



Oregon

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Board-approved October 7, 2016

**EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE
MEETING AGENDA
BOARD OFFICE**

August 19, 2016
9 A.M.

Committee Members:

Mohamud Daya, MD
Wayne Endersby, EMT-I
Chris Poulsen, DO, Interim Chair
Mike Verkest, Paramedic

Staff:

Joseph Thaler, MD, Medical Director
Nicole Krishnaswami, JD, Operations & Policy Analyst
Netia N. Miles, Licensing Manager
Shayne J. Nylund, Committee Coordinator

Absent by Prior Notification:

Kara Kohfield, Paramedic, Chair

PUBLIC SESSION

1	Call Meeting to Order – Introductions/Attendance	Poulsen
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The Meeting was called to order at 9:01 a.m.

Members of the public introduced themselves:

Shawn Baird, *Oregon Ambulance Association*
Paul Bollinger, *Health Share of Oregon*
Jonathan Chin, *Washington County Emergency Medical Services*
Dave Lapof, *Mid Columbia Fire and Rescue*
Aaron Monnig, *Multnomah County Emergency Medical Services*
Mark Stevens, *EMS Section Oregon Fire Chiefs Association*
Margaret Strozyk-Hayes, *Hamlet Fire and Rescue Department*

2	Meeting Minutes – Review of Board Approved Minutes from May 20, 2016	Poulsen
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Dr. Daya moved to approve the February 19, 2016, minutes as written. Dr. Poulsen seconded the motion. The motion unanimously passed.

DISCUSSION ITEMS

In reviewing this rule, please consider the Fiscal Impact.

3	OAR 847-035-0011: EMS Advisory Committee	FIRST REVIEW	Poulsen
The proposed rule amendment requires that the physician members of the EMS Committee have at least two years of experience actively practicing as Oregon EMS supervising physicians.			

Dr. Poulsen reviewed the proposed changes to OAR 847-035-0011 before the Committee.

COMMITTEE RECOMMENDATION: The Committee recommended forwarding proposed changes to OAR 847-035-0011 as written. Forward to the full Board for review.

In reviewing this rule, please consider the Fiscal Impact.

4	OAR 847-035-0030: Scope of Practice	FIRST REVIEW	Daya
The proposed rule amendment broadens the EMT scope of practice to allow blind insertion of any supraglottic airway device rather than limiting the scope to only cuffed pharyngeal airway devices and removes the limitation on performing tracheobronchial tube suctioning to only endotracheal intubated patients to allow EMTs to also perform this suctioning on tracheostomy patients. The proposed rule amendment also adds a provision to allow Paramedics to maintain ventilators during transport if the Paramedic is trained on the specific device and is acting under written protocol or direct orders.			

Dr. Daya reviewed the proposed changes to OAR 847-035-0030.

The EMT scope of practice OAR 847-035-0030(9)(c) **currently** reads: *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.*

The **proposed revision** to (9)(c) reads: *Insert a supraglottic airway device to facilitate ventilation through the glottic opening by displacing tissue and sealing of the laryngeal area.*

The EMT scope of practice OAR 847-035-0030(9)(d) **currently** reads: *Perform tracheobronchial tube suctioning on the endotracheal intubated patient.*

The **proposed revision** to (9)(d) reads: *Perform tracheobronchial tube suctioning.*

In addition, the Committee proposed amending the Paramedic scope of practice language to read: *(12)(b) Maintain mechanical ventilation during transport if trained on the particular equipment and if acting under*

specific written protocols. The Medical Director for the Oregon Medical Board stated members of the full Board had some concerns about Paramedics initiating respirators in the field out of the hospital. Specifically there were concerns about the risks of barotrauma and over-oxygenation. The full Board also inquired if there should be a statement placed in the rule regarding Paramedics contacting a receiving physician after initiating respirators in the field to confirm the respirator settings.

Dr. Poulsen acknowledged the Board’s inquiry; however, he stated that it is up to the supervising physicians and the agencies to provide the proper training to the Paramedics for the device. Dr. Daya suggested adding the word *Initiate* to proposed new addition OAR 847-035-0030(12)(b), as this would allow a much broader implication, specifically if resources were limited.

Lastly, the Committee reviewed OAR 847-035-0030(10)(f), which currently reads: *Perform tracheobronchial suction of an already intubated patient.* It was agreed that it could be removed from the AEMT scope of practice due to being redundant language.

COMMITTEE RECOMMENDATION: The Committee recommended changing the proposed new OAR 847-035-0030(12)(b) to read: *Initiate and maintain mechanical ventilation during transport if trained on the particular equipment and if acting under specific written protocols.*

In addition, the Committee recommended removing language OAR 847-035-0030(10)(f) from the AEMT scope of practice which currently reads: *Perform tracheobronchial suction of an already intubated patient.* Forward to the full Board for review.

5	Washington State Department of Health Scope Chart	Poulsen
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The Committee reviewed correspondence from David Lehrfeld, MD, Medical Director, Emergency Medical Services & Trauma Systems, Oregon Health Authority (OHA), who requested the Board keep a scope of practice chart similar to the Washington State Department of Health’s scope chart. In the letter to the Committee, Dr. Lehrfeld stated he thinks their chart is very well written and would be useful for the Board to have a similar document.

Mr. Verkest pointed out that there already is an easy to read Oregon EMS Provider Scope of Practice document, which is color coded and is broken down by provider level.

As the Board is responsible for EMS providers’ scope of practice, it would be the Board’s responsibility to maintain a similar chart. It was pointed out that a historical chart is currently provided on the Board’s website, which has been easily utilized and has met everyone’s needs thus far. It was also pointed out that should a detailed chart such as the one proposed be required, it could create a significant workload issue for Board staff to maintain on a regular basis, as the EMS Committee’s scope of practice changes regularly. In addition, the Board has concerns about currently having different charts available to the public as there could be conflicting information contained in them. Therefore, it was suggested that research be done to find out who at DHS is maintaining and posting the current EMS provider scope of practice document.

COMMITTEE RECOMMENDATION: The Committee recommended gaining a better understanding of OHA’s needs and clarifying who at OHA created and maintains the color-coded EMS provider scope chart. After additional research, the topic will be brought back for discussion at a future Committee meeting.

6	Scope of Practice Change Request: Allow A-EMTs to Establish Intravenous Access via Intraosseous (IO) Infusion in Adult Patients	Verkest
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The Committee reviewed a scope of practice change request from Margaret Strozyk-Hayes, Hamlet Fire and Rescue Department. The proposed change request is to allow Advanced Emergency Medical Technicians (AEMT) to also establish intravenous access via intraosseous (IO) infusion on an adult patient under OAR 847-035-0030(10)(e). Currently OAR 847-035-0030(10)(e) reads: *Initiate and maintain an intraosseous infusion in the pediatric patient.* In the scope of practice change request, Ms. Strozyk-Hayes states if AEMTs are allowed IO access in pediatric patients, it would seem to be in the best interest of patient care to allow it for adults also.

Mr. Verkest stated it isn't unreasonable to allow AEMTs to establish intravenous access via IO infusion on an adult patient if the EMS agency is willing to provide the training and take on the increased cost. He also stated the risk is relatively the same as establishing an IO infusion on a pediatric patient. Dr. Daya stated if AEMTs were allowed IO access on adult patients, they also may need to administer IO anesthetic Lidocaine as outlined in the EMT-Intermediate scope of practice under OAR 847-035-0030(11)(c)(F). He expressed concern that an IO without Lidocaine is a painful experience for a conscious patient. It was stated that another option is to allow AEMTs to establish an IO infusion on an adult patient, provided they are under the supervision of an EMT-Intermediate or Paramedic as they have the ability to administer Lidocaine.

The Committee suggested obtaining additional research regarding recommended lidocaine usage for both conscious and unconscious patients, as well as the types of tools that are used for administering IO infusions. In addition, Mr. Verkest will research what ultra-rural areas, such as Alaska, allow in their scope of practice.

COMMITTEE RECOMMENDATION: The Committee recommended leaving the current language in place at this time. Further research will be done, and this item will be brought back for discussion at a future Committee meeting.

7	Public Comments	Poulsen
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Mark Stevens, EMS Section Oregon Fire Chiefs Association, stated that the Regional EMS Personnel Licensure Interstate Compact (REPLICA), which addresses the issue of allowing EMS personnel to work across state lines without having to be licensed in multiple states, will be introduced by Oregon Senator Chuck Thomsen at the next legislative session.

8	Confirm Next Meeting Date – November 18, 2016, 9:00 A.M	Poulsen
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By consent, the Committee approved the next meeting date as November 18, 2016.

ADJOURN at 10:25 a.m.