

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, August 24, 2007, 9:00 AM

OREGON MEDICAL BOARD

1500 SW 1st Ave Ste 620
Portland, OR 97201-5847

*Board Accepted 10/12/07
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

Kathleen Haley, Executive Director
Diana Dolstra, Licensing Manager
Jennifer Lannigan, Licensing Coordinator

GUESTS

Shawn Baird, Oregon Ambulance Association
Jonathan Chin, Washington County EMS
Nic Granum, Oregon Volunteer Firefighters Association
John Heiser, MD, McMinnville Fire Department
Grant Higginson, MD, MPH, DHS Public Health Division
Randy Jackson, Keizer Fire District
Gregg Lander, Chemeketa Community College, EMT Consortium
Bob Leopold, DHS EMS
Gary McLean, Oregon State Paramedic Association
Elizabeth Morgan, DHS EMS
Pontine Rosteck, AMR
Ritu Sahni, MD
Mark Stevens, Tualatin Valley Fire & Rescue

AGENDA

Welcome Matt Eschelbach, DO, new physician member on the EMT Advisory Committee

Select Committee chair for next 12 months (four meetings)

Approve minutes of the May 11, 2007 EMT Advisory Committee meeting

Blood glucose testing for First Responders – John Heiser, MD, McMinnville Fire Department

DHS EMS Office Update – Grant Higginson, MD, MPH, DHS Public Health Division, and Bob Leopold, DHS EMS & Trauma Systems

Two-hour Physician-EMT contact time per OAR 847-035-0025 (3) regarding First Responder and EMT certification; follow-up from DHS EMS Office/State EMS Committee

DHS EMS Office report – EMT levels consistent with EMS National Scope of Practice

Final Review of OAR 847-035-0030 – Adding Fentanyl to EMT-I scope of practice

Financial impact of adding fentanyl to EMT-I scope of practice

Request for clarification of pre-hospital care and EMTs in the hospital – Susan Coombes, OHSU, Regulatory and Compliance Program

Schedule next 12 months of Committee meetings

Next meeting agenda items

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

WELCOME MATT ESCHELBACH, DO, NEW PHYSICIAN MEMBER ON THE EMT ADVISORY COMMITTEE

The Committee members welcomed, Matthew M. Eschelbach, DO, to service on the Committee.

SELECT COMMITTEE CHAIR FOR NEXT 12 MONTHS (FOUR MEETINGS)

The Committee elected Paul Rostykus, MD to be the Committee Chair for the next four meetings.

APPROVE MINUTES OF THE MAY 11, 2007 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE MAY 11, 2007 EMT ADVISORY COMMITTEE MEETING.

Motion passed unanimously.

BLOOD GLUCOSE TESTING FOR FIRST RESPONDERS

John Heiser, MD, McMinnville and St. Paul Fire Departments, presented a request to add blood glucose testing to the First Responder scope of practice. He shared that in many rural areas there are no EMTs available on the scene to test blood sugar levels to aid in obtaining a diagnosis. He indicated that he is not aware of any other states that include blood glucose testing in the First Responder scope of practice. He listed testing supplies, initial training and continuing education as costs associated with adding this skill to the First Responder scope of practice. Dave Lapof, EMT-B, reported that there would be an annual cost for agencies associated with registering as a temporary clinical testing lab per the Clinical Laboratory Improvement Amendments (CLIA) law, although there is a waiver, for a \$150 fee. Mr. Lapof wondered if there would be a way the EMT Advisory Committee could add this as an option for First Responders, according to the supervising

physician's preference. Rose Howe, EMT-I, indicated that allowing First Responders to test blood glucose seems to make sense, given they are allowed to administer oral glucose.

Ritu Sahni, MD, DHS EMS Medical Director, indicated the following points: DHS EMS does not currently certify First Responders, although there is a proposed rule amendment to effect certification by DHS EMS; DHS EMS could not currently add blood glucose testing to the First Responder Department of Transportation (DOT) 40-hour curriculum as it is not within DHS EMS' purview to do so; if blood glucose testing is added to the First Responder scope, there must be a way to ensure proper training is obtained; adding blood glucose testing to the First Responder scope is not a national movement; and there is no harm to administering oral glucose to a patient without first checking blood glucose level, even if the patient's glucose level is normal or high.

Gregg Lander shared that First Responders at most have limited blood borne training. Liz Morgan, DHS EMS, indicated one disadvantage of adding more skills to First Responder scope is that treatment could be delayed due to increased time spent in dealing with equipment and decision-making. Rose Howe, EMT-I indicated that in many rural and frontier areas, First Responders are the backbone of emergency medical services, and, as such, she would advocate for this skill to be added to their scope. Jonathan Chin, Washington County EMS, stated that he is not aware of the benefit of adding this skill to the First Responder scope. Matt Eschelbach, DO, stated that he believes the benefits outweigh the risks associated with adding this skill to the First Responder scope and that Oregon could be a leader in doing so.

Paul Rostykus, MD, summarized the main issues associated with this topic: protocols, how to guarantee initial training and education within the DOT curriculum, and costs/fiscal impact to agencies.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD ADD CAPILLARY BLOOD GLUCOSE TESTING TO THE FIRST RESPONDER SCOPE OF PRACTICE FOR FIRST RESPONDERS WHO HAVE A SUPERVISING PHYSICIAN.

Motion passed unanimously.

ACTION PLAN: Board staff to draft amendment to OAR 847-035-0030 (8) to add capillary blood glucose testing to the First Responder scope of practice for first review of the rule at the next EMT Advisory Committee meeting. Dave Lapof to assist in determining if language regarding training needs to be included in the rule amendment.

DHS EMS OFFICE UPDATE

Grant Higginson, MD, MPH, DHS Office of Community Health and Health Planning Administrator, shared the DHS EMS & Trauma systems have recently moved from the sixth to the fourth floor in their building, but the address and phone numbers remain the same. He shared that in June EMS completed recertification of over 7200 EMTs. He indicated that EMS has almost finalized substantial revisions to OAR Chapter 333, Division 265—Emergency Medical Technicians. He reported that there is still a lack of consensus regarding some issues, such as paramedic internships, the role of the Associate degree for paramedics, some EMT-I Bridge course issues, and whether to make Oregon a national registry state for EMT recertification. Dr. Higginson indicated the goal is to have draft rules to present at the September EMS conference in Bend. He introduced Ritu Sahni, MD, the new DHS EMS Medical Director and Bob Leopold, the new DHS EMS & Trauma Systems Director.

TWO-HOUR PHYSICIAN-EMT CONTACT TIME PER OAR 847-035-0025 (3) REGARDING FIRST RESPONDER AND EMT CERTIFICATION

Paul Rostykus, MD, requested follow-up from the state EMS Committee meeting in June regarding the Oregon Medical Board EMT Advisory Committee's request to add a requirement for EMTs to meet with the supervising physician at least two hours per year to OAR Chapter 333, Division 265. Ritu Sahni, MD, DHS EMS Medical Director, reported that the group working on revisions to OAR Chapter 333, Division 265 was not sure what language the EMT Advisory Committee wanted. He added that there was a general agreement amongst this group that language which would put the onus on EMTs to meet with their supervising physicians would not be supported. Grant Higginson, MD, MPH, indicated that the state EMS Committee and the OAR Chapter 333, Division 265 revision group said that the supervising physician can require the meeting of all the EMTs the physician supervises and the same requirement does not have to be in OAR Chapter 333, Division 265.

DHS EMS OFFICE REPORT – EMT LEVELS CONSISTENT WITH EMS NATIONAL SCOPE OF PRACTICE

Ritu Sahni, MD, DHS EMS Medical Director, reported that nothing has officially changed and his report will only be informational at this time. He stated that at some point the national registry examinations are going to reflect the scopes of practice. He added that on the national policy level, the hopes are for more consistency in scope of practice for all levels of care and in EMS provider titles across the country. Dr. Sahni indicated that the current Oregon scopes of practice for all provider levels exceed the proposed national scopes of practice. Grant Higginson, MD, MPH, indicated that at the recent OAR 333 Division 265 revision group meeting a proposal was made that Oregon become a national registry state. Kathleen Haley, JD, Board Executive Director, requested that Dr. Sahni provide her some printed materials on the national registry proposals for the Oregon Medical Board members.

FINAL REVIEW OF OAR 847-035-0030 – ADDING FENTANYL TO EMT-I SCOPE OF PRACTICE

EXHIBIT A

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD APPROVE THE ADDITION OF ADMINISTRATION OF FENTANYL TO THE EMT-INTERMEDIATE SCOPE OF PRACTICE IN OAR 847-035-0030.

Motion carried unanimously.

FINANCIAL IMPACT OF ADDING FENTANYL TO EMT-I SCOPE OF PRACTICE

Paul Rostykus, MD, indicated that there would not be a significant fiscal impact to EMS agencies associated with the addition of fentanyl to the EMT-I scope of practice. Costs could include purchasing the drug, record-keeping, training, and writing standing orders. Rose Howe, EMT-I, said the EMT-I curriculum committee will be meeting soon to review the new curriculum, although a specific date has not yet been set.

REQUEST FOR CLARIFICATION OF PRE-HOSPITAL CARE AND EMTs IN THE HOSPITAL

Susan Coombes, OHSU, Regulatory and Compliance Program, had requested in writing that the EMT Advisory Committee discuss where pre-hospital care begins and ends; if an EMT is allowed to continue to function under the EMT scope of practice once inside of a hospital; and if an EMT can be hired by a hospital as an EMT. The Board had previously responded to her in writing that there is a gray area of transition between the back of the ambulance and the ED gurney in a room when the ED Staff has clearly taken over. EMTs carry out their pre-hospital duties in the ED until the transition has been completed. Carrying out the appropriate

orders from a physician who has assumed care of the patient is included in the EMT scope. The Board has determined that if someone who holds an EMT certification is employed by a hospital, that individual is not working as an EMT but under some other title/position, such as an ER Tech. Grant Higginson, MD, MPH, indicated that DHS had also been asked to look into this issue from a hospital licensing standpoint and that the position of DHS EMS is very similar to that of the Oregon Medical Board as expressed above.

ACTION PLAN: Board staff to send response to Susan Coombes indicating the EMT Advisory Committee discussed the issue and the Committee's position is consistent with what had previously been communicated to her.

SCHEDULE NEXT 12 MONTHS OF EMT ADVISORY COMMITTEE MEETINGS

The Committee scheduled future meetings for the following dates:

November 2, 2007	May 9, 2008
February 8, 2008	August 15, 2008

NEXT EMT ADVISORY COMMITTEE MEETING AGENDA ITEMS

Dr. Rostykus requested that the following items be added to the agenda of the next EMT Advisory Committee meeting: DHS EMS update on the revisions to OAR Chapter 333, Division 265 regarding recertification requirements; review of EMT-I curriculum Bridge course and next steps; and first review of the addition of blood glucose testing to the First Responder scope of practice in OAR 847-035-0030 (8).

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 10:45 AM.

OREGON ADMINISTRATIVE RULES
CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS
PROPOSED RULES CHANGES – OCTOBER 2007
FINAL REVIEW BY THE BOARD

The proposed rule amendment adds the administration of fentanyl to the EMT-I scope of practice.

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, 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:
 - (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.