

Medical Directors Committee
Governors' EMS and Trauma Advisory Council
Position Paper on the EMS National Scope of Practice Model Draft 2

We agree in principle with the 'EMS Agenda for the Future' and the 'National EMS Scope of Practice Model'. We believe there should be a relationship between competency certification and professional licensure, and each State should have the authority to establish a Scope of Practice, within the State, within parameters allowing execution of duties to best serve each community's needs allowing reasonable local variation based on education, equipment allocation, field organization, and local medical delegation. Enhancement of professional recognition thru continuing education, advancement of practice skills, and periodic and regular testing should be pathways allowing access to higher levels of certification/licensure with ultimate designation/credentialing based on medical delegation, and consistent with State and national standards.

As stated, the 'EMS Scope of Practice' model is a consensus with no regulatory authority. Within the context of local variability, within the State of Texas in particular, it should only be used to establish consistency in protocols and procedures as deemed appropriate to each locale, credentialed and delegated by Medical Direction. At no time should a protocol or procedure known to a respondent be withheld because of minimal or maximal limits on his/her accreditation/licensure during life/limb threatening incidents, and should be inherent as part of the medical delegation and outside the concept of illegal authority, but subject to peer review and censure, and not define a scope of practice. Safe and effective care is THE primary import.

We perceive today the levels characterized are equivalent to those already found in the State of Texas and are glad specific educational levels are no more stringent than the standards already established in our State. As the majority of the EMS programs in the State of Texas are not nationally accredited, we feel it would be premature to require National EMS Education Program Accreditation which would limit the availability of educational programs for EMS personnel in a large portion of our State. The equivalencies as stated are: EMR=ECA; EMT=EMT Basic; AEMT=EMT Intermediate; and Paramedic=Paramedic. As is understood the psychomotor skills equate to categories associated with entry level competence at each licensure level. The EMR category should function with an EMT or higher category. The EMT should be capable of performing initial patient assessment and triage as many 'EMT-B's are already involved in Emergency Medical Dispatch. The AEMT, representing the minimum staffing for patients requiring limited advanced care at the scene or in transport may be the highest level in certain locales, should be allowed training in the use of the Combitube. The Paramedic should have entry level skills based on continuing education and practical assessment to include endotracheal intubation using a variety of techniques including 'rapid sequence intubation', needle and retrograde cricothyrotomy, and surgical cricothyrotomy.

We understand EMS in most States is based on certification or licensure that is legislated. However, in Texas and certain other States the practice of pre-hospital care is based on delegated authority. We ask the Committee to include language accepting the option of States to maintain delegation of medical authority with the understanding that delegated medical authority emanates from qualified medical direction. Our goal is to allow advancements in medical care be incorporated into the pre-hospital setting and continue the 'EMS Agenda for the Future'.

Respectfully submitted,

Steven Ellerbe, D.O.
Committee Chair, Medical Directors Committee
Governors' EMS and Trauma Advisory Council

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May 26, 2005

Dan Manz, Principle Investigator
EMS National Scope of Practice Model Project
c/o NASEMSD
201 Park Washington Court
Falls Church, VA 22046-4527

Dear Mr. Manz,

After careful review of the second draft entitled "EMS Scope of Practice" we were pleased to note a number of changes that we feel improved the document immensely.

This having been said we still have a number of concerns that prevent the Governor's EMS and Trauma Advisory Council, Education Committee (GETAC), from a complete endorsement.

We would like to see the phrase "Freedom Within Limits" removed from the document. Historically speaking Americans want to have the freedom to make the correct choices to provide the best patient care. We feel it prematurely places the document into an unfavorable position.

With respect to Emergency Medical Responder page 21, line 24, we are concerned that the suggested prevention of transport by EMR certified individuals would place an unrealistic burden on a number of our rural services. We respectfully request that this restriction be omitted. Page 23, line 13, stated that EMT is the minimum staffing for transport ambulance. We feel that Emergency Medical Responders are capable of fulfilling this role. In trauma situations, it is imperative that EMRs be able to immobilize a patient's cervical spine and apply a short and long spine board to reduce the chance of spinal cord injury.

Continuing with comments on the EMR level we are equally concerned that this provider (with training) would be restricted from using a glucometer, page 22, line 23-25, as well as administering oral glucose. The rationale for this objection again specifically relates to our rural areas that often face unique challenges including extended transport times and distances as well as manpower issues.

At the EMT level we have a number of concerns that suggest a focus that is perhaps more narrow than is needed and in some cases restrictive to the point of not being able to provide adequate patient care.

We suggest that if no other provider is available the EMT is completely capable, and in many cases preferable, in matters of performing an adequate assessment and making appropriate triage decisions. On page 23, lines 17-23, the document states that an EMT is not capable of making the appropriate disposition decision of patients for treatment in the

pre-hospital setting. In many areas the EMT will be only responder to care for patients. With this in mind, we suggest that triage be returned to this level of treatment.

As stated earlier with regard to the EMR, Texas faces many rural issues. We are concerned that patients from these as well other areas might be significantly impacted. On page 24, lines 1-5, we sincerely appreciate the need for advancing EMS education. With this in mind we must still strongly suggest that the EMT be allowed to administer SL nitroglycerine, nebulized breathing treatments, auto injector based medications and all airway devices that do not penetrate the vocal cords.

On page 25, lines 35-40, the advanced EMT level, we suggest that specific methods of unassisted advanced airway management be left to delegated medical control. We do not feel that a specific listing of skills is needed or prudent at this point in U.S. pre-hospital emergency medicine.

On page 25, line 35, we feel that the Intraosseous Access should be added to this level for all patients indicated by medical control.

Lastly at the advanced EMT level we strongly believe that specific medication deemed necessary should not be restricted to a certain route of administration. Administration routes for any needed medication should be at the discretion of medical direction.

At the Paramedic Level we begin by restating, with slight modification, that specific methods of advanced airway management are left to delegated medical direction. We do not feel that a specific listing of skills or medications is needed or prudent at this point in U.S. pre-hospital emergency medicine.

As a matter of point, pharmacologically assisted intubation should remain as an option to this level of certification based upon delegated medical direction.

We also feel that the Advanced Practice Paramedic should be returned to the document. With an eye toward the future of emergency medicine we firmly believe that there will be a place for this level of care and a need from our citizens.

It is our sincere hope not only to increase the ability of our EMS providers to provide quality patient care not only in Texas, but all over this great land of ours. As a delegated practice state we would like to combine aspects of the scope of practice and delegated practice to help us achieve the aforementioned goal of providing quality patient care. Thank you all of your staff for the hard work, forethought, and time invested in this document.

We look forward to working with you and hope to hear from you soon.

Sincerely,

Jodie Harbert
EMS Education Chairman
Texas GETAC

Scott Mitchell
EMS Education Member
Texas GETAC

Scott Bolleter
EMS Education Member
Texas GETAC

Cc: Debbie Cason UTSW Dallas

May 27, 2005

Dan Manz, Principle Investigator
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Dear Mr. Manz,

After reviewing the "EMS Scope of Practice, Draft 2", we are very pleased to see many of the suggestions you've received incorporated into the new document. The changes undoubtedly reflect the level of care EMS is currently providing across the country. The amount of input you've received demonstrates the dedication and strong desire to build an even stronger model.

The EMS Committee of the Governor's EMS and Trauma Advisory Council (GETAC) of Texas, would like to make several recommendation we feel are needed.

We would like to see the phrase "Freedom Within Limits" removed from the document. Historically speaking Americans want to have the freedom to make the correct choices to provide the best patient care. We feel it prematurely places the document into an unfavorable position.

With respect to the Emergency Medical Responder, we are concerned that the suggested prevention of transport by EMR certified individuals would place an unrealistic burden on a number of our rural services. While an ambulance staffed minimally with 2 EMTs is ideal and should be enforced when possible, we feel that there should be allowable exceptions. Page 23, line 13, stated that EMT is the minimum staffing for transport ambulance. We respectfully request that this restriction be omitted. We feel that Emergency Medical Responders are capable of fulfilling this role. Additionally, in trauma situations, it is imperative that EMRs be able to immobilize a patient's cervical spine and apply a short and long spine board to reduce the chance of aggravating a spinal cord injury.

Continuing with comments on the EMR level we are equally concerned that this provider (with training) would be restricted from using a glucometer, page 22, line 23-25, as well as administering oral glucose. The rational for this objection again specifically relates to our rural areas that often face unique challenges including extended transport times and distances as well as manpower issues.

At the EMT level we have a number of concerns that suggest a focus that is perhaps more narrow than is needed and in some cases restrictive to the point of not being able to provide adequate patient care.

We suggest that the EMT is completely capable, and in many cases preferable, in matters of performing an adequate assessment and making appropriate triage decisions. On page 23, lines 17-23, the document states that an EMT is not capable of making the appropriate disposition decision of patients for treatment in the pre-hospital setting. In many areas the EMT will be only responder to care for patients. Additionally, forcing the more advanced personnel to take the time to reassess patients instead of initiating potentially life saving care and transport may prove detrimental. With this in mind, we suggest that patient assessment be returned to this level of treatment.

As stated earlier with regard to the EMR, Texas faces many rural issues. We are concerned that patients from these as well other areas might be significantly impacted. On page 24, lines 1-5, we sincerely appreciate the need for advancing EMS education. With this in mind we must still strongly suggest that the EMT be allowed to administer SL nitroglycerine, nebulized breathing treatments, auto injector based medications and all airway devices that do not penetrate the vocal cords.

On page 25, lines 35-40, the advanced EMT level, we suggest that specific methods of advanced airway management and limited medication administration be left to delegated medical control. We feel that a specific listing of airway skills is neither needed nor prudent at this level in pre-hospital emergency medicine.

Additionally, on page 25, line 35, we feel that the intraosseous access should be added to this level for all patients indicated by medical control.

Lastly at the Advanced EMT level we strongly believe that specific medication deemed necessary should not be restricted to a certain route of administration. Administration routes for any needed medication should be at the discretion of medical direction.

At the Paramedic Level we begin by restating, with slight modification, that specific methods of advanced airway management are left to delegated medical direction. Again, we do not feel that a specific listing of skills or medications is needed or prudent.

As a matter of point, pharmacologically assisted intubation should remain as an option to this level of certification based upon delegated medical direction.

The requirement for paramedic training to be delivered from nationally accredited programs is of some concern also. We would like to see state accreditation acceptable, with the understanding that it falls in line with national standards.

We also feel that the Advanced Practice Paramedic should be returned to the document. With an eye toward the future of emergency medicine we firmly believe that there will be a place for this level of care.

Lastly, we feel it imperative that a bi-annual or tri-annual review process be added, allowing a process of gathering input and making changes as needed.

It is our sincere hope not only to increase the ability of our EMS providers to provide quality patient care not only in Texas, but all over this great land of ours. As a delegated practice state we would like to combine aspects of the scope of practice and delegated practice to help us achieve the aforementioned goal.

We look forward to working with you and hope to hear from you soon.

Sincerely,

Pete Wolf, EMS Committee Chairman
Governor's EMS and Trauma Advisory Council of Texas