

**EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE**

**Friday, March 10, 2006 at 9:00 AM**

***BOARD ACCEPTED 4/14/06***

***COMMITTEE APPROVED 6/2/06***

**BOARD OF MEDICAL EXAMINERS**

1500 SW 1st Ave, Suite 620

Portland, Oregon 97201

**MEMBERS PRESENT**

Paul S. Rostykus, MD, Chair

Toni R. Grimes, EMT-P

Rose Howe, EMT-I

Dave Lapof, EMT-B

Gregory Lorts, MD

**STAFF PRESENT:**

Kathleen Haley, Executive Director

Diana Dolstra, Licensing Manager

Jennifer Lannigan, Licensing Coordinator

**GUESTS**

Peggy Andrews, Chemeketa Community College

Shawn Baird, Woodburn Ambulance, Oregon State Ambulance Association

Tim Hennigan, DHS-EMS & Trauma

Kevin Henson, Turner Fire

Alan Hull, Estacada Fire

Randy Jackson, Keizer Fire District

Gregg Lander, Chemeketa Community College

Mark Liepold, Boring Fire

Brian Mahoney, Oregon State Public Health Emergency Preparedness

Gary McLean, EMT-P, OSPA

David Mull, American Medical Response (AMR)

John Praggastis, OSPA

Pontine Rosteck, AMR

Terri Schmidt, MD, OHSU, AMR

Eric Schult, Tualatin Valley Fire & Rescue (TVFR)

Mark Stevens, TVFR

John Stouffer, Gresham Fire

Lindsay Williams, Woodburn Ambulance

**AGENDA**

Welcome Rose Howe, EMT-I to the EMT Advisory Committee

Approve minutes of the December 9, 2005 EMT Advisory Committee meeting

EMT and physician Committee member term expiration June 30, 2006

Terminology for supervising physician – Paul Rostykus, MD and Tim Hennigan, DHS-EMS & Trauma

First responder update – Tim Hennigan, DHS-EMS & Trauma

Update from DHS-EMS on the review of their statutes (ORS) and rules (OAR) and recommendations – Tim Hennigan, DHS-EMS & Trauma

Clarification of airway terminology – Toni Grimes, EMT-P

Supervising Physician Forum report – Paul Rostykus, MD

Are dislocation reductions soft tissue care?

Discuss ability of EMTs to provide immunizations during a disaster – Paul Rostykus, MD

EMT-Intermediate scope of practice clarifications:

Use of epinephrine for non-anaphylaxis situations

Should EMT-Is have EKG interpretation in their scope of practice? – Paul Rostykus, MD

Chempacks – Paul Rostykus, MD

Other business:

Cryothyrotomies for EMT-Ps

EMT-I Bridge course/scope training clarifications

Future meeting date

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

**WELCOME ROSE HOWE, EMT-I TO THE EMT ADVISORY COMMITTEE**

Dr. Rostykus and the other Committee members welcomed Rose Howe, EMT-I to service on the EMT Advisory Committee. Ms. Howe practices in Monument, Oregon. She expressed her appreciation for being elected to serve on the Committee.

## **APPROVE MINUTES OF THE DECEMBER 9, 2005 EMT ADVISORY COMMITTEE MEETING**

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE ACCEPTS THE MINUTES OF THE DECEMBER 9, 2005 EMT ADVISORY COMMITTEE MEETING AS AMENDED.**

**Motion passed unanimously.**

### **EMT AND PHYSICIAN COMMITTEE MEMBER TERM EXPIRATION JUNE 30, 2006**

The current member terms for Paul Rostykus, MD, Chair, and Rose Howe, EMT-I, are due to expire on June 30, 2006. Dr. Rostykus is filling a physician member position, and Ms. Howe is filling an EMT member position. Dr. Rostykus is finishing his first term on the Committee, and he could pursue a second term if desired. Ms. Howe is completing a term vacated by John Herbold, EMT-I, and she could pursue two full terms if desired. It was determined that recruitment for both positions will be opened to the public.

**ACTION PLAN:** Board staff to send out recruitment notice for both positions to the public. EMT Committee to interview candidates at the June 2006 Committee meeting. New members to begin service on the Committee at the September 2006 meeting.

### **TERMINOLOGY FOR SUPERVISING PHYSICIAN**

Tim Hennigan, DHS-EMS & Trauma, reported that a legislative proposal has been submitted to change “supervising physician” to “EMS Medical Director” in ORS 682. He relayed that if this proposed legislation is adopted, EMS will be changing their administrative rules to reflect the change. He indicated that the definition of “EMS Medical Director” will specifically designate that individual shall be a physician. Paul Rostykus, MD, recommended it be made clear that the designation of physician means an MD or DO. Mr. Hennigan relayed that EMS would solicit input from the BME regarding this rule language as it is developed.

### **FIRST RESPONDER UPDATE**

Tim Hennigan, DHS-EMS & Trauma, reported that EMS has developed a workgroup to evaluate Oregon’s current First Responder program, including scope of practice issues. He referenced a summary sheet on the Oregon First Responder Program that included an introduction and history of the program, program status, assessment of program needs, and next steps. He indicated that this information and progress reports will be made available to stakeholders and the public on the EMS website. He also indicated that several stakeholders are involved in this process, including certified First Responders, training agencies, Oregon Fire Chiefs, Oregon Fire Medical Administrators, Oregon Volunteer Fire Fighters, Oregon Ambulance Association, educators, law enforcement and wilderness medical providers, and the BME.

Mr. Hennigan said the workgroup has met a few times in the past several months and that members were sent away with some action items. One of the action items was for the EMS office to come up with an estimated cost out to maintain the administrative process of monitoring, regulating, and enforcing First Responders. He indicated that the workgroup determined that the national standard curriculum should be utilized for First Responder training. Mr. Hennigan reported that he sent a survey to the National Council of State EMS Training Coordinators requesting information about their First Responder programs and has received survey information back. This feedback will be compiled and presented to the workgroup. He also relayed that EMS has partnered with Public Health Preparedness to incorporate public health preparedness training into the First Responder program, which will allow the First Responder program to qualify for some federal funding and thereby hold down costs to providers and agencies.

Mr. Hennigan said the next meeting of the workgroup is scheduled for April 12, 2006.

### **UPDATE FROM DHS-EMS ON THE REVIEW OF THEIR STATUTES (ORS) AND RULES (OAR) AND RECOMMENDATIONS**

Tim Hennigan, DHS-EMS & Trauma, reported that the EMS & Trauma Systems ORS and OAR revision workgroup met in late 2005 and provided proposed administrative rule language that is being further developed and will be returned to the work group to verify that the intent is accurately reflected in the proposed rules. He reported that, given the broad scope of the issue of continuing medical education and initial curriculum relating to EMT education and certification, it was decided that individuals who wish to focus specifically on these topics in the administrative rule revision process will come together to do so. Jeanne Arana, Director, DHS-EMS & Trauma, is facilitating this effort.

### **CLARIFICATION OF AIRWAY TERMINOLOGY**

### ***EXHIBIT A***

Toni Grimes, EMT-P, reported that, based on the current scope of practice, it could be interpreted that the laryngeal mask airway (LMA) falls under the category of cuffed pharyngeal airway device. She also specified that the Board has previously determined that the LMA is not an appropriate device to be used by EMT-Bs and EMT-Is.

Ms. Grimes presented a definition of a cuffed pharyngeal airway device as “1) 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 2) 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.” This definition will be used as a proposed revision to OAR 847-035-0030 (9)(c).

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS A CUFFED PHARYNGEAL AIRWAY DEVICE BE DEFINED AS ABOVE IN OAR 847-035-0030 (9)(c).**

**Motion passed unanimously.**

**ACTION PLAN:** Board staff to draft revision to OAR 847-035-0030 (9)(c) to include the above definition of a cuffed pharyngeal airway device, to reflect that first review of the rule revision has occurred.

## **SUPERVISING PHYSICIAN FORUM REPORT**

Paul Rostykus, MD, reported that a supervising physician forum was held in February 2006 at Sunriver as part of the Oregon College of Emergency Physicians (OCEP) conference. He said about 12 supervising physicians attended the forum, as well as Tim Hennigan, DHS-EMS & Trauma. Dr. Rostykus indicated that topics discussed at the forum included EMT-I scope of practice, standing orders, and the issue of potentially changing the term “supervising physician” to “EMS Medical Director” in statute and the administrative rules. It was discussed that there is not a current, accurate list of email contacts for Oregon supervising physicians. Tim Hennigan, DHS-EMS, indicated that efforts are ongoing to update such a list. Dr. Rostykus indicated that a next forum is being planned for September 22, 2006, as part of the Oregon DHS-EMS conference.

## **ARE DISLOCATION REDUCTIONS SOFT TISSUE CARE?**

Paul Rostykus, MD, relayed that the issue regarding whether dislocation reductions constitute soft tissue care may remain a gray area. Terri Schmidt, MD, EMT-P, OHSU, American Medical Response (AMR) Reach and Treat (RAT) Team, indicated that only EMT-Ps are doing dislocation reductions for the AMR RAT Team, although it is not a common occurrence. Paul Rostykus, MD, highlighted that it was the consensus of the Committee members that dislocation reductions constitute soft tissue care only in specific remote/wilderness settings and that only EMT-Ps shall perform dislocation reductions in specific remote/wilderness settings only with special training and protocols by supervising physicians.

## **DISCUSS ABILITY OF EMTs TO PROVIDE IMMUNIZATIONS DURING A DISASTER**

Shawn Baird, Woodburn Ambulance, Oregon State Ambulance Association (OSAA), addressed the issue of plans being developed simultaneously by multiple entities regarding the functions EMS will perform and how EMTs are to proceed in the event of a declared disaster. He requested that language be added to the administrative rules that would clarify that EMTs would function at the direction of the Public Health Director in the event of a state or federally declared disaster. He agreed to collaborate with the state EMS office to draft proposed language for OAR 847-035 to bring back for further consideration by the Committee at their next meeting. He indicated that the next state EMS Committee meeting is scheduled for June 2006.

**ACTION PLAN:** Shawn Baird, Woodburn Ambulance, OSAA, to bring proposed administrative rule language to the next BME EMT Advisory Committee meeting for further

discussion. Put the issue of EMTs providing immunizations during a disaster on the agenda of the next Committee meeting.

**EMT-INTERMEDIATE SCOPE OF PRACTICE CLARIFICATIONS:      *EXHIBIT A***

**USE OF EPINEPHRINE FOR NON-ANAPHYLAXIS SITUATIONS**

The Committee reached consensus that EMT-Is' use of epinephrine should not be restricted solely to anaphylaxis, as it is at the discretion of the supervising physician to decide when and how the EMT-I may use epinephrine, and conditions such as asthma and severe bronchospasm are covered in EMT-I training.

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS "1:10,000" BE STRICKEN FROM EPINEPHRINE IN OAR 847-035-0030 (10)(f)(B)(i).**

**Motion passed unanimously.**

**ACTION PLAN:** Board staff to draft revision to OAR 847-035-0030 (10)(f)(B)(i) to remove the specification of 1:10,000 from epinephrine under the EMT-I scope of practice, to reflect that first review of the rule revision has occurred.

**SHOULD EMT-Is HAVE EKG INTERPRETATION IN THEIR SCOPE OF PRACTICE?**

The Committee reached consensus that EKG interpretation should fall under the EMT-I scope of practice, as it is a given that EKG interpretation is required in order to administer antiarrhythmics and perform cardiac defibrillation with a manual defibrillator, which are already in the EMT-I scope of practice. In order to bring the administrative rules in line with this, it was agreed that "Initiate electrocardiographic monitoring and interpret presenting rhythm" would be moved from the EMT-P scope of practice in OAR 847-035-0030 (11) to the EMT-I scope of practice in OAR 847-035-0030 (10).

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS "INITIATE ELECTROCARDIOGRAPHIC MONITORING AND INTERPRET PRESENTING RHYTHM" BE MOVED FROM THE EMT-P SCOPE OF PRACTICE IN OAR 847-035-0030 (11) TO THE EMT-I SCOPE OF PRACTICE IN OAR 847-035-0030 (10).**

**Motion passed unanimously.**

**ACTION PLAN:** Board staff to draft revision to OAR 847-035-0030 to move EKG interpretation from the EMT-P scope of practice to the EMT-I scope of practice, to reflect that first review of the rule revision has occurred.

## **CHEMPACKS**

## **EXHIBIT B**

Paul Rostykus, MD, highlighted current administrative rule language regarding scope of practice in the event of a release of chemical agents, specifically that EMTs may administer atropine sulfate and pralidoxime chloride in the event of a release of chemical agents, using protocols approved by DHS-EMS & Trauma and adopted by the supervising physician.

Brian Mahoney, DHS-Public Health Emergency Preparedness Program, Strategic National Stockpile Coordinator, gave a presentation on the Chempack (*Exhibit B*). Highlights from his presentation include the following points: The Chempack is a cache of nerve agent antidotes that are being forward-placed in communities for availability to emergency health-care providers in the event of a release of nerve agents or organic phosphates. The Chempack is meant for mass casualties or emergency events. The Chempack is a federal program from the Centers for Disease Control and Prevention (CDC) that is being given to the states for free and is voluntary. There are two versions of the Chempack, one for use in EMS settings and one for use in hospitals. The sites where the Chempacks will be placed in Oregon have been selected and assessed for readiness to have the Chempack placed. Current plans for placement include eight hospital packs and 14 EMS packs, some of which will be placed in hospitals. Memorandums of agreement (voluntary) will be obtained from each site, and each site will write its own operational plan. Placement is slated to occur within the next few months.

It was discussed that the following issues may be relevant for the BME and the BME EMT Advisory Committee: training issues, scope of practice, administrative rules, and supervising physician and agency support. Gregory Lorts, MD, proposed that a minor language change could be made to the EMT-B scope of practice in OAR 847-035-0030 (9)(m), replacing “atropine sulfate and pralidoxime chloride” with “appropriate medications and antidotes” in order to allow EMTs to utilize the Chempacks, but it was agreed that no change would be formally recommended to the scope of practice concerning Chempacks at this meeting. Brian Mahoney clarified that the decision to use the Chempack will not always be preceded by a disaster declaration.

## **OTHER BUSINESS:**

### **CRICOTHYROTOMIES FOR EMT-Ps**

Kevin Henson, Turner Fire, addressed the issue of percutaneous versus surgical cricothyrotomies for EMT-Ps. He requested that the moderator of “percutaneous” for “cricothyrotomy” be stricken from the scope of practice for EMT-Ps in OAR 847-035-0030 (11)(b)(C) to allow EMT-Ps to perform surgical cricothyrotomies as well. Gregory Lorts, MD, recalled that when this issue was last addressed by the Board, perhaps a year or two ago, the Board determined that a surgical cricothyrotomy was too aggressive to be included in the EMT-P scope of practice. Mark Stevens, Tualatin Valley Fire & Rescue (TVFR), indicated that surgical cricothyrotomy has been a part of the EMT-P national curriculum for quite a while and that Washington state allows EMT-Ps to perform this procedure. Kevin Henson agreed to get data from other states regarding whether surgical cricothyrotomy is included in their EMT-P scopes

of practice. Pontine Rosteck, American Medical Response, agreed to bring back outcome data associated with this procedure being performed in Clark County, Washington. Eric Shult, TVFR, indicated that a paramedic is researching this issue currently and that a recent study indicated that surgical cricothyrotomy was superior to other devices in terms of success and ease of use. Tim Hennigan, DHS-EMS & Trauma, indicated he would send out an email survey to the National Council of State EMS Training Coordinators to see what information they can share, as well as check with the Area Trauma Advisory Board (ATAB).

**ACTION PLAN:** Members of the public to bring scope of practice and outcome data to support proposal to allow surgical cricothyrotomies for EMT-Ps back to the next EMT Advisory Committee meeting. Put the issue of cricothyrotomies for EMT-Ps on the agenda of the next Committee meeting.

### **EMT-I BRIDGE COURSE/SCOPE OF PRACTICE TRAINING CLARIFICATIONS**

Gary McLean, EMT-P, OSPA, requested that the BME EMT Committee clarify if the Committee is requiring all currently certified EMT-I's to take an upgrade class for the new EMT-I scope of practice and if the Committee is requiring all supervising physicians to use the DHS-EMS upgrade course to update the training of EMT-I's. The Committee clarified that it is the Committee's role to make recommendations to the BME regarding scope of practice, and that the Committee and BME had approved the EMT-I curriculum by adopting the curriculum into the scope of practice, but it is not the role of the Committee nor the Board with First Responders and EMTs to require training. It was discussed that questions regarding training and implementation requirements be directed to DHS-EMS & Trauma.

Tim Hennigan, DHS-EMS & Trauma, reported that all certified EMT-I's must complete a training course given by an individual who has completed the train-the-trainer Bridge course by June 30, 2008. He relayed that if a certified EMT-I fails to complete a training course by June 30, 2008, DHS-EMS will make that EMT-I's certification invalid. He also shared that DHS-EMS is strongly encouraging all supervising physicians to use the Bridge course materials to train their EMT-I's to maintain consistency and standards in training, but DHS-EMS will not be aware if a supervising physician chooses to alter that curriculum. Mr. Hennigan indicated that at least five Bridge courses will be offered in 2006, and Bridge courses are slated to be offered in 2007 as well. It was recommended that enhanced communication regarding the EMT-I training course requirements be disseminated from DHS-EMS & Trauma.

### **FUTURE MEETING DATE**

The next meeting date will be Friday, June 2, 2006 at 9:00 AM.

### **ADJOURNMENT**

There being no further business to discuss, the meeting was adjourned at 11:50 AM.

**OREGON ADMINISTRATIVE RULES**  
**CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS**  
**PROPOSED RULES CHANGES – APRIL 2006**  
**FIRST REVIEW BY THE BOARD**

**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, 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 agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, 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 [~~1:10,000~~];

(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) Insert an orogastric tube;

(h) 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;

**(i) Initiate electrocardiographic monitoring and interpret presenting rhythm;**

[~~(+)~~] **(j)** 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) Percutaneous 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) Initiate electrocardiographic monitoring and interpret presenting rhythm;~~]

[~~(e)~~] **(d)** Provide advanced life support in the resuscitation of patients in cardiac arrest;

[~~(f)~~] **(e)** Perform emergency cardioversion in the compromised patient;

~~[(g)]~~ **(f)** Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;

~~[(h)]~~ **(g)** Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;

~~[(i)]~~ **(h)** Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;

~~[(j)]~~ **(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

~~[(k)]~~ **(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.

*Board of Medical Examiners  
CHEMPACK Project Overview*

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Brian Mahoney, MPH  
Oregon State Public Health  
March 10, 2006

*Organizational Levels*

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- \*Federal: Centers for Disease Control and Prevention, Strategic National Stockpile owns the material
- \*State: Department of Human Services, Oregon State Public Health manages the project
- \*Local: Agencies and hospitals control the assets and decide when use is necessary


*Objectives*

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- \*Provide overview of CHEMPACK
- \*Obtain guidance for supporting EMTs

*EMS and Hospital Containers*

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*Purpose of Chempack*

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- \*Decrease morbidity and mortality from an intentional or accidental release of nerve agent or related compounds (organophosphates).
- \*Forward deployment of antidotes
- \*For use as emergency re-supply or for mass casualty incidents

*Storage*

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## *Contents*

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- \*Mark 1 auto injector
- \*Atropine
- \*Pralidoxime
- \*Atropen
- \*Diazepam
- \*Sterile Water
- \*Sensaphone



## *General Issues*

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- \*Site selection (19)
- \*Configuration (~8 Hospital and ~14 EMT)
- \*Memorandums of Agreement
- \*Local operational plan
- \*Site preparations and placement
- \*Funding and ongoing costs
- \*Replacement



## *EMS Scenario*

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- \*Local large exposure
- \*Hot, warm and cold zone
- \*Rescuers have some antidote
- \*Rescuers require more antidote
- \*Local cache operational plan implemented
- \*Controlled by DEA registrant



## *BME Issues*

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- \*Training
- \*Scope of Practice
- \*Oregon Administrative Rules
- \*Medical Directors' support
- \*Exercises



## *Hospital Scenario*

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- \*Large influx of victims
- \*Require immediate and long term care
- \*Local cache operational plan implemented
- \*Controlled by DEA registrant



## *CHEMPACK Questions?*

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