

EMS

**EMERGENCY
MEDICAL
SERVICES**

**THE
NATIONAL
EMS SCOPE
OF
PRACTICE
MODEL**

DRAFT 1.0

For review and comment only.
Do not cite or quote.

Introduction to Draft Scope of Practice and Review Process

Background- We are pleased to share the first draft of the *National EMS Scope of Practice Model*. Your participation in the review and comment process is essential in making the best choices about the future levels of EMS providers in the United States. This project has been supported jointly by the National Highway Traffic Safety Administration and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

The *National EMS Scope of Practice Model* is the next step in implementing the vision contained in the *EMS Education Agenda for the Future: A Systems Approach*. If you are not familiar with the Education Agenda, we invite you to read it prior to reviewing Draft 1.0 of the *Scope of Practice Model*. The Education Agenda is located at www.nhtsa.dot.gov/people/injury/ems/EdAgenda/final/index.html. The *Scope of Practice Model* is founded upon the *National EMS Core Content* document that is available at www.naemsp.org.

The *National EMS Scope of Practice Model* is one essential component in a uniform system of EMS personnel licensing that serves a public need for patient protection as well as a professional need for workforce development and recognition. The Pew Commission has recommended that health professions establish scope of practice models and the task force is pleased to be making tangible progress towards fulfilling that directive for EMS.

Process- Many individuals and organizations have been involved in the development of this draft. Representatives from the following organizations and groups have participated:

- National Association of State EMS Directors
- National Council of State EMS Training Coordinators
- International Association of Fire Fighters
- International Association of Fire Chiefs
- American Ambulance Association
- National Association of EMS Educators
- National Registry of EMTs
- American College of Surgeons/Committee on Trauma
- American Academy of Pediatrics
- National Association of EMS Physicians
- American College of Emergency Physicians
- National Association of EMTs
- Committee on Accreditation of EMS Programs
- The Citizen Advocacy Center

Though representatives of these groups participated in preparing Draft 1.0, the document has not yet been reviewed or endorsed by their respective organizations.

Based on the comments received, this draft will be revised and submitted for review and refinement by a National Review Team in the Spring of 2005. The final version of the *National EMS Scope of Practice Model* is due to NHTSA by Fall 2005.

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Issues and task force rationale- As Draft 1.0 was being prepared, the task force deliberated many issues. While not wishing to constrain comments on any subject related to the document, it may be helpful for reviewers to know the background of a few subjects where choices were made and alternatives do exist.

Names of Levels-

Committee discussions and issues- A variety of names were proposed for the levels of EMS personnel described. One option was to choose a common title such as “EMT,” “Community Health Advanced Medical Practitioner,” etc., and then designate the levels as Common Title 1, Common Title 2, Common Title 3 and Common Title 4. While there is some comparability for the proposed names Emergency Medical Responder, the Emergency Medical Technician, and the Paramedic with the current national standard curricula levels of First Responder, EMT-Basic, and Paramedic, there is currently not a nationally recognized level that compares with the proposed Advanced Practice Paramedic. The task force attempted to strike a balance between preserving traditional titles for which there is some public and professional recognition with the need to be descriptive and contemporary. (See *EMS Provider Levels* and *EMS Provider’s Scope of Practice* sections)

Questions of the task force for the reviewers-

- Is a common titling system preferable over individual titles for each type of provider?
- Are the names proposed descriptive and useful for public understanding?
- Do the names proposed reflect and support the professional preparation associated with each level?

Numbers of levels

Committee discussions and issues- The Draft 1.0 document proposes four different levels of providers. There was considerable discussion within the group about the need for a fifth level that would fit between the proposed Emergency Medical Technician and Paramedic levels. There was some feeling that the EMT level as proposed represents too large a scope of practice to realistically prepare the entry level ambulance workforce to perform. For the EMT level in particular there was recognition of issues associated with increasing education requirements. After deliberating the potential workforce impact issues, the task force decided an expansion of scope for EMTs is important for patient care. While the task force broadly supported the skills associated with the proposed EMT level, it wondered if there is a need for a less comprehensive initial training program as the first level of provider prepared to work in an ambulance. This would allow an opportunity for some additional training and possibly field experience before advancing to a level with a scope of practice that includes advanced interventions such as non-previously prescribed pharmacology. (See *EMS Provider’s Scope of Practice* section and *Appendix A*)

Questions of the task force for the reviewers-

- Do the four levels proposed represent appropriate divisions within the EMS workforce? Is four the correct number or would three, five, or some other number be more appropriate?

- If an additional level were created and placed between the proposed EMT and the proposed Paramedic, which skills should be drawn from those two levels to form the new level?

Skills by level

Committee discussions and issues- Central to the establishment of a scope of practice is a description of the interventions and procedures allowed within the level. The document represents an effort to be broadly descriptive without being overly prescriptive. In a change from the current paradigm where the national standard curricula commonly drive the scope of practice for the various levels of EMS providers, this document envisions a system more parallel to other health care providers where work setting and other environmental factors play a larger role in determining what skills and interventions a specific provider is authorized to use. The descriptions in this draft do not imply what **every** provider will be allowed to perform by their individual medical director or local EMS system, but rather, describe the outside boundaries of what **any** provider at a specific level will be allowed to perform. However, to assure uniform national levels of certification, this document does specify the minimum entry requirements for each provider level. Every person licensed at a given level must be educated and certified to meet these minimum entry level requirements. (See *EMS Provider's Scope of Practice* section and *Appendix A*)

Questions of the task force for the reviewers-

- Are the skills and other descriptions of the proposed levels reasonable and appropriate?
- The skills and interventions associated with the proposed Emergency Medical Responder and the Emergency Medical Technician levels are somewhat beyond the current First Responder and EMT-Basic levels. Will it be feasible and realistic to add training time to these levels to prepare people for entry level competence with the proposed scopes of practice?
- The task force identified both pro and con issues related to requiring associate degree preparation for the paramedic level and decided to allow for both certificate and associate degree programs. Given the scope of practice described and with consideration of other workforce issues, is this the proper approach for preparing paramedics?

Advanced practice paramedic

Committee discussions and issues- This is a level that has no widely comparable status within current U.S. EMS systems. An academically prepared EMS level was described in the original *EMS Agenda for the Future*. The task force felt that this position would be desirable within some systems for operational purposes and on an individual basis for career development by some EMS personnel. The feasibility of this position will depend upon many factors such as EMS reimbursement, educational program evolution, physician participation and others. (See *EMS Provider Levels- Advanced Practice Paramedic* and *EMS Provider's Scope of Practice- Advanced Practice Paramedic sections*)

Questions of the task force for the reviewers-

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- Do enough EMS systems have a need for providers at this level to make establishing the level feasible?
- Will it be possible for the health care education system to prepare enough of these providers to meet anticipated needs?
- Will physicians be willing to provide medical direction for providers at this level?
- Can reimbursement be arranged to reflect the types of services a person at this level might deliver?

How to make comments- Comments and suggestions for improvements to this draft are invited. These may address the questions posed, structural aspects of the draft, clinical matters, or any other areas. If you have research, position papers, or other forms of support for your comments, please provide citations or copies. Please forward your comments in written form to: Amy Starchville at NASEMSD, 201 Park Washington Court, Falls Church, VA 22046-4527. All comments received will be reviewed by the project's Principal Investigator, Dan Manz, and the Expert Writer, Gregg Margolis. Depending upon the nature and subject of the comments, additional review by other members of the project administrative team, technical advisory group, or task force will also occur. It should be stressed that this draft is only a starting point for dialogue on EMS scopes of practice and that all input from any source is welcome and will be considered as the document is refined. Comments may be received through January 30, 2005.

Summary- In the final analysis, the *National EMS Scope of Practice Model* Task Force intends for this document to be **evolutionary** rather than **revolutionary**. It is important to preserve the best of what is working well within EMS practice as we move towards a scope of practice model that more closely parallels other health care professionals. Your efforts in giving feedback about the draft document are greatly appreciated.

The National EMS Scope of Practice Model
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The Vision

Emergency Medical Services (EMS) of the future will be community-based health management that is fully integrated with the overall health-care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health-care resources and it will be integrated with other health-care providers and public health and safety agencies. It will improve community health and result in a more appropriate use of acute health-care resources. EMS will remain the public's emergency medical safety net.

Executive Summary

Will go here.

1 Introduction

2
3 EMS providers treat nearly 20 million patients a year in the United States. Many of these
4 patients have complicated medical or traumatic conditions that require considerable
5 knowledge, skill, and judgment. Some are critically ill or injured, and the proper care can
6 literally make the difference between life and death. For most patients, the
7 medical/trauma crisis that each experience is not a matter of life or death, yet it is no less
8 significant to an individual and his/her family. Emergency Medical Services in the United
9 States are diverse, highly sophisticated, and complex systems. As of 2003, there were
10 840,669 certified prehospital care providers in the United States (Lindstrom and Losavio
11 2004), and the nation's annual expenditure for EMS topped \$6.75 billion (Sayer, Brown
12 et al. 2001).

13
14 Despite many successes, the United States EMS System faces many challenges as it
15 transitions to a more community-based health management system as part of the vision
16 for EMS described in the *EMS Agenda for the Future* (1996). The *National EMS Scope
17 of Practice Model* is part of the continued commitment to realizing this vision. This
18 document is an essential component of an integrated, systematic approach to EMS
19 regulation, education, and certification/licensure as defined in the *EMS Education
20 Agenda for the Future: A Systems Approach*. This system will help ensure safe and
21 effective patient care to those who need out-of-hospital emergency care, while meeting
22 the needs of our diverse country.
23

24 **History of the Occupational Regulation in EMS**

25
26 The development of modern civilian Emergency Medical Services (EMS) stems largely
27 from lessons learned in providing medical care to soldiers injured in military conflict. As
28 far back as the Greek and Roman empires, there were informal systems of providing care
29 to battlefield injuries. The first organized triage, military transportation, and medical care
30 systems evolved during the Napoleonic Wars under chief physician Baron Dominique-
31 Jean Larrey. Future military conflicts, including the American Civil War, World Wars I
32 and II, and the Korean Conflict brought about a greater understanding of emergency
33 medicine. It was clear that there was a significant improvement in the outcome of injured
34 soldiers who received rapid care. In these early years, there was no need to regulate the
35 quality of care provided to battlefield injuries.
36

37 In the late 1800s, based in large part on wartime lessons, a number of rescue squads and
38 ambulance services emerged in the civilian sector throughout the United States. While
39 well intentioned, most of these rescue personnel were untrained, poorly equipped,
40 unorganized, and unsophisticated. These systems were unregulated, and no standards
41 existed. By the 1960s, prehospital care in the US had evolved into a patchwork of well
42 intentioned, but uncoordinated efforts. This all changed in the mid-sixties.
43

1 In 1966, the National Academy of Sciences published a report entitled *Accidental Death*
2 *and Disability: The Neglected Disease of Modern Society*. This report quantified the
3 magnitude of traffic-related death and disability while vividly describing the deficiencies
4 in prehospital care in the United States. The “white paper” made a number of
5 recommendations regarding ambulance systems, including a call for ambulance
6 standards, state-level policies and regulations, and adopting methodology for providing
7 consistent ambulance services at the local level (National Academy of Sciences 1966).

8
9 Also in 1966, the Highway Traffic Safety Act established the Department of
10 Transportation (DOT) and awarded that agency the authority and responsibility to
11 improve EMS education, including the development and implementation of training
12 standards. States were encouraged to develop state EMS offices with part of the costs
13 paid by the Highway Safety Programs.

14
15 One function of state EMS offices was to ensure the competence of EMS providers
16 functioning in that state. In many states, there was a legislative backlash resulting from a
17 large increase in the requests for licensure of allied health professionals in the late 1960s.
18 These requests became so numerous as to prompt the Federal Department of Health,
19 Education and Welfare (now the Department of Health and Human Services) to call for a
20 moratorium on the licensing of allied health workers in the early 1970s.

21
22 While occupational licensure represents the most rigorous form of protecting the public
23 from incompetent providers, most states opted for “certification” as an alternative form of
24 credentialing EMS providers. Unfortunately, certification is a poorly understood
25 concept, and generally does not offer the protection to the public and due process to the
26 individual of the licensure system.

27
28 By 1990, EMS in the United States had enjoyed many successes. Not only did EMS
29 systems grow, but EMS became a career and volunteer activity for hundreds of thousands
30 of talented, committed, and dedicated individuals. Emergency medical care was
31 available to virtually every citizen in the country by simply dialing 9-1-1 from any
32 telephone. This was an extraordinary accomplishment in a relatively short period of
33 time.

34
35 Despite tremendous progress, EMS in the early 1990s was being impacted by major
36 factors in the broader health-care system. In 1992, the need for a long-term strategic
37 direction was recognized by the National Association of EMS Physicians and the
38 National Association of State EMS Directors, and the *EMS Agenda for the Future* was
39 initiated with support from the National Highway Traffic Safety Administration
40 (NHTSA) and the Maternal and Child Health Bureau of the Health Resources and
41 Services Administration (HRSA). Published in 1996, the *EMS Agenda for the Future*
42 proposed a bold vision for greater integration of EMS into the US health-care system.
43 *The Agenda* proposed that EMS represents the intersection of public safety, health care,
44 and public health and is in a unique position to improve the overall health of the
45 community.

46

1 In 1998, the Pew Health Professions Commission Taskforce on Health Care Workforce
2 Regulation published *Strengthening Consumer Protection: Priorities for Health Care*
3 *Workforce Regulation*. The report recommends that a national policy advisory board
4 should develop standards, including model legislative language, for uniform scopes of
5 practice authority for the health professions. The report emphasizes the need for states to
6 enact and implement scopes of practice that are nationally uniform and based on the
7 standards and models developed by the national policy advisory body.

8
9 Demonstrating their commitment to *The Agenda*, NHTSA and HRSA jointly supported
10 the development of the *EMS Education Agenda for the Future* in 1998. The project team
11 was charged with developing an integrated system of EMS regulation, education,
12 certification/licensure, and educational program accreditation. The *EMS Education*
13 *Agenda: A Systems Approach* recognized the need for a variety of integrated and
14 coordinated initiatives to meet the needs of the current EMS system and to realize the
15 vision of the *EMS Agenda for the Future*.

16
17 The *National EMS Scope of Practice Model* describes an approach to defining the
18 preparation, roles, and functions of EMS personnel that creates a national standard for
19 state licensure as an EMS professional. The envisioned system relies on a “hand-in-
20 glove” relationship between competency certification and professional licensure. A more
21 traditional licensure system would offer the following benefits:

- 22 1. A more rigorous standard for the right to enter practice
- 23 2. A more precise system for monitoring the qualifications and continued
24 competence of licensed individuals
- 25 3. An improved system for the adjudication of allegations of incompetence against
26 licensed individuals
- 27 4. Facilitated reciprocity when licensure is coupled with standardization of the scope of
28 practice and common educational standards

29 The advantages cited above will improve the fundamental role of professional
30 licensure—to protect the public.

31
32 The authors of this document honor the legacy of the pioneers of our profession by
33 building on the solid foundation they laid. We hope to create a future that will make
34 them proud. We recognize the hard work and contribution of every EMS provider and
35 the countless lives that they have touched. We respectfully propose the *National EMS*
36 *Scope of Practice Model* as a tribute to our past, with admiration for our extraordinary
37 accomplishments, and as a bridge to a future of service and dedication.

39 ***The Risk of Role Creep***

40
41 One of the greatest risks to patient safety occurs when EMS providers are placed into
42 situations and roles where they are not experientially or educationally prepared. There
43 are numerous political, economic, social, and cultural reasons why providers are
44 pressured into functioning beyond their intended role. In many cases, the individual

1 provider has no malicious intent, but is simply unaware of the consequences of such
2 actions.

3
4 It is the shared responsibility of medical direction, clinical and administrative
5 supervision, regulation, and quality assurance to ensure that providers are not placed in
6 situations where they will be tempted to exceed their scope of their practice. In many
7 cases, the pressure can be extraordinary. For the protection of the public and to ensure
8 patient safety, regulation must exist to prevent the tendency of the roles of EMS
9 providers to creep from their original intent.

11 **Scope of Practice**

12
13 Scope of practice is a legal description of the distinction between a licensed health-care
14 provider and the lay public and between different licensed
15 health-care providers. It describes the authority, vested by a
16 state, in health professionals who practice within that state.
17 Scope of practice establishes which activities and procedures
18 performed without licensure represent illegal activity. In
19 addition to drawing the boundaries between the professional
20 and the lay person, scope of practice defines the boundaries
21 between professionals, creating either exclusive or overlapping domains of control over
22 the delivery of service.

Scope of Practice is
a description of
what a licensed
individual legally
can, and cannot, do.

23
24
25
26
27
28
29
30
31 Scope of practice need not define every activity of a provider. In general, scopes of
32 practice should focus on activities that are regulated by law. This includes technical
33 skills that, if done improperly, represent a significant hazard to the patient and therefore
34 must be kept out of the hands of the untrained. Scopes of practice typically do not
35 regulate non-medical tasks or non-invasive tasks with no physiological/clinical
36 implications. Care must be taken to consider the level of cognition necessary to perform
37 a skill safely. Particularly problematic skills are those that are simple to perform, but
38 require considerable clinical judgment to know when they should, and should not, be
39 performed.

41 ***Scope of Practice vs. Standard of Care***

42
43 Scope of practice does not define a standard of care, nor does it define what should be
44 done in a given situation (i.e., it is not a practice guideline). It defines what is legally
45 permitted to be done by some or all of the licensed individuals, but not what must be
46 done. Central to the concept of scope of practice is individual responsibility.

47
48 There is usually a difference between the scope of practice of the profession, and the
49 skills that a licensed individual is authorized to perform. Licensed individuals must never
50 function beyond the scope of practice of the profession. In addition, each licensed
51 individual is responsible to perform only activities and procedures that he/she is

1 adequately educated, trained, experienced, and authorized to perform. Just because an
 2 activity or procedure *can* legally be performed, does *not* mean that it must, or should, be
 3 performed.
 4

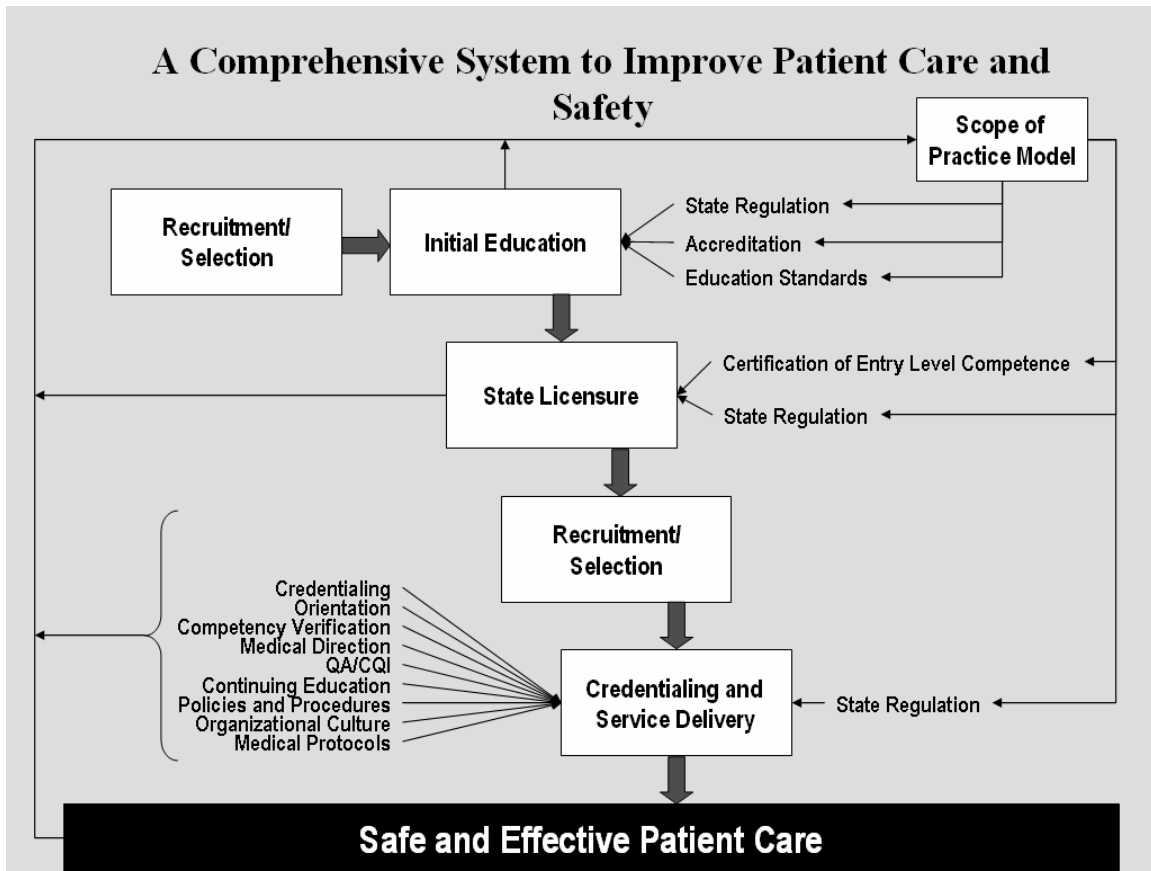
	Scope of Practice	Standard of Care
Purpose	Deals with the question, “Are you/were you <i>allowed</i> to do it?”	Deals with the question, “Did you do the right thing, and did you do it properly?”
Legal implications	Criminal Offense	Civil Liability
Variability	May vary from individual to individual. Does not vary based on circumstances.	Situational, depends on many variables
Defined by	Established by statute	Determined by SOP, literature, expert witnesses, and juries
Miscellaneous	It is hard to deal with cognitive roles.	Used to evaluate professional judgment

5
6

7 **Scope of Practice as Part of a Comprehensive Approach to Safe**
 8 **and Effective Prehospital Care**

9

10 Scope of practice is only one part of a health-care regulation, and regulation is only one
 11 component of a comprehensive approach to improved patient care and safety. Safe and
 12 effective EMS care is the cumulative effect of a cascade of thousands of individual
 13 decisions involving every level of EMS leadership, supervision, management, and
 14 regulation. Safe and effective patient care is the shared responsibility of everybody
 15 within the EMS system, and must be our collective first priority. Safe and effective care
 16 cannot be accomplished through any single activity, but is best accomplished with an
 17 integrated system of checks and balances. All components of the comprehensive
 18 approach to safe and effective patient care are mutually supportive and dependent.
 19 Figure 1 illustrates the interconnected nature of many of the components of a
 20 comprehensive system.



1
2 Figure 1: A comprehensive approach to safe and effective prehospital care.
3
4

5 ***Scope of Practice for Special Populations***

6
7 EMS professionals are expected to meet the urgent health-care needs of all patients,
8 regardless of age or co-morbidity, consistent with their defined scope of practice.
9 Recognized special populations include, but may not be limited to, children, elders,
10 patients with disabilities, and patients with limited access to health care due to
11 geographic, demographic, socioeconomic, or other reasons.
12

13 ***Scope of Practice during Disasters, Public Health Emergencies,***
14 ***and Extraordinary Circumstances***

15
16 It is virtually impossible to create a scope of practice that takes into account every unique
17 situation, extraordinary circumstance, and possible practice situation. This is
18 complicated by the fact that EMS providers are an essential component of disaster
19 preparedness and response. In many cases, EMS providers are the only medically trained
20 individuals at the scene of a disaster when other health-care resources may be
21 overwhelmed. This document cannot account for every situation, but rather is designed

1 to establish a system that works under normal circumstances. It is assumed that the scope
2 of practice of EMS providers may be modified or changed in times of disaster or serious
3 crisis with proper education, medical direction, and quality assurance to reasonably
4 protect patient safety.
5

6 **How to Use This Document**

7
8 In 1996, the *EMS Agenda for the Future* identified at least 44 different levels of EMS
9 provider certification in the US, and it is presumed that the number has increased since
10 that time. This patchwork of EMS provider certifications has created considerable
11 problems, including but not limited to:

- 12 ❖ Public confusion
- 13 ❖ Reciprocity challenges
- 14 ❖ Limited provider mobility
- 15 ❖ Difficulty in implementing telemedicine programs
- 16 ❖ Decreased efficiency due to duplication of effort
- 17 ❖ Decreased credibility

18
19
20 The document serves as a guide for State EMS Offices that are statutorily responsible for
21 regulating EMS in their respective jurisdictions. The vision of the *National EMS Scope*
22 *of Practice Model* is to standardize EMS provider licensures nationwide and to increase
23 system efficiency.

24
25 The authors of the *National EMS Scope of Practice Model* recognize the right of any
26 State to deviate from this document. States choosing to exercise that right should make a
27 decision to do so fully understanding the implications. *Failure to implement the National*
28 *EMS Scope of Practice Model at a State level fragments the national EMS system. It*
29 *isolates individual States and their EMS providers. It complicates reciprocity,*
30 *recruitment, and professional recognition, not only in that state, but throughout the*
31 *country. Failure to standardize licensure levels confuses the public, and forces the State*
32 *to develop and defend its own infrastructure (accreditation, certification, etc.) to support*
33 *other levels.*

34
35 States are strongly encouraged to adopt the licensure levels for EMS providers identified
36 by the *National EMS Scope of Practice Model* to strengthen the national EMS system.

37
38 The paucity of data about EMS providers' scope of practice and efficacy of patient care
39 in the out-of-hospital setting today limits an EMS system's ability to make decisions on
40 an evidence-driven basis. While some foundational systems for comprehensive data
41 collection are evolving (e.g., National EMS Information System) and others present
42 opportunities for future analysis (e.g., Longitudinal EMT Attributes and Demographics
43 Study), scientific conclusions were not available at the time of publication of this model.
44 Resources must be directed toward reliable and validated EMS data collection systems
45 throughout the United States.

1
2 Statistical analysis and research on patient safety, scope of practice, and EMS provider
3 competency must become a priority among the leadership of national associations,
4 federal agencies, and research institutions. When this data collection, subsequent
5 analysis, and scientific conclusions are published and replicated, later generations of the
6 *National EMS Scope of Practice Model* and interpretive guidelines should be driven by
7 those findings.
8
9

10 **Overview of the EMS Profession**

11
12 This document defines the practice of EMS providers. EMS providers are unique health-
13 care providers in that they provide emergency care and transportation in an out-of-
14 hospital setting under the direction of a physician. EMS providers are not independent
15 practitioners. While the practice is not independent, it is relatively unsupervised and
16 often has little backup. Therefore, EMS providers must be able to exercise considerable
17 judgment, problem-solving, and decision-making skills.
18

19 Most (but not all) EMS providers work in emergency medical services that respond to
20 emergency calls. Emergency response is typically a local government function (or
21 contracted by local government to a private entity). In most communities, citizens call 9-
22 1-1 when they need emergency medical care, and the appropriate EMS resources are
23 dispatched. In the case of emergency calls, EMS providers are unique in that they
24 typically have a “duty to act.” Many EMS providers provide transportation services for
25 patients requiring medically supervised transportation, either exclusively or in addition to
26 emergency response. These “scheduled transports” generally do not fall under the “duty
27 to act” responsibility of emergency response.
28

29 EMS providers generally practice emergency medicine out of the hospital. They respond
30 and provide care to the patient in the setting in which the patient became ill or injured,
31 including the home, field, work, industrial, and recreational settings. In some cases, EMS
32 providers “stand-by” at mass gatherings or high-risk activities. EMS providers are not
33 trained to provide home health-care services.
34

35 Emergency Medical Services are a local function and organized in a variety of ways. The
36 most common models are municipal government (fire-based or third-service) or a
37 contracted service with a private (profit or not-for-profit) entity. EMS providers also can
38 be categorized in a variety of ways. Higher level providers tend to be paid (either full- or
39 part-time), while lower levels have large numbers of volunteer or partially paid
40 personnel.
41

42 EMS provides out-of-hospital medical care to those with perceived urgent needs. It is a
43 component of the overall health-care system. EMS delivers treatment as part of, or in
44 combination with, systematic approaches intended to attenuate morbidity and mortality
45 for specific patient subpopulations. The positive effects of EMS care are enhanced by

1 linkages with other community health resources and integration within the health-care
2 system.

3

4 **EMS Provider Levels**

5

6 The United States is a tremendously diverse country. Every state, in fact every EMS
7 jurisdiction, faces different health-care, emergency medicine, and EMS challenges.
8 Licensure levels must be responsive and flexible enough to meet the needs of patients in
9 urban as well as rural/frontier environments. Licensure levels must also be flexible
10 enough to accommodate career, volunteer, full-time or part-time providers. All of this
11 must be accomplished while ensuring patient safety, facilitating reciprocity, and
12 decreasing confusion of the public and providers.

13

14 It is recognized that only a few licensure levels are practical. The creation of too many
15 licensure levels creates confusion and inconsistency (as some states choose not to adopt
16 some levels). The support of the educational infrastructure (developing educational
17 standards, national accreditation, national certification, continued competency
18 requirements, etc.) requires a tremendous expenditure of resources and is only viable if
19 there are a finite number of levels. Therefore, the challenge is to create a system that
20 meets the diverse needs of the country, while keeping the number of licensure levels as
21 small as possible.

22

23 A different licensure level represents a substantial difference in skills, practice
24 environment, knowledge, qualifications, services provided, needs, risk, level of
25 supervisory responsibility, amount of autonomy and/or judgment/critical
26 thinking/decision making.

27

28 ***Emergency Medical Responder***

29

30 The Emergency Medical Responder provides immediate lifesaving care for critical
31 patients who become suddenly ill or injured outside of the hospital. This individual
32 possesses the basic knowledge and skills necessary to provide lifesaving interventions
33 while awaiting additional EMS response. Emergency Medical Responders function as
34 part of a comprehensive EMS response, under medical direction. Emergency Medical
35 Responders perform basic interventions with minimal equipment.

36

37 Educational Requirements: Eligibility for licensure at this level requires completion of
38 an approved Emergency Medical Responder training program.

39

40

1 ***Emergency Medical Technician***

2
3 The Emergency Medical Technician provides basic and limited advanced emergency
4 medical care and transportation for critical and emergent patients who become suddenly
5 ill or injured outside of the hospital. This individual possesses the basic knowledge and
6 skills necessary to provide care in a patient transport situation. Emergency Medical
7 Technicians function as part of a comprehensive EMS response, under medical direction.
8 Emergency Medical Technicians perform interventions with the basic and limited
9 advanced equipment typically found on an ambulance. The Emergency Medical
10 Technician is a link from the scene to the emergency health-care system.

11
12 Educational Requirements: Eligibility for licensure at this level requires completion of
13 an approved Emergency Medical Technician course.
14

15 ***Paramedic***

16
17 The Paramedic is an allied health professional who provides emergency medical care,
18 including the use of invasive techniques and pharmaceutical interventions, for critical and
19 emergent patients who become suddenly ill or injured outside of the hospital. This
20 individual possesses the complex knowledge and skills necessary to provide care in a
21 patient transport situation. Paramedics function as part of a comprehensive EMS
22 response, under medical direction. Paramedics perform interventions with the basic and
23 advanced equipment typically found on an ambulance. The Paramedic provider is a link
24 from the scene into the emergency health-care system.

25
26 Educational Requirements: Because of the amount of complex decision making,
27 eligibility for licensure requires completion of an accredited Paramedic program at the
28 Certificate or Associates Degree level.
29

30 ***Advanced Practice Paramedic***

31
32 The Advanced Practice Paramedic provides a broad spectrum of out-of-hospital care,
33 referral, and disposition for patients who contact the EMS system. The Advanced
34 Practice Paramedic performs a comprehensive assessment of the patient and the
35 environment, renders care, and refers the patient to appropriate health-care and
36 community resources for effective, efficient, and safe disposition of the case. Practice at
37 this level requires a physician supervisor, who ensures accountability for medical
38 decisions and judgments. The Advanced Practice Paramedic is a link for patients to
39 access the most appropriate health-care recourses.

40
41 Educational Requirements: Because of the amount of independent decision making,
42 eligibility for licensure at this level requires completion of an accredited Advanced
43 Practice Paramedic program at the Bachelors degree level or higher.
44

1 **EMS Provider’s Scope of Practice**

2
3 EMS skills and knowledge represent a continuum of complexity and risk. As the
4 provider level increases, the knowledge required to practice safely, the skill complexity
5 (the difficulty in acquiring and maintaining skill competency), and the potential for harm
6 increases.

7
8 Communities must assess their needs and the resources they are willing and able to invest
9 in prehospital emergency care.
10

11 ***Emergency Medical Responder***

12
13 The Emergency Medical Responder’s scope of practice is limited to a simple skill set
14 focused on lifesaving interventions for critical patients. Typically, the Emergency
15 Medical Responder renders on-scene emergency care while awaiting additional EMS
16 response.

17
18 The Emergency Medical Responder’s scope of practice includes simple, non-invasive
19 interventions to reduce the morbidity and mortality associated with acute out-of-hospital
20 medical and traumatic emergencies. Emergency care is based on assessment findings.
21 Additionally, the Emergency Medical Responder provides care designed to minimize
22 secondary injury and comfort the patient and family while awaiting additional EMS
23 resources.

24
25 A major difference between the lay rescuer and the Emergency Medical Responder is the
26 duty to respond as part of an organized EMS response.
27

28 The Emergency Medical Responder is not part of the minimum staffing of transporting
29 EMS units. The scope of practice is limited to simple skills that are effective and can be
30 performed safely in an out-of-hospital setting with medical direction.
31

32 The Emergency Medical Responder always transfers care to higher trained personnel.
33 The Emergency Medical Responder does not terminate further EMS response. The
34 Emergency Medical Responder serves as part of an EMS response system ensuring a
35 progressive increase in the level of assessment and care.
36

37 Permitted Skill Set

- 38 • Airway and Breathing
 - 39 ○ Oral and nasal airways
 - 40 ○ Upper airway suctioning
 - 41 ○ Supplemental oxygen therapy
 - 42 ○ Bag-valve-mask ventilation
- 43 • Pharmacological interventions
 - 44 ○ Unit dose auto-injectors for self or peer administration

- 1 • Medical/Cardiac Care
- 2 o Automated external defibrillation

3

4 Prohibited Skills

- 5 • Any procedure specifically identified as “permitted skills” at a higher level
- 6 • The administration or assistance of any medication other than oxygen or auto-injected
- 7 medication for self or peer rescue

8

9 In many communities, Emergency Medical Responders provide a mechanism to increase

10 the likelihood that trained personnel and lifesaving equipment can be rapidly deployed to

11 serious emergencies. In all cases, Emergency Medical Responders are part of a tiered

12 response system. Emergency Medical Responders work alongside other EMS and health-

13 care providers as part of an integral part of the emergency care team.

14

15

16 ***Emergency Medical Technician***

17

18 The Emergency Medical Technician’s scope of practice is limited to a fundamental skill

19 set focused on the acute management and transportation of critical and emergent patients.

20 This may occur at an emergency scene until transportation resources arrive, from an

21 emergency scene to a health-care facility, between health-care facilities, or in other

22 health-care settings.

23

24 The Emergency Medical Technician’s scope of practice includes basic, limited advanced

25 and pharmacological interventions to reduce the morbidity and mortality associated with

26 acute out-of-hospital medical and traumatic emergencies. Emergency care is based on

27 assessment findings. Additionally, Emergency Medical Technicians provide care to

28 minimize secondary injury and provide comfort to the patient and family while

29 transporting the patient to an emergency care facility.

30

31 The Emergency Medical Technician’s knowledge, skills, and abilities are acquired

32 through formal education and training. The Emergency Medical Technician has the

33 knowledge and is expected to be competent in all of the skills of lower level providers.

34 The major difference between the Emergency Medical Technician and the Emergency

35 Medical Responder is the ability to provide medical transportation of emergency patients.

36

37 The Emergency Medical Technician is the minimum staffing for patients requiring care at

38 the scene and transportation to an acute care facility. The scope of practice includes

39 lower risk advanced skills that are effective and can be performed safely in an out-of-

40 hospital setting with medical direction and limited training.

41

42 The Emergency Medical Technician transports patients to an appropriate medical facility.

43 The Emergency Medical Technician is not prepared to independently make decisions

44 regarding the disposition of patients. The Emergency Medical Technician serves as part

45 of an EMS response system ensuring a progressive increase in the level of assessment

1 and care. The Emergency Medical Technician may make destination decisions in
2 collaboration with medical direction. The principal disposition of the patient encounter
3 will result in the direct delivery of the patient to an acute care facility. In systems
4 intending to refer patients to alternative health-care resources, the Emergency Medical
5 Technicians will interface with an Advanced Practice Paramedic.

6
7 In addition to emergency response, Emergency Medical Technician providers often
8 perform medical transport services of patients requiring care within their scope of
9 practice.

10 11 12 Permitted Skill Set

- 13 • Airway and Breathing
 - 14 ○ Manually triggered ventilators
 - 15 ○ Rate and volume automatic transport ventilators
 - 16 ○ Esophageal-tracheal multi-lumen airways
 - 17 ○ Tracheobronchial suctioning
- 18 • Assessment
 - 19 ○ Blood glucose monitoring
- 20 • Pharmacological Interventions
 - 21 ○ Assisting patients with prescribed and over-the-counter medications
 - 22 ○ Administration of Medical Director–approved over-the-counter medications
 - 23 ○ Administering nitroglycerine for ischemic chest pain
 - 24 ○ Administering auto-injected epinephrine for anaphylaxis
 - 25 ○ Administering an inhaled beta agonist
 - 26 ○ Maintaining a non-medicated intravenous infusion
- 27 • Trauma Care
 - 28 ○ Spinal immobilization
 - 29 ○ PASG

30 31 Prohibited Skills

- 32 • Any IV medications
- 33 • Endotracheal Intubation
- 34 • EOA/EGTA
- 35 • Ipecac
- 36 • Any procedure specifically identified as “permitted skills” at a higher level

37
38 In many communities, Emergency Medical Technicians provide a large portion of the
39 prehospital care. In some jurisdictions, especially rural areas, Emergency Medical
40 Technicians are the highest level of prehospital care. In some communities that utilize
41 emergency medical dispatch systems, Emergency Medical Technicians are part of a
42 tiered response system. In all cases, Emergency Medical Technicians work alongside
43 other EMS and health-care providers as part of an integral part of the emergency care
44 team.

1 **Paramedic**

2
3 The Paramedic's scope of practice includes a fundamental skill set focused on the acute
4 management and transportation of critical and emergent patients. This may occur at an
5 emergency scene until transportation resources arrive, from an emergency scene to a
6 health-care facility, between health-care facilities, or in other health-care settings.

7
8 The Paramedic's scope of practice includes invasive and pharmacological interventions
9 to reduce the morbidity and mortality associated with acute out-of-hospital medical and
10 traumatic emergencies. Emergency care is based on an advanced assessment and the
11 formulation of a field impression. The Paramedic provides care designed to minimize
12 secondary injury and provide comfort to the patient and family while transporting the
13 patient to an emergency care facility.

14
15 The Paramedic has knowledge, skills, and abilities developed by appropriate formal
16 education and training. The Paramedic has the knowledge and is expected to be
17 competent in all of the skills of lower level providers. The major difference from the
18 Emergency Medical Technician is the Paramedic's ability to perform advanced care that
19 has greater potential risk to the patient if improperly or inappropriately performed, is
20 more difficult to attain and maintain competency, and requires significant background
21 knowledge in basic and applied sciences.

22
23 The Paramedic is the minimum staffing for patients requiring advanced care at the scene
24 or during transportation. The scope of practice is limited to advanced skills that are
25 effective and can be performed safely in an out-of-hospital setting with medical direction.

26
27 The Paramedic transports patients to an appropriate medical facility. The Paramedic is
28 not prepared to independently refer patients. The Paramedic serves as part of an EMS
29 response system ensuring a progressive increase in the level of assessment and care. The
30 Paramedic may make destination decisions in collaboration with medical direction. The
31 principal disposition of the patient encounter will result in the direct delivery of the
32 patient to an acute care facility. In systems intending to refer patients to alternative
33 health care resources, the Paramedics will interface with an Advanced Practice Paramedic
34 provider.

35
36 In addition to emergency response, Paramedics often perform medical transport services
37 of patients requiring care within their scope of practice.

38 39 Permitted Skill Set

- 40 • Airway and Breathing
 - 41 ○ Endotracheal intubation
 - 42 ○ Percutaneous cricothyrotomy
 - 43 ○ Pleural decompression
 - 44 ○ Gastric decompression
- 45 • Pharmacological Interventions
 - 46 ○ Peripheral venous access (including intraosseous catheter insertion)

- 1 ○ IV fluid infusion
- 2 ○ Enteral and perenteral administration of approved prescription medications
- 3 ○ Accessing implanted central IV port
- 4 ○ Venous blood sampling
- 5 ● Medical/Cardiac Care
- 6 ○ Cardioversion
- 7 ○ Manual defibrillation
- 8 ○ Transcutaneous pacing

9

10 Prohibited Skills

- 11 ● Any procedure specifically identified as “skills permitted” at a higher level
- 12 ● The use of paralytic or thrombolytic medications
- 13 ● Retrograde intubation
- 14 ● Tube thoracostomy
- 15 ● The initiation and/or maintenance of blood products
- 16 ● The administration of colloid IV solutions

17

18 In many communities, Paramedics provide a large portion of the prehospital care and
19 represent the highest level of prehospital care. In some communities that utilize
20 emergency medical dispatch systems, Paramedics are part of a tiered response system. In
21 all cases, Paramedics work alongside other EMS and health-care providers as part of an
22 integral part of the emergency care team.

23

24 ***Advanced Practice Paramedic***

25

26 The Advanced Practice Paramedic’s scope of practice includes interventions to reduce
27 the morbidity and mortality associated with critical, emergent, and lower acuity medical
28 and traumatic conditions. In addition to being competent in all of the skills and
29 knowledge of the Paramedic, a major focus of the Advanced Practice Paramedic’s care is
30 the assessment and disposition of patients who access the emergency medical system, but
31 may not need to be transported to an emergency department. The Advanced Practice
32 Paramedic, with medical supervision, can release or redirect patients without
33 transportation to an emergency department. Patient care must take into consideration the
34 complex psychosocial aspects of the situation and public health needs. The Advanced
35 Practice Paramedic provides care that is safe, effective, and efficiently utilizes existing
36 health-care resources.

37

38 The Advanced Practice Paramedic’s scope of practice includes invasive and
39 pharmacological interventions to reduce the morbidity and mortality associated with the
40 broad range of complaints of patients accessing the emergency medical care system.
41 Care and disposition are based on a comprehensive assessment and the formulation of a
42 field impression. The Advanced Practice Paramedic provides care designed to safely and
43 efficiently route patients to existing health-care resources.

44

1 The Advanced Practice Paramedic has knowledge, skills, and abilities developed by
2 appropriate formal education and training. The Advanced Practice Paramedic has the
3 knowledge and is expected to be competent in all of the skills of lower level providers.
4 The major difference from the Paramedic is the ability to refer patients to appropriate
5 health-care resources. The Advanced Practice Paramedic may also perform more
6 advanced care that has greater potential risk to the patient if improperly or
7 inappropriately performed, is more difficult to attain and maintain competency, and
8 requires extensive knowledge in basic and applied sciences.

9
10 The Advanced Practice Paramedic is considered the minimum provider level for EMS
11 systems that desire to release or refer patients. The scope of practice is limited to skills
12 that are effective and can be performed safely in an out-of-hospital setting with medical
13 supervision.

14
15 Medical supervision of Advanced Practice Paramedics includes rigorous prospective and
16 retrospective activities that significantly exceed standards of conventional EMS systems.
17 Medical oversight and responsibility are provided by a close relationship with a Physician
18 Supervisor. The parameters of medical oversight and consultation are based on an
19 agreement between the supervising physician and the Advanced Practice Paramedic.

20
21 The Advanced Practice Paramedic treats and refers all patients safely and efficiently.
22 The Advanced Practice Paramedic is not an independent practitioner. The Advanced
23 Practice Paramedic serves as part of an EMS response system ensuring the appropriate
24 disposition of patients.

25
26 The Advanced Practice Paramedics' clinical care capabilities enable them to be deployed in
27 locations where little or no EMS system infrastructure is in place. These locations may either
28 have no EMS system in place normally, or the EMS system may have been decimated.
29 Examples may include (but are not limited to) oil drilling platforms, expeditions into
30 wilderness areas, care of refugees, commercial fishing vessels, wildland fires, and
31 catastrophes/disaster locations. Operations in these settings are known for traumatic injuries or
32 medical emergencies that warrant immediate intervention, as well as minor trauma and
33 discomfort associated with medical conditions resulting from exposure, dehydration, and
34 environmental irritants.

35 Key characteristics of the challenges for EMS personnel in these situations is the absence
36 of reliable direct communication with medical resources, limited options for
37 transportation, and/or other traditional EMS system components that are compromised or
38 impossible at the point of patient care.

39
40 In addition to conventional emergency medical knowledge and skill sets, the Advanced
41 Practice Paramedic must be familiar with issues such as sheltering, injury prevention,
42 sanitation, risk assessment, environmental protection, fatigue and pain management, and
43 comprehensive pharmacology. Other factors affecting patient care may include delays in
44 the availability of transportation and extended transportation times.

1 The Advanced Practice Paramedic is prepared to render care when both the patient and
2 employer expect a rapid return to service. The Advanced Practice Paramedic is expected
3 to operate in a highly rigorous environment, under exhaustive standing orders and
4 protocols with an extensive skill set and pharmaceutical armament. These individuals
5 may or may not be affiliated with a conventional EMS provider.
6

7 In addition to clinical care, Advanced Practice Paramedics play an important role in
8 integrating EMS systems into the existing health-care and public health systems and in
9 monitoring, clinical supervision, quality improvement, peer education, and medical care
10 in extended care situations.
11

12 At this level, legal recognition of the Advanced Practice Paramedic should be rapidly
13 available from a state where the supervising physician is already licensed.
14

15 Permitted Skill Set

- 16 • Airway and Breathing
 - 17 ○ Rapid sequence intubation
 - 18 ○ Surgical cricothyrotomy
- 19 • Pharmacological Interventions
 - 20 ○ Central venous access
 - 21 ○ Blood products administration
 - 22 ○ Local anesthesia
- 23 • Trauma Care
 - 24 ○ Anterior packing for epistaxis
 - 25 ○ Dislocation reduction
 - 26 ○ Trephination of nails
 - 27 ○ Wound closure
- 28 • Medical/Cardiac Care
 - 29 ○ Urinary catheterization

30 Skills Prohibited

- 31 • Surgical procedures (including, but not limited to, Burr holes, field amputation,
32 perimortem c-section)
- 33 • Independent practice
- 34 • Prescribing medications

35
36
37 The Advanced Practice Paramedic is an important part of the Emergency Medical System
38 in some communities and will form an intersection and bridge between EMS, health-care
39 and public health systems. The Advanced Practice Paramedic will be able to provide
40 medical supervision to lower level EMS personnel. The Advanced Practice Paramedic
41 serves as part of a community EMS response system that ensures efficient and effective
42 use of health-care resources. With medical supervision, the Advanced Practice
43 Paramedic provider can make transport or disposition decisions.
44
45
46

1 Knowledge

2
3 Typically, scope of practice refers to the tasks and roles that licensed personnel are
4 legally authorized to perform. In general, it does not include the requisite knowledge
5 necessary to perform those tasks and roles competently. As outlined in the *EMS*
6 *Education Agenda for the Future*, the major responsibility for determining the knowledge
7 necessary to safely perform tasks and roles falls to educators. The authors of the Scope
8 of Practice offer the following schema to provide guidance to the presumed depth and
9 breadth of cognitive material envisioned for each provider level.

	Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
Critical	Simple	Fundamental	Complex	Comprehensive
Emergent		Simple	Fundamental	Comprehensive
Lower Acuity			Simple	Complex

11
12 Simple, fundamental, complex, and comprehensive refer to a progressive increase in the
13 depth of coverage in each respective topic areas. Critical, emergent, and lower acuity
14 refer to the acuity levels assigned to “Conditions and Components” in Appendix -- of the
15 *National Core Content: The Domain of EMS Practice*. Applying this matrix, the
16 Emergency Medical Technician would possess fundamental knowledge of all the Patient
17 Complaints, Presenting Signs and Symptoms, and Disorders denoted as critical, and
18 simple knowledge of those denoted as emergent.

19
20 It is recognized that the terms used above are inherently subjective. Clearly, two equally
21 qualified experts will have a different interpretation as to exactly what is “fundamental,”
22 what is “complex,” and what is the difference. Obviously, the judgment of experts will
23 be needed to come to consensus as Educational Standards are developed. This matrix is
24 included to provide general guidance, and we trust that the development and review
25 process will resolve the majority of the differences of opinion.

27 Specializations

28
29 In some cases, specialty certifications may be used to respond to local needs for
30 flexibility or to recognize continuing education. Specialty certifications may evolve to
31 accommodate subtle differences in skills, practice environment, knowledge,
32 qualifications, services provided, needs, risk, level of supervisory responsibility, amount
33 of autonomy and/or judgment/critical thinking/decision making.

34
35 It is beyond the purview of this project to define the wide array of possible specialty
36 certifications that might exist now or in the future. However, a premise of this document
37 is that *specialty certifications must not be used to change the scope of practice of an EMS*
38 *provider*.

Appendix A: Interpretative Guidelines

The interpretive guidelines are used to help guide the users of this document by providing insight into the discussions and deliberations that revolved around the decisions of the Scope of Practice Task Force. These interpretive guidelines represent the collective opinions of the Scope of Practice team in May 2004.

The interpretive guidelines are included to allow future users to apply similar methodology in deciding the appropriateness of new interventions at each provider level. The interpretive guidelines are intended to guide the development of educational standards and should assist state regulatory agencies in developing and further refining their administrative or legislative rules. *These guidelines should not appear in practice acts.*

Airway and Breathing Skill Sets

Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
Oral airway Nasal airways BVM Sellick's Maneuver Head-tilt chin lift Jaw thrust Modified chin lift Mouth to barrier Mouth to mask Mouth to mouth Mouth to nose Mouth to stoma Obstruction—manual Oxygen therapy Nasal cannula Non-rebreather face mask Upper airway suctioning	MTV Humidifiers Partial rebreathers Venturi mask ETML airway Tracheobronchial suctioning Intubation confirmation procedures Rate and volume ATV	BiPAP/CPAP Needle chest decompression Chest tube monitoring Percutaneous cricothyrotomy ETCO2 NG/OG tube Endotracheal intubation Non-paralytic, pharmacologically assisted intubation (without paralytics) Nasotracheal intubation Airway obstruction removal by DL PEEP	Surgical cricothyrotomy Paralytic medications Ventilators

Assessment Skill Sets

Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
Manual BP	Pulse oximetry Blood glucose mon Manual and auto BP	EKG interpretation Interpretive 12 Lead Blood chemistry analysis	Hemodynamic monitoring ICP monitoring

--	--	--	--

1

2 **Pharmacological Intervention Skill Sets**

3

Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
<u>Tech of Med Administration</u> -Unit dose auto-injectors for self or peer care	<u>Assisted Medications</u> -Assisting a patient in administering his/her own prescribed medication, including auto-injection -OTC <u>Administered Meds</u> -MD-approved over-the-counter medications -Nitroglycerine -Auto-injected Epi-Pen -Activated charcoal -Medication inhaler -Oral glucose <u>Tech of Med Administration</u> -Buccal -Oral -Maintenance of a non-medicated IV infusion	Peripheral IV insertion IV fluid infusion Central line monitoring IO insertion IV drip <u>Med Administration</u> -Aerosolized -Nebulized -Endotracheal -IM/SQ -IV (push and drip) -NG -Rectal -Sublingual -IO -Topical Accessing implanted central IV port Thrombolytic monitoring Venous blood sampling	Blood administration Arterial line monitoring Central line insertion Thrombolytics initiation Local anesthesia Tetanus

4

5 **Emergency Trauma Care Skill Sets**

6

Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
Cervical collar Manual stabilization Extremity splinting Eye irrigation Rapid extrication <u>Hemorrhage Control</u> -Direct pressure -Pressure point	Selective spinal immobilization Seated spine immobilization Long board Traction splinting Tooth replacement Mechanical pt restraint <u>Hemorrhage Control</u> -Tourniquet -MAST/PASG	Morgan lens Chemical pt restraint	Anterior pack for epistaxis Dislocation reduction Trephination of nails Wound closure

7

8

1 **Medical/Cardiac Care Skill Sets**

2

Emergency Medical Responder	Emergency Medical Technician	Paramedic	Advanced Practice Paramedic
CPR AED Assisted normal delivery	Mechanical CPR Assisted complicated delivery	Cardioversion Carotid massage Manual defibrillation TC pacing	Urinary catheterization Monitoring Transvenous pacing

3

4

1 Definitions

3 **Academic**—Based on formal education; scholarly; conventional.

4 **Academic institution**—A body or establishment instituted for an educational purpose
5 and providing college credits or awarding degrees.

6 **Accreditation**—The granting of approval by an official review board after specific
7 requirements have been met. The review board is non-governmental and the review is
8 collegial and based on self-assessment, peer assessment, and judgment. The purpose of
9 accreditation is public accountability.

10 **Advanced Level Care**—Care that has greater potential risk to the patient if improperly
11 or inappropriately performed, is more difficult to attain and maintain competency, and
12 requires significant background knowledge in basic and applied sciences. Includes
13 invasive and pharmacological interventions.

14 **Certification**—The issuing of certificates by a private agency based upon standards
15 adopted by that agency that are based upon competency.

16 **Continuing education**—The continual process of life-long learning.

17 **Core content**—The central elements of a professional field of study. The core content
18 does not specify the course of study.

19 **Credentialing agency**—An organization that certifies an institution's or individual's
20 authority or claim of competence for a course of study or completion of objectives.

21 **Curriculum**—A particular course of study, often in a special field. For EMS education it
22 has traditionally included detailed lesson plans.

23 **Educational affiliation**—An association with a learning institution (academic), the
24 extent to which can vary greatly from recognition to integration.

25 **EMS System**—Any specific arrangement of emergency medical personnel, equipment,
26 and supplies designed to function in a coordinated fashion. May be local, regional, state,
27 or national.

28 **Licensure**—The act of granting an entity permission to do something that the entity
29 could not legally do without such permission. Licensing is generally viewed by
30 legislative bodies as a regulatory effort to protect the public from potential harm. In the
31 health-care delivery system, an individual who is licensed tends to enjoy a certain amount
32 of autonomy in delivering health-care services. Conversely, the licensed individual must
33 satisfy ongoing requirements that ensure certain minimum levels of expertise. A license
34 is generally considered a privilege and not a right.

- 1 **National EMS Core Content**—The document that defines the domain of out-of-hospital
2 care.
- 3 **National EMS Education Program Accreditation**—The accreditation process for
4 institutions that sponsor EMS educational programs.
- 5 **National EMS Education Standards**—The document that defines the terminal
6 objectives for each provider level.
- 7 **National EMS Scope of Practice Model**—The document that defines scope of practice
8 for the various levels of EMS providers.
- 9 **Outcome**—The short-, intermediate-, or long-term consequence or visible result of
10 treatment, particularly as it pertains to a patient's return to societal function.
- 11 **Practice analysis**—A study conducted to determine the frequency and criticality of the
12 tasks performed in practice.
- 13 **Registration**—A listing of individuals who have met the requirements of the registration
14 service.
- 15 **Registration agency**—Agency traditionally responsible for the delivery of a product
16 used to evaluate a chosen area. States may voluntarily adopt this product as part of their
17 licensing process. The registration agency is also responsible for gathering and housing
18 data to support the validity and reliability of their product.
- 19 **Regulation**—Either a rule or a statute that prescribes the management, governance, or
20 operating parameters for a given group; tends to be a function of administrative agencies
21 to which a legislative body has delegated authority to promulgate rules/regulations to
22 "regulate a given industry or profession." Most regulations are intended to protect the
23 public health, safety, and welfare.
- 24 **Scope of practice**—Defined parameters of various duties or services that may be
25 provided by an individual with specific credentials. Whether regulated by rule, statute, or
26 court decision, it tends to represent the limits of services an individual may perform.
- 27 **Testing agency**—Agency traditionally responsible for delivering a contracted
28 examination. The responsibility of interpreting the results and defending the validity of
29 those judgments is placed on the contractor.

1 **References**

2

3 Will go here.

1 **Acknowledgements**

2
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