

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE
Friday, August 15, 2008, 9:00 AM

OREGON MEDICAL BOARD
1500 SW 1st Ave Ste 620
Portland, OR 97201

Board Accepted 10/17/08
Committee Approved 11/14/08

MEMBERS PRESENT

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

STAFF PRESENT

Diana Dolstra, Licensing Manager

GUESTS

Peggy Andrews, Chemeketa Community College
Jonathan Chin, Washington County EMS
Doug Kelly, EMS, Chief, Redmond Fire & Rescue
Bob Leopold, DHS EMS & Trauma Systems
Dave Pickhardt, Redmond Fire & Rescue
Ritu Sahni, MD, DHS EMS & Trauma Systems
Mark Stevens, Oregon Fire Medical Administrators Association

AGENDA

Approve minutes of the May 9, 2008 EMT Advisory Committee meeting

Selection of Committee Chair

National EMT scope of practice – Ritu Sahni, MD, MPH

Hemostatic dressings – discuss FDA classifications and if physician prescription is needed – Paul Rostykus,
MD

Update on First Responder program, recertification issues – Bob Leopold and Ritu Sahni, MD, MPH, EMS &
Trauma Systems

Non-emergency blood draws and scope of practice – Doug Kelly, EMS, Chief, Redmond Fire & Rescue and Dave Pickhardt, Redmond Fire & Rescue

Confirm dates of next Committee meetings

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

APPROVE MINUTES OF THE MAY 9, 2008 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE MAY 9, 2008 EMT ADVISORY COMMITTEE MEETING, AS AMENDED.

Motion passed unanimously.

SELECTION OF COMMITTEE CHAIR

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

HEMOSTATIC DRESSINGS

Dr. Rostykus said that this was an item on the last meeting's agenda that the Committee felt needed more research done on determining the classifications of hemostatic dressings by the Food and Drug Administration (FDA). Dr. Rostykus said he had done quite a bit of research on the Internet and found which hemostatic dressings require a prescription. He said that he suspects it has something to do with what the manufacturing company requests from the FDA rather than anything else (such as route of application).

The Committee felt their decision at the May 9, 2008 meeting should stand, which was that hemostatic dressings that are contained (part of the dressing) should fall under the First Responder scope of practice, and those that need to be applied independent of a dressing would be considered as a medication and fall within the EMT-Paramedic scope of practice.

UPDATE ON FIRST RESPONDER PROGRAM

Ritu Sahni, MD, Medical Director at EMS and Bob Leopold, Director of EMS, presented the Committee with an update on the new First Responder program through EMS. First Responders must provide EMS with a First Responder certificate and EMS will then give them a state First Responder certificate and in two years the First Responder must obtain 12 hours of CME.

The change is that the State will maintain a single database for First Responders rather than the multiple databases currently in existence. EMS will issue First Responder certificates, and will require 12 hours of CME every two years for recertification. The First Responder certification costs \$15.00. First Responders may identify affiliation with two agencies. First Responders have a scope of practice with and without a medical director/supervising physician. Agencies can still provide First Responder training, as well as schools. An EMT can renew certification without being affiliated with an agency. An EMT can work without agency affiliation but not without a supervising physician and standing orders. When running criminal background checks on First Responders, EMS does withhold certification until the results of the criminal background check are in the office.

NATIONAL EMT SCOPE OF PRACTICE

Three meetings ago, Ritu Sahni, came to the EMT Advisory Committee to update the Committee on the National EMT scope of Practice. Now, Dr, Sahni says, the topic has become broader and is a vision of EMS, and the group has the name of the Vision 2012 Taskforce. 2012 is the year all the programs must be accredited if the students want to sit for the EMT-Paramedic examination. The Taskforce met three months ago and came up with a work plan to look at each level of provider in the state and go through a work sheet to note what we do in Oregon now: initial training, initial certification, testing, recertification, medical direction, scope of practice for search and rescue, transport and hospital, and what is the proposed national standard for each certification level. The Taskforce wants to have some goals in place by end of spring 2009. The Taskforce will present these goals to the State EMS Committee and then there will be stakeholder meetings all over the state by the end of 2009. The Taskforce will reconvene in November-December 2009, and move forward with a legislative concept for 2011. The Taskforce hopes to have a presentable product after the feedback stage.

Dr. Sahni said that the major fear voiced so far is that after all the work to create the EMT-Intermediate, it will be thrown out. The Taskforce is talking about all four levels of certification (FR, EMT-B, I, P), medical direction, dispatchers and educators. There are two national certifications at about the level of our Intermediate; the Advanced EMT is lower than our Intermediate and requires more hours of training.

The Vision 2012 Taskforce has received letters from people who are concerned, but there are no proposed changes at this time as the Taskforce is still reviewing all areas before recommending any changes. Letters and emails are being taken under advisement, and senders are thanked and informed that no changes are contemplated at the present time. There will be meetings in all areas of the state to hear from EMS constituents. There are no preconceived ideas of what the plan will look like.

NON-EMERGENCY BLOOD DRAWS AND SCOPE OF PRACTICE

EXHIBIT A

Doug Kelly, Chief, Redmond Fire & Rescue, was the first to fill out the new EMT Scope of Practice Change form on the Board's web site. He is requesting EMT-Intermediates be allowed to do blood-draws as a non-emergency procedure.

Mr. Kelly asked how the non-emergency scope of practice is defined and he asked whether all the non-emergency care procedures need to be listed in the scope of practice. Non-emergency procedures may need clarification rather than a change in the rules. What started this request to the Committee was a lawyer saying that drawing blood was not within the scope of practice of an EMT-P in a non-emergency situation. There are reasons that police use EMT-Ps to do this, which is not to bog down the hospitals that do this and to keep things moving quickly. Mr. Kelly read the definition of non-emergency care from ORS 682.025, but not the part of the definition that reads: "in the course of providing prehospital care."

The EMT-Intermediate scope of practice says that EMT-Is may perform emergency and non-emergency care procedures and the scope of practice lists only the emergency procedures, which does include drawing peripheral blood specimens.

When the non-emergency definition was added to the rules and non-emergency was added to the scope of practice, it was not the intent to list every non-emergency procedure, or to create a parallel non-emergency scope of practice.

Dr. Sahni said that one could then say that there is no limit to the scope of practice for non-emergencies, which is not appropriate. For instance, there would be no limit to the medications that an EMT-Basic could give if they were in a non-emergency situation. He would propose having the rules say what the procedures are that this level can perform, and not differentiate between emergency and non-emergency.

Doug Kelly referred to OAR 847-035-0030 (7), and with input from Dr. Rostykus suggested dropping the first sentence and in the second sentence dropping emergency or emergency care. The Committee and guests attending the meeting reviewed the rest of the scope of practice and proposed changes referring to language regarding non-emergency procedures.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE WILL DRAFT RULE CHANGES TO DELETE REFERENCES TO EMERGENCY AND NON-EMERGENCY CARE WITHIN THE FIRST RESPONDER AND EMT SCOPE OF PRACTICE WHERE PRACTICAL FOR CLARITY.

Motion passed unanimously.

ACTION PLAN: Staff and Committee to draft rules amending references to emergency and non-emergency procedures and add to agenda of the 11/14/08 Committee meeting.

Dr. Rostykus said that there is a larger issue of the role of EMTs in hospitals, in prehospital care, and what the role of the EMT will be in the future. This is not an issue that will be solved today, but will be added to the agenda for the next meeting.

Toni Grimes said she sees EMTs being able to help someone out with some sort of a medical issue, testing a patient to rule out another medical issue; providing screening procedures, such as for cholesterol screening, glucose for low blood sugar, fluid replacement. These issues will be brought back to the next Committee meeting.

Dr. Rostykus asked whether EMS should be expanded beyond prehospital care. This question should be discussed by the Vision 2012 Taskforce.

ACTION PLAN: Dave Lapof added discussion of the value of the non-supervised First Responder to the agenda of the 11/14/08 Committee meeting.

CONFIRM DATES OF NEXT COMMITTEE MEETINGS

Friday, November 14, 2008 is the date of the next meeting, following by a tentative February 13 and May 15, 2009. Confirm additional dates at next meeting, and schedule for rest of 2009.

ADJOURNMENT

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

EXHIBIT A

July 28, 2008

To: Oregon Medical Board

From: Doug Kelly, EMS Chief
Redmond Fire & Rescue
341 NW Dogwood Ave
Redmond, OR 97756
541-504-5010

To Whom It May Concern:

Approximately three years ago Redmond Fire & Rescue was approached by the Redmond Police Department for the possibility of conducting Driving While Under the Influence of Intoxicants (DUI) blood draws. Our supervising physician, Dr. Matt Eschelbach, understood at the time that this was in our scope of practice (Redmond Fire operates with an all Paramedic line staff). The protocol was drafted and has been in place since 2005.

On occasion Redmond Fire & Rescue is notified by Redmond Police through 911 that they are bringing in a DUI suspect for a search warrant blood draw. Redmond Fire then notifies dispatch for a run number and readies the procedure/equipment. The suspect is brought into our main station first aid room; the search warrant is read by the arresting officer to the suspect. The paramedic draws two peripheral blood specimens. The blood specimens are then handed to the officer as evidence.

Until recently this process has run smoothly. The number of cases being summoned by the District Attorney has steadily increased. The fiscal obligation for overtime and staffing has led us as an organization to end the service to the police. The police are looking at options but would prefer us to continue the service.

A recent case, the second to actually go to a hearing, raised an interesting question that goes beyond peripheral blood draws.

This subpoena was not for the DUI trial but rather a hearing on a motion by the defense attorney to dismiss the blood draw because the paramedic acted beyond their scope of practice. The defense attorney argued that under OAR 847-035-0030 (10)(e) peripheral blood draws are in the EMT-Intermediate and Paramedic scope of practice but only in an emergent situation. This begs the question, what care procedures can EMT's and Paramedics provide in nonemergency settings?

After the hearing I contacted Elizabeth Morgan in the Professional Standards Division of the Oregon Health Division. Elizabeth had the interpretation of the OAR as not being worded clearly since all care procedures seem to fall under "emergency care

procedures". Elizabeth maintains the understanding that EMT-Intermediates and Paramedics can do both emergency and nonemergency procedures at any time while operating within the state and local operating procedures.

After my discussion with Elizabeth she referred me to Kathleen Haley from the Oregon Medical Board (OMB) of whom I left a rather lengthy phone message stating the issue. I received a return phone call from Angie Springer on July 25, 2008 of the OMB. Angie informed me that the interpretation from the OMB is that the procedures are to be conducted only when we respond to an emergency situation. Paramedics throughout the State respond daily to non-emergency incidents often far more than emergency incidents; consider the large number of non-emergency patient transfers. Medical Priority Dispatching, used extensively across the country has specific response levels for non-emergency request. Secondly, paramedics offer great services in areas outside of the EMS setting. In the definitions provided by OMB the level of response is not mentioned for emergency or nonemergency settings.

I then questioned Angie on the interpretation in regards to paramedic's scope of practice. What procedures shall a paramedic conduct when operating within our protocols in a nonemergency event? For example, if working at the local fairgrounds first aid booth a person attending the fair presents to the first aid booth with a complaint of dehydration. We have the ability to treat and allow the patron to return to the fair. Can we offer that service? As Paramedics can we not operate under a set of standing orders? After recognizing non-emergent dehydration can we not establish an IV and administer fluid?

Limiting all procedures EMT's may conduct only to emergency situations is neither practical nor reasonable. Being a fire department that has Advanced Life Support transport ambulances it is reasonable that most our transports are non-emergency; either in dispatch priority or transport urgency. Therefore how shall we conduct any of the procedures in a nonemergency setting? Clearly the implications reach far beyond Redmond Fire & Rescue.

If the OMB interprets the scope of practice being limited to emergencies only, every EMT and Paramedic in the State of Oregon is operating outside of the current scope of practice. For example, OAR 847-035-0030 (7) defines the First Responder scope of practice...*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;

Oregon Medical Board EMT Scope of Practice Change

Please complete the following questionnaire regarding your request for an addition, deletion, or change to the First Responder or EMT scope of practice. Please provide as much information as you can to speed the review process. If you do not have an answer, you may leave a section blank and we will research the answer as time permits. Your proposal will be reviewed by the Oregon Medical Board's EMT Advisory Committee and the Department of Human Service/EMS's State EMS Committee will be consulted on proposed changes to the scope of practice. If we have questions concerning the proposal for change, we will be back in touch with you for additional information. Once the proposal is complete, it will be placed on the agenda of the next EMT Advisory Committee meeting.

1. What is your proposed change to the scope of practice?

2. Why is this change needed? Why is this the best method of addressing it?

3. What are the advantages or benefits of the proposed change?
(Is there a patient benefit?)

4. What are the disadvantages or risks of the proposed change?
(Is there a potential for harm?)

5. Who else might be affected by the change? How will they be affected?

6. Who might oppose the change? Why might they oppose it?

7. Education:

A. Is this currently being taught in the EMT or First Responder curriculum?

Yes No

B. What would be the training needed to add this to the scope of practice?

8. What are the financial impacts of the proposed change?

a. Cost of education and/or training

b. Cost of equipment and/or medication

c. Cost of permits (Clinical Laboratory Improvement Amendments (CLIA), Drug Enforcement Administration Registration (DEA), others?)

9. Is the proposed change currently being done in other EMS systems in the U.S.? In other countries?

10. What research or evidence is there that the proposed change is useful, beneficial, or works (please list references if any)?

NAME:	
AGENCY NAME:	
POSITION:	
ADDRESS:	STATE & ZIP
PHONE:	FAX:
CELL-PHONE:	E-MAIL:

Oregon Medical Board's EMT Advisory Committee
Department of Human Service/EMS's State EMS Committee