

8/28/09 EMT Meeting Minutes
EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE
Friday 28, 2009 9:00 AM.

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

Exhibits: A, B, C, D.

MEMBERS PRESENT

Dave Lapof, EMT-B (Interim Chair)
Matt Eschelbach, DO
Terri Schmidt, MD
Toni R. Grimes, EMT-P
Rose Howe, EMT-I

STAFF PRESENT

Malar Ratnathicam, Licensing Manager
Angie Springer, Executive Assistant

GUESTS

Shawn Baird, Oregon Ambulance Assoc./ Woodburn Ambulance
Pontire Rosteck, AMR
Gary McLean, OSPA
Peggy Andrews, Chemeketa Community College.
Bob Leopold, DHS-EMS/Trauma
Ritu Sahni, MD, DHS EMS & Trauma Systems
Mark Stevens, OFMAA/Tualatin Valley Fire & Rescue

1. Tab A - Minutes of EMT meeting on 5/28/09.

Correction made by Rose Howe on item #6. Minutes read "three" candidates applied for the open EMT-I committee position, when only two candidates applied. Correction made to May 28, 2009 minutes.

Dr Sahni requested that the last sentence in item #8 be changed to read as follows: "A final report will be prepared in preparation for a legislative agenda and initiative in 2011, and proposed rule change prior to that." May 28, 2009 minutes will be changed to include the additional language.

Dr. Matt Eschelbach motioned to approve the minutes with the changes communicated. The motion was seconded by Dr. Terri Schmidt. The minutes were approved by the committee members

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2. Tab B – Elect Committee Chair.

Toni Grimes proposed Dave Lapof to be the committee chair. The motion was seconded by Dr. Matthew Eschelbach. All committee members approved Dave Lapof to be the EMT Committee Chair.

3. Tab C – Final Review OAR 847- 035-0030 10 (k).

Dr. Matthew Eschelbach made a motion to approve the clarified language. The motion was seconded by Dr. Terri Schmidt. Discussion was originally brought forth by the question “ Were EMT I’s able to interpret STEMI’s?’ The committee’s recommendation was that this was not the intent. It was agreed that an intermediate could apply multi lead monitoring and transmit this information electronically as it was already covered in the EMT-Basic for non-invasive monitoring.

The EMT I’s would still interpret and monitor rhythms to allow them to treat the patient based on their scope of practice. The clarified language was approved by the committee members. The amended language in Scope of Practice 10 (k) will read as follows:

Electrocardiographic rhythm interpretation. (Exhibit A - page 9)

9. Tab I – Final Review to add the drug Ondansetron to OAR 847-035-0030.

Motion was made by Dr. Matthew Eschelbach to add the drug Ondansetron, the motion was seconded by Rose Howe.

While the committee felt Peggy Andrews was correct that a valid survey needs to be completed and that more hours may need to be added to the curriculum, the committee felt this was a medication that will need to be added to the Scope of Practice in the best interest of patient care. Dave Lapof asked how this would be implemented prior to the new curriculum for initial training. It was the consensus of the committee and those in attendance that this would be taught as a local level. All committee members voted to add the drug Ondansetron to the Scope of Practice. **(Exhibit D – page 8).**

4. Tab D - Final Review OAR 847-035-0030 (11) (g)

Rose Howe made a motion to accept the clarified language, the motion was seconded by Toni Grimes. The clarified language was approved by the committee members.

Discussion as to how this related to the change in 10 (k).

The committee agreed this allowed the EMT-Paramedic to utilize electrocardiographic interpretation in their treatment of all illnesses.

The amended language in (11) (g) will read as follows:

Electrocardiographic interpretation. The word “rhythm” was removed. **(Exhibit B – page 9).**

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OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD

PROPOSED RULES CHANGES – OCTOBER 2009

FINAL REVIEW BY THE BOARD

Proposed rules change in the EMT-I scope of practice and the initiation of electrocardiographic rhythm interpretation, and add electiocardiographic interpretation to the EMT-P scope.

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.

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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) A First Responder may perform the following 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 additional procedures only when the First Responder is 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) Maintain an open airway through the use of:
 - (A) A nasopharyngeal airway device;
 - (B) A noncuffed oropharyngeal airway device;
 - (C) A Pharyngeal suctioning device.

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(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 the following 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;

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- (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

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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 the following procedures:

(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;

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(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;

(L) Anti-Emetic;

(i) Ondansetron;

(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.

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(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~~ Eelectrocardiographic ~~monitoring for~~ rhythm interpretation; (EXHIBIT A)

(l) Perform cardiac defibrillation with a manual defibrillator.

(11) An Oregon-certified EMT-Paramedic may perform the following procedures:

(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) Electrocardiographic interpretation. (EXHIBIT B)

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

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

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(j) **(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) **(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.

5. Tab E – Final Review OAR 847-035-0011

Motion was made by Toni Grimes to remove outdated language, the motion was seconded by Rose Howe. Committee members approved the removal of the outdated language. The amended language would **strike out all language in # 3 (a), (b), and (c)**. # 4 will be numbered as #3. **(Exhibit C page 12)**.

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OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD

PROPOSED RULES CHANGES – OCTOBER 2009

FINAL REVIEW BY THE BOARD

<p>Proposed rules change deletes outdated terms of office (2002, 2003 and 2004) for the initial members of the EMT Advisory Committee.</p>
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847-035-0011

EMT Advisory Committee

(1) There is created an EMT Advisory Committee, which shall consist of five members appointed by the Oregon Medical Board. The Board shall appoint two physicians and three EMTs from nominations provided from EMS agencies, organizations, and individuals.

(a) The two physician members shall be actively practicing physicians licensed under this chapter who are supervising physicians, medical directors, or practicing emergency medicine physicians.

(b) The three EMT members shall be Oregon certified emergency medical technicians who have been residents of this state for at least two years, certified as emergency medical technicians for not less than two years. At least two of the three EMT members shall be actively practicing prehospital care, and at least one of the three EMT members shall be an EMT-Paramedic.

(c) Two of the five committee members shall be from rural or frontier Oregon.

(2)(a) The term of office of a member of the committee shall be three years and members may be reappointed to serve not more than two terms.

(b) Vacancies in the committee shall be filled by appointment by the board for the balance of an unexpired term and each member shall serve until a successor is appointed and qualified.

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~~[(3) Notwithstanding the term of office specified in section (2):~~

~~(a) One EMT shall serve for a term ending June 30, 2002,~~

~~(b) One EMT and one physician shall serve for a term ending June 30, 2003, and~~

~~(c) One EMT and one physician shall serve for a term ending June 30, 2004.]~~

~~[(4)] (3) The members of the advisory committee are entitled to compensation and expenses as provided in ORS 677.280. (EXHIBIT C)~~

6. Tab F – Survey Results Presentation by Rose Howe.

Rose Howe presented a snap shot of survey results **(Her presentation was done prior to the committee voting to add the drug Ondansetron to the Scope of Practice.)**

She received 52 responses from both rural and urban areas. It was noted that there were not enough responses to draw a formal conclusion though it did give a view of the general use of different medications currently in the EMT-I scope. Extensive discussion by committee members and those in attendance on collecting data and the challenge this has been for the state. Further discussion on this topic is noted during the presentation on Tab G. Committee members thanked Rose Howe for her work in gathering the information for this presentation.

7. Tab G – Presentation on State Use Data by Dr. Sahni.

Dr. Sahni, outlined what little information the state was able collect as it pertains to the EMT-I's. While Rose Howe's survey did not have enough responses it does show how difficult this issue is in obtaining good information. Dr. Sahni did say they were seeing a decline in the number of Intermediates and thought most were reverting to the Basic level. He would like time to make a presentation at the next EMT meeting on the national scope.

8. Tab H – Presentation by Peggy Andrews on educational hours needed to add the anti-emetic drug Ondansetron.

Peggy Andrews informed the committee that two additional hours will need to be added for this classification of medication to the curriculum as this is not covered in the current curriculum. Peggy did want to point out that an average of five students per year move from EMT Intermediate to the Paramedic level. Additional discussion centered around adding additional drugs to the Scope of Practice without taking a look at the addition in curriculum hours and/or removing other drugs from the Scope of Practice. Peggy Andrews said that when the original EMT-I curriculum committee meets they go down the list of medications and picked the ones that seemed obvious to add to the scope. She believed that no formal research was done to determine which maybe best. It was the educator's

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preference that a detailed survey needs to be done before anymore drugs are added to the scope.

10. Tab J – Discussion on use of suctioning on the pharyngeal airway device – EMT Basic.

Tony Grimes brought in a King LTS airway device to show the suctioning port on this device and the use of a French Cather with it. She encountered agencies in her response area that were taught that they cannot use this feature. In the intermediate scope they can insert an oral gastric tube. While this device (King LTS) is inserted it allows for a French catheter to be inserted. Her point is since they are not initiating an oral gastric tube, they should be able to use it. It was the consensus of the committee and those in attendance that this was not initiating an oral gastric device. Peggy said she would make sure the Education Consortium was made aware of this information.

The committee members agreed to the use of the device. No change made to the Scope of Practice language.

11. Other Business.

1. Dr. Sahni

Brought forward a request to add dispensing of medication to the Paramedic scope of practice. This was different from the present wording in that dispensing would allow for medication to be dispensed and thus taken by the patient over a period of time. This would be during times of emergency as declared by the county health officer or Governor as described elsewhere. Dr. Sahni said he is working on language with the Health Divisions attorney on this issue

2. Shawn Baird

Brought forward a request to allow Paramedics to administer immunizations prior to an outbreak of an epidemic (H1N1) and to mitigate the spread. After much discussion Dr. Sahni said he would speak to the division's attorney about language similar to this. All felt that this required quick action prior to the next EMT-Committee meeting and would convene a teleconference to address this.

Dave Lapof will contact the OMB Executive Director, Ms. Kathleen Haley to discuss a temporary rule adoption to change language to the EMT Scope of Practice. Dr. Sahni will provide proposed language from EMS attorney to Dave, for discussion with Ms. Haley.

12. Confirm Next Scheduled Meeting.

Next EMT meeting was scheduled on November 20, 2009 at 9:00 AM in the OMB Board room.

Meeting adjourned at 12:35 PM.