Bureau of EMS: VITALS

Florida Bureau of Emergency Medical Services

January 2005 Volume 1, Issue 2

Special points of interest:

- Bureau of EMS enhancing communications
- The Changing Face of EMS?
- EMS Advisory Council January 19-21, 2005, Miami Airport Hilton

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Enhancing Communications

In my teachings of sound management practices, I routinely focus on the importance good communication skills. I always tell my students that if you have a long term problem in a company it is more than likely due to a lack of or poor communications. In an effort to avoid any long term issues, the bureau is continually looking to enhance means of communicating with the EMS community. Through this newsletter, my travels, the EMS web site, and the advisory council, the bureau is better able to disseminate information and resources. In spite of all these efforts, we still are not reaching everyone.

In an effort to improve and expand our current communication model, we will be adding three new features. First, in an attempt to give out more timely information to as many individuals as possible, we will be sending out notification of the more important events to our constituency group leaders. Second, as soon as technology permits, we will be creating a list serve that will enable us to electronically transmit this newsletter to you. Finally, we are revising our web site to make it more user friendly and useful.

Your input is important to us. We are anxious to improve our service. I will be monitoring and answering e-mails in reference to this newsletter. In your e-mail please identify yourself and where you are from. I am looking forward to seeing you at the January Advisory Council meeting.

Sincerely,

Don Bennett

Did you know that only 1% of EMS calls reported are transported by rotor wing aircraft.

Thoughts from the Field:

The Changing Face of EMS?

A Review of the Proposed National EMS Scope of Practice

Submitted by Geoffrey T. Miller

Since the 1960s, EMS has witnessed many great improvements, in its approach to regulated and standardized delivery of education and patient care. However, medicine and medical technology are evolving at a very rapid pace. For this reason, the EMS profession must review and make necessary changes to ensure that appropriate and current knowledge, skills and abilities are employed to deliver the highest quality prehospital care. For the last several months, the national EMS community has had an opportunity to review and comment on the proposed *National EMS Scope of Practice Model*. This process is an essential element in implementing an integrated, systematic approach to regulation, education and certification/licensure as defined in the *EMS Education Agenda for the Future: A Systems Approach* published by NHTSA in 2000.

Development of the Scope of Practice is the second step in a three part process to revise and update the EMS curriculum. The first step was the development of the "EMS core content" which defines the knowledge, skills and abilities that an EMS provider might be allowed to perform. This encompasses the entire spectrum of practices and procedures. The final step is the revision of the EMS curriculum to deliver the appropriate learning opportunity for each level of the adopted Scope of Practice.

The goal of this scope of practice model is to standardize EMS providers nationally and increase efficiency within the entire community. In the 1996 *EMS Agenda for the Future*, 44 different levels of EMS provider certification were identified. It is easy to see how such a wide variation would be problematic. Further, it has been identified that this problem "creates public confusion, reciprocity difficulties, poor provider mobility, duplication of effort (poor efficiency), and ultimately, decreased credibility" of the EMS system. Although the model is considered a guideline, states are cautioned to avoid deviation from the model. States that choose to alter or discard the model will have to develop and defend their own infrastructure (accreditation, certification, etc).

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Did you know that cardiac arrest is less than 1% of all reported calls.

Ask the Director

Dear Colleagues:

We look forward to receiving your questions, comments, ideas on topics to address, and how to improve this newsletter. Your feedback can be emailed to: **DEMO_EMS@doh.state.fl.us**

Thank you.

Don Bennett

Did you know that over 55% of EMS personnel responding in Florida are certified paramedics.

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Scope of Practice v. Standard of Care

There has been some confusion between these two terms, so let's take a minute to review the difference between scope of practice and standard of care.

A *Scope of Practice* is a legal description of the distinction between a licensed healthcare provider and the lay public and between different licensed healthcare providers. It details and establishes which activities and procedures can, and cannot, be performed by a particular type of healthcare provider. It defines the boundaries and distinctions between the various types and levels of providers while ensuring comprehensive control over the appropriate delivery of healthcare service.

The *Standard of Care* is the degree of care that a reasonably prudent person would exercise in the circumstance in question. This is a practical guideline, directing the healthcare provider as to what must be done in a given situation.

Proposed EMS provider levels

The proposed draft of the Scope of Practice model has identified four EMS provider positions; the *Emergency Medical Responder* (*EMR*), the *Emergency Medical Technician* (*EMT*), the *Paramedic*, and the *Advanced Practice Paramedic*. Each level of provider has a suggested scope of practice building more knowledge, skills and ability, from EMR to Advanced Practice Paramedic. The following sections highlight the basic description of each provider level and the suggested educational requirements.

1) Emergency Medial Responder (EMR)

An EMR is synonymous with a First Responder in the state of Florida. The EMR will fulfill the role of the entry-level responder. These individuals will render basic on-scene care, providing immediate life-saving procedures for critically ill or injured patients outside of the hospital. The EMR will have basic knowledge and skills to provide these life-saving interventions, with minimal equipment, working under medical direction, awaiting additional EMS response as part of the comprehensive EMS response. The EMR will always transfer care to a higher trained provider within the EMS system and will not terminate EMS response.

Unlike the layperson rescuer, the EMR is part of the organized EMS response with a duty to act. The essential goal of this individual is to provide a mechanism to increase the rapid delivery of life-saving skill and knowledge to serious emergencies in a community. The EMR will work alongside other EMS providers and are part of the tiered response system.

The EMR will be required to complete an approved Emergency Medical Responder training program that will include training in the use of:

- automated external defibrillators (AEDs),
- oxygen,
- basic airway adjuncts (OPA, NPA, Suctioning, BVM),
- basic assessment skills,
- auto-injectors (for self- and-peer care), and
- rapid extrication.

A detailed list of skills and procedures can be reviewed in the *National EMS Scope of Practice Model* Draft 1.0.

2) Emergency Medical Technician (EMT)

The second level of provider is the EMT (Note: no longer EMT-Basic). This individual will possess the basic knowledge and skill necessary to provide patient care on scene and during transport situations. Their scope of practice will continue to focus on a fundamental skill set to manage and transport critical and emergent patients. This includes "basic, limited advanced and pharmacological interventions" associated with the acute management of medical and traumatic emergencies. Further, the EMT will continue to minimize secondary injuries, provide comfort care and assist families while treating and transporting patients. All skills performed by the EMT are established as effective procedures that can be performed safely with medical direction and limited training.

The EMT is intended to satisfy the minimum staffing personnel requirement for prehospital patients who require transport to a healthcare facility. The EMT will continue to serve as part of the EMS response system "ensuring a progressive increase in the level of assessment and care."

The EMT will be required to complete an approved Emergency Medical Technician training program that is essentially no different that the current model. A detailed list of skills and procedures can be reviewed in the *National EMS Scope of Practice Model* Draft 1.0.

3) Paramedic

The Paramedic will remain a healthcare professional who provides emergency medical care including the use of invasive techniques and pharmaceutical interventions for critical and emergent, medical and trauma patients. Paramedics will continue to deliver care in the field, during transport from a scene and between facilities, and in other healthcare settings. The Paramedic scope of practice increases the knowledge, skills and abilities of the EMT to include procedures that have a greater potential for risk and are generally more difficult to attain and maintain competency.

The Paramedic will continue to be the minimum staffing requirement for patients who require advanced care at the scene or during transport. Paramedics will continue to practice under the supervision of a medical director. The paramedic may make patient destination decisions, however, the "principle disposition of a patient encounter will result in the direct delivery of the patient to an acute care facility" based on the draft model.

The draft has proposed that the following skills be prohibited from practice by paramedics:

- surgical cricothyrotomy, paralytic medications, and ventilators,
- hemodynamic monitoring, and ICP monitoring,
- blood administration, arterial line monitoring, central line insertion, thrombolytics administration, local anesthesia, and tetanus administration,
- anterior packing for epistaxis, dislocation reduction, trephination of nails, and wound closure,
- Urinary catheterization, and transvenous pacing.

Several of the skills listed are currently permitted in Florida for Paramedic practice and may require further discussion and comment. Keep in mind that in many of Florida's communities, Paramedics provide a large portion of the prehospital care services, representing the highest level of EMS care.

Under the proposed model, the Paramedic will be required to complete an accredited Paramedic training program at either the certificate or Associate Degree level. Again, the training program requirements for the Paramedic do not differ significantly from the current model. A detailed list of skills and procedures can be reviewed in the *National EMS Scope*

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> "We are interested in issues that affect the EMS industry in today's world."
> -Don Bennett

Did you know that Florida EMS Providers respond to over 2.9 million calls every year.

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of Practice Model Draft 1.0.

4) Advanced Practice Paramedic

In addition to all of the knowledge, skills and abilities of the three previous levels of providers, the Advanced Practice Paramedic will include interventions aimed at reducing death and disability associated with critical, emergent and lower acuity medical and trauma problems. The Advanced Practice Paramedic will assess and make decisions regarding the disposition of patients. This individual, with medical supervision, will be able to release or re-direct patients without transportation to the emergency department. Medical oversight and consultation of the Advanced Practice Paramedic will be based on an agreement between the physician and provider. The Advanced Practice Paramedic will be considered the "minimum staffing level for EMS systems that desire to release or refer patients." Further, the Advanced Practice Paramedic may or may not be affiliated with a conventional EMS provider, based on the draft model.

One of the goals of the development of the Advanced Practice Paramedic is to provide a link to areas with little or no access to conventional EMS systems. Examples include but are not limited to: oil drilling platforms, commercial maritime vessels and disaster/catastrophes locations where communications have been lost or interrupted. The Advanced Practice Paramedic will be challenged in these situations (absence of reliable communication, medical resources and transportation options) to provide care in the traditional sense.

The scope of practice for the Advanced Practice Paramedic includes all "permitted skills" of the previous three as well as those listed as the prohibited skills for Paramedic. In addition to conventional EMS skills, this individual will be familiar with sheltering, injury prevention, sanitation, risk assessment, environmental protection, pain management and comprehensive pharmacology. The Advanced Practice Paramedic will be expected to operate under extensive standing orders and protocols with an extensive skill set.

The Advanced Practice Paramedic will be required to complete an accredited Advanced Practice Paramedic program which is expected to be similar to a Bachelors degree level or higher. Much of this decision is based on the amount of independent decision making that an Advanced Practice Paramedic will utilize. A detailed list of skills and procedures can be reviewed in the *National EMS Scope of Practice Model* Draft 1.0.

A Final Note and Duty to Act

Each level of knowledge, skills and ability in the proposed scope of practice model represents a continuum of increasing complexity and risk. As provider levels increase from EMR to Advanced Practice Paramedic, so does the required knowledge and skill complexity and acquisition and, most importantly, the potential for harm. The community of interest should assess their needs and determine the necessary and appropriate resources to deliver prehospital care services under the final adopted EMS Scope of Practice model.

The Scope of Practice Model and associated documents can be viewed at the following site: www.emsscopeofpractice.org. I would strongly urge providers from the community of interest to review and provide feedback (in writing) to the State Bureau of EMS. Comments may be received through January 30, 2005 (to the national task force, so get them to the State Bureau of EMS by January 21). As you review this document, please keep in mind that this is a living and evolving process that will see additional changes as the profession advances.

An open forum to discuss the EMS Scope of Practice Model will be held at the EMS Advisory Council constituency meetings in Miami on Wednesday, January 19, 2005 from beginning at 10:00 a.m. to 12 noon in the Florida EMS Educators meeting room.

We Need Your Ideas!

The Bureau of Emergency Medical Services needs your help in creating a name for our newsletter. Be creative!

Submit ideas by e-mail:

DEMO_EMS@doh.state.fl.us

Or by mail:

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Dr. Joe Nelson is the new State EMS Medical Director.

We're on the web!
http://www.fl-ems.com

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Thank You Dr. Hendry

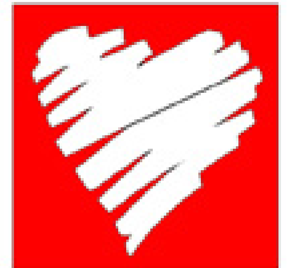
The Bureau's Emergency Medical Services for Children (EMSC) Program would like to take this opportunity to extend our sincerest gratitude to Dr. Phyllis Hendry. Since 1999, Dr. Hendry has served as the EMSC Medical Advisor with fortitude, enthusiasm and compassion. Her dedication helped to build new and productive partnerships and brought the EMSC Program to a level that earned the National EMSC Heroes Award for State Programs in 2002.

In February, Dr. Hendry will be resigning her position as EMSC Medical Advisor. While we regret losing her as part of our staff, her influence and her vision for the children of Florida will always serve as a foundation for the EMSC Program. We thank her for giving so much of herself in the interest of our children and wish her well in her future endeavors.

Did you know that in Florida over 7 thousand patients received defibrillation last year.

Did you know that EMS call volume in Florida increases over 10% in the winter months.

NATIONAL EMERGENCY MEDICAL SERVICES WEEK 2005



Tip of the Month

Do not forget to add the late fees to any certification application submitted to the Bureau of EMS.

Thank You Dr. Slevinski

After 20 years of dedicated service to the Bureau of EMS, Dr. Rick Slevinski has resigned his post as State EMS Medical Director. It is difficult to put into words our gratitude for his tireless efforts to enhance Florida's EMS system over the years. Dr. Slevinski's altruistic attitude and his passion for EMS has been a driving force within the EMS Bureau and we have learned much from him. A true leader in every sense, he has always given his best and inspires others to do the same. He leaves the bureau with our sincerest gratitude for a job well done. We will miss him and wish him only the best.

Did you know that in Florida 3 lead EKG monitoring is done 3 times as often as multi-lead EKG monitoring.