

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, November 2, 2007, 9:00 AM

OREGON MEDICAL BOARD

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

Board Accepted 01/11/08
Committee Approved 2/1/08

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

Jerry Andrews
Peggy Andrews, Chemeketa Community College
Jonathan Chin, Washington County EMS
Tina Greiner, Oregon Volunteer Firefighters Association
Gregg Lander, Chemeketa Community College, EMT Consortium
Bob Leopold, DHS EMS & Trauma Systems
Gary McLean, Oregon State Paramedic Association
Eric Schult, Tualatin Valley Fire & Rescue
Mark Stevens, Tualatin Valley Fire & Rescue, Oregon Fire Medical Administrators Association
Lynda Thomas, Monument Volunteer Ambulance
Donna Wilson, DHS EMS & Trauma Systems

AGENDA

Approve minutes of the August 24, 2007 EMT Advisory Committee meeting

First Review Administrative Rules: 847-035-0030 (8) – Add capillary blood glucose testing to First Responder scope

DHS EMS update on revisions to OAR Chapter 333 Division 265 – EMT recertification requirements

Use of Fentanyl by EMT-Is – limited to parenteral use, not transdermal (Duragesic)

First Responders – non-invasive monitoring – does this include acquiring and transmitting 12 lead ECGs?

EMT-I curriculum and bridge course review – report from consortium

Development of a standardized approach for considering changes to the EMT Scope of Practice

What is the procedure the community colleges teach for starting IV's; and what is actually being done? – Dave Lapof, EMT B

Other business

Confirm dates of next Committee meetings

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

APPROVE MINUTES OF THE AUGUST 24, 2007 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE EMT ADVISORY COMMITTEE APPROVES THE MINUTES OF THE AUGUST 24, 2007 EMT ADVISORY COMMITTEE MEETING.

Motion passed unanimously.

**FIRST REVIEW ADMINISTRATIVE RULES: 847-035-0030
ADD BLOOD GLUCOSE TESTING FOR FIRST RESPONDERS**

Dave Lapof, EMT-B, reviewed that at the last EMT Advisory Committee meeting the Committee recommended adding capillary blood glucose testing for First Responders who have a supervising physician. Mr. Lapof stated that since the last Committee meeting he learned that King County EMS has a training program and a test for blood glucose monitoring, primarily for their EMT-Basics, although some agencies allow First Responders to do blood glucose testing. He added that there has been much public input on this issue since the last Committee meeting, indicating members of the EMS provider community are not in favor of this scope change for a number of reasons: calibration of equipment, current monitoring strips, costs, maintaining proficiency, and lack of need for the change from a treatment standpoint.

Rose Howe, EMT-I, stated that she discovered Oregon was a leader in the movement to allow EMT-Basics the ability to do blood glucose testing. She also relayed that in the majority of other states, the First Responder level is akin to the EMT-Basic level of provider. She said other states have done studies that indicate allowing basic-level providers to do blood glucose testing is helpful in terms of patient care, but that the monitoring is done after initial treatment with glucagon, to determine responsiveness and need for further treatment.

Paul Rostykus, MD, indicated he spoke to Ritu Sahni, MD, DHS EMS Medical Director, about this issue. Dr. Rostykus relayed that Dr. Sahni said the National scope does not even include capillary blood glucose testing at the EMT-Basic level and that there is no evidence indicating it is effective to do so.

Gregg Lander, State EMT Education Consortium, indicated that none of the members of the Consortium were in favor of this addition to the First Responder scope of practice. He said the Consortium members expressed concern about the potential for putting patients at risk.

The Committee determined to take no action to add capillary blood glucose testing to the First Responder scope of practice.

DHS EMS OFFICE UPDATE ON REVISIONS TO OAR CHAPTER 333 DIVISION 265 – EMT RECERTIFICATION REQUIREMENTS

Bob Leopold, DHS EMS Director, gave an update on the revisions to OAR Chapter 333 Division 265 on EMT recertification requirements. He stated that DHS EMS is putting forth a draft of the new regulations, which are on the EMS website and are being widely distributed. DHS EMS will be holding public hearings in LaGrande, Portland, and Eugene. The changes include the following: an Associates degree or higher degree is still required for EMT-P certification, but no longer is a particular Associates degree specified; requirements for CME hours are being changed as follows to bring standards closer to the National requirements: every 2 years a First Responder must obtain 12 hours, an EMT-B must obtain 24 hours, an EMT-I must obtain 36 hours, and an EMT-P must obtain 48 hours. The rule amendments will be adopted January 1, 2008 if all goes smoothly with the review process. Mr. Leopold said the CME requirements would be effective for the 2009-2011 recertification cycle so that agencies and providers can prepare. To mitigate costs and reduce the fiscal impact associated with additional CME requirements, the following were offered as options to obtain CME: reading journals, watching videos, distance learning, as well as computer-adapted testing and skills proficiency demonstration to maintain national registry certification. Mr. Leopold indicated that another proposed change is to move the ambulance service licensing date from June 30 to September first to improve workflow issues within EMS.

USE OF FENTANYL BY EMT-IS – LIMITED TO PARENTERAL USE, NOT TRANSDERMAL (DURAGESIC)

EXHIBIT A

Paul Rostykus, MD, relayed that a concern has been raised regarding the recent addition of fentanyl to the EMT-I scope of practice. Dr. Rostykus summarized the concern being the use of the fentanyl transdermal system (Duragesic) and oral transmucosal system (Actiq) by EMT-IS as these are contraindicated for acute pain. Dr. Rostykus stated that the Committee's discussions on the use of fentanyl by EMT-IS had been in terms of intravenous (IV) and intraosseous (IO) use only.

It was discussed that, in general, it may not be clear in the administrative rules and in current protocols whether the supervising physician, EMT, or both have the responsibility to limit the EMT's scope and in what situations (physician on scene or not). Bob Leopold, DHS EMS Director, indicated that DHS EMS and Ritu Sahni, MD, DHS EMS Medical Director, are working with agency directors in the state to draft model protocols in an attempt to standardize protocols and address issues such as this.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE OREGON MEDICAL BOARD AMEND OAR 847-035-0030 TO SPECIFY THE ADMINISTRATION OF ANALGESICS FOR ACUTE PAIN UNDER THE EMT-I SCOPE OF PRACTICE.

Motion passed unanimously.

ACTION PLAN: Board staff to draft amendment to OAR 847-035-0030 to specify the administration of analgesics for acute pain under the EMT-I scope of practice, reflecting that first review of the rule amendment has occurred (see *Exhibit A*).

FIRST RESPONDERS: NON-INVASIVE MONITORING – INCLUDE ACQUIRING AND TRANSMITTING 12-LEAD ECGs?

Paul Rostykus, MD, stated that the question has come up regarding whether non-invasive monitoring includes acquiring and transmitting 12-lead electrocardiographs (ECGs). Dr. Rostykus indicated his understanding is that only EMT-Paramedics are reading and interpreting ECGs. He posed the question: can First Responders and EMT-Bs put the leads on, acquire and transmit the signal? He phrased the question alternately as: Is a non-invasive device a 12-lead ECG?

Matt Eschelbach, DO, indicated that, particularly for rural Oregon, he believes it is important that EMT-Bs be able to acquire and transmit the signal so that a decision can be made regarding an appropriate facility (appropriate level hospital) to which to transport the patient.

Bob Leopold, DHS EMS Director, said he would ask Ritu Sahni, MD, DHS EMS Medical Director, to put together some information on this topic for the next EMT Advisory Committee meeting.

ACTION PLAN: Dr. Rostykus to discuss whether non-invasive monitoring includes acquiring and transmitting 12-lead ECGs with Ritu Sahni, MD. Bob Leopold, DHS EMS, to ask Dr. Sahni to put together some information on this topic for the next EMT Advisory Committee meeting. Add the issue of whether non-invasive monitoring includes acquiring and transmitting 12-lead ECGs on the agenda of the next Committee meeting.

EMT-I CURRICULUM AND BRIDGE COURSE REVIEW – REPORT FROM CONSORTIUM *EXHIBIT B*

Donna Wilson, DHS EMS, distributed a handout that summarizes where things stand for the new EMT-I curriculum (see *Exhibit B*), which started three years ago. She reported an exam pass rate for the EMT-Is attempting certification under the new curriculum of 58.5%, which she said is higher than the national average certifications pass rate. She stated that the consortium is not happy with the low pass rate and that the consortium continues to attempt to help improve that situation. She indicated that providers, particularly in rural areas, are very appreciative of the information and hungry to learn more to improve patient care. Ms. Wilson said that EMT-Is have until June 2008 to finish their curriculum upgrade. She relayed that she would not change anything in terms of the curriculum if she had the process to do over again. She shared that the next meeting of the entire original curriculum committee will be after January 1, 2008, to come back together in discussion with the course instructors and rural providers in particular to evaluate the curriculum.

Peggy Andrews, Chemeketa Community College, stated that she thinks the new curriculum is solid. She said that other educators do not have issues with the curriculum itself, although they have some concerns about the low certification pass rate. She relayed that individuals attending the Bridge class have largely been receptive of the curriculum while noting that it is a large amount of information to learn in a short period of time. She added that she, too, would not change anything in terms of the curriculum if she had the process to do over again.

Paul Rostykus, MD, asked if it is now the time for the EMT Advisory Committee to address recommended changes to the curriculum. Gregg Lander, Chemeketa Community College and EMT Consortium, recommended that the EMT Advisory Committee leave it to the curriculum committee to address changes to the curriculum, rather than the EMT Advisory Committee. It was agreed that members of the EMT Advisory Committee would bring recommendations regarding changes to the curriculum to the next EMT Advisory Committee meeting in order to discuss those recommendations with representatives of the curriculum consortium. Donna Wilson, DHS EMS, indicated that she the contact person for input to the curriculum review.

ACTION PLAN: Add a report from the EMT-I curriculum consortium to the agenda of the next EMT Advisory Committee meeting. EMT Advisory Committee members to bring input regarding recommended changes to the curriculum to the next EMT Advisory Committee meeting.

DEVELOPMENT OF A STANDARDIZED APPROACH FOR CONSIDERING CHANGES TO THE EMT SCOPE OF PRACTICE

EXHIBIT C

Paul Rostykus, MD, offered a list of questions for EMT Advisory Committee members to consider when proposing changes to the EMT scope of practice. Feedback regarding the list of questions from other members of the Committee and the public were favorable. It was recommended that both the DHS EMS office and the State EMS Committee be consulted on proposed changes to the scope of practice. Dr. Rostykus stated that the individual who proposes a change to the scope should be prepared to answer as many of the questions on the list as possible and Board staff or Dr. Rostykus can forward the proposed change with any input based on the questions to the DHS EMS office and State EMS Committee in preparation for the next EMT Advisory Committee meeting.

ACTION PLAN: Dr. Rostykus will incorporate suggestions to the list and forward the list to Board staff and the DHS EMS office (see *Exhibit C*). Board staff and Dr. Rostykus to share the list with any individual who proposes a change to the EMT scope of practice, and consult the DHS EMS office and State EMS Committee on proposed changes prior to the subsequent EMT Advisory Committee meeting.

WHAT IS THE PROCEDURE THE COMMUNITY COLLEGES TEACH FOR STARTING IVs AND WHAT IS ACTUALLY BEING DONE? – DAVE LAPOF, EMT-B

Dave Lapof, EMT-B, stated that there was a great deal of discussion at the EMS pre-conference in the Intermediate/Advanced Life Support class skill stations regarding IV starts. He raised the question of the technique community colleges are teaching for IV starts. Peggy Andrews, Chemeketa Community College, said they teach both Betadine followed by alcohol and alcohol alone techniques. She added that IV starts are not taught as part of the EMT-I Bridge course. Gregg Lander, Chemeketa Community College and EMT Consortium, stated there is another substance that is clear that is being used in the field, but that the techniques used across the state vary. Jerry Andrews indicated that his agency has a relationship with the Infection Control Department at their primary receiving hospital such that if a field IV becomes infected at the hospital, the hospital feeds that information back to the agency so that the agency can follow-up to address IV start techniques with the appropriate field provider. Jonathin Chin, Washington County EMS, indicated that the hospitals are emphasizing strict enforcement of IV start procedures as Medicare is no longer covering in-house IV site infections.

OTHER BUSINESS

State EMS Conference – Supervising Physician Forum

Paul Rostykus, MD, shared that the supervising physician forum at the State EMS conference was a success. He reported that 14 supervising physicians attended. He said that two agency managers attended and they discussed agency issues such as unions, negotiations, and contracts. He said there is another forum tentatively planned for April 4, 2008 in Eugene. The day before the forum is slated to be a one-day short course for the National Association of EMS Physicians (NAEMSP). Dave Lapof, EMT-B, announced that next year's state EMS conference will be held October 9-11, 2008 in Bend. It was announced that the conference committee is re-forming for the next conference year and the next meeting will be this Monday, November 5, 2007, in the afternoon at Tualatin Valley Fire and Rescue.

STEMI and Stroke Program Conference

Dr. Rostykus announced he has been working with DHS EMS, the American Heart Association, Oregon stroke networks, and some other groups to put together a conference on May 30, 2008 in Eugene with two tracks: 1) stroke care and 2) pre-hospital and hospital emergency department interface, particularly putting together ST segment elevation myocardial infarction (STEMI) programs and stroke programs. Dr. Rostykus said the thrust of the conference is looking at how to get the various entities (supervising physicians, cardiologists, neurologists, emergency department managers, and EMS agency managers) working together to make the system function effectively. He said involvement is wanted from EMS agencies that are either actively doing STEMI or stroke programs or are interested in doing such programs.

CONFIRM DATES OF NEXT COMMITTEE MEETINGS

The Committee scheduled future meetings for the following dates:

February 1, 2008

May 9, 2008 (tentative)

August 15, 2008 (tentative)

ADJOURNMENT

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

OREGON ADMINISTRATIVE RULES
CHAPTER 847, DIVISION 035 – OREGON MEDICAL BOARD
PROPOSED RULES CHANGES – JANUARY 2008
FIRST 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.

EMT Intermediate Report

Currently certified active EMT Intermediates 1,180

⊕ EMT Intermediates certified under the new curriculum 79

⊕ 2006 6 classes

- ⊕ Chemeketa - 16 students
- ⊕ Clackamas - 10 students
- ⊕ Rouge - 20 students
- ⊕ Treasure Valley - 10 students
- ⊕ Umpqua - 14 students (two classes)

⊕ 2007 9 classes

- ⊕ Tillamook Bay - 9 students
- ⊕ Lane - 16 students
- ⊕ BMCC - 7 students (two classes)
- ⊕ Columbia Gorge - 6 students
- ⊕ Clackamas - 9 students
- ⊕ OHSU/OIT - 10 students
- ⊕ Umpqua - 8 students

⊕ 2008 2 classes

- ⊕ Lane
- ⊕ Treasure Valley

EMT Intermediate Testing

- ⊕ Exam has gone through two revisions, students in the testing process have received rescores
 - ⊕ Final revision July 2007
- ⊕ Exam is online now for all community colleges
 - ⊕ Exception Lane CC has firewall issues and will continue to paper pencil test

EMT Intermediate Bridge Classes

- ⊕ Not yet completed with the process 420
 - ⊕ 35 signed up for the Canyonville class - Friday 11/2/07
 - ⊕ Two non MTU classes currently in progress completion this month

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?