

# **EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE**

**Friday, February 9, 2007, 9:00 AM**

## **BOARD OF MEDICAL EXAMINERS**

1500 SW 1st Ave, Suite 620

Portland, Oregon 97201

*Board Accepted 4/13/07*

*Pending Committee Approval*

### **MEMBERS PRESENT**

Paul S. Rostykus, MD, Chair

Toni R. Grimes, EMT-P

Rose Howe, EMT-I

Dave Lapof, EMT-B

### **MEMBER ABSENT**

Gregory Lorts, MD

### **STAFF PRESENT:**

Kathleen Haley, Executive Director

Diana Dolstra, Licensing Manager

### **GUESTS**

Peggy Andrews, Chemeketa Community College

Jon P. Cloutier, ZOLL

Tina Greiner, OVFA

Michael Heffner, Salem Fire

Grant Higginson, MD, DHS PHD EMS/TS

Randy Jackson, Keizer Fire District

Karl Koenig, Clackamas Co. Fire District

Gregg Lander, Chemeketa Community College

Gary McLean, ECCEMS, OSPA

### **AGENDA**

Approve minutes of the December 8, 2006 EMT Advisory Committee meeting

EMS Office Update & Senate Bill 162 – Grant Higginson, MD, MPH, Acting Director of EMS & Trauma

Final review of OAR 847-035-0030 Scope of Practice

Adds physician assistants to the health care providers that can sign a life-sustaining treatment order & allows EMT-Bs to administer atropine chloride & pralidoxime chloride by autoinjector in the event of a release of organophosphate agents.

National Association of EMS Physicians – Annual Meeting – Report from Paul Rostykus, MD

Supervising Physician Forum report – Paul Rostykus, MD

National (NHTSA) EMS Scope of Practice Model – Paul Rostykus, MD

Request change EMT-I scope of practice from morphine to opioids

Other business

Future meeting dates: Tentatively scheduled for: May 11, 2007 and August 24, 2007

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Paul Rostykus, MD, Chair, called the meeting to order at 9:00 AM.

**APPROVE MINUTES OF THE DECEMBER 8, 2006 EMT ADVISORY COMMITTEE MEETING**

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE DECEMBER 8, 2006 EMT ADVISORY COMMITTEE MEETING.**

**Motion passed unanimously.**

**EMS OFFICE UPDATE & SENATE BILL 162**

**EXHIBIT A**

Grant Higginson, MD, MPH, Department of Human Services, Acting Director of Emergency Medical Services & Trauma Systems, introduced himself. He reported that DHS-EMS is in the process of recruiting for a half-time Medical Director position and scheduling an interview. He indicated he is trying to include all the stakeholders in the interview process. He reported that DMS-EMS is also recruiting for and already has about ten applicants who qualify for the EMS Director position.

Dr. Higginson reported that the administrative rules (OAR 250 and OAR 255) that deal with ambulance agencies and the ambulances themselves were adopted and the rules were filed with the Secretary of State on February 1, 2007. He added that changes to OAR 265, which deal with EMTs, have not made any more progress as of yet because of his own schedule.

For the discussion of Senate Bill 162, Dr. Higginson provided a breakdown by Section of the most important components of the bill, and went through the most important Sections. Dr. Higginson referenced the letter that Dr. Rostykus, as Chair of the EMT Advisory Committee, had sent to him voicing some concerns the Committee members had with SB 162 and asking for some clarification of the proposed structure within DHS-EMS. Dr. Higginson also referenced his response to Dr. Rostykus' letter.

In response to Dr. Rostykus' question: "Is the expansion of responsibilities and authorities for the EMS and Trauma system program at the State going too far?," Dr. Higginson said that the way he read the NHTSA reassessment and Advisory Team report is that there really is a need for a more active leadership role in creating comprehensive systems not only for trauma but for the EMS prehospital side as well. He explained there are no plans for taking over regulatory responsibility for

either prevention or rehabilitation activities within a hospital, but he does think in order to create systems they need broader language than they have now.

Dr. Higginson explained that there are two sets of definitions because there are two different statutes, ORS 431 Public Health and Safety and ORS 682 Ambulances and Emergency Medical Personnel. He indicated he is aware that there are some inconsistencies that need to be cleared up, such as throughout SB 162 “supervising physician” needs to be changed to “local agency EMS Medical Director.”

Dr. Rostykus’ letter asked for more information on committee relationships, term limits, and a request for a chart which shows the relationships of the committees.

Dr. Higginson said that the question has been asked of who should be the Executive Director of the Board of Emergency Medical Responders? There has been a suggestion that it be the EMS Medical Director rather than the EMS Director. Dr. Higginson pointed out that the Medical Director position is a half time technical position that will be needed for medical expertise and relation-building with local EMS directors. He said he feels that as the EMS Director is a full-time administrative-manager position it is a better match for this position.

Dr. Rostykus said that the EMT Advisory Committee felt that the Executive Director of the Board of Emergency Medical Responders should be filled by a different person than the EMS Medical Director. The Committee felt there should be a dialogue between the Executive Director of the Board and the EMS Medical Director over issues and decisions.

Dr. Higginson said there should be dialogue, but when the Board decides to take disciplinary action or change rules, it is nice to have dialogue but it is ultimately the Board’s decision, not the decision of the EMS Medical Director. Dr. Higginson said that there had been discussion with Legislative Council about creating a truly independent board like the Board of Medical Examiners or Board of Nursing, but the Legislative Council recommended not doing that because it did not think this idea had a chance of passing this Session. As a result the bill was written with the board staffed within the office of DHS-EMS but still as an autonomous, independently functioning board.

Dr. Higginson indicated there is a \$1 million policy enhancement package in the Governor’s recommended budget that will be funding the changes outlined in SB 162. Dr. Higginson said he has not heard whether the Legislative fiscal analyst will support this large a budget package for this bill. Dr. Higginson said he will be providing descriptions of all the new positions that are a part of the SB 162 budget package as Dr. Rostykus requested, and that the descriptions will help give a better idea of what these new positions will be doing in the new DHS-EMS that is the vision of SB 162.

Dr. Higginson said he realized that amendments will be needed in the bill and that he has been working with various groups to obtain their input so as to gain consensus. He indicated he has heard that most people generally support the bill but that details need to be changed before they would be totally behind it.

## **FINAL REVIEW OF OAR 847-035-0030 SCOPE OF PRACTICE**

## **EXHIBIT B**

It was summarized that first part of the rule adds physician assistants to the list of health care providers who may execute a life-sustaining treatment order honored by a First Responder or EMT. The second change is in the language of the EMT-Basic scope of practice to allow EMT-Bs to administer atropine sulfate and pralidoxime chloride by autoinjector in the event of a release of organophosphate agents after completing DHS-EMS training and using protocols approved by DHS-

EMS and adopted by their supervising physician. The change in rule eliminates the need for a direct verbal order from the supervising physician or the need to be under the direction of an EMT-P on the scene. This new language allows EMT-Bs to use Chempacks.

Dr. Higginson said that protocols for EMT-Bs to administer atropine sulfate and pralidoxime chloride by autoinjector should be sent to DHS-EMS and he will approve them.

Dr. Rostykus said that there is training available to EMT-Bs through the Chempack program. There is already a requirement for EMT-Bs to obtain DHS-EMS-approved training and use DHS-EMS approved protocols to administer these two drugs at the Umatilla Army Depot, so this is already in place.

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS ADOPT RULE CHANGES IN THE EMT-BASIC SCOPE OF PRACTICE TO ALLOW "AUTOINJECTION" OF DRUGS IN RESPONSE TO A RELEASE OF "ORGANOPHOSPHATE AGENTS" USING PROTOCOLS APPROVED BY DHS-EMS AND ADOPTED BY THE SUPERVISING PHYSICIAN, AND REMOVING THE REQUIREMENT THAT EITHER THE SUPERVISING PHYSICIAN PROVIDE THE EMT-BASIC WITH A DIRECT VERBAL ORDER OR THAT THE EMT-BASIC BE UNDER THE DIRECTION OF AN EMT-PARAMEDIC ON THE SCENE.**

**Motion approved unanimously.**

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS ADOPT RULE CHANGES IN OAR 847-035-0030 (5) THAT ADD PHYSICIAN ASSISTANTS TO THE HEALTH CARE PROVIDERS THAT CAN SIGN A LIFE-SUSTAINING TREATMENT ORDER.**

**Motion approved unanimously.**

## **NATIONAL ASSOCIATION OF EMS PHYSICIANS – ANNUAL MEETING      EXHIBIT C**

Dr. Rostykus gave a brief description of this annual meeting of the National Association of EMS Physicians. He said that four Oregon supervising physicians attended. He indicated that three days before the conference the National Association of EMS Physicians Directors Course and Practicum is held where supervising physicians learn what kind of things are involved in being an EMS Medical Director. Dr. Rostykus said he did this course about 10-12 years ago, and he thought it was very valuable. He said he would encourage all supervising physicians to take the course.

Dr. Rostykus provided a brief summary of the topics covered by this three day meeting.

## **SUPERVISING PHYSICIAN FORUM REPORT**

## **EXHIBIT D**

Dr. Rostykus reported that the Supervising Physician Forum meets twice a year and the last meeting was on January 29, 2007 at Sunriver. Dr. Rostykus discussed ways of attracting more attendance, which might include holding the meeting in a more central location in the state. He encouraged EMTs to get their supervising physician signed-up to attend this semi-annual meeting. He

said that out of the 140 or so supervising physicians in Oregon he has only 20 on his supervising physician e-mail list. He reported that there is another forum on September 21, 2007 at the EMS Conference in Bend, and there will be an invitation to EMT training officers to take part in joint discussions and case presentations.

Dr. Rostykus briefly went over the agenda of the January 29, 2007 meeting. A member of the public asked whether Dr. Rob Vissers' talk on EMS Airway Management reflects the same issues as at the national level. Dr. Rostykus responded that Dr. Vissers considers himself an airway expert, but he clearly states he is not a prehospital expert. Dr. Rostykus said that Dr. Vissers noted that the difficulty for ER physicians, let alone for EMTs, is getting the training. Dr. Rostykus said other problems include recurrent training and the frequency of training in order to be adequately trained.

Dr. Rostykus said that during the same talk on EMS Airway Management, Dr. Vissers was asked how EMTs get initial training and follow-up training on surgical cricothyrotomies. Dr. Vissers responded that Residents get to perform two to six cricothyrotomies during their training and EMTs probably do not get any in their training.

Peggy Andrews said that training on performing a surgical cricothyrotomy is being added to the EMT-P curriculum, but after the training is completed the EMT is probably never going to perform one. She summarized that the problem is maintaining the skill once the initial training has been accomplished.

## **NATIONAL (NHTSA) EMS SCOPE OF PRACTICE MODEL**

## **EXHIBIT E**

Dr. Rostykus created a table comparing Oregon's EMT scope of practice to the National levels. Dr. Rostykus did this mostly for information. He said the question is whether there might be questions on the National exam that our EMT-Basics may not have been exposed to, which may be only MAST (Military Anti-Shock Trousers) pants.

Gregg Lander said that there are things that are not in the Oregon scope of practice that educators teach in classes, and this comparison of the Oregon scope of practice versus the proposed National minimum skills is very helpful to the educators in reviewing their classes. It was decided that the EMT Advisory Committee will hear back from the Oregon EMT Education Consortium at a future meeting.

## **REQUEST CHANGE EMT-I SCOPE OF PRACTICE FROM MORPHINE TO OPIOIDS**

Ritu Sahni, MD, an EMT supervising physician in Lake Oswego, spoke about this at the last meeting of the EMT Advisory Committee. In an e-mail to Dr. Rostykus, Dr. Sahni said that the tri-county area (Clackamas, Multnomah and Washington counties) switched to fentanyl as the primary pain medication, but the EMT-I can only give morphine under the current scope. Some agencies are carrying both drugs, with potential drug issues. Many agencies would prefer the general term "opioids" rather than "morphine." A letter from Ethan Wilson, MD, a supervising physician from Corvallis, recommends EMT-Is be able to administer all opioids, including synthetics.

Dr. Rostykus felt there were three issues: adding fentanyl to the EMT I scope of practice; possibly rewriting the EMT-I scope of practice, which is currently written with categories of drugs and then specific drugs; and determining where are we in the new EMT-I scope of practice and when we want to consider making changes to it. The agreement when the EMT-I curriculum was changed was to leave it alone for a couple of years to give it a chance to mature and see how it went and then consider changes.

Toni Grimes moved and it was seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS APPROVE THE ADDITION OF FENTANYL TO THE EMT-INTERMEDIATE SCOPE OF PRACTICE.**

Dave Lapof said that people are requesting to add one drug now, and wondered if another one comes along will the Committee add another drug? He said he understood there was to be a period when the Intermediate scope of practice remained the same so that it could be assessed as to whether it was working.

Toni Grimes said she liked the idea of adding fentanyl because the Paramedics use it. She wants to move this forward more quickly because she worries that there are patients that may be going without pain medication because the EMTs that respond first to a call may wait until the paramedics arrive to administer fentanyl.

Karl Koenig proposed the use of the term “opioid” instead of specific drugs as the term covers both drugs; most agencies are hybrid between morphine and fentanyl; and training for one pain medication is similar to training for other pain medications.

Dr. Rostykus said that fentanyl takes effect quicker, doesn’t last as long, probably results in less hypotension, is a more potent drug, but its biggest drawback is its potential for abuse.

Peggy Andrews said that she is not opposed to adding fentanyl because she has heard quite a few requests for it while she has been teaching the bridge classes. She added that, however, when the new Intermediate scope of practice was implemented about a year ago it was agreed that there would be no changes for a two-year period so that the Committee could look at what needed to be fixed. She said if there are deletions and additions during the two years it will be impossible to know what to change.

Dr. Rostykus also said that fentanyl and morphine are so much alike he not sure of the contraindications of giving one after the other has been given, except for what the protocols say.

Gregg Lander said that the request to add fentanyl should be based on evidence that patients are not receiving pain medication specifically because EMT-Is can administer morphine but not fentanyl.

Gary McLean asked what will be the process of evaluation of the Intermediate scope of practice at the end of the two years. He asked when it is going to start; whose responsibility it is to evaluate the new scope of practice; and how long it will take to get the results.

Peggy Andrews said the Curriculum committee will reconvene this fall and will evaluate issues that came up from people who attended the upgrade classes; plan on surveying the agencies and ask how many times the skills or medications were used and are there elements that should be added that are not there. She said she would hope to have this process complete by the end of this year.

Dr. Rostykus recommended the Committee should gather some information specifically on whether fentanyl is better than morphine; is this an issue in the agencies; and how often are patients not getting appropriate care?

Toni Grimes moved to amend the motion and Dave Lapof seconded that

**THE EMT ADVISORY COMMITTEE WILL GATHER MORE INFORMATION REGARDING THE ISSUE OF ADDING FENTANYL TO THE EMT-INTERMEDIATE SCOPE OF PRACTICE AND PATIENT CARE ISSUES AND BRING THIS TOPIC BACK FOR DISCUSSION AT THE NEXT COMMITTEE MEETING.**

**Motion carried unanimously.**

**ACTION PLAN: The Committee to gather more information regarding adding fentanyl to the EMT-Basic scope of practice. Rose Howe will contact some emergency agencies in Eastern Oregon. Dr. Rostykus will talk to Dr. Sahni and Dr. Wilson and invite them to the Next Committee meeting or have them provide information to the Committee.**

### **FUTURE MEETING DATES**

The next meetings of the EMT Advisory Committee are scheduled for May 11, 2007 and August 24, 2007.

### **ADJOURNMENT**

There being no further business to discuss, the meeting was adjourned at 11 AM.

**Description of SB 162 - EMS/Trauma Systems Bill  
February 2007**

Section 2, (starting page 1), re-writes the general duties of the EMS/TS program; making them more specific. It increases the scope of authority to cover all providers and vehicles. It requires the development of a comprehensive state EMS plan that focuses on systems of care for life-threatening illness and injury. It requires robust data systems linked to quality improvement. It maintains the EMS Director position and requires medical direction (EMS Medical Director, subsection 5, page 3).

Section 4, (starting page 3), is a set of definitions. There previously were none and legislative counsel felt it was important to develop them.

Sections 5-9, (starting page 5), creates a Critical Illness and Serious Injury Steering Committee. It is an umbrella advisory committee with defined, substantive responsibilities. The state EMS Committee and STAB are subcommittees of this steering committee, and both have defined authorities including involvement in quality improvement. Both committees are represented on the umbrella Steering Committee. The state EMS for Children committee and other medical specialty committees (as needed) are also noted as subcommittees. This concept has been discussed with STAB and the state EMS Committee, however, the Steering Committee and its relationship with existing advisory committees remains somewhat contentious.

Sections 10-11, (starting page 8), mandate a comprehensive reporting and data management system. The reporting system for trauma remains mandatory. While a comprehensive prehospital reporting system is required, reporting is voluntary at this time. The issues of access to data and confidentiality of data are addressed. The need for data analysis and its link to quality improvement are specified.

Section 12, (starting page 10), allows for enhanced reimbursement to providers subject to the availability of funds (this ability already exists in statute).

Sections 15-18, (starting page 10), creates a Board of Emergency Responders similar to other health professional boards. Members are Governor appointed. The EMS Director serves as Executive Director and EMS/TS program staff provides support for the Board. Scope of practice determination remains with the BME and teaching institute accreditation is still a responsibility of the Department of Education.

Sections 19-37, (starting page 12), are housekeeping changes.

Sections 39-46, (starting page 26), creates an EMS Strike Team capability. Similar to Conflagration Act for fire service, this provision allows the Governor to deploy EMS personnel and equipment during a declared emergency. The Department of Human Services (EMS/TS program) is responsible for planning and implementation if needed. Payment for deployments and liability are covered.

There is a related program enhancement package of approximately \$1 million per year in the Governor's Recommended Budget (tobacco fee increase dollars).

**OREGON ADMINISTRATIVE RULES**

**CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS**

**PROPOSED RULES CHANGES – APRIL 2007**

**FINAL REVIEW BY THE BOARD**

The proposed rule 1) adds physician assistants to the health care providers who can sign a life-sustaining treatment order; and 2) replaces the term “chemical agents” with the term “organophosphate agents” and removes the requirement that either the supervising physician provide the EMT-Basic with a direct verbal order or that the EMT-Basic be under the direction of an EMT-Paramedic on the scene when an EMT-Basic administers atropine sulfate and pralidoxime chloride by autoinjector.

**847-035-0030**

**Scope of Practice**

(1) The Board of Medical Examiners has established a scope of practice for emergency and nonemergency care for First Responders and EMTs. First Responders and EMTs may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001 (5).

(2) The scope of practice for First Responders and EMTs is not intended as statewide standing orders or protocols. The scope of practice is the maximum functions which may be assigned to a First Responder or EMT by a Board-approved supervising physician.

(3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.

(4) Standing orders for an individual EMT may be requested by the Board or Section and shall be furnished upon request.

(5) No EMT may function without assigned standing orders issued by Board-approved supervising physician.

(6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician, ~~or a~~ nurse practitioner~~;~~ **or physician assistant** if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

(7) The scope of practice for emergency and nonemergency care established by the Board for First Responders is intended as authorization for performance of procedures by First Responders without direction from a Board-

approved supervising physician, except as limited by subsection (2) of this rule. A First Responder may perform the following emergency care procedures without having signed standing orders from a supervising physician:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for soft tissue injuries;
- (g) Provide care for suspected fractures;
- (h) Assist with prehospital childbirth; and
- (i) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a

copy of that report to the senior EMT with the transporting ambulance.

(8) A First Responder may perform the following procedures only when the First Responder is providing emergency care as part of an agency which has a Board-approved supervising physician who has issued written standing orders to that First Responder authorizing the following:

- (a) Administration of medical oxygen;
- (b) Open and maintain an airway through the use of a nasopharyngeal and a noncuffed oropharyngeal and pharyngeal suctioning devices;
- (c) Operate a bag mask ventilation device with reservoir;
- (d) Provision of care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia; and
- (e) Administer epinephrine by automatic injection device for anaphylaxis;
- (f) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator, only when the First

Responder:

(A) Has successfully completed a Section- approved course of instruction in the use of the automatic or semi-automatic defibrillator; and

(B) Complies with the periodic requalification requirements for automatic or semi-automatic defibrillator as established by the Section.

(9) An Oregon-certified EMT-Basic may perform emergency and nonemergency procedures. Emergency care procedures shall be limited to the following basic life support procedures:

(a) Perform all procedures that an Oregon-certified First Responder can perform;

(b) Ventilate with a non-invasive positive pressure delivery device;

(c) Insert a cuffed pharyngeal airway device in the practice of airway maintenance. A cuffed pharyngeal airway device is:

(A) A single lumen airway device designed for blind insertion into the esophagus providing airway protection where the cuffed tube prevents gastric contents from entering the pharyngeal space; or

(B) A multi-lumen airway device designed to function either as the single lumen device when placed in the esophagus, or by insertion into the trachea where the distal cuff creates an endotracheal seal around the ventilatory tube preventing aspiration of gastric contents.

(d) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;

(e) Provide care for suspected shock, including the use of the pneumatic anti-shock garment;

(f) Provide care for suspected medical emergencies, including:

(A) Obtaining a capillary blood specimen for blood glucose monitoring;

(B) Administer epinephrine by subcutaneous injection or automatic injection device for anaphylaxis;

(C) Administer activated charcoal for poisonings; and

(D) Administer aspirin for suspected myocardial infarction.

(g) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator;

(h) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(i) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician;

(j) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(k) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician and that are in the possession of the patient at the time the EMT-Basic is summoned to assist that patient; and

(l) In the event of a release of military chemical warfare agents from the Umatilla Army Depot, the EMT-Basic who is a member or employee of an EMS agency serving the DOD-designated Immediate Response Zone who has completed a Section-approved training program may administer atropine sulfate and pralidoxime chloride from a Section-approved pre-loaded auto-injector device, and perform endotracheal intubation, using protocols promulgated by the Section and adopted by the supervising physician. 100% of EMT-Basic actions taken pursuant to this section shall be reported to the Section via a copy of the prehospital emergency care report and shall be

reviewed for appropriateness by Section staff and the Subcommittee on EMT Certification, Education and Discipline.

(m) In the event of a release of ~~chemical~~ **organophosphate** agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride **by autoinjector**, using protocols approved by the Section and adopted by the supervising physician. ~~[-if:~~

~~(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or~~

~~(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.]~~

(10) An Oregon-certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:

(a) Perform all procedures that an Oregon-certified EMT-Basic can perform;

(b) Initiate and maintain peripheral intravenous (I.V.) lines;

(c) Initiate and maintain an intraosseous infusion;

(d) Initiate saline or similar locks;

(e) Draw peripheral blood specimens;

(f) Administer the following medications under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician:

(A) Physiologic isotonic crystalloid solution.

(B) Vasoconstrictors:

(i) Epinephrine

(ii) Vasopressin;

(C) Antiarrhythmics:

(i) Atropine sulfate,

(ii) Lidocaine,

(iii) Amiodarone;

(D) Antidotes:

(i) Naloxone hydrochloride;

(E) Antihypoglycemics:

(i) Hypertonic glucose,

(ii) Glucagon;

(F) Vasodilators:

(i) Nitroglycerine;

(G) Nebulized bronchodilators:

(i) Albuterol,

(ii) Ipratropium bromide;

(H) Analgesics:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine;

(I) Antihistamine:

(i) Diphenhydramine;

(J) Diuretic:

(i) Furosemide;

(g) Administer immunizations in the event of an outbreak or epidemic as declared by the Governor of the state of Oregon, the State Public Health Officer or a county health officer, as part of an emergency immunization program, under the agency's supervising physician's standing order;

(h) Administer routine or emergency immunizations, as part of an EMS Agency's occupational health program, to the EMT's EMS agency personnel, under the supervising physician's standing order.

(i) Insert an orogastric tube;

(j) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for such maintenance have been provided by the physician, nurse practitioner or physician assistant at the sending medical facility;

(k) Initiate electrocardiographic monitoring and interpret presenting rhythm;

(l) Perform cardiac defibrillation with a manual defibrillator.

(11) An Oregon-certified EMT-Paramedic may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to:

(a) Perform all procedures that an Oregon-certified EMT-Intermediate can perform;

(b) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Tracheal suctioning techniques;

(C) Cricothyrotomy; and

(D) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway.

(c) Initiate a nasogastric tube;

(d) Provide advanced life support in the resuscitation of patients in cardiac arrest;

(e) Perform emergency cardioversion in the compromised patient;

(f) Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;

(g) Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;

(h) Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;

(i) Initiate placement of a urinary catheter for trauma patients in a prehospital setting who have received diuretics and where the transport time is greater than thirty minutes; and

(j) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician.

(12) The Board has delegated to the Section the following responsibilities for ensuring that these rules are adhered to:

(a) Designing the supervising physician and agent application;

(b) Approving a supervising physician or agent; and

(c) Investigating and disciplining any EMT or First Responder who violates their scope of practice.

(d) The Section shall provide copies of any supervising physician or agent applications and any EMT or First Responder disciplinary action reports to the Board upon their request.

(13) The Section shall immediately notify the Board when questions arise regarding the qualifications or responsibilities of the supervising physician or agent of the supervising physician.

National Association of EMS Physicians (NAEMSP)  
Annual Meeting, Naples, FL Jan. 11-13, 2007

NAEMSP Directors Course & Practicum

Protocols

- CPR - fast hard continuous
- STEMI to PCI center
- CHF - NTG, CPAP, ACEI, furosemide - Not morphine
- Alternate airways: Combitube, King LT, LMA

Equipment

- IO access - EZ-IO
- CPAP
- Alternate airways
- ECG transmission
- EMS data transmission
- E-charting

EMS System Development

- Cooperation with Public Health
- EMS equal to Fire & Law
- Emergency Preparedness: EMS at the table, EMS funding, Regionalization

Quality

- Aggregate data analysis
- Adverse event & near miss reporting
- e-PCR

Next year in Phoenix, January 10-13, 2008



**OREGON EMS  
SUPERVISING PHYSICIAN'S  
FORUM**



MONDAY, JANUARY 29, 2007

10:30 AM – 4:00 PM

**AGENDA**

- 10:00-10:30    REGISTRATION**
- 10:30-11:00    INTRODUCTIONS AND AGENDA**
- 11:00-12:00    NATIONAL ASSOCIATION EMS PHYSICIAN'S  
MEETING UPDATE & FUTURE OF THE SUPERVISING  
PHYSICIANS FORUM - PAUL ROSTYKUS, MD, MPH**
- WORKING LUNCH
- 12:00-13:00    OREGON EMS OFFICE UPDATE INCLUDING STATE  
EMS DIRECTOR MEDICAL DIRECTOR POSITION –  
GRANT HIGGINSON, MD, MPH**
- 13:00-13:45    SELECTIVE SPINAL IMMOBILIZATION  
DAVID GRANT, MD**
- 13:45-14:15    AEROMEDICAL UPDATE – RICK LINDQUIST, MD**
- 14:15-14:30    BREAK**
- 14:30-15:15    STEMI & CVA – AMERICAN HEART ASSOCIATION  
OREGON INITIATIVES –  
PAUL ROSTYKUS, MD, MPH & KRISTEN EILERS**
- 15:15-16:00    EMS AIRWAY MANAGEMENT – ROB VISSERS, MD**
- 16:00            ADJORN**

	Current Oregon EMT Scope of Practice				Proposed Minimum National Skills			
	<i>First Responder</i>	<i>EMT-B</i>	<i>EMT-I</i>	<i>EMT-P</i>	<i>EMR</i>	<i>EMT</i>	<i>AEMT</i>	<i>Paramedic</i>
Examinations	X	X	X	X				
Vital signs;	X	X	X	X	X	X	X	X
Noninvasive diagnostics	X	X	X	X		X		
Airway by positioning	X	X	X	X	X	X	X	X
CPR & and obstructed airway	X	X	X	X				
Soft tissue injury care	X	X	X	X	X	X	X	X
Suspected fracture care	X	X	X	X	X	X	X	X
Assist prehospital childbirth	X	X	X	X				
PCRf	X	X	X	X				
<b>If Supervising Physician</b>					<b>If Supervising Physician</b>			
Oxygen administration	X	X	X	X	X	X	X	X
Nasopharyngeal and a noncuffed oropharyngeal device	X	X	X	X	X	X	X	X
Pharyngeal suctioning	X	X	X	X	X	X	X	X
Operate a bag mask ventilation device with reservoir;	X	X	X	X	X	X	X	X
Oral glucose for hypoglycemia	X	X	X	X		X		
Epinephrine by autoinjector for anaphylaxis	X	X	X	X				
Automatic or semi-automatic defibrillation	X	X	X	X	X	X	X	X
Ventilate with a non-invasive positive pressure delivery device;		X	X	X				
Mechanical positive pressure ventilation						X	X	X
Cuffed pharyngeal airway device		X	X	X			X	X
Shock treatment (PASG)		X	X	X				
PASG for fracture splinting						X	X	X
CBG		X	X	X		X	X	X
Epinephrine SQ for anaphylaxis;		X	X	X				
Activated charcoal for poisonings		X	X	X		X	X	X
Aspirin for MI		X	X	X				
Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;		X	X	X				
Other emergency tasks as requested if under the direct visual supervision of a physician		X	X	X				
Assist patient with own sublingual NTG		X	X	X		X	X	X
Assist patient with own metered dose inhalers		X	X	X		X	X	X
Atropine & Pralidoxime by autoinjector		X	X	X	X	X	X	X

EMT Scope of Practice Oregon vs National Model

	Current Oregon EMT Scope of Practice			Proposed Minimum National Skills				
	<i>First Responder</i>	<i>EMT-B</i>	<i>EMT-I</i>	<i>EMT-P</i>	<i>EMR</i>	<i>EMT</i>	<i>AEMT</i>	<i>Paramedic</i>
IVs			X	X			X	X
IOs			X	X			X	X
Draw blood			X	X				X
Physiologic isotonic crystalloid solution.			X	X			X	X
Epinephrine;			X	X			X	X
Vasopressin;			X	X				X
Atropine sulfate;			X	X				X
Lidocaine;			X	X				X
Amiodarone;			X	X				X
Naloxone hydrochloride;			X	X			X	X
Hypertonic glucose;			X	X			X	X
Glucagon;			X	X			X	X
Nitroglycerine;			X	X			X	X
Albuterol;			X	X			X	X
Ipratropium bromide;			X	X				X
Morphine;			X	X				X
Nalbuphine Hydrochloride;			X	X				X
Ketorolac tromethamine;			X	X				X
Diphenhydramine;			X	X				X
Furosemide;			X	X				X
Nitrous oxide							X	X
OG tube			X	X				X
Maintain established IV meds			X	X				
Initiate & interpret ECG rhythm			X	X				
Manual defibrillation			X	X				X

## EMT Scope of Practice Oregon vs National Model

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Endotracheal intubation;				X				X
Tracheal suctioning				X			X	X
Percutaneous cricothyrotomy				X				X
Surgical cricothyrotomy				X				
Transtacheal jet insufflation				X				
NG				X				X
ALS care				X				
Emergency cardioversion				X				X
External transcutaneous pacing				X				X
Needle thoracentesis				X				X
Femoral intravenous line				X				
Access implanted central lines & indwelling catheters								
Urinary catheter				X				
Any medications or blood products under protocol				X				X
BiPAP/CPAP/PEEP								X
Capnography								X
12 lead ECG								X
Spinal immobilization						X	X	X
Morgan lens								X