



EMS Focus Webinar FAQ – The New National Scope of Practice and What it Means for You

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The following answers are provided by:

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1. Can you discuss the process and decisions involving glucometers and CLIA?

The Clinical Laboratory Improvement Amendments (CLIA), enacted in 1988, require all laboratories that examine materials derived from the human body for diagnosis, prevention or treatment purposes to be certified by the Secretary of Health and Human Services. CLIA allows for entities to apply for a certificate of waiver (COW) to perform tests that are determined by FDA or CDC to be so simple that there is little risk of error. EMS agencies can apply for a CLIA waiver for specific tests, such as blood glucose testing with glucose monitoring devices cleared by the FDA for home use. Learn more about CLIA waivers [on the CMS website](#).

2. Did your group evaluate the impact that paramedic program accreditation has had on the industry, especially in non-urban areas, before advocating AEMT program accreditation?

The Expert Panel discussed the impact of accreditation on patients, communities and the EMS profession. That included an examination of the limited research on the impact of accreditation, including [Dickison et al.'s landmark study](#) published by Prehospital Emergency Care on the positive effects of EMS program accreditation for paramedics.

3. Did I understand correctly that you are recommending use of waveform capnography for all supraglottic airway placements, including for supraglottic airways performed at the EMT level?

The use of waveform capnography is recognized as the standard of care for confirming and monitoring placement of all invasive airway management techniques. The 2018 National EMS Scope of Practice Model recommends supraglottic airways only at the AEMT and paramedic levels. However, any time a supraglottic airway is inserted, guidelines recommend that waveform capnography is used. If a state or local agency allows for BLS level use of SGA, capnography should be used.

4. When will the EMS Education Standards be released and what does the future of the Education Standards for each level look like?

The revision of the EMS Education Standards has just kicked off, with the new guidelines scheduled to be released in 2020; you can find out more about the project on [ems.gov](https://www.ems.gov). Most of the changes to the guidelines will likely directly reflect the changes made to the Scope of Practice Model, but it's too early in the process to know exactly what the revision to the guidelines for each provider level will entail.

5. Is there an opportunity for State EMS Office education representatives to participate in the education update? If so, how does this person apply for or plug into the opportunity?

The National EMS Education Standards Revision team welcomes input from the entire EMS community. The revision process will be open and will provide ample opportunity for EMS professionals and EMS organizations to participate. One way to ensure you are aware of these opportunities is to visit [ems.gov](https://www.ems.gov) and [sign up](#) to receive email updates from the NHTSA Office of EMS.

6. Why are we getting rid of assisting patients with prescribed medications?

References to “assist patients in taking their own prescribed medications” have been identified as confusing by educators and practitioners and the Expert Panel chose to remove them from the Scope of Practice Model. Placing a tablet in a patient’s mouth, activating an inhaler, or delivering a dose of medication via autoinjector is clearly an act of medication administration, whether that medication is prescribed to the patient or carried in the EMS professional’s inventory. Preparing, administering and evaluating the effectiveness of prescription and non-prescription medication is not in the 2018 National EMS Scope of Practice Model for EMS personnel, with the exceptions described in the document’s interpretive guidelines and those authorized by States and medical directors.

7. Can you clarify high-flow NC?

High flow nasal cannula has emerged as an innovative and effective modality for early treatment of adults with respiratory failure with diverse underlying diseases, and is able to deliver adequately heated and humidified medical gas at flows up to 60 L/min. It is

considered to have a number of physiological advantages compared with other standard oxygen therapies. For these reasons, it was included in the National EMS Scope of Practice Model at the paramedic level.

8. Why is BiPAP not included in the Scope of Practice Model for any level?

The Expert Panel reviewed scientific literature that suggests that BiPAP offers no clinical advantage over CPAP in cases of acute cardiogenic pulmonary edema that may initially present as type 1 respiratory failure. Therapeutic outcomes were considered along with the level of risk to patients, the economic burdens of costs of additional equipment and supplies, as well as associated costs of additional hours of education, requirements to maintain competency, and level of supervision needed to complete the task/skill. The panel supports CPAP on adults (13+ years of age) at EMT, AEMT, and paramedic levels.

9. The American Heart Association has moved away from the 5-year revision in favor of ongoing updates as new evidence is published. Is that an eventual update model for the EMS Scope of Practice Model?

The Expert Panel agreed the 2018 National EMS Scope of Practice Model should be updated regularly, but there are too many variables to be more specific about how often this should occur. One of the deliverables of this project was the creation of an urgent process to make rapid changes in response to such things as a public health crisis, new evidence, etc. More information can be found under “Resources” at <https://www.ems.gov/education.html>.

10. How will the new Scope of Practice Model impact care for pediatric patients?

EMS care for special populations, including children, was a consideration throughout the revision of the Scope of Practice Model. The project was co-funded by the EMS for Children program at the Health Resources & Services Administration, and several pediatric experts were part of the Expert Panel or consulted during the process of writing the new Model. Find more on Special Populations, including pediatric patients, in Section 3 of the Scope of Practice document.

11. For AEMT education programs, what would be involved with getting accredited?

National EMS Program Accreditation is already available at the AEMT level for programs that are affiliated with a nationally accredited paramedic program. Standards are available at www.coaemsp.org.

12. Was there any discussion in regard to accreditation of EMT along with AEMT?

Although the *Education Agenda* contains a recommendation for national EMS program accreditation at all levels, the Expert Panel discussed at length the time and resources

required for EMS educational programs to attain and maintain national accreditation. At this time, it is not practical to accredit EMR and EMT programs because current program content is not sufficient in depth and breadth to support national accreditation.

13. Was there consideration of how expanding and altering the Scope of Practice Model would impact the length of education programs at all levels, and how that might further impact the availability of appropriately educated EMS professionals in the volunteer and career workforce?

The Expert Panel included representatives of all levels of EMS education and certification, as well as different service model types. During the revision of the Model, the effect on education programs and students was certainly considered. Reflecting the people-centered vision for EMS described in EMS Agenda 2050, the panel focused on what would be best for patients and communities when making recommendations about all four levels.

14. If state offices have questions about rationale, or need background/context that is not included in the final document, who is the best point of contact for us?

For more information, contact the NHTSA Office of EMS or Kathy Robinson with the National Association of State EMS Officials.

15. Will there be funding available for transition/education/equipment?

Though there is not dedicated funding available to implement the revised 2018 National EMS Scope of Practice Model, several existing federal and state grants could be used to support its implementation. Visit www.grants.gov to search for federal grant opportunities and contact your State EMS Office to learn more about its available resources.

16. Is there really going to be much of a difference between a paramedic and an AEMT?

It is important to note that while we often focus on the skills and tasks allowed at each provider level, there are other differences. In the revised Scope of Practice Model, the skills and tasks at the paramedic level certainly vary from those at the AEMT level. However, the more important differences between the two provider levels lie in the education they receive and competencies they master. AEMTs experience minimal autonomy for limited advanced skills. Paramedics perform focused advanced skills and pharmacological interventions that are engineered to mitigate specific life-threatening conditions, medical, and psychological conditions with a targeted set of skills beyond the level of an AEMT. Paramedics operate with collaborative and accessible medical oversight, recognizing the need for autonomous decision-making.

17. Could you speak to the recommendation that licensed individuals are accountable for tasks routinely performed by the lay public. Are there examples?

Interventions that are regularly performed by the lay public, such as self-administered medications, blood glucose monitoring, and pulse oximetry were considered at length. It is noted that patients receive health education and training from their primary care provider to perform activities that are tailored to their personal medical histories and response to prescribed interventions over time. The Expert Panel maintains that licensed individuals at all levels are highly accountable for the medical care they provide as well as the maintenance and calibration of medical equipment used in the course of a patient encounter. Health professionals are not only educated to provide an intervention, they also receive education in the associated risks and potential complications, related pharmacology (when medications are involved), and they are able to analyze the effectiveness of treatment. Perhaps the most critical difference between the lay public and EMS personnel assuming responsibility for a particular task/skill: licensed individuals are taught to assimilate information and apply critical thinking skills to know when to and when not to apply an intervention in a particular scenario. Licensed personnel are held to be medically and legally accountable and responsible for their actions.

18. Has CoAEMSP been involved in this effort?

Yes. The Committee on Accreditation of Educational Programs for the EMS Professions participated in the national engagements and provided input to the Expert Panel.

19. What were the discussions on anatomy, physiology and pathophysiology as it relates to Scope of Practice and National EMS Education Standards?

The Expert Panel focused on what skills, tasks and competencies would be most beneficial in helping EMS professionals serve their communities and patients. The National EMS Education Standards revision process, which is in its early stages, will examine what level of education and knowledge in these areas is necessary for EMS clinicians to perform their roles.

20. Will we see the need for minimum degree requirements for the paramedic profession addressed at all in the education standards?

No. The National EMS Education Standards revision effort will focus on delineating what knowledge, skills and abilities are necessary for providers at each of the four levels—not what type of program or degree is required.

21. Was the Span of Scope—in what practice areas and settings EMS professionals should practice in—discussed during the process?

In the executive summary of the new EMS Scope of Practice Model document, it states “...the U.S. is transforming its health care system to provide quality care leading to improved health outcomes achieved through interdisciplinary collaboration. EMS personnel are key to this transformation through innovative approaches in a variety of practice settings. The Expert Panel strongly supports the national call for the elimination of barriers for all professions to practice to the full extent of their education, training, and competence with a focus on collaborative teamwork to maximize and improve care throughout the health care system.”

22. Was any consideration given to collapsing EMT and AEMT into a single level?

Yes. The Expert Panel discussed combining or removing levels throughout the process. However, it was determined that each existing level remained a viable and separate scope of practice level.

23. How will the new Scope of Practice Model affect training for the Emergency Medical Responder (EMR), a 40- to 60-hour certification?

The Expert Panel considered many factors when making decisions about the Scope of Practice Model at each level, including the amount of education and training required. However, the focus was on what would allow EMS practitioners to best serve patients and communities, and the project’s scope did not include determining the length of time it would take to achieve competency at each level. The revision of the EMS Education Standards will look further at that subject, although there is no national requirement for the number of hours in an EMR course.

24. How can I petition my state to expand the scope of EMR, EMT and paramedic?

Please contact your State EMS Office directly for the answer to this question.

25. How quickly does the NREMT change its written exams to reflect the new Scope of Practice Model?

NREMT is already looking at the changes to integrate into testing but the exam is based on the NREMT Practice Analysis, not the National Scope of Practice Model.

26. Will this new national Scope of Practice Model reduce the scope for EMT-Intermediates in the state if they move forward with the AEMT transition?

This question should be asked of your State EMS Office. EMT-I is no longer a national provider level. Many states have chosen to phase out the EMT-I certification level over time and transition to the national model of EMR, EMT, AEMT and paramedic.
