



EMS Provider Scope of Practice Change Request

Revised 7/2015

Please complete the following questionnaire regarding your request for an addition, deletion, or change to the EMS Provider scope of practice. Please provide as much information as you can to speed the review process. If you do not have an answer, you may leave a section blank and we will research the answer as time permits. Your proposal will be reviewed by the Oregon Medical Board's EMS Advisory Committee and the Department of Human Service/EMS's State EMS Committee will be consulted on proposed changes to the scope of practice. If we have questions concerning the proposal for change, we will be back in touch with you for additional information. Once the proposal is complete, it will be placed on the agenda of the next EMS Advisory Committee meeting.

1. What is your proposed change to the scope of practice and which provider level/s will be affected?

OCAR 847-035-0030: Scope of Practice

Add IM administration of naloxone to Emergency Medical Responders: "may administer naloxone via intranasal device, auto-injector, or intramuscular for suspected opioid overdose"

2. Why is this change needed? Why is this the best method of addressing it?

SB 384 gave the Oregon Health Authority direction to develop materials to train bystanders in the administration of naloxone. Their materials include IM administration

(<https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Documents/naloxone/naloxone-training-protocol.pdf>) (<https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/Naloxone-Training-Protocol.aspx>)

EMTs are allowed to give IM epi for anaphylaxis so know how to perform the skill.

3. What are the advantages or benefits of the proposed change? (Is there a patient benefit?)

1) Intranasal naloxone may not work when administered to a congested patient.

2) It is slower to act and may not be as effective. (<http://ndews.umd.edu/sites/ndews.umd.edu/files/pubs/Disparity%20in%20Naloxone%20Administration%20by%20Emergency%20Medical%20Service%20Providers%20and%20the%20Burden%20of%20Drug%20Overdoses%20in%20US%20Rural%20Communities.pdf>)

3) If redosing is needed, it cannot be administered via the IN route.

4) The retail cost of the autoinjector is \$855, and an added autoinjector is around \$40. A single needle for IM injection is around 64 cents.



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4. What are the disadvantages or risks of the proposed change? (Is there potential for harm?)

Disadvantage: training the EMRs who are already certified. The training can be added to future classes for EMRs.

5. Who else might be affected by the change? How will they be affected?

EMS trainers would need to include the training in the skillsets for EMRs and EMTs, though EMTs already are trained on IM epi for anaphylaxis.

6. Who might oppose the change? Why might they oppose it?

Since bystanders are allowed to administer IM naloxone, EMRs and EMTs should also be allowed to administer it. I do not see this as a change that would be opposed.

7. Education:

A. Is this currently being taught in the EMS Provider curriculum?

Yes No

B. What would be the training needed to add this to the scope of practice?

EMRs would need to learn how to give an IM injection. EMTs would need to be educated that it is added to their Scope of Practice.

Outside In, Portland, has trained over 902 bystanders to give it IN or IM and have over 400 reports of successful use

(<http://www.bizjournals.com/portland/blog/health-care-inc/2014/09/price-of-addiction-a-year-later-a-bright-spot-in.html?page=all>)



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- 8. What are the financial impacts of the proposed change?
 - a. Cost of education and/or training
 - b. Cost of equipment and/or medication
 - c. Cost of permits (Clinical Laboratory Improvement Amendments (CLIA), Drug Enforcement Administration Registration (DEA), others?)

It would be a decreased cost if agencies are using autoinjectors vs an IM needle. Agencies could cover this in the normal training for recertification.

- 9. Is the proposed change currently being done in other EMS systems in the U.S.? In other countries?

Twenty-three states are allowing bystanders to administer naloxone as of Nov. 2014 (<https://www.whitehouse.gov/blog/2014/12/17/updated-infographic-overdose-prevention-state-state>) Twelve states allow EMTs to administer naloxone (<http://ndews.umd.edu/sites/ndews.umd.edu/files/pubs/Disparity%20in%20Naloxone%20Administration%20by%20Emergency%20Medical%20Service%20Providers%20and%20the%20Burden%20of%20Drug%20Overdoses%20in%20US%20Rural%20Communities.pdf>). The Outside In article referred to previously states 27 states allow it.

- 10. What research or evidence is there that the proposed change is useful, beneficial, or works (please list references if any)?

The American Journal of Public Health, April 2015, recommends more states allow EMTs to administer naloxone IN or IM (<http://ndews.umd.edu/sites/ndews.umd.edu/files/pubs/Disparity%20in%20Naloxone%20Administration%20by%20Emergency%20Medical%20Service%20>) Here is an excerpt: Conclusions: When drug overdose primary prevention fails, EMS personnel are the health care system's first responders and are uniquely positioned to treat prescription opioid and heroin overdose cases. In rural communities, the following actions may position EMS responders to save more lives:
 1. Obtaining additional EMS training to obtain the proper certification to administer pharmaceuticals such as naloxone.
 2. Changing the scope of practice to allow EMT-basics to administer intranasal or intramuscular naloxone. This change may save lives and reduce the burden of complications from opioid or heroin overdose, particularly in the rural environment.

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E-mail EMS Scope of Practice Change Request form to all of the following:

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OR send by mail to:

Oregon Medical Board
EMS Advisory Committee
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and

Department of Human Service/EMS & Trauma Systems
State EMS Committee
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