

**EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE**  
**Friday, February 1, 2008, 9:00 AM**

**OREGON MEDICAL BOARD**  
1500 SW 1<sup>st</sup> Ave Ste 620  
Portland, OR 97201

*Board Accepted 4/11/08*  
*Pending Committee Approval*

**MEMBERS PRESENT**

Paul S. Rostykus, MD, Chair  
Toni R. Grimes, EMT-P  
Rose Howe, EMT-I  
Dave Lapof, EMT-B  
Matt Eschelbach, DO

**STAFF PRESENT**

Diana Dolstra, Licensing Manager  
Jennifer Lannigan, Licensing Coordinator

**GUESTS**

Peggy Andrews, Chemeketa Community College  
Shawn Baird, Oregon State Ambulance Association  
Jonathan Chin, Washington County EMS  
Randy Jackson, Keizer Fire District, Oregon Fire Medical Administrators Association  
Gregg Lander, Chemeketa Community College, EMT Consortium  
Bob Leopold, DHS EMS & Trauma Systems  
John Phelps, ZOLL Medical  
Ritu Sahni, MD, DHS EMS & Trauma Systems  
Lynda Thomas, Monument Volunteer Ambulance

**AGENDA**

Approve minutes of the November 2, 2007 EMT Advisory Committee meeting

Final Review Administrative Rules: 847-035-0030 (10) – Administration of analgesics for acute pain in EMT-I scope

EMT-I curriculum, scope of practice update, and Bridge course review – Peggy Andrews, Chemeketa Community College

National EMS scope of practice – Ritu Sahni, MD, MPH and Bob Leopold, DHS EMS

Lidocaine by EMT-I's for intraosseous (IO) infusion in conscious patients – Scope of practice notes lidocaine as an antiarrhythmic

Discuss whether non-invasive monitoring includes acquiring and transmitting 12-lead ECGs

Development of a standardized approach for considering changes to the EMT scope of practice

EMT-P position on Committee – End of term June 30, 2008

Confirm dates of next Committee meetings

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Paul Rostykus, MD, Chair, called the meeting to order at 9:00 AM. He highlighted that the Board's name changed to the Oregon Medical Board (OMB) as of January 1, 2008.

#### **APPROVE MINUTES OF THE NOVEMBER 2, 2007 EMT ADVISORY COMMITTEE MEETING**

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE NOVEMBER 2, 2007 EMT ADVISORY COMMITTEE MEETING AS AMENDED.**

Motion passed unanimously.

#### **FINAL REVIEW ADMINISTRATIVE RULES: 847-035-0030 (10) – ADMINISTRATION OF ANALGESICS FOR ACUTE PAIN IN EMT-I SCOPE OF PRACTICE *EXHIBIT A***

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD ADOPT THE AMENDMENT TO 847-035-0030 (10) TO SPECIFY THE ADMINISTRATION OF ANALGESICS FOR ACUTE PAIN UNDER THE EMT-I SCOPE OF PRACTICE.**

Motion passed unanimously.

#### **EMT-I CURRICULUM, SCOPE OF PRACTICE UPDATE, AND BRIDGE COURSE REVIEW**

Peggy Andrews gave an update on the EMT-I curriculum, scope of practice, and Bridge course review. She reported that the EMT-I curriculum group reconvened in early January to review how things were going with curriculum implementation. The group included individuals who were on the original curriculum committee as well as instructors who have been teaching the new course. She reported that the consensus from the meeting was the curriculum was solid and did not need revision. She added that the group did agree the curriculum needs more hours (perhaps as many as 100 additional hours in addition to the current 144 hours) and recommended that schools add hours as they can to accommodate the curriculum. She said the additional hours would most likely be focused on anatomy and physiology as well as pharmacology. Ms. Andrews said that the group decided to do more surveys to assess how the curriculum is working, and that the plan is that Ritu Sahni, MD, EMS DHS, will develop and send out the surveys. She indicated that no changes will be made to the curriculum until the group can get more feedback through the surveys.

#### **NATIONAL EMS SCOPE OF PRACTICE *EXHIBIT B***

Ritu Sahni, MD, MPH, presented the vision of the National Highway Traffic Safety Administration (NHTSA) national EMS scope of practice and how it impacts EMS in Oregon (see *Exhibit B*). He highlighted that

NHTSA is currently working on national EMS education standards that are scheduled to be completed in September 2008; these standards will replace the current NHTSA curricula in 2010. Other components of the national agenda include national EMS education program accreditation and national EMS certification. Dr. Sahni reported that at the end of 2012 or beginning of 2013, at the paramedic level, only those students who have graduated from a nationally accredited educational program will be allowed to sit for the national certification examination. Dr. Sahni also pointed out the ramifications for states should those states decide to adopt a state scope of practice that differs significantly from the national EMS scope of practice or choose to implement educational standards that differ from the national standards (see *Exhibit B*).

Dr. Sahni said that DHS EMS plans to put together a workgroup in late Spring 2008 to look at what changes need to be made in Oregon's statutes, rules, regulations and curricula to prepare for the upcoming national scope and educational standards implementation. Dr. Sahni will serve as Chair of this workgroup, and Paul Rostykus, MD, will potentially serve as Co-Chair. Dr. Sahni indicated that input from the two EMS regulatory bodies – the Oregon Medical Board and DHS EMS & Trauma Systems – as well as major stakeholders throughout the state will be crucial to the success of this effort. He said the process is expected to take about 12 to 18 months, during which time the workgroup identifies what things need to change, whether to change them, and how to change them.

## **LIDOCAINE BY EMT-IS FOR INTRAOSSEOUS INFUSION IN CONSCIOUS PATIENTS**

*EXHIBIT C*

Paul Rostykus, MD, stated that EMT-Intermediates can use the EZ-IO (a device used to achieve vascular access for intraosseous infusion), and he indicated the recommended protocol for conscious patients with the EZ-IO is that they get intraosseous Lidocaine to help with pain. Dr. Rostykus also pointed out that EMT-IS can administer Lidocaine as an antiarrhythmic. So, Dr. Rostykus posed the question, can EMT-IS use Lidocaine for EZ-IOs? The Committee agreed that EMT-IS can use Lidocaine as an intraosseous infusion anesthetic.

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD AMEND OAR 847-035-0030 TO ADD THE ADMINISTRATION OF LIDOCAINE AS AN INTRAOSSEOUS INFUSION ANESTHETIC UNDER THE EMT-I SCOPE OF PRACTICE.**

**Motion passed unanimously.**

**ACTION PLAN:** Board staff to draft amendment to OAR 847-035-0030 (10) to add the administration of Lidocaine as an intraosseous infusion anesthetic under the EMT-I scope of practice, reflecting that first review of the rule amendment has occurred (see *Exhibit C*).

## **DISCUSS WHETHER NON-INVASIVE MONITORING INCLUDES ACQUIRING AND TRANSMITTING 12-LEAD ECGs**

Paul Rostykus, MD, asked the question, who can do 12-lead electrocardiograms (ECGs)? He indicated that currently First Responders can do non-invasive monitoring. So, he asked, is a 12-lead ECG that is transmitted, not interpreted, considered non-invasive monitoring? He said EMT-IS can initiate electrocardiographic monitoring and interpret presenting rhythm, which is different than interpreting ST elevation. He summarized that currently Paramedics are the only EMS providers who can interpret 12-leads, apart from a presenting rhythm.

Dave Lapof, EMT-B, stated that he has spoken with many stakeholders in the state about this issue, and he said the vast majority of them take the position that EMT-Bs should be able to acquire and transmit 12-leads.

The Committee determined that the EMT rules in OAR 847-035 currently cover acquisition and transmittal of 12-leads under non-invasive monitoring, and that no change to the rules is needed.

## **DEVELOPMENT OF A STANDARDIZED APPROACH FOR CONSIDERING CHANGES TO THE EMT SCOPE OF PRACTICE** **EXHIBIT D**

Paul Rostykus, MD, reminded the Committee and public in attendance that the Committee had previously formulated a list of questions to pose to any individual who may propose a change to the EMT scope of practice (see *Exhibit D*). The Committee requests that the individual proposing the change in scope provide answers to the questions for the EMT Committee's consideration during their discussion of the proposed change. Dr. Sahni requested that any proposed change to the EMT scope of practice submitted to the Board be forwarded to him at DHS EMS so that he can independently research the issue prior to the subsequent OMB EMT Committee meeting.

It was moved and seconded that

**THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD POST THE SCOPE OF PRACTICE CHANGE QUESTIONS ON THE BOARD WEBSITE.**

**Motion passed unanimously.**

**ACTION PLAN:** Ritu Sahni, MD, to work with Dr. Rostykus and Board staff to post a form with the scope of practice change questions (see *Exhibit D*) on the Oregon Medical Board website.

### **EMT-P POSITION ON COMMITTEE – END OF TERM JUNE 30, 2008**

Paul Rostykus, MD, indicated that the EMT-P position on the Committee currently held by Toni Grimes is due to expire on June 30, 2008. Ms. Grimes is serving her first term and is eligible to serve a second term.

**ACTION PLAN:** Toni Grimes, EMT-P, to indicate to Board staff if she is interested in serving a second term on the Committee. Board staff to post notice of the Committee vacancy on the Board website and distribute notice to professional associations and organizations. Candidates to be interviewed at the next Committee meeting to be held in May 2008. Committee to forward recommendation for appointee to Board for selection at Board meeting to be held in July 2008.

### **CONFIRM DATES OF NEXT COMMITTEE MEETINGS**

The Committee scheduled future meetings for the following dates:

May 9, 2008

August 15, 2008

November 14, 2008 (tentative)

### **ADJOURNMENT**

There being no further business to discuss, the meeting was adjourned at 10:50 AM.

## OREGON ADMINISTRATIVE RULES

## CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD

## PROPOSED RULES CHANGES – APRIL 2008

## FINAL REVIEW BY THE BOARD

**Proposed rule amendment specifies that EMT-Intermediates (EMT-Is) may administer analgesics for acute pain only.**

**847-035-0030****Scope of Practice**

(1) The Oregon Medical Board 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, 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 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.

(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 **for acute pain**:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine,

(iv) Fentanyl;

(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.

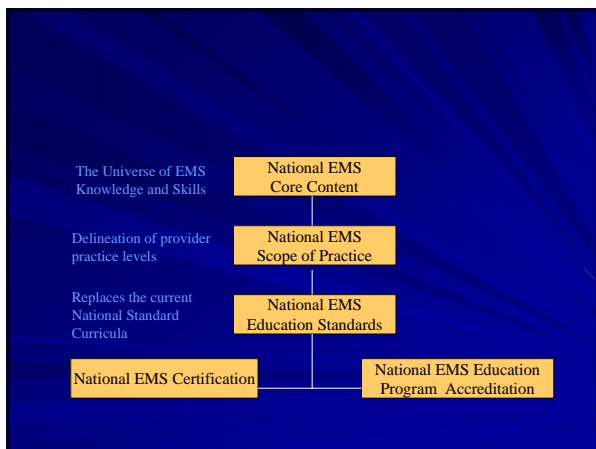
## National EMS Vision: How does it effect our State?

Ritu Sahni, MD, MPH  
Medical Director  
Oregon State EMS and Trauma  
System

- ### Overview
- EMS Agenda for the Future
  - IOM Report
  - What activities occurred and are occurring?
    - National EMS Scope of Practice
    - National EMS Education Standards
    - National Accreditaion
  - Risks/Benefits/Opportunities

- ### EMS Agenda for the Future
- EMS Education Agenda for the Future: A Systems Approach
    - Released in 2000
    - Calls for Five Components
      - National EMS Core Content
        - Released in July 2005
      - National EMS Scope of Practice Model
        - Released in September 2006
      - National EMS Education Standards
        - Scheduled to be completed in September 2008
      - National EMS Education Program Accreditation
      - National EMS Certification

- ### Institute of Medicine Recommendations
- ...state governments adopt a common scope of practice for EMS personnel, with state licensing reciprocity.
  - ...states accept national certification as a prerequisite for state licensure and local credentialing of EMS providers.
  - ...states require national accreditation of paramedic education programs.



- ### A note about National Certification
- NREMT Certification?
    - An independent verification of clinical competency
  - Oregon Certification (Licensure)
    - The right to work
    - Based on competency plus other factors
  - Employment
    - Responsible for other competencies (driving, paperwork, etc)

## Ongoing Steps

- National Scope of Practice completed
  - 4 levels of provider
    - Emergency Medical Responder (EMR)
    - Emergency Medical Technician (EMT)
    - Advanced Emergency Medical Technician (AEMT)
    - Paramedic
  - Oregon levels exceed this “floor” but very close.
  - Oregon intermediate significantly exceeds AEMT.

## Ongoing Steps

- National EMS Educational Standards are current project
  - Current comment phase (NEMSES.org)
  - Will be completed in fall of 2008
  - Will include “Instructional Guidelines.”
  - Textbook manufacturers will tailor to these standards.
  - Around 2010, NHTSA will remove NHTSA Curricula (which are in our rules) and replace with Standards
  - Same time, NREMT examinations will change to new levels/new standards.

## Ongoing Steps

- National Education Program Accreditation
  - 2013 – Only students that graduate from CoAEMSP accredited schools can sit for the Registry Examination (paramedic only)

## Implications for all States

- If you decide to have a State Scope of Practice that differs significantly from the National EMS Scope of Practice Model
  - Your state becomes responsible for testing any content outside the National SOP Model and practice analysis
  - Text content will not match your state program to educate EMS personnel
  - Reciprocity of personnel in or out of your state becomes more complicated
  - You become responsible for defending to your public why you have chosen to differ from the national educational model
  - Your existing laws, regulations and policies may not reflect the coming system

## Implications for All States

- If you choose not to follow the National EMS Educational Standards-
  - You will have to develop your own texts and educational support materials
  - Your programs may not be eligible for accreditation
  - Your personnel may not be eligible for national certification testing
  - You will have to defend your choice to differ from national standards
  - There will be a “mis-match” on the educational experience of persons entering or exiting your state seeking reciprocity
  - Your personnel may not be able to receive reciprocity upon entering Registry-only states

## Discussion?

**OREGON ADMINISTRATIVE RULES**  
**CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD**  
**PROPOSED RULES CHANGES – APRIL 2008**  
**FIRST REVIEW BY THE BOARD**

**Proposed rule amendment adds the administration of Lidocaine as an intraosseous infusion anesthetic under the EMT-Intermediate (EMT-I) scope of practice.**

**847-035-0030**

**Scope of Practice**

(1) The Oregon Medical Board 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.

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(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, 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 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.

(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 for acute pain:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine,

(iv) Fentanyl;

(I) Antihistamine:

(i) Diphenhydramine;

(J) Diuretic:

(i) Furosemide;

**(K) Intraosseous infusion anesthetic:**

**(i) Lidocaine:**

(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.

**Oregon Medical Board  
EMT Advisory Committee  
Scope of Practice Change Questions**

1. What is the proposed change to the scope of practice?
2. Why is this change needed? (What is the change needed? Why is this the best method of addressing it?)
3. What are the advantages or benefits of the proposed change?
4. What are the disadvantages or risks of the proposed change?
5. Who else might be affected by the change?
6. Who might oppose the change?
7. What are the educational requirements of the proposed change?
8. What are the financial impacts of the proposed change?
9. Is the proposed change currently being done in other EMS systems in the US? In other countries?
10. What research or evidence is there that the proposed change is useful, beneficial, or works?