital. Organizational issues previously identified (see 1.01) and the absent of criteria for making an assessment under this

standard would appear to undermine the effectiveness and acceptance of this standard by the hospital community.
5.02 Comment: In general, it would seem appropriate for this standard to be associated with the hospital(s) that provides on-line medical direction to the EMS response agencies. Perhaps, some additional language would add needed clarity.
5.03 Comment: In general, this standard addresses several areas of significant import to an EMS system. However, it is recommended that language be added that would establish the expectation that the determination of optimal clinical care, including hospital destination issues, be established collaboratively with the hospital and physician communities. Too, similar collaboration should be incorporated in the language associated with system monitoring and evaluation.
5.04 Comment: There exists an argument that that Homeland Security and Emergency Management structures should have the lead responsibility for development mass fatality plans in collaboration with medical examiners, hospitals, EMS and funeral home/mortuary services to name a few. While the standard, as is currently written, is not completely inappropriate, it would benefit from a more global perspective. Quite possibly, EMS will have a very small role in mass fatality management and its focus will/should, likely, be skewed toward the population of salvable patients.
5.05 Comment: It would seem to be a reasonable expectation for EMS providers to be included in a hospital's planning for facility evacuation given the likely need for patient transport support. It might be worth considering adding, "*if requested by the hospital*" after "*shall assist*".
5.06 Comment: This particular area of analysis definitely deserves a collaborative approach between the EMS system and the system's trauma care facility(s). Not infrequently, cases that might by-pass the local trauma care facility result in contentious exchanges that could be avoided with an organized and collaborative performance improvement process.
5.07 Comment: This standard, as written, does not seem to reflect a collaborative and cooperative process that is inclusive of participation and negotiation with hospital and medical staff representatives. While there is little argument for the benefit and need to develop an effective response to pediatric emergencies, such an undertaking should neither be unilateral nor independent of broad hospital and medical input.
5.08 Comment: The collaborative language is appropriate (see 5.07).

9-17-07
5.01 This is the job of the hospitals and JARCO
5.02 OK assist
5.03 Good goal
5.04 OK assist
5.05 OK assist
5.06 OK
5.07 Good goal
5.08 OK

9-18-07

Section 5 – facilities – what will the responsibility for this be in a county with no hospital?

9-20-07

Section 5.01-This section needs clarification as to what is meant by EMS-related capabilities of acute care facilities. This may be unrealistic due to the complex processes of evaluation that are already in place.
Section 5.02-Transport and transfer destination protocols are already in place at the state level. Don't fragment the policies by giving individual county power to determine where patients are transported.

****

5.01 Why do we need to rate those outside of our control?
5.05 I think it would be ok to assist, but the paid care facility staff would need to initiate this. They are the people being paid to manage the welfare of their clients.

****

5.01 Already being followed during PCEMSA monthly meetings with Floyd Valley Hospital representative in attendance.
5.02 through 5.08 Already being done at the local and county level.

9-21-07

5.01 **Comment:** We are concerned about the ramifications of a public EMS service providing oversight to private facilities. (5.02, 5.03, 5.04, 5.05)

****

5.01 Wouldn't the hospital do this?
5.02 The hospital would need to ask for assistance, we cannot force assistance.
5.04 Always willing to assist, but again we cannot force the hospital to ask for assistance.
5.05 Who are we assisting for this planning? 9-21-07

Data Collection/System Evaluation

7-13-07
Any ideas on how were would get the follow up information from the hospitals for QI?

7-19-07
6.01 Unfunded mandate. Is this a specific program or general program. Not all counties are the same.
6.04 Good one for the attorneys. Every response is different. Unknown information or changing conditions are very common during times of emergency. The idea is fine, and I believe responses and procedures are reviewed by our EMS groups. Improve may be more appropriate than ensure.

8-17-07
6.02 This should be transporting agencies only (as mandated by code)?
6.03 All agencies would have to be HIPAA compliant? Linking such records will be difficult, unless you have a single dispatch system that every agency utilize the same identification number.
6.05 Does the county have to have their own database system to collect this data?

8-28-07
6.04 Another level of accountability for the dispatchers. We already work with the local EMS crews to determine if appropriate dispatching is being done; another way in which the liability issue can be placed on the county. It works dine the way it is, why fix it when it is not broke.

8-29-07
Standard 6.03 would allow EMS to perform quality audits for system response and clinical aspects of care: while quality audits provide an excellent mechanism for improvement in system issues and quality of care pre-hospital, EMS does not have the expertise to determine the system response nor the clinical aspects of care after the patient arrives at the hospital. Once a patient reaches a higher level of care, whether this is EMS to hospital or hospital to hospital, the lower level of care does not have the expertise nor right to attempt to audit the care provided. If the lower level of care had this expertise, they would not have needed to transfer care to the higher level of care.

9-06-07
Section 6.01 – 6.08 Data collection is a great idea but when unfunded you get what you get.

Section 6.03 How is this going to work with HIPAA our local hospital would fight us on this one. Some time it's hard enough to get any information.
Section 6.04 Is this going to be done by code or rule with out one or the other our dispatch would not even consider this.
Section 6.05 Where is the funds coming from to pay for the software and were is the funds coming from for this position?

9-11-07

6.04 Comment: A most appropriate expectation, However, shared dispatching facilities with non-EMS organizations are, sometimes, problematic in establishing a functional collaborate performance improvement process. Consequently, the dispatching and its related functions are critical elements that must be considered in developing an accountable organizational structure (see 1.01).
6.05 Comment: The need for timely and accurate data to support a quality performance improvement process is without question. However, the integration of hospital clinical data into an integrated management system will be challenging. Too, how this standard relates to existing data bases (e.g. trauma registry) will, likely, be a source of some discussion. While this standard is somewhat global in its current language, some further clarity and definition would be recommended. Too, any data requirements on the part of service providers should be carefully considered and accompanied by a commitment by IDPH to only require data that is relevant and for which utility can be demonstrated.

9-17-07

6.01 OK
6.02 OK
6.03 Where will the money come from to put this in place? This could be several tens of thousands of dollars to implement.
6.04 OK, but some systems may not have control or access to the Communications Center data.
6.05 Who will pay for this system, and what if the larger departments have systems that are tied to the rest of the city and they will not convert or merge data with other systems?
6.06 This is a good goal, but asking too much of volunteers and paid departments alike without funding full time personnel just for some of these tasks
6.07 Another unfunded mandate. How will the system ensure that it "shall have the resources" when there is no funding mechanism identified?
6.08 OK, this is currently done at the various levels now

9-18-07

6.02, 6.05 – How is this verified? Is there going to be numbering system instituted state-wide for data collection purposes? I know this was a topic of the initial trauma system standards – how to track a patient through the system.

9-20-07

6. data collection – show me what our data reporting is actually doing statewide? We have invested extra money in the software to try to get maximum benefits of collecting data.

****

6.03 Who is going to pay for this and who will manage this?
6.05 Who will pay for this?
6.06 This seems to add an enormous amount of work to volunteer EMS squads.
6.07 Who will fund this? If the funding isn't in place, I believe that it is an unfunded mandate.

****

6.01 through 6.03 Already being done at the local level.
6.04 Post incident reviews are completed.
6.05 Each squad enters their own data at this time. *Funding and staffing is necessary to complete.
6.06 through 6.08 Not being completed at this time. *Funding and staffing is necessary to complete.

9-21-07

6.07 These requirements need to have state support not only in regulations but in funding to meet them.

****

6.06 **Comment:** This is a very time consuming task and is unrealistic to expect from an EMS agency in a predominately rural setting, especially when enlisting the help of volunteer EMS providers.

****

6.05 Integrated data between agencies? Probably not going to happen. Departments within the State Government don't even have integrated data and you are asking private, public and non-profit agencies to integrate. Wow.
6.06 There are people who go to college specifically to do this type of work and none of them want to volunteer their time. Seems like something the State should assist with.
6.07 Where should we get those resources?
6.08 Our EMS System is our governing agency, local services, and county ems advisory group. Who should we report results to? 9-21-07

Public Information and Education

7-19-07
7.01 Unfunded mandate. Many presently do some of these activities. How often and what level of participation is required?

7-24-07
Is public information and education a systems requirement?

8-03-07
Therefore, I think the public education element (Section 7.01, 7.02, 7.03, and 7.04) is very important to public safety. Also, I think there should be a close working relationship with local zoning officials and EMS providers to promote safety when developing new subdivisions in the county or issuing building permits for new homes. This could include having fire and ambulance services review subdivision development plans in the county before they are approved or setting minimum standards for road width, cul de sac length and radius state wide. You could educate the public by identifying rings of safe and unsafe response times or set boundaries where EMS services cannot be provided in a timely manner. The combination of education and regulation could prevent an unnecessary added burden to the already overloaded EMS providers.

8-17-07
7.02 Injury Prevention instead of Injury Control.

8-28-07
7.04 This is already being done at the local hospital. Why task the EMS crews with this? They are all volunteer's in the county and already have more responsibilities than there is time for.

9-06-07
Section 7.01 – 7.04 How is this going to be funded? Some great ideas but with out funding they will go no where.

9-11-07
7.03 Comment: The inclusion of EMA is worthy of support. However, the recent emphasis on disaster planning partnerships would suggest a broader representation to include hospitals, local public health, community health clinics and other community partners as appropriate.

9-17-07
7.01 Good goal but where will the funds come from?
7.02 Good goal, but who will pay for this?
7.03 Good goal

9-20-07
7.01 Good idea, but who pays for the materials?
7.02 Who will pay for this? Where do you want volunteers to find even more time from to complete the extra tasks?
7.04 By promoting do you mean do the teaching and training? I don't believe that anyone should be made to teach.

****

7.01 Not being completed at this time. *Funding and staffing is necessary to complete.
7.02 Already being done at the local level and by Floyd Valley Hospital.
7.03 Already being completed by the Emergency Manager.
7.04 Already being done at the local level and by Floyd Valley Hospital.

9-21-07
7.01 Most Appopriate.

****

7.04 Who decides what it the appropriate percentage of general public that would have CPR and HOW do you plan to enforce that the citizens of our communities MUST be trained?

****

7.01 We think this is a great idea. " What every EMS System in the State of Iowa should expect from the Bureau of EMS" is marketing tools to assist with this.
7.02 The county EMS system can promote, but the Bureau of EMS should provide programs.
7.04 What is the appropriate percentage and who will pay for the training?

Disaster Medical Response

7-19-07

8.07 Deploy locally, county, region, state, other? Many EMS services are limited as to deployment.

8.08 Planning is a continual process. To ensure is a goal that even the federal government has not found the solution to. Possibly just rephrase. Funding source is another question, depending on level required.

8-29-07

Standard 8.09 encourages EMS to ensure the hospitals internal and external disaster plans are fully integrated in the county medical response plan: while EMS knowledge of the hospital plans is worthwhile, EMS should be preparing for pre-hospital events rather than attempting to manage the local hospital. The integration of hospital plans into a county plan is a function of the county emergency management agency, not EMS.

9-06-07

Section 8.04 The training can be done, how are we going to fund the equipment for the responders?

9-11-07

8.01 Comment: The collaborative language is appropriate (see 7.03).

8.09 Comment: Integration and collaboration are hallmarks of a successful disaster and emergency preparedness response plan. Rather than encouraging hospitals to integrate their plans, this standard would be better served to emphasize the need for EMS providers to integrate their plans with community planning partners. Similarly, the recommended guideline should place the emphasis on the EMS provider rather than the hospital. Also, the reference to *"pre-hospital medical care agencies"* needs some clarification; perhaps, with examples. Approved by: Region 5 Hospital Preparedness Steering Committee,

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9-17-07

8.0 OK

8.2 OK

8.3 OK

8.4 OK

8.5 Agree, but will every person in the county have to be involved in the exercise? What is meant by exercises conducted annually?

8.6 Is this only when there is a significant event?

8.7 OK

8.8 OK

8.9 OK, encourage is proper language

9-20-07

8.05 What level of incident command to people need to be trained to? Do all members need to participate in the same exercise? If the exercise is mandated, who pays for expenses? Will formal EMS hours be granted if the exercises is mandated by the EMS Bureau?

****

8.01 through 8.09 Already being done at the local and county level.

9-21-07

8.04 Should use the IA Fire Service Training Bureau's credentialing for HAZMAT Ops.

****

8.04 Clarify, this makes it sound like we have to equip ems responders for response to hazardous materials incidents. We do not have the resources.
8.06 Clarify, how do you determine the effectiveness of a disaster plan if it has not been used in the last year. Are you saying to review plan annually?
8.08 Do you have an example of such a plan? How do you "ensure" continuation of EMS services during disasters? No sure this is worded well.

Funding

7-12-07
Another very important question is, where is all of the funding going to come from to try and implement this and then manage it?

****

When will the county(s) be required to fund the program?

7-17-07
Where is the funding?

7-24-07
Why isn't funding for EMS, and specifically for these systems (earmarked for these specific purposes) also included?

8-01-07
Who is going to pay for this? Is the state going to fund it? I am guessing it will cost upwards of $50,000 to $100,000 or even more for our rural county. As Chairman of the Board of Supervisors of Washington County I have large concerns about another unfunded state mandate.

8-16-07
1.14 System Finance We are all aware that the state and the counties do not have any money to fund this. Being realistic how will this be done? The statement of each county shall identify funding mechanism…is empty. The county EMS administrator does not have the power to implement taxes or fees. Without funding, implementation of this system is impossible. If taxes are going to be raised or fees are going to be imposed, will the general public be allowed to voice their opinions?

8-24-07
This proposal mandates that each County fulfill several requirements but does not provide financial support. Unfunded mandates like this are not received well by the effected agencies or the public and nearly always result in increased costs and/or the reduction or related services.
Many provisions appear to be written with too narrow a scope and do not provide the flexibility to allow for creative compliance. An example is the requirement for all PSAP operators to be trained to EMD standards. Today's technology allows direct transfer of a caller with the push of a button. Regions like ours that have multiple PSAPs can easily

transfer calls to an EMD dispatch while simultaneously alerting first response agencies. In a case like this, it is unnecessary to expend the money and burden personnel resources to ultimately accomplish the same goal.
It is my opinion that the draft as is currently written will create serious financial hardships on local governments and may actually result in negative impacts to current levels of patient care in many jurisdictions. I therefore urge you not to implement the Iowa System Standards on a State-wide basis. Rather, I encourage the EMS Division of Public Health to assist those communities and/or areas of the State that they have identified as substandard on an individual basis to better manage each of their unique situations.
In addition: I sent this as a draft to my City Manager who asked that his comment be added as well. As follows:
In addition to the points you raise, I question where the funding for the "new" level of oversight is going to come from, and who the individual will be answerable to. While I agree with the principles behind establishing an acceptable threshold for level of care, I believe that state would be better served by doing an evaluation of the condition of EMS response across the state so the areas that are already meeting the threshold are known. I believe it would be at best a redundancy, and at worst a waste of resources, to establish this system in areas that do not need it. Better to concentrate on those areas deemed substandard, and with the resources saved by not putting it in place where it is not needed, provide more assistance to those that do. This is not an issue that needs a one-size-fits-all solution, which is what is being proposed.

8-30-07
Several members of PCEMSA believe the Bureau of EMS should secure a funding source to offset the cost prior to making any mandated system standards.

General Comments

7-12-07
For the most part very clearly laid out and thorough. I like the plan for rolling the whole thing out.

****

Wow—what a draft—looks great for what I skimmed. The only question I had was is it written any where that the EMS crew are to leave a minimum written report / document before leaving the ER? NOTE: Individual contacted and question resolved with current administrative rule covering Patient Care Report—Craig Keough

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7-16-07
Would it be possible to provide brief professional biographical summaries of the Stakeholder committee?

****

Interesting omissions No emphasis on having processes and systems in place to maintain patient confidentiality, HIPPA compliance Technology and communication has evolved beyond two way radio communication. Do the PSAP being able to handle alternate methods of communication e.g. inbound text messaging or email. While there are no standards in place today, these methods are being used for emergency communications, just not to 911 at this moment. GPS might be standard to consider phasing in, both for helping ambulances find their location as well as for dispatching air medical services. Thank you for the opportunity to comment.

7-17-07
If the IDPH is attempting to let Iowans know of expectations then it should come from the state level. This is where consistency would be generated.
What ever happened to the KISS method? Let's truly keep any changes simple.
I will admit that I did like the "Glossary of Terms" pages.
Thank you for the opportunity to provide feedback.

****

I finally had a chance to review the new standards and, although I see some controversial areas for Iowa EMS, I think you've done a good job. Thanks.

7-18-07

I am currently the director of the ER at Grundy County Memorial Hospital as well as the director of the Grundy Center and Wellsburg Ambulances. I just read through the proposed county EMS system. I wholeheartedly agree that such a system is needed. Our current Grundy Center Ambulance is short staffed and has no paramedics and too few EMT-I's. Therefore, most transfers to from GCMH have to go out by outside agencies. We have been contemplating how to organize a paid paramedic service either in Grundy Center or in the central portion of Grundy County. The paramedics would perform most of the transfers while each community within the county would just need to provide first responders/EMT-B's. Our hospital is supportive but is not willing to provide that service. Hopefully, the proposed county system would provide the proper nidus to get this started.

Unfortunately, I am neither a lawyer nor an administrator. How can we put this plan into action? Will the state provide each county with a template for making the protocols-or at least an example of one already in place? When can we take this to the County Board of Supervisors? Do some counties already have this in place? Would the system be mandated in all counties? When? Please keep me updated.

7-19-07

Hopefully we all remember this is not a perfect world. Many things that may appear to benefit the system may hamper it sustainability. Generally, there appear to be several unfunded mandates with this latest version. During disasters and other emergencies, some standards may become impossible to meet. This could create unwanted legal difficulties. Several standards may be somewhat vague or have gray areas in them; which could also create legal problems. A couple standards may go beyond the authority of the committee, when making standards that effect other agencies. Again additional legal actions. Future legal actions could possible lead back to the committee members involved in the creation of the standards.

Much thought and effort have been put into these proposals. I thank the committee. I hope responses from others are considered and may require additional information or input, to assist them in this very important project. We all work for and think of the people we serve. Thanks again.

7-20-07

Thank you for your timely and informative reply. I can understand one of the main objectives is to improve upon what we have and provide a better service to the people. Any time standards are mentioned and objective terms are first presented, it seems to start a short panic. Then after additional information is available, most people understand what it truly means to us all. I applaud you all for your efforts. Some people that contacted me, may have gotten the idea the standards, as presented, were to be implemented shortly. I will share this information with others, and thanks again.

7-24-07
Lots of hard work no doubt went into this document.

7-25-07
After reading the draft on IA System Standards I have a few comments and concerns. You refer to several documents as models, such as the EMS communications plan, the Trauma system model and guidelines. Could you include a place to reference this. It has been a long time since I viewed some of these and need to compare and refresh my memory.
Glossary of terms: show ALS as Paramedic level or above. Is this consistent with a national standard? What about the Intermediate level?
BLS level is Intermediate level or below. I have the same question here.
The model as a whole is a step in the right direction. Let us know about the meetings if you want additional input. Many are interested here.

****

Overall the draft would be beneficial for EMS services but would require direction to obtain the minimum standard.

8-01-07
If these are suggested standards to go by only, then maybe they are okay to have as goals. If they are enforceable by penalty or fines and are mandated, then I am NOT in favor of them.

8-03-07
I read the draft of the Iowa EMS System Standards and found the information very interesting. I have two comments. First, are ALS, BLS, and AED acronyms? If they are, they should be spelled out in your document. (second comment under Response & Transportation)

8-15-07
I looked over the proposed draft of standards for EMS. They look really good. Lots of work went into them I can see. My only comment is under definition of ambulance- perhaps add something to the effect of licensed as an emergency vehicle and meets standards set by the BOEMS. As I read it now I could get an old hearse "convert" it to an ambulance and transport patients. Someone could use a Simpson station wagon for an ambulance? I think the standards are great, having grown up in rural Iowa and been an EMS provider for many years (Anita was my preceptor and we know she is old as dirt!) it is a step forward for EMS in Iowa.

8-16-07

This is regards to the proposed changes in the Iowa EMS system. First of all I have a general question. Is the system in such a state of disrepair that everyone needs to change? This leads to the question of how the system got into this condition under the leadership of the DPH. To me the DPH is passing the buck to the counties to fix their mistake. My major areas of concern with the new proposal are in the systems organization and management, the funding of, and response and transport.

My assumption is that the committee has thought about some or all of these issues. Is there a place where the questions and concerns being raised can be reviewed by the public?

Everyone that I know involved in EMS wants to provide the best care that we can. It is my hope that the proposal does what the committee wants, my fear is that this will lead to more people leaving the EMS field. Thanks for listening.

8-28-07

Could you send me a list of the "scheduled presentations" on these draft standards?

Craig: I received you fax. I have a supervisor in Plymouth county who is concerned about the cost implications of the standards. Has IDPH done or plan to do any education with counties? What is your sense of what funding will be tapped to meet the standards?

8-29-07

Thank you for the opportunity to offer comment on the proposed changes to the Iowa EMS Systems Standards. Our hospital ER and Trauma committee reviewed the changes at their meetings last week and summarized a number of potential issues and concerns about the changes that could and would affect the actual practice and delivery of coordinated and professional EMS services to patients in our rural Iowa communities. Attached is a summary of the comments that came from our committees and we appreciate having the opportunity to forward them to you for your review and consideration. The proud history of high quality EMS services in our state is our mutual objective and we look forward to continuing that quality focused heritage.

****

On behalf of the Plymouth County Sheriff's Office, I have several comments concerning the standardization of the EMS system in Iowa, specifically how it will impact the Communication Center (Dispatch) of which the Sheriff is in charge. Most of what is being proposed is once again and UNFUNDED mandate from the state. I realize there is a need to standardize some policies and procedures, but at who's expense? My office can not absorb another increase in its budget. I would rather direct the money to my people rather than trying to meet a standards passed off from the State of Iowa.

I appreciate the opportunity to voice my concerns on behalf of the Plymouth County Sheriff's Office. I see the proposed standards as an attempt to better the EMS system in each county, however, not every county has the same geographical lay-out and not every county has the same need. The system in Plymouth County works extremely well and for

the time and expense needed to implement many of these standards, it is not necessary. I would encourage the committee to find a permanent funding source before handing this off to the local counties. I see much of the proposal as a means to add responsibilities to the county and diminish the responsibilities of the state. Thank you!

8-30-07

The Plymouth County EMS Association (PCEMSA) would like to thank the committee members who worked on the Iowa EMS System Standards, "What every Iowan can expect from Emergency Medical Services". It is evident the committee spent a lot of time to provide the highest quality services to all Iowans. It is a very comprehensive set of standards that every squad should be providing.

There are several sections of proposed standards that are not being met in Plymouth County at this time mainly due to lack of funding, staffing, and time. These sections require significant time and paperwork to be completed. If/when the standards pass, PCEMSA is concerned how these standards will be met. PCEMSA is just an advisory board and not an administrative board and the squads are all volunteers. No one is willing to volunteer that much time to make sure these standards are being met and the proper paperwork is being completed. Someone will need to be hired to make sure these standards are met, who will pay for it?

Since the standards are open for public comment and the standards address issues with other agencies, PCEMSA decided to contact all interested parties so they had time to review the standards and start a dialog about how Plymouth County will meet these standards. PCEMSA contacted the Board of Supervisors, Plymouth County Communication Center, and Emergency Management. Local squads were encouraged to contact their government officials (city, township), Medical Directors, Hospitals, and any other organizations that work with EMS.

Thank you for your dedication to providing quality emergency medical care to Iowans.

9-05-07

The Plymouth County Emergency Medical Services Association (PCEMS) has brought to our attention a document for public comment concerning the proposed Iowa EMS System Standards. Our Board has reviewed the proposed standards and the comments made by the PCEMSA regarding those proposals. We would like to inform you of our own concerns as a Board as to the effects these proposals could have on the citizens of Plymouth County.

Iowa has 99 Counties, each of which has its own unique needs for Emergency Medical Services as well as methods for providing them. It is our opinion that one set of standards does not necessarily fit all. Plymouth County has 24,000 citizens living in, geographically, the 4th largest County in Iowa. We have seven volunteer ambulance services (LeMars, Remsen, Merrill, Akron, Oyens, Hinton, and Kingsley) which work in cooperation with one another to provide outstanding local service to our people. We feel that many of the proposals in the draft document would only serve to mandate an unnecessary layer of over-centralized control which would hinder response times and serve as a detriment to the overall quality of services.

We also would like to reiterate that our EMS people are volunteers. Then know their communities and their communities know them which add to the quality of care in our County. It should be noted that many of the proposed standards are already being met or exceeded by these volunteers. We believe, however, that some of the draft proposals create unnecessary paperwork, training rules, and reporting procedures that will only make it more difficult for our services to recruit new First Responders and Paramedics and to retain current members. This will eventually lead to a loss of personnel and the closure of some of our Community ambulance services which would be a great detriment to the safety of the citizens of our County.

It also should be noted that many of the draft proposals are unfunded mandates. Local governments have a difficult time funding the myriad of mandates they already have and to add more creates budgeting stresses which will lead to cutbacks of other essential services. If current services are already being provided without the hiring of the proposed additional personnel, then why mandate them?

In closing we wish to express our full support for the PCEMSA and their comments regarding the draft proposals. We hope you will look seriously at their remarks as well as ours and to consider them before making any final decisions. We acknowledge that the Iowa EMS Bureau is trying to affect positive change and has the best interests of all Iowans at heart. We simply disagree on how standards should change and whether or not they are applicable to every Iowa County. Thank you for your time and consideration.

Sincerely,

Plymouth County Board of Supervisors

9-06-07

Glossary of Terms BLS – Interventions identified at the Intermediate level or below.

I have am very concerned with this definition. If you choose to say all Intermediate skills are at the BLS level whether that means I85 or I99. Medicare will start paying all services in Iowa at the BLS level for advance skills like IV starts and meds etc. In the Medicare manual it says that each level of payment is base on each states level of care. Once Medicare does this other insurance companies will follow. Think about the financial impact this will have on all of the services in Iowa.

****

Larry I know there was a lot of hard work put into this but with all things new there will always be positives and negatives as with these standards. I ope with these standards we can get EMS mandated in the code that every county shall provide EMS and we get permanent funding for EMS in Iowa. If any one would like to contact me about my comments please feel free.

9-11-07

Gentlemen: It has been brought to our attention that the State of Iowa is requesting public comment on the new Iowa EMS Systems Standards. After reviewing the proposed draft we would like to voice our concerns concerning this document.

The City of Le Mars is a community of approximately 10,000 residents. Our EMS staff has strived to stay in compliance with the Iowa Department of Public Health and the State of Iowa. Within the last 60 days, the city has hired a full-time director as we felt the annual call volume and the amount of regulation dictated so. Now we are notified the state is suggesting each county be responsible for EMS services. In our opinion, another layer of bureaucracy in not needed and is detrimental to emergency care given to our citizens.

According to the proposed regulations, the State of Iowa is proposing to have the county responsible for EMS services. Not only would we lose the control over Emergency Medical Services for our community, we feel the costs to provide services will increase and become less efficient. Training, staffing, and management on a county-wide basis would in effect, reduce the current local volunteers currently on staff and hinder any staff recruitment efforts in the future.

Just as the, law enforcement, and school administration should be kept under local control, we fell very strongly our management of Emergency Medical Services should be kept under local control. We kindly ask you to "re-think" your proposal and leave the management of our local EMS service in local hands.

Sincerely,

CITY OF LE MARS 9-11-07

9-12-07

Larry, it appears that you and your EMS Bureau colleagues have been tackling some of the tough issues facing the EMS industry. I am reminded of the efforts during my tenure at UIHC to look at EMS, especially the air medical piece, in a more global and interdependent view. Needless to say, I did not enjoy a strong following in my efforts. As I am now having the pleasure of working with hospitals in southeast Iowa to further their disaster preparedness, the proposed Iowa EMS System Standards were brought to the attention of our Region 5 Hospital Preparedness Steering Committee for discussion. As the scope of the proposed standards includes some disaster and emergency preparedness issues, there was an interest to look closely at what was being proposed. Too, the fact that several of the hospitals in Region 5 are engaged in providing ambulance service certainly heightened the interest in the proposed standards. At the conclusion of the Steering Committee's deliberations, a consensus evolved that is represented by the comments and observations presented in the attached. I hope you find this document to be helpful and we hope it will stimulate further discussion and thought as the Bureau moves forward in the development of its "Roadmap".

Like most undertakings of the magnitude reflected in the Standards' document, not all of the discussions and assumptions are clear to the reader. While they may be implicitly clear to and understood by the authors, those reviewing the document are sometimes left to interpret and, perhaps, speculate on intentions and conclusions. In other words, I believe our Steering committee did its best to interpret the standards and accompanying narrative in the context that the authors intended.

The Bureau staff and the members of the Stakeholder Committee are certainly to be commended for their work and efforts to tackle some most important and difficult issues that our facing our EMS providers, It is certainly my hope which , I believe, is shared by

the Region 5 Steering Committee, that these efforts will result in meaningful improvement in the fiscal, clinical and response time performance within Iowa's EMS system.
Should you have any questions regarding the attached comments and observations, please do not hesitate to contact me.

9-14-07
Thanks for the opportunity to comment on "The Iowa EMS System Standards". As you know, the Boone Fire Department is not a transporting service, as we only tier with the Boone County Ambulance for emergencies in our fire district. However, we are recognized by the state as an EMT-I service.
After reading the "System Standards" many thoughts come to mine. I like the idea of everyone being on the same page, especially in these times; it's essential for continuity of services, safety of the responders, and ultimately for the good of the patient in question. Although I feel many of the proposed standards are good, I wonder how many entities and jurisdictions will be able to find the time, resources, manpower, and funding to satisfy those standards. We're career department and I serve as the Assistant Fire Chief/Training Officer. Until my promotion to this position, I had no idea how many standards were out there, and the amount of training that was required to keep us in good standing and to keep our personnel safe. Our department is fortunate that we have a full time person attempting to stay ahead of all that is required for the department.
I feel that the majority of the standards would be perfect in the perfect world, but I would question how practical they actually are. I don't envision too many departments or counties being able to keep up with all of the new proposed standards. I've heard some horror stories of different departments and counties dealing with NIMS in the last several years. Although our department took the lead to become NIMS compliant in the city, I can only imagine what some smaller volunteer departments went through, and are going through presently.
Bottom line; even though our department has been living by some of the proposed standards for some time, I feel the new set of standards should be very carefully looked at again, with the situation in a number of smaller less populated counties being considered. Again, thank you for allowing me to comment on the proposed standards.

****

These are very valid and I am glad Craig pointed them out so eloquently. Any time that the state or federal government puts more work onto volunteers, whether EMS, Fire Service or other volunteer organizations, without providing the funds to carry out the "mandates" they set us up for failure to follow the mandates due to time constraints—making a living has to come first since if there is no food/shelter, there is no longer the chance to volunteer time or talent. Thanks.

9-17-07

Larry, Thanks for providing more light on the subject. Too often we see only part of the project when we receive a draft and don't see the plan behind it. Thanks for providing more information on the intent. Thanks again to you and all the members of the committee working on the system. Have a great week.

****

Dear Larry, Overall the idea of providing the same level of care for all citizens of Iowa is very altruistic. The problem is that without a funding mechanism, I don't see how this is possible. For years there has been somewhat of a disparity between paid Fire and EMS response in cities and the volunteer response in the rural parts of the State. Many volunteer squads do a wonderful job of providing service on limited funds, but by placing more requirements on the rural squads as far as paperwork, reporting, response times and performance standards without a funding mechanism to pay for the needed increase in personnel and equipment creates a large gap between what is ideal and what is really achievable.

The principles laid out in this document would also impact the urban communities if they were expected to take up the slack between the ideals and the current situation in many of the rural areas. If the Bureau of EMS pushes this standard forward, it will become another unfunded mandate for the EMS providers in the State.

Larry, I would like to thank you and the rest of the committee for all the time and effort you put into this project. Once again I feel that there are some very good goals communicated in this document, but I am concerned about have the Bureau of EMS creating more rules for EMS delivery systems without providing any money to see it come true. Unfunded mandates and setting up first responders for failure by creating more regulations for them to follow without the proper funding or personnel to accomplish the goals will not provide better service or more EMT's in the State. It becomes more and more difficult for volunteer services to meet the current standards and putting more regulations on them and requiring more administrative work out of them will not help this situation. Without a funding mechanism and a way to hire full time people to administer this proposed system it will create more deficiencies than it will improve the current system.

If you would like to discuss any of the specifics of my answers please contact me…

Thanks again to you and the rest of the committee.

****

I agree with James Clarks Jrs. Notes or email to you. That is the professional approach to these new proposed rules. This is the volunteer without time or money to do all of this. The volunteer from small rural can not stand any more mandates, unfunded mandates, additional paperwork and more reporting. Please stop or you and the committee will be the first step in the loss of the volunteer network. Have you not all seen and heard of the loss of volunteers everywhere and it is getting worse. This is an exact reason why this has happened and is happening. If this is what the reporting gets us then we need to stop reporting.

I am a 34 year volunteer firemen and emt with the Hostein fire and ambulance dept. I am currently chief and I am going to retire next year. One of the reasons is the state fire and ems is wearing me out on the have to mandates. You keep passing work that should be done by the state off to the volunteers, reporting is a good example, before we sent a copy of our paperwork to you and you put in the system. Now you passed off that job to us to enter into the system. Maybe you need to start doing it the old way and then you can have the data and reviews that you want.
We are tired out and mostly from reporting. Our department always ran with around 30 people and we are having a hard time staying at 24 now. We are a combination department which helps but more and more people want to come on for the fire side only. We have to stop having paid people come up with jobs for volunteers. It is time maybe the state takes on more jobs and not pass them to us and it is time to step up with funding to help us provide ems and fire care. There will be a time and it is already there for some departments that they can not provide what is needed due to man power and funding. If you lose the volunteer then you will be passing on the cost to the health care which is already to expensive.
Get Medicare to pay more, figure out a way to collect our money when we do a call. After we pay expenses based on about 150 calls we maybe can bank 30,000 and that is because we take nothing from the fund, not even a per call fee. How far do you think 30,000 would go for a hospital or county toward the operation of a ambulance in the rural.
Our response times are well below you guidelines, if you want a 20 minute or longer response time then keep giving us more to do as when the volunteers are gone our area will have a minimum of 20 minutes in the best case.
This is the guy off the street response. I started when the funeral home gave the fire department their ambulance and back then you drove as fast as you could, loaded the patient and drove as fast as you could to the hospital or doctors office. Then the emt classes started and I think Rick Vomocka taught our class. Things have improved but things also have not and that being unfunded mandates, paper work and ideas that probably can not happen in the rural setting. James R. Clark Jr. did a very good job on a line by line basis.
I am just asking you to stop and think about what will happen to our volunteer base out here that is already losing ground.

9-18-07
Overall, I think the standards are reasonable and worthy. Every person calling 911 in Iowa should be able to depend on a certain level of quality response, and this is a step in that direction.

****

After talking with Dr. Mallory I see where statewide these ideas are coming from, however, I see many more questions than answers. I understand after speaking with Dr Mallory that each county has its own “headache”, Problem child”, and “nightmarish” scenario(s).

Many of these things mentioned are already in place. Such as disaster and cooperation. These parts should remain. These are items the PUBLIC at large shall expect. The portions pertaining to governance, however, and enforcement should lie at the state and regional level through an "independent" board without bias or predjuice. These should not be placed in the hands of local units to be meted out haphazardly or un-evenly from one service to another or even one county to another.

- a scenario of nightmarish proportions would be where county A has a concern via a service in county A about a service county B. County A has no authority to discipline county B – nor force county B to "bend" to its demands. Appealing to regional or state governance adds another level of involvement to ensure what? *"Well service B in county B has met the guidelines as established by county B – and yes they meet the minimum standards, but they do not match or come to the level of county A – oh well…"*

I make these lengthy comments in hopes that they echo or sound an alarm of concern about potential for abuse and greater misunderstanding. IF only ALL 99 counties had it as good as Marshall County and its immediate border communities as far as cooperation and elimination of redundant services.
I appreciate your time and attention. Thank you for the opportunity to offer opinions and comment.

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I know that time is running close on this and I wanted to share with you what Cedar County services related to me so you could put it in your "comments bank". I just returned from a conference and have received all of the comments I was trying to get from Cedar County services so I could give you a composite. As I was gone, I was not able to address the county meeting like I wanted to in order to shine a positive note on the system standard concept and perhaps share my own ideas at the meeting. I don't really feel that many services understand the overall concepts presented but I promised to pass along what the county service's concerns were as expressed to me: (Note: My personal comments are in parenthesis)
1. How to fund a full time EMS Coordinator? (I personally fell this needs to come from the county budget, just as county law enforcement, and other agencies do)
2. Their concern in finding a medical director to cover the entire county may be difficult in that we do not have a central hospital and our towns transport in four different directions. (My understanding from the proposal is that the system medical director would have a physician-based advisory committee made up of the individual service's medical directors.)
3. How does this affect those towns who cover two or even three counties? (I presume that having state-based system standards would mean that each county that a town serves would be using the same unified standards: thus eliminating these exact problems)
4. There is confusion on how we would evaluate a hospital system with six or even different hospitals serving Cedar County.
5. Last, but not least, they wanted me to pass along that "if it is not broken, why fix it?"

I know you will receive a variety of positive and negative comments about the system standards and I really hope that people will participate in the yearlong pilot evaluations so everyone can begin to understand the whole purpose behind the proposed changes.

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Please keep in mind that the volunteer pool is getting smaller and already overworked. I do think that sending in the run sheets to the state ems would take some pressure off and should be considered to either fund a fee for every report done by someone into the data base or take over the entry yourself. I would suggest a 10.00 fee for each run report entered, 7.50 for the data entry and 2.50 for equipment and misc. expenses such as internet and the computer. They do not last for ever.
I have been on for 34 years. I remember saving a lot of people, I remember providing basic medical care for a lot of people and comfort. I do not ever remember killing anyone. Does every call get the same response time? No and if the volunteer pool gets less the response time will get higher as a lot of people work out of town in small rural towns. Would it be nice to have a paramedic on every call? Sure are they needed on every call? No. We have calls where we help someone back up in their chair.
In the rural setting we have to stay with the ABC's package, load and go. When you are 20 minutes from a hospital, deal with life threatening and get going. Over assessment at the scene takes to much time. I still feel the secondary assessment has to be done in route as you will be half way there by the time that is done. Our goal is to be in route within 5 min. be at the hospital between 30 and 45 min.

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As you know I am all for going forward in the improvement of patient care. I think the issue that is going to create a lot of problems is using a county demographics. I am sure Stuart is not the only ambulance service that is in more than 1 county. I would hope this will be addressed, regional coverage achieves the goals. County by county because of the disparity in population. Rural call volume is not going to give adequate coverage to the areas that may have a higher call volume than the center of the counties. In setting out to achieve this change in ambulance service across the State of Iowa some obvious factors would be major traffic ways the amount of population traveling is usually more than the population of the rural area they go through. The age of the rural population verses the urban. I am not sure of the numbers but per capita I would guess the percentage is higher. The length of transport times from rural verses urban think about the State thoughts on National I verses Paramedic. The past history is not a good indicator of what the State is thinking. I would think if you are going to be with a pt 30 to 40 mins it would be in the best interest to know why you are doing something not see this do this. I am sure all of the topics I am bring up are old news but I have been taught in all of the years being involved in EMS that do what is best for Patients, I hope this is the driving force on the changes that are made.

9-19-07

I was very excited as I read this plan. There are a few things I have some thought on. Is there discussion on county-to-county standardization state wide? Nationally? For the areas that cross counties, say for instance, Strawberry Point, who service a four county area, this could get confusing. Paramount Ambulance, who service Iowa and Illinois. Another area I was interested in is the financial aspect. Would service reimbursement stay the same and the services operate as they do now? Duane Millard from Edgewood researched and sent out a couple of months ago, a comparison of different services in the area on what each service charged for transport. Quite the comparison, everyone was very different. And if this were the case, and things remain unchanged in this area, how would that affect grant money that could be applied for at the county level, or even the local level? On the other hand, if things were to change, financially that is, how would some of the townships recoup the funding that is lost through ambulance revenue, for the services that are operated by the townships, and how receptive are they going to be to this change?

These are really the only questions I have at this time, otherwise, I think the plan would be beneficial to the communities and the standardization can only benefit the services. Thank you for your time.

9-20-07

Gentlemen:

The Board of Directors of the Iowa EMS Association voted unanimously this afternoon to not support the current proposed Iowa EMS System Standards. Please officially document our position as opposed.

It was the consensus of our board that no one has received any positive comments related to the draft standards from our constituents and in fact, we had received several concerns and negative comments.

Generally the board discussion centered on the opinion that the scope of the project seems to be much broader that system standards. While the board supports the creation of system standards, this document seems to look more like a system development document than a standards document. While system development is also important in our state, we feel that further stakeholders would need to be involved to make the program a success.

We also understand the concept of creating a couple of “test” sites or Counties and evaluating the success of the proposal at some future period. There are no apparent evaluation criteria to determine whether or not the program meets the objectives of the project. We feel these criteria would need to be set forth up front and be objectively evaluated.

Again, while the board supports each of the projects concepts, the proposed document in our opinion, goes beyond the scope of system standards and needs a considerable amount of further input and consideration. While we cannot endorse this document, we remain eager to participate in further system and standards development in Iowa.

On behalf of the Board of Directors,

John Hill, President

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I've read the Iowa System Standards, and I don't know if I fully understand them. We had some discussion at the County EMS meeting, and it involved our EMA manager. He is already moving in this direction with his planning, and supports the idea. I hear and see resistance to one EMS system in the entire county. More so with the hospital based services that have employees that are in a paid position versus the volunteers. This may have a direct impact on their lives since this is their primary job. The volunteers may even benefit from it. There are so many differences within our county; we have city services, hospital-based services, and private services. I don't understand how these can combine in to one system.

Would the County EMS system be a stand-alone entity, and how will it work financially with more than one hospital involved. Will there be paid providers and volunteer providers within the same system. Will some employees get pain X dollars per hour, and others paid Y dollars per hour, and another paid Z dollars as a flat fee for a call? Will everyone be paid the same that works within this system? Or will each person continue to work for his or her own service, and it is managed at the county level, which is also confusing. One of my duties/goals is to bring the EMS crew and the hospital closer together. They are segregated and are almost the "step-child" of the hospital, and I see this as separating the two even more.

I haven't talked with the doctors, but they are each familiar with their own EMS personnel, and their skill level, as well as the majority of the patients within their own area, and most likely they see them in their own clinic. I think of this as an advantage, having your medical director closely involved with the crew and patient.

I can see advantages to these ideas; it will most likely improve care. It will be hard to sell the idea to change to most providers. I am just unclear on how different types of service will join together, and what the impact of each service will be.

I think that I would benefit from a presentation that would explain these plans and ideas, and eliminate some of the false beliefs that people are coming up with. If I am better educated and aware, then I can pass along the information.

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After reading through this proposal, I am somewhat confused as to the implementation of a County Agency to monitor EMS agencies within the county. Are they replacing the regional coordinators and some state officials or is it somewhat a duplication of control! How are the persons on the county agency to be paid for doing the monitoring and program development for the county? Are they to inspect, evaluate, and correct problems within community ambulance services, and how do they accomplish this? Many of the points are well taken, and well developed, and many of them are already in place. How necessary are more requirements, especially for volunteers as compared to the unknown outcome of implementation? With the effort put into this project be very caring and dedicated people, I can assume that these are weaknesses in the ability of Iowa EMS squads, paid and volunteer when considering patient care? Needs assessments can be good or they be idealogical. I understand that paid services can meet the minimum standards, but I also know that rural EMS has so many variable and considerations, such

as staffing, day persons, someone to take on all this paperwork along with just trying to keep the service going and EMT's from burning out. When paperwork and regulations are compounding the volunteers time, I fear services will drop, and is that the best care for the community-to call an ambulance from 20 miles away or farther? Could that set us back to vehicle transport of 40 years ago rather than wait? We now have "Standard of Care" "Scope of practice" State "Protocols" for each level to follow in order to provide the best patient care possible for the community. I need some help understanding what will be different under these rules. Where are EMT's failing at providing quality care and which of these will guarantee an improvement in this care. I am totally into the best patient care possible, so if this will improve than, each county does need paid boards to oversee the EMS system, through taxes as the Bureau is supportd. I appreciate all the effort put into studying the problems in EMS and trying to solve them. Local, County, EMS control may be the answer, it seems. What will the state Bureau's role be in EMS then? Thank You for putting this proposal out for examination. I am also sure that as a small town EMS provider, I don't fully understand everything in this document either, which may be another issue. I look forward to further comments on County EMS Systems.

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Wapello county did discuss this at Local Emergency Planning commission and then again at our Wapello County EMS Association in July/August. There does not seem be much support for the document, by elected officials or volunteers that are EMS or Fire providers in our area. We do realize that goal is to move EMS forward in Iowa, and understand this will take some thinking outside the box, which may be uncomfortable. At this time, there are too many problems with the document with the biggest concern involving elected officials "county" and a funding source.
The system standards as they read will eliminate most volunteers in our area who currently do s good job and provide the public and their community with the EMS service.
Wapello county supervisors made the EMS funding go away when the TB sanitarium (which was designated as the county hospital and later a nursing home) was closed. The only hospital in the county is private, and had taken in the ALS ambulance service. ORMICS does not get any tax funding from city or county. We serve as the "mother ship" for our volunteers. We are all members of the community where we live and have a vested interest in the future of this document.

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On the positive, many of the line items have good intent for EMS or services are already doing them successfully. I commend the efforts of the EMS stakeholder group on this tough project!
Why are we not assessing our state's current systems, county be county to see best practices? We need to spend more time making EMS work in Iowa, then regulating it to disfunctionality! This entire concept will be money driven if it is to be successful.

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Van Buren County Hospital personnel have met several times over the proposed EMS System Standards. The committee member are Lisa Schnedler-Administrator of Van Buren County Hospital, Doug DeHart-Assistant Hospital Administrator and Ambulance Director, Dr. Blair-Chief of Staff, Maureen Sedlacek-Director of Nursing, and Tim springsteen-Assistan Director of the Ambulance. These comments reflect the thoughts and feelings of the entire group. We didn't have a comment on every section, so we have them listed in order of the draft we were working with at this time.
We, as a group, thin that this is a good attempt, and a necessary one, at developing a congruent EMS System throughout the state. On a whole, we liked most of the document. Some things need clarification and others need stronger language. We appreciate the chance to review and give comments on this very important first step to a better EMS System for the State of Iowa.

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I know that there are good ideas in the document and there are good goals that could possibly be achieved. However, simply listing ideas and not providing funding for them seems to set many communities up for failure. Many people in my town and those that surround it provide EMS to help others and provide a service for our community. Many of the ideas listed in this document give me the impression that the volunteer services are going to have a difficult time surviving and meeting the proposed standards. Many of the items listed in this document are administrative functions and funding to pay someone was not mentioned. I hope that the committee will not pass a document filled with unfunded mandates.

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At this time, neither the local squads and/or PCEMSA have the funding, staff or time to implement the Proposed System Standards. We recommend hiring a minimum of one full-time position (County EMS Director), with the possibility of a second employee, to complete the standards as proposed. All Iowa codes, Administrative Rules, Medical direction coordination, Protocols, Policies and Procedures, Staffing, Training, CQI, Data Collection, Reporting, and other various tasks from the current 8 squads will become the responsibilities of the County EMS Director. Even though many of the proposed standards are already being completed at the local and county level, each squad may have different procedures or protocols. It will be the responsibility of the County EMS Director to standardize procedures.
Several member of PCEMSA believe the Bureau of EMS should secure a funding mechanism prior to making mandates for Proposed System Standards. The Bureau of EMS is passing sown administrative and regulator responsibility to the county level. Funding should follow down from the state budget to offset the cost.

9-21-07

It looks as if you're establishing another layer of structure-has there been a funding source to cover these extra duties or created layer? I am a fan of keeping things simple and making sure we consider the customers both the external (patient) and the internal (responder). A balance will need to be struck to accomplish the committee's goals and I do not see a clear cut picture of what this going to look like in the EMS System Standards. Is the goal to duplicate your job efforts at the county level to ensure everything is being done that IDPH needs done to ensure standards of care?

I also see regionalization a possibility at least in a more rural area.

You will see resistance in E 9-1-1 boards and the county sheriff's office-two things come to mind:

1. Representatives are from taxing entities and the sheriff is the ultimate authority of the county.
2. Bi-laws/Constitutions will need to have restructuring to allow a specific EMS representation and them you'll see request from other agencies i.e. fire, health and who ever else has an organization.

Bottom line is this will need to be funded as some level to even have a ghost's chance at working.

Respectfully,

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While standards are very useful in giving direction to better the EMS services, the mandate to utilize a county system seems inappropriate. Similar to the National Fire Protection Agency standards for the Fire Service it would be useful to have Iowa EMS Standards for all EMS services to aspire to.

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I would like to take this opportunity to respond to the proposed draft of the "Iowa EMS System Standards" as proposed by the Emergency Medical Services Advisory Council (EMSAC).

I realize the IDPH goal is to standardize emergency care state-wide. The benefits listed in the overview are credible and in my opinion are being accomplished on an on-going basis. The concern I have is the transformation from, as in our in Plymouth County, a municipal service to a county service. I feel the major benefactor would be the Bureau of EMS at the expense of the counties. Currently, we serve the City of Le Mars and the surrounding area in a compliant and efficient manor. With some of the changes proposed, I feel we would lose some of the efficiencies and would increase the costs to the tax payer whether the costs were passed on through the state or county level.

A further concern of mine is staffing. Currently our service is fully staffed by 14 EMTs of which the average years on our crew is 18 years. By shifting control to a county level, I feel we could lose, at a minimum, of 1/3 of our staff. As you are well aware, recruitment efforts are becoming more difficult as time moves forward.

I feel strongly that if the current system is not broke, don't fix it. We in Plymouth County, as individual municipal services, are servicing the public well. By implementing

the proposed standards, you may create efficiencies on a state. Level, but would create larger problems on the local level with increased costs, loss of volunteers, and would add yet another level of bureaucracy.
Thank you for allowing me to express my concerns regarding this matter.

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I am a full time employee of Long Lines in Sgt. Bluff, am a husband and father of a 3 month old baby boy, have made 120 runs and 24 trainings at our station for a grand total of 252 hours of runs and training this year. Not to mention completing FFII during the year as well. THIS is why we feel so strongly about adding work to the shoulders of the volunteers in our communities… They are already doing their part!
In conclusion as a volunteer, you are creating a huge workload for departments that do not have the appropriate funding to complete all of this. Thank you,

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The Clay County Emergency Medical Services Association (CCEMSA) would like to thank the committee for the time they have spent preparing this document. We appreciate your efforts and commitment to promoting and protecting the health of Iowans through EMS. CCEMSA spent a considerable amount of time reviewing this document and this letter is based on comments form EMS Advisory Council, EMS Services, Clay County Board of Supervisors, Clay County Board of Health, E-911 Board, Clay County Fire Chiefs Association, and the Clay County Department Heads which includes the Clay County Sheriff and the Clay County Emergency Manager.
Conceptually the idea of providing the same level of care for all citizens of Iowa is a good one, however, may not e obtainable. Same level of care would require same level of training and more importantly same level of funding. Rural Iowa does not have the population to support this concept. It is unrealistic to think you are going to have the same training opportunities and the same level of funding in the rural area as you would in the urban area.
It is our understanding that while developing the minimum Iowa EMS System Standards the stakeholder group used some guiding principles, including clear, concise language that is easily understood by both the EMS/health care community and the general public. In reviewing this document we struggled with the intent, each person interpreted the information differently. It is unclear what is a suggestion and what is a mandate. If your premise for implementing and utilizing the Iowa EMS System Standards are to create an "inclusive system" where all EMS providers, service programs and other health care professionals are consistent and meet performance expectations to assure high quality patient care, this document will need to considerably revised.
Futhermore, there was some confusion if regards to how these standards will be implemented. Can the Bureau adopt these standards without legislative review?
Finally, will there be a stakeholders group that identifies "What every EMS System can expect from the Bureau of EMS"?
Thank you again for considering our comments and if you have any questions regarding our remarks, please feel free to contact me

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RE: Comments on EMS System Standards Overview

In accordance with Iowa Code Chapter 25B, better know as the "State Mandate Act", your item 1.01 System Administration: County EMS Structure states, " by any means available. I find this unacceptable. Should "the county" have requirements or mandates by the State of Iowa? A financial stream, from the state to the county, must be clearly identified. This is again repeated in section 1.14 system Finances: Funding Mechanism states the MINIMUM STANDARD: Each county EMS system shall identify funding mechanisms that are sufficient to ensure its continued operation and shall maximize use of its fiscal resources. In many areas of this plan it speaks to research, planning, training, staffing, resources, reviewing, monitoring, developing policy and procedures, all of which take time and money to complete. Without adequate support from the State of Iowa it is impossible for local government to comply.

Other areas of this plan speak to Continuous Quality Improvement, protocol development, reviews and other items that currently are completed by the Bureau of EMS. If local government takes on this responsibility, what impacts will that have on the staffing of the Bureau of EMS?

Is this a system to truly help the citizens of Iowa or is it a system that pushes the states workload and/or initiates new additional state "requirements" on an already overburdened local tax base? These are, as this document reads unfunded mandates. Until these items can be further defined and an adequate funding stream from the State of Iowa identified I must strongly oppose this initiative.

I look at the list you provided of benefits of implementing and utilizing the Iowa EMS System Standards. I must disagree with many of you points as "benefits'. Pushing unfunded mandates down to the county level in no way will not strengthen nor is it "proactive initiatives". It is simply adding another burden at the local level. This will likely prove to be a step back in EMS if our small rural populations must fund, support and await a transporting unit from a "regional" or big city. Our local volunteers cannot and will not meet these standards. You are setting them up to fail.

The term used throughout this document as the "county" must be clearly identified and assigned to a specific function of local government. I would highly advise the Iowa Department of Public Health, Bureau of EMS bring in more stakeholders to review this process. The elected officials need to be aware of the burden you intend to push down to "the county" level. I request you engage with Iowa Association of Counties (ISAC) and invite the Board of Supervisors Association. I would further suggest you also engage in your planning the Iowa League of Cities and request representatives from city government to be aware of your intent.

With the above items said, I support EMS in the state of Iowa. I have been certified in EMS for 30 years. I want to see EMS advance in Iowa, but not on the back of local government. I must be a partnership not a dictatorship. We continue to need our small volunteer departments to serve our citizens in a timely manner. It would seem to me, if you truly wanted a "regional" concept to mature in Iowa, the State should retain the current and increase their support across their regions to assure equal and fair guidance

across the state. Pushing the responsibility to the local level " the county" will like find 99 different ways of doing business for EMS.
Thank you for the opportunity to comment. I will keep in touch and eagerly watch the process as the EMS field grow and changes in the future.