BOARD OF MEDICAL EXAMINERS
1500 SW 1st Ave, Suite 620
Portland, Oregon 97201

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, June 3, 2005, 9:00 AM

MEMBERS PRESENT

Gregory Lorts, MD, Chair
John J. Herbold, EMT-I
Dave Lapof, EMT-B
Paul S. Rostykus, MD
Jon Tardiff, EMT-P

STAFF PRESENT:

Diana Dolstra, Licensing Administrator

GUESTS

Peggy Andrews, Chemeketa Community College
Shawn Baird, Woodburn Ambulance, Oregon Ambulance Association
Chris Benson, OFMAA, Lane County Fire District #1
Jon P. Cloutier, Oregon Volunteer Fire Association
Casey Craig, Woodburn Ambulance
Denise A. Giard, Albany Fire/OFMAA
Tina Greiner, Jefferson RFPD/OVFA
Toni Grimes, Woodburn Ambulance
Tim Hennigan, Department of Human Services-EMS
Kevin Henson, Turner Fire
Gregg Lander, Chemeketa Community College
Jane McLaughlin, EMT-P, Chiloquin Volunteer Ambulance
Gary McLean, EMT-P, OSPA
Terry Ney, Sheridan Fire District
John Praggastis, OSPA
Pontine Rosteck, AMR
Eric Schult, Tualatin Valley Fire and Rescue
Mark Stevens, Tualatin Valley Fire & Rescue
John Walls, Eugene Fire/EMS
Paula Wilson, Portland Community College

AGENDA

Approve minutes of the March 11, 2005 EMT Advisory Committee meeting.

Update to the EMT-Intermediate curriculum development – Peggy Andrews, Chemeketa Community College

Review and interview candidates applying for the EMT-P position on the Committee

Final Review of OAR 847-035-0030 – Changing terminology of airway device

How are supervising physicians arranging for non-PSAP-dispatched EMS agencies?

Senate Bill 698

Other business

Future meeting

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Gregory Lorts, MD, Chair, called the meeting to order at 9:00 AM.

APPROVE MINUTES OF THE MARCH 11, 2005 EMT ADVISORY COMMITTEE MEETING

Committee members noted a few changes that needed to be made in spelling, and editorially.

It was moved and seconded that

THE MINUTES OF THE MARCH 11, 2005 EMT ADVISORY COMMITTEE MEETING BE ACCEPTED AS AMENDED.

Motion passed unanimously.

UPDATE TO THE EMT-INTERMEDIATE CURRICULUM DEVELOPMENT

Peggy Andrews said that the Education Modality Workgroup is completing the assignment of learning levels to each of the objectives that they had identified, and they have added all of the course contents to those objectives. They have met with a psychometrician but they have not started writing test questions yet. They are in the process of developing a bridge course for instructors to bring them up to speed from the old curriculum to the new curriculum, and working on a bridge course for existing Intermediates to bring them up to speed.

Tim Hennigan said that the time line established by the Committee is to start the bridge program for instructors this summer, and the curriculum is being made available to the colleges in November 2005. This gives instructors time to review and obtain resources for the new curriculum and start teaching the new curriculum in the winter term of 2006. The bridge course for already certified Intermediates is supposed to be rolled out in July 2005.

Peggy Andrews said that the bridge course for the already certified Intermediates will be about 30 hours. The bridge course for instructors is 30-40 hours. The format for the bridge course for the already certified Intermediates may be to video tape the members of the

Intermediate Curriculum Development Committee responsible for specific portions of the curriculum doing a presentation on their portion of the curriculum and then take the whole video out on the road in the mobile training unit. In this way the curriculum is presented consistently throughout the state.

REVIEW AND INTERVIEW CANDIDATES APPLYING FOR THE EMT-P POSITION ON THE COMMITTEE

Dr. Lorts thanked Jon Tardiff for his long years of service to the EMT Advisory Committee, and previous to that the staff of the Board of Medical Examiners. Dr. Lorts gave some background on the process of nominating a new Committee member: each candidate will have the chance to present their experience and credentials to the Committee, answer any questions from the Committee and then, after each candidate has had a chance to speak, the Committee will vote on their top three candidates. These names will be forwarded to the Board for their consideration and vote at the Board meeting on July 14-15, 2005. The first meeting for the new Committee member will be the September 2005 meeting, and the term is for three years.

Toni R. Grimes, EMT-P, Operations Manager, Woodburn, Ambulance Service, Inc. She has been working for Woodburn Ambulance since 1987. It is a small private agency that responds to emergency advanced life support and transportation for a 400 square mile area. She has held every position available in the company; she does two shifts a week, three to five calls per shift, with a transport time of 20 minutes to over an hour. They respond to various hospitals in Portland, Silverton and Salem.

She feels there are some pretty extreme hurdles that EMS will be crossing in the next few years, most of them associated with Medicare reimbursement, which will impact employee retention and the growth of the EMS field. She believes the EMT Advisory Committee will be the leading factor in what EMS will look like in the next few years, whether that is good or bad. She promises a sincere commitment to EMS to ensure it continues forward and never takes a step back.

J. Kevin Henson, EMT-P, Chief, Turner Fire District. He has been involved in EMS for 20-25 years at every level, from the small rural volunteer service to high volume urban services, to state EMS offices, and as staff in another state to a Board similar to Oregon's. He feels it is important to get some additional skills to the ALS provider in the rural area, but he worries that the state doesn't provide enough training in assessment, particularly for providers where there is a low call volume. He's not sure the additional skills for the Intermediates will make much difference in the urban area. He's been an educator for 15 years, for three different universities. Turner is a tiny town south of Salem, and they transport primarily into Salem. He responds on five calls a week and is actively involved in EMS education. He's been in the state for a year and a half.

Jane R. McLaughlin, EMT-P, EMS Chief, Chiloquin Volunteer Ambulance Service. She has been involved in EMS for approximately 23 years, and has held every EMT position. She volunteered for the past 23 years; worked for a hospital based ambulance (Merle West) for nine years; firefighter-paramedic with Klamath Co. District 1 for 3 years. She retired from Klamath County and was hired as EMS Chief at Chiloquin. There are 200-250 transports per year. She does all the ALS responses; there are 20 volunteers. She does their training, and she is a reviewer for the Intermediate curriculum. Being a paramedic in the rural area is not the ideal.

She has seen that the Intermediate scope has needed to be broadened; good training will make it an excellent scope of practice. Her service area covers 900 square miles; the transport time is as short as 25 minutes and as long as 2 hours and she transports to Merle West Medical Center. She'd like to see more Intermediates and she has a vision of how First Responders can be used differently.

Terry Ney, Assistant Chief, Sheridan Fire District. The Fire District covers 107 square miles, 65 volunteers, and 4 paid staff. He manages the EMS staff. They run about 1040 calls a year, with 50 transports a month; he's in on half of them. He has been involved in EMS for about 20 years; he started out as an EMT 1. He's worked in both rural and urban settings. He has taught EMT classes for about 15 years. He sees a lot of changes coming to Oregon from the outside; moving EMTs from pre-hospital care providers to out-of-hospital care providers. There is one physician with a part-time office in Sheridan and the same in Willamina. 80% of the patients go to McMinnville.

John Walls, EMT-P, firefighter, City of Eugene, director of the Lane Community College Intermediate program. Since EMS changes daily, he thought he would like to be a part of it. He is a full time paramedic/firefighter; 80% on the medic units, training the paramedics how to do the job. He is also on the Lane County divers search and rescue. He was a flight medic with Life Flight Network. He is excited about the new Intermediate curriculum, which he teaches. He interacts a lot with Intermediates and Basics.

Paula Wilson, EMT-P, Paramedic Program Director, PCC, which has satellite campuses in Hillsboro, Tillamook and the Gorge, and which offer all levels of EMT courses. She also works part-time paid at McMinnville Fire, average 15-20 calls in 24 hours, and she also works as a flight medic at Premier Jets. She has attained critical care certification, which is one of the highest levels of certification that a paramedic can obtain at this time. She co-authored an EMT-Basic book. She is also getting tutored in Spanish as there is a large Spanish population where she works and she would like to communicate with them in their language. She has a lot of committee experience. Over the last three years, she has been to every EMT Advisory Committee meeting, which shows her passion and dedication to for what the Committee does.

Dr. Rostykus confirmed that the EMT-P's the Committee's nominations for the EMT-P position for the Board to vote on could come from anywhere in the state, and do not have to be a rural EMT-P. He also clarified that Chief Henson has not been a resident of Oregon for two years, nor certified as an EMT for two years, and therefore does not currently meet the qualifications, per OAR 847-035-0011 (1)(b).

The Committee members voted by paper ballot for their top three nominees, which will go to the Board for a vote at their quarterly meeting on July 14-15, 2005. The three nominees are:

1. Toni Grimes
2. Jane McLaughlin
3. Terry Ney

NOTE: 7/15/05 – The Board voted to approve the nomination of Toni Grimes, EMT-P as the new EMT member on the EMT Advisory Committee.

FINAL REVIEW OF OAR 847-035-0030 – CHANGING TERMINOLOGY OF AIRWAY DEVICE

Jon Tardiff spoke on the proposed rules, which standardize the airway language; most of them are now called a cuffed oropharyngeal airway, and to specify for the EMT-First Responders a noncuffed oropharyngeal airway. There were a few additional changes as noted in the proposed rules, such as allowing EMT-Basics to obtain a capillary blood specimen rather than a peripheral blood specimen, and changing needle cricothyrotomy to percutaneous cricothyrotomy. (***Exhibit A***).

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD ADOPT THE PROPOSED RULES CHANGE IN OAR 847-035-0030.

Motion passed unanimously.

HOW ARE SUPERVISING PHYSICIANS ARRANGING FOR NON-PSAP-DISPATCHED EMS AGENCIES?

Dr. Rostykus spoke on this subject, since this is an issue down in southern Oregon. How do other people deal with non-911 dispatch EMTs who go and work at race tracks and drag strips? Dr. Rostykus has said that he will only supervise EMTs who are in agencies; he does not supervise free-lance EMTs.

Tina Greiner worked at the Woodburn drag strip and said that all they were allowed to do was first aid, no matter the level of the EMT. If the patient needs more than that the EMT call for an ambulance. She said that they had to be at least an EMT-Basic to work there but all the EMTs could do was evaluate the patient and determine if the patient needed a higher level of care and then the EMT called 911.

Tim Hennegan said he talked to someone from Dr. Rosytkus' area about this subject and explained to him that Oregon administrative rules require four things: 1. They have to be a valid Oregon certified EMT. 2. They have to be employed by a recognized EMS agency, either transport or non-transport agency. 3. They have to have a supervising physician approved through the EMS office, and 4. They have to have signed standing orders. EMTs working in non-traditional settings, such as industrial settings, are allowed to work within their scope of practice, if it is part of their job to respond if there is a medical emergency, and if they meet the four conditions listed above. If they do not meet the conditions above, then they are only allowed to do first aid.

Tim Hennigan said that agencies or proposed agencies notify EMS, and EMS makes sure that there is a supervising physician agreement and they have everything they are required to have and they are given an identification number for affiliation purposes. It does not cost them anything.

SENATE BILL 698

Dave Lapof said that he went down to the hearing of SB 698, and the bill never left Committee. The Oregon Society of Physician Assistants didn't know why the bill was being brought, so they requested the Committee to postpone any decision, but the Committee wanted everyone's testimony at the hearing. The Committee wanted to get back to the Office of Rural Health.

John Praggastis said that there were two situations, one in Halfway and one in Vale, where they had no physician to answer the radio for crews coming to the hospital or to help with on-scene advice. They wanted to be able to have physician assistants who are in the hospital ER to be able to answer the radio during the night from EMTs on transporting ambulances or at the scene.

OTHER BUSINESS

Dr. Rostykus said that Shawn Baird wanted to know if the Committee members were okay with having their email addresses on the Public Committee list. The Committee members agreed, and email addresses of Committee members are now on the Public list of the Committee members.

Dr. Rostykus also said that as part of the State EMS conference in September there is going to be a supervising physician forum, which will be on September 16th. There will be a key note speaker, W. Ann Maggiore, JD, EMT-P, speaking on legal issues in EMS. The conference will be on topics of interest to supervising physicians.

Dr. Lorts thanked Jon Tardiff for the twenty-plus years that he has spent on the EMT Advisory Committee, and he trusts that his input will continue. He said that Jon has been a meticulous reviewer of all the information that has gone through the Committee that he has been responsible for about 90% of the housekeeping rules and he has kindly volunteered for all the projects and special committees. He will be tremendously missed.

NEXT MEETING DATE

The next meeting date will be Friday, September 9, 2005 at 9:00 AM.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 11:00 AM.

EXHIBIT A

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS

PROPOSED RULES CHANGES – JULY 2005

FINAL 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 **[**~~an~~**]** **a nasopharyngeal and a noncuffed orophyngeal airway** **[**~~oropharyngeal and nasopharyngeal airway~~**]** 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;

(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 **[**peripheral**]** **capillary** blood specimen for blood glucose monitoring**[**~~, obtained via fingerstick, heelstick, or earlobe puncture~~**]**;

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

(C) Administer activated charcoal for poisonings[~~, following local written standing orders~~]; 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 [~~or pharyngoesophageal~~] 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) 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) **[**~~Needle~~**]** <u>**Percutaneous**</u> 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) Provide advanced life support in the resuscitation of patients in cardiac arrest;

(f) Perform emergency cardioversion in the compromised patient;

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

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

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

(j) 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) 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.