

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, December 9, 2005 at 9:00 AM

Board Accepted as Amended 1/13/06

APPROVED BY COMMITTEE AS AMENDED 3/10/06

BOARD OF MEDICAL EXAMINERS

1500 SW 1st Ave, Suite 620

Portland, Oregon 97201

MEMBERS PRESENT

Paul S. Rostykus, MD, Chair

Gregory Lorts, MD

Dave Lapof, EMT-B

Toni R. Grimes, EMT-P

STAFF PRESENT:

Diana Dolstra, Licensing Manager

Jennifer Lannigan, Licensing Coordinator

GUESTS

Peggy Andrews, Chemeketa Community College

Jeanne Arana, DHS-EMS

Casey Craig, Woodburn Ambulance

Merlin Curry, Clackamas Community College

Tim Hennigan, DHS-EMS

Rose Howe, Monument Volunteer Ambulance

Randy Jackson, Keizer Fire District

Luke Kieffer, Tualatin Valley Fire & Rescue

Kara Kohfield, Blue Mountain Hospital Volunteer Ambulance

Gregg Lander, Chemeketa Community College, EMT Consortium

Gary McLean, EMT-P, East Clackamas County EMS, OSPA

Pontine Rosteck, American Medical Response

Mark Stevens, Tualatin Valley Fire & Rescue

John Stouffer, Gresham Fire

Joseph Wosley, Tualatin Valley Fire & Rescue

AGENDA

Approve minutes of the September 9, 2005 EMT Advisory Committee meeting.

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

Review and Interview candidates applying for the EMT position on the Committee

- Rose Howe, EMT-I
- Kara Kohfield, EMT-I

Report from DHS-EMS on the review of their statutes and rules (ORS/OAR) and recommendations – Jeanne Arana, Director, DHS-EMS & Trauma

Discuss Proposed Statutory Changes for Medical Director Regulations – John Stouffer

- Move authority for appointing supervising physicians from the BME to DHS-EMS
- Change “supervising physician” to EMS Medical Director”
- DHS-EMS appoint a county medical director

Add a qualification for one Board member to be an EMS Medical Director, or draft administrative rule language to add to Committee membership a Board member who is a liaison to the Committee

Clarification as to whether the Laryngeal Mask Airway (LMA) is in the EMT-Basic scope of practice as a cuffed pharyngeal airway – Paul Rostykus, MD

Does “provide care for soft tissue injuries” include reducing dislocated joints in the First Responder scope of practice?

Discuss ability of EMTs to provide immunizations during a disaster – Paul Rostykus, MD

EMTs in the hospital emergency room – Paul Rostykus, MD

Other business: Supervising physician forum in Sunriver; Fire Department Medical Administrators annual luncheon

Future meeting date

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

APPROVE MINUTES OF THE SEPTEMBER 9, 2005 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE EMT ADVISORY COMMITTEE ACCEPTS THE MINUTES OF THE SEPTEMBER 9, 2005 EMT ADVISORY COMMITTEE MEETING.

Motion passed unanimously.

UPDATE TO THE EMT-INTERMEDIATE CURRICULUM DEVELOPMENT

Peggy Andrews, Chemeketa Community College, reported that the first EMT-I Bridge/instructor course was completed a few weeks ago in Bend. She said 23 people completed the training and are now prepared to deliver the curriculum. Instructors who attend the Bridge course are given a written curriculum as well as Power Point presentations for the lectures. Interested parties can contact DHS-EMS for the course curriculum materials. Ms. Andrews relayed that five more Bridge courses are planned, the next one being in February in Coos Bay. She added that the schedule of Bridge courses has been posted on the instructor lists state-wide, and DHS-EMS has that information. She stated that for most of the schools, the EMT-I courses will be starting January 3, 2006, when school reconvenes. She indicated that the curriculum is designed so that it can be delivered as part of scheduled continuing education in agencies and will satisfy EMT-I recertification requirements, in lieu of current continuing education requirements.

Gary McLean, EMT-P, inquired of the Committee if all EMT-Is must take the course before using the new EMT-I scope of practice.

Peggy Andrews clarified that the only new skill that was added to the EMT-I scope was intramuscular (IM) injections. She stated that the intent of the course is to bring EMT-Is up to speed on the theory and background knowledge for cardiology and pharmacology primarily so that they can make better decisions in practice.

Dr. Lorts stated that the Committee did not make a policy statement requiring all EMT-Is to take the course.

Dr. Rostykus highlighted, however, that DHS-EMS is stating that EMT-Is who do not take the course will lose their certification. Currently certified EMT-Is have until 6/30/07 to complete the course in order to maintain their certification. If they do not complete the course by 6/30/07, their certification will lapse, and they would have one year to complete the course and reinstate their certification, or opt to demonstrate that they have achieved the EMT-B recertification requirements and recertify at the EMT-B level. If they opt to recertify at the EMT-B level, they would still have one year in which they could take the course to recertify at the EMT-I level.

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

The Committee interviewed Rose Howe, EMT-I, and Kara Kohfield, EMT-I.

Rose Howe completed the EMT-Basic course in 1999 and has been an EMT-I since 2000. She works with Monument Volunteer Ambulance in Eastern Oregon. She has been honored with awards for "Most Dedicated EMT," "Most Inspirational EMT," "EMT-I of the Year" and the "Dan Cary Award" by Grant County and "EMT-I of the Year" by the State of Oregon. She is one of the primary recertification training officers for local EMTs, and she is on call 24/7 for her community. She has received grants for equipment for Monument EMTs. She has also been a member of the EMT-I curriculum development committee for Oregon. She stated that she is

invested in EMTs at all levels, be they in urban or rural settings, having access to training to keep current on new procedures and developments in the EMS community. Ms. Howe said her agency responds to about 50 calls per year, with a call often taking four hours or longer given the remoteness of the area.

Kara Kohfield has been an EMT-I since 1996 and a 911 Dispatcher with the John Day Police Department in Eastern Oregon since 2000, handling EMT, fire and law enforcement dispatching. She has also been an Incident Medical Specialist in Region 6, John Day, since 2000. She has been honored with local awards for “EMT-I of the Year” (1998 and 1999) and “Dispatcher of the Year” (2001, 2003, and 2004) and community service awards from EMS-DHS and the Oregon State Police (2001). She has approximately nine years of ambulance experience. She responds to about 400-500 calls per year in 12-hours shifts with Blue Mountain Hospital Volunteer Ambulance.

Diana Dolstra clarified for the Committee and the candidates that the current EMT position on the Committee expires on June 30, 2006 and is then open again for recruitment. She added that filling the remainder of the current term would not impact the term limits in effect for Committee members, that being two terms of three years each, if the person who fills the current term elects to re-apply and is appointed again. Ms. Dolstra said that announcements for the new full term which begins on July 1, 2006 will be sent out after the March 2006 Committee meeting, and interviews will happen at the June meeting, with the new member taking office at the September 2006 meeting.

Committee members voted by secret ballot. The ballot results indicated that Rose Howe, EMT-I, will be recommended to the Board as the Committee’s top candidate, followed by Kara Kohfield, EMT-I. The Board will vote for a new member at the next scheduled meeting on January 12-13, 2006.

NOTE: 1/13/06—The Board voted to appoint Rose Howe to serve as the new member of the EMT Committee.

REPORT FROM DHS-EMS ON THE REVIEW OF THEIR STATUTES AND RULES (ORS/OAR) AND RECOMMENDATIONS

Jeanne Arana, Director, DHS-EMS & Trauma Systems, provided the Committee with a report from the EMS and Trauma Systems Section workgroup created to examine the Oregon administrative rules (OAR) and Oregon revised statutes (ORS) that govern those programs, as well as the OARs and statutes that govern stakeholder programs, such as the Board of Medical Examiners (BME). Paul Rostykus, MD, BME EMT Committee Chair, and Diana Dolstra, BME Licensing Manager, have participated in this workgroup.

Ms. Arana indicated that after meetings in August, October, and November of this year, the workgroup unanimously recommended the current ORS Chapter 682 and OAR language that reference and define “supervising physician(s)” and “Medical Director(s)” be changed to reference and define “EMS Medical Director(s).” She indicated that this shift is a national EMS trend. She highlighted that, as statutes currently reference “supervising physician(s),” statutory

change would need to precede changes in the OARs. She clarified that it would be important to make sure that “EMS Medical Director” is defined in statute as a physician.

Ms. Arana also reported that other issues discussed by this workgroup included the following: moving all operational and administrative responsibilities under the EMS and Trauma Systems Section within DHS or alternately, under the BME; creating a state EMS Medical Director; and having a dedicated seat on the BME for a supervising physician. She indicated that the workgroup did not reach a consensus on these issues.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THAT THE BOARD OF MEDICAL EXAMINERS SUPPORT A LEGISLATIVE CONCEPT TO CHANGE STATUTORY LANGUAGE THAT REFERENCES AND DEFINES “SUPERVISING PHYSICIAN(S)” AND “MEDICAL DIRECTOR(S)” TO REFERENCE AND DEFINE “EMS MEDICAL DIRECTOR(S),” FOLLOWED BY CHANGES TO OAR CHAPTER 847, DIVISION 035, TO MAKE REGULATORY LANGUAGE CONSISTENT.

Motion passed unanimously.

NOTE: 1/13/06—The Board voted to maintain the use of the term “physician” in the designation of supervisor for EMTs and First Responders.

DISCUSS PROPOSED STATUTORY CHANGES FOR MEDICAL DIRECTOR REGULATIONS

John Stouffer, Gresham Fire, presented a number of recommendations regarding Medical Director regulations for discussion. First, he echoed the recommendation made by the EMS and Trauma Systems workgroup noted by Ms. Arana above, that regulatory language referencing “supervising physician” be changed to reference “EMS Medical Director.”

Second, he recommended the shifting of responsibility for Medical Directors (supervising physicians) and EMT scope of practice issues from the BME to the state EMS office, to consolidate EMS regulatory authority into one agency and provide one point of contact for EMS-related issues. He indicated that he envisions a committee or board similar to the EMT Committee that would be responsible for defining scope of practice issues, but associated with the state EMS office rather than the BME.

Dr. Lorts commented that the current system of regulation of scope of practice issues by the BME has some advantages as well, one of which is that it offers some checks and balances to EMS in terms of definition of the practice of medicine.

Third, Mr. Stouffer recommended the appointment of a single Medical Director per county and a single set of protocols per county. He relayed that, under such a system, resources can be pooled, a smaller number of Medical Directors could focus their energy and expertise on EMS

and the state could provide education and potentially some financial assistance to those physicians. He stated that this system works well in other states.

Toni Grimes, EMT-P, shared a concern with having a single Medical Director per county, that being that in counties in which there is a great deal of diversity in terms of the size of EMS agencies, associated with a higher operating budget, smaller agencies such as volunteer departments may not be able to meet the requirements imposed upon all agencies within the county to the same extent that large agencies could.

Dr. Lorts shared his opinion that such a system may not work very well in small, rural counties, as the Medical Director would have difficulty keeping track of all the EMS activities across the county. He said he is not sure such a system would be an improvement for the whole of Oregon.

Dave Lapof, EMT-B, questioned how agencies in the same county that handle quite diverse volumes of calls and transports per year would contribute to the compensation of the Medical Director, and whether any system of pro-rated compensation based on volume of calls/transports would lead to competition amongst agencies. He also stated that it seems agencies would need a great deal of time to prepare to rollout operations under such a system.

Peggy Andrews commented that having one Medical Director per county may be counter-productive to facilitating greater supervising physician involvement in EMT activities as well as to matching supervising physicians to agencies in terms of culture. In counties with large and small EMS agencies, the same Medical Director would be expected to be a good compliment to and effective with both large and small agencies, which may not be a realistic expectation.

Mr. Stouffer highlighted that the county Medical Director could appoint Assistant Medical Directors or advisors who are physicians and who could assist in quality assurance and education. He also clarified that it is not intended that each Medical Director be a government employee, but, rather, an independent contractor. He stated that the decisions of the Medical Director should be based on standards of quality practice, not solely on fiscal impact.

Dr. Rostykus summarized Mr. Stouffer's fourth recommendation: Oregon should have liability coverage for supervising physicians performing EMS duties who are in good standing and have fulfilled their duties in accordance with the law.

ADD A QUALIFICATION FOR ONE BOARD MEMBER TO BE AN EMS MEDICAL DIRECTOR, OR DRAFT ADMINISTRATIVE RULE LANGUAGE TO ADD TO COMMITTEE MEMBERSHIP A BOARD MEMBER WHO IS A LIAISON TO THE COMMITTEE

Dr. Rostykus indicated that at a previous DHS-EMS conference, the issue of having a member of the Board of Medical Examiners be a Supervising Physician was discussed. Another idea that was discussed was to appoint a Board member to be a liaison from the EMT Committee to the Board, similar to the way in which a Board member serves as a liaison from the Physician Assistant and Acupuncture Committees to the Board.

Diana Dolstra clarified that professional organizations, such as the Oregon Medical Association (OMA), put forth names to the Governor's office as nominees for Board membership, and the Board itself has no input into such nominations or the selection of Board members. She added that this is why the second idea above, to have a Board member serve as a liaison from the EMT Committee to the Board, may be preferential, as it is within the Board's authority to appoint such a liaison. A Board liaison would attend all meetings of the EMT Committee and report back to the full Board on the issues being addressed by the Committee.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS APPOINT A BOARD MEMBER TO SERVE AS A LIAISON FROM THE EMT COMMITTEE TO THE BOARD.

Motion passed unanimously.

CLARIFICATION AS TO WHETHER THE LARYNGEAL MASK AIRWAY (LMA) IS IN THE EMT-BASIC SCOPE OF PRACTICE AS A CUFFED PHARYNGEAL AIRWAY

Paul Rostykus, MD, summarized some of the history of this issue, and pointed out that the Committee has not defined what constitutes a laryngeal mask airway (LMA) nor a cuffed pharyngeal airway device.

Peggy Andrews stated that the EMT-I curriculum workgroup previously recommended to the EMT Committee that the LMA was not an appropriate airway for the EMT-I level and that it not be put into the EMT-I scope, and it was not.

Dr. Lorts stated that previous work for the Committee by Jon Tardiff, EMT-P, indicates that a cuffed pharyngeal airway device would include an LMA.

The Committee discussed problems associated with defining a cuffed pharyngeal airway device as including or not including specific brand names of devices, such as LMA, Combitube, or King LT airway.

Dr. Lorts suggested the Committee could determine that a cuffed pharyngeal airway device does not include the LMA. He relayed that the LMA does not protect the airway, whereas other cuffed pharyngeal airway devices protect the airway, which he sees as the essential difference.

Dr. Rostykus stated that the LMA protects the airway to some degree, although its cuff is a bit different from that of other cuffed devices.

Peggy Andrews stated that, from the research she has done, across the nation the LMA is not typically put into the scope of practice until the intermediate level, and more frequently not until the paramedic level.

Dr. Rostykus suggested that the Committee gather more information to assist in developing a definition of a cuffed pharyngeal airway device that is generic enough to encompass specific brand name products.

Toni Grimes, EMT-P, agreed to gather more information on this issue for the Committee.

ACTION PLAN: Toni Grimes to research a definition of cuffed pharyngeal airway device, whether the LMA would constitute a cuffed pharyngeal airway device, and if the LMA would then be under the EMT-B scope of practice. Ms. Grimes to send her information to other Committee members and to Diana Dolstra prior to the next meeting. Put this on agenda of the next Committee meeting.

DOES “PROVIDE CARE FOR SOFT TISSUE INJURIES” INCLUDE REDUCING DISLOCATED JOINTS IN THE FIRST RESPONDER SCOPE OF PRACTICE?

Dr. Rostykus stated that the scope of practice for First Responders includes providing care for soft tissue injuries, per OAR 847-035-0030 (7) (f). He then raised the question of whether reducing a dislocation is included in care for a soft tissue injury.

Dr. Lorts stated his opinion that a dislocation is a hard tissue injury.

Pontine Rosteck, American Medical Response (AMR), indicated that there is a large reach and treat specialty team for AMR, the RAP team, supervised by Terri Schmidt, MD, from OHSU, which has protocols that allow all EMTs to do shoulder dislocation under certain circumstances, but it is usually in a frontier situation where distance, time and extrication are factors. Ms. Rosteck indicated that in these situations Dr. Schmidt gives each RAP personnel member direction and instruction, and that typically it is the paramedic on the team who is doing the shoulder dislocation. Ms. Rosteck said that these protocols have been in place for years, and she can ask Dr. Schmidt to send a letter to the EMT Committee clarifying how this came about.

Peggy Andrews clarified that paramedics are not taught how to relocate dislocations in their initial training.

DISCUSS ABILITY OF EMTs TO PROVIDE IMMUNIZATIONS DURING A DISASTER

Paul Rostykus, MD, stated that the issue of whether EMTs can provide immunizations during a disaster has come before the Committee a few times. He indicated that the Board has previously determined that, in nonemergency situations, EMTs cannot provide immunizations.

Toni Grimes, EMT-P, stated that New Mexico has added immunizations to the scope of practice for EMT-Is, strictly for disaster events. Ms. Grimes shared her opinion that clarifying procedures for EMTs in the administrative rules in the event of a emergency could be helpful so that personnel and county and state officials would have an understanding of the EMT scope in these situations.

Dr. Lorts relayed that the chain of decision-making in regards to a declared emergency in Oregon would be the Governor to the state health officer (a physician) to the county health officers (physicians), who would then give orders to EMT-Ps to initiate or administer medications. As such, it seems that paramedics would be permitted to do immunizations in a declared disaster.

Jeanne Arana indicated that there is legislation being pursued in Oregon and nationwide to give authority to the local county public health officer to declare a disaster in their jurisdiction, independent of the Governor. She added that, until such legislation is in place, any clarification to the current administrative rules could be made under the Governor declaring a state of emergency. She also said that perhaps any rules language should not be limited to just immunizations, as EMTs would be doing anything they are told to do if there is a state of emergency.

EMTs IN THE HOSPITAL EMERGENCY ROOM

Paul Rostykus, MD, stated that the issue of EMTs providing care in the hospital emergency room has also previously come before the Committee.

Jeanne Arana briefly reviewed the history of this issue and summarized that the basic issue is that, as paramedics provide pre-hospital care, they cannot practice in an emergency department because that is no longer a pre-hospital setting. She stated that, in their discussion of this issue, DHS-EMS had not reached any consensus.

Dr. Lorts stated that, while there is certainly a role for EMT-type activities outside of the ambulance pre-hospital care setting, the EMT scope of practice does not address that. He added that if there is interest from the EMT community or elsewhere to address this, that should be opened up as a new area with its own scope, but that the Board decided not to pursue that avenue, as non-pre-hospital care is not within the scope of practice for the EMTs' pre-hospital care.

Dr. Rostykus said he could speak about this issue with an EMT/nurse he knows who runs an emergency department who seems to have found a work around for this situation by calling EMTs something different when they are performing duties in the emergency department. He said that, if the work around is there, it may be a non-issue.

<p>ACTION PLAN: Dr. Rostykus to speak with an EMT/nurse who runs an emergency department regarding using EMTs in the emergency department and to report back to the Committee after this discussion.</p>

OTHER BUSINESS

Dr. Rostykus announced that anyone interested in more information on the upcoming supervising physician/EMS Medical Director forum in Sunriver can email him or speak to him at the conclusion of this meeting.

Dave Lapof, EMT-B, announced that the Fire Department Medical Administrators is having their annual luncheon on December 14, 2005.

FUTURE MEETING DATE

The next meeting date will be Friday, March 10, 2006 at 9:00 AM.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 12:15 PM.