

I A F F

EMERGENCY MEDICAL SERVICES

Paramedic Expanded Scope

Monograph 6



International Association
of Fire Fighters



Emergency Medical Services

Paramedic Expanded Scope

Monograph 6



**Department of Emergency Medical Services
International Association of Fire Fighters, AFL-CIO, CLC**

Copyright © 1997 by the International Association of Fire Fighters.® This publication is protected by copyright. No part of it may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without written permission from the International Association of Fire Fighters, Department of Emergency Medical Services.

International Standard Book Number: 0-942920-27-9

Foreword

Today more than 80 percent of fire departments perform some level of emergency medical services (EMS), making professional fire fighters the largest group of providers of prehospital emergency care in North America. No other organization – public or private – is capable of providing prehospital emergency response as efficiently and effectively as fire departments. Fire department operations are geared to rapid response, whether it is for EMS or fire suppression. Cross-trained/dual-role fire fighters are trained to aggressively attack their work whether it involves a fire, a rescue, or a medical emergency. It is no surprise that study after study has shown that fire department-based prehospital emergency medical care systems are superior to other provider types.

However, as we look into the future of prehospital emergency medical care, we are called upon to evaluate our role and the possible need for change in the context of a rapidly evolving medical care system. We must look at what we have learned during the past century and create a vision for the future of fire-based EMS. This vision must address necessary legislation for the protection of fire-based systems. It must address public education, prevention, and the possible expansion of the scope of practice for paramedics. This vision must consider the effects of managed care organizations on prehospital EMS, as well as revenue recovery for the services fire fighters perform. It must also protect fire-based systems from the threat of privatization, as well as protect the citizens we serve by preserving the nation's universal emergency access number, 9-1-1. The information in this series of monographs is designed to guide local fire department leaders through the process of developing a vision for the future of a fire-based EMS system. This monograph is the **sixth** in the series and contains information on the changing role of EMS professionals. This section provides examples of EMS systems already providing care beyond the traditional scope while it offers sound criteria for deciding if expanded scope is right for your community.

The role of the professional fire fighter is constantly changing. We are called upon to act as multi-faceted first responders answering not only fire calls but rescue, hazardous materials, and emergency medical calls. By answering the challenge of change, we can continue to meet the needs of the communities we serve and do what we do best — protect property and save lives.

Harold A. Schaitberger
General President

Acknowledgments

The IAFF would like to acknowledge the Department of Emergency Medical Services staff, specifically Jonathan Moore and Sandy Miller, for their work in the development of this publication.

The IAFF also wishes to recognize the members of the IAFF EMS Committee for their editorial review and support:

James L. Hill, District 7 Vice President, Co-Chair
Dominick F. Barbera, District 12 Vice President, Co-Chair
Robert B. McCarthy, President, PFF of Massachusetts
Patrick Cantelme, President, IAFF Local 493, Phoenix, AZ
Dan Fabrizio, President, IAFF Local 2, Chicago, IL
Mark A. Lloyd, President, IAFF Local 385, Omaha, NE
Richard L. Mayberry, President, IAFF Local 522, Sacramento, CA
Gary Rainey, Secretary, IAFF Local 1403, Metro-Dade Co., FL
Ronald L. Saathoff, President, IAFF Local 145, San Diego, CA

IAFF DEPARTMENT OF EMERGENCY MEDICAL SERVICES

Lori Moore, MPH, EMT-P, Director



International Association of Fire Fighters® AFL-CIO, CLC
Department of Emergency Medical Services
1750 New York Avenue, NW
Washington, DC 20006
(202) 737-8484
(202) 737-8418 (FAX)

Paramedic Expanded Scope Table of Contents

POTENTIAL CHANGES IN THE ROLE OF THE PaRAMEDIC - EXPANDED SCOPE OF PRACTICE	1
EDUCATION OR PRACTICE: WHICH SCOPE IS EXPANDING?3	
Chronology	3
The Future	5
POTENTIAL ADVANTAGES OF EXPANDED SCOPE OF PRACTICE	7
POTENTIAL DISADVANTAGES OF EXPANDED SCOPE OF PRACTICE	8
ROADBLOCKS TO EXPANDED SCOPE OF PRACTICE	9
CONCLUSION	10
GLOSSARY	13
Appendix 1. Paramedic Expanded Scope of Practice-Rules Survey	

POTENTIAL CHANGES IN THE ROLE OF THE PARAMEDIC –EXPANDED SCOPE OF PRACTICE

In 1966, the National Highway Safety Act was enacted, creating the emergency medical technician (EMT). The role of this new health and safety professional was to reduce mortality from highway automobile accidents and other emergencies by providing on-scene prehospital emergency medical care. By 1969, a national EMT training standard was published by the American Academy of Orthopedic Surgeons, with the first course being tested in 1971.

In 1973, the Federal Emergency Medical Services Act defined EMS as:

...a system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services under emergency conditions in an appropriate geographical area.¹

By 1977, a division of the Department of Transportation, the National Highway Traffic Safety Administration (NHTSA), had designed and published the Emergency Medical Technician-Paramedic: National Standard Curriculum. This curriculum defined the role of the paramedic as a list of tasks:

- Recognizing a medical emergency; assessing the situation; managing emergency care and if needed, extrication; coordinating efforts with those of other agencies that may be involved in the care and transportation of the patient; and establishing rapport with the patient and others to decrease their state of crisis.
- Assigning priorities of emergency treatment and recording and communicating data to the designated medical command authority.

-
- Initiating and continuing emergency medical care under medical control including the recognition of presenting conditions and initiation of appropriate invasive and non-invasive treatments, e.g., surgical and medical emergencies, problems with ventilation and respiration problems, cardiac dysrhythmias, cardiac standstill, and psychological crises; and assessing the response of the patient to that treatment and modifying medical therapy as required under the direction of a physician or other authorized personnel.
 - Exercising personal judgment in case of interruption in medical direction caused by communication failure or in cases of immediate life-threatening conditions (under these circumstances, providing such emergency care as has been specifically authorized in advance).
 - Directing and coordinating transport of the patient by selecting the best available method(s) in conjunction with medical authority.
 - Recording in writing or dictation the details related to the patient's emergency care and the incident.
 - Directing the maintenance and preparation of emergency care equipment and supplies.²

Almost seventeen years later, paramedic textbooks use the same description of a task framework to define the role of a paramedic.³ While EMS systems, training methods, and equipment have evolved, the paramedic's curriculum has not. In practice, however, some emergency medical care providers have ventured into non-emergent areas.

EDUCATION OR PRACTICE: WHICH SCOPE IS EXPANDING?

The scope of practice refers to the boundaries of a medical care provider's actions. A clear scope of practice would precisely define what actions could be taken by a given medical professional. Other than the paramedic's role statement found in the paramedic national standard curriculum, the scope of practice for paramedics has not yet been standardized.

The paramedic national standard curriculum does, however, define the minimum information required for any recognized paramedic education program. States or local EMS leaders may expand individual programs by adding to the curriculum, either for student enrichment or to fill a community's specific prehospital care needs. For example, while the National Standard Curriculum does not include immunization objectives, the Texas Department of Health has held workshops to teach Texas paramedics to administer immunizations as part of its "Shots Across Texas" program.

In 1994, Lee County, Florida paramedics were instructed by the county public health unit in skin type tuberculosis (TB) testing. While TB testing is not part of the standard curriculum, it is part of the Lee County expanded scope of education and practice.

CHRONOLOGY

Over the past twenty years the field of EMS has undergone changes that have effectively broadened the work of EMTs and paramedics to fill needs for primary health care in their communities. The following chronology gives examples of EMS providers in expanded roles and the response of leaders in the EMS community to the increasing responsibilities handled by EMTs and paramedics.

As early as 1975, the Springfield and Eugene, Oregon fire departments were dispatching cross-trained fire fighter/EMTs to local businesses to provide on-site care for minor medical problems of employees and customers.⁴

In 1991, the Pinellas County, Florida EMS system providers attempted to set up a 12-week education program to add a version of “treat and release”: field laboratory tests, immunizations, and “refer and schedule” procedures to the paramedic scope of education and eventually their scope of practice. The program was stopped due to lack of funding and a Florida law that allows EMTs and paramedics to provide only emergency care.⁵

In 1993, nine “Outreach Paramedics” began an 8 week (128 hour) course in Taos, New Mexico. Single-role paramedics and cross-trained fire fighter/paramedics studied expanded histories and assessment skills, immunizations, and simple lab tests. Funding for this Rural Health Demonstration Project came from the Federal Office of Rural Health Policy.

Also in 1993, the Indiana EMS Commission and Indiana Paramedic Association (IPA) began developing a “physician-extender” program. The program would include education in child immunizations, critical care during inter facility transport, and primary care in patients’ homes.

By 1994, it was clear that, in many areas of the country, the face of EMS was changing. Prehospital providers were being trained to deliver out-of-hospital care based on the perceived needs of the community. However, many EMS leaders believed that expansion of the roles of paramedics and EMTs required significant study. These leaders called for research, particularly in the areas of funding and reimbursement for services, liability of providers, and in assessing community needs.

-
- Determine the **need** for expanded role paramedics before making changes in established systems
 - Customize programs to the needs of sponsoring communities
 - Cooperate, network, and build alliances with **all** health care providers in a community to determine which providers can best fill an expanded role⁶

By the end of 1994, paramedics in rural Lee County, Florida began performing TB skin tests and TB patient medication follow-up. Additionally, sixteen Red River, New Mexico paramedics began performing expanded-scope duties that included wound management, immunizations, throat and wound cultures, and health surveillance.

In 1996, the Phoenix Fire Department implemented a program known as Mobile Health One. In this pilot program, a fire fighter who was also trained as a registered nurse, a paramedic, and a physician's assistant responded to designated calls according to established protocols, provided on-scene care, and in most cases, released the patient to remain home. This fire fighter provided a wide range of care under her physicians assistant credentials, including immunizations, suturing, referrals, physicals, and writing prescriptions as required. The fire department concluded that the program fills a need in the urban setting and has the potential for financial savings to the citizen, health care payers, and the city.⁷

THE FUTURE

Will the future change the paramedic from a prehospital emergency care provider to a patient care agent? While there are both advantages and disadvantages to expanding the scope of practice of the paramedic, the primary concern should be placed first on maintaining the integrity of the 9-1-1 emergency response system. It is crucial that all communities have this essential public service accessible to all citizens. **Only when the emergency medical response capability is guaranteed, should a community consider an expanded scope of practice program.**

In addition, expanding the scope of practice for paramedics and EMTs should be **based solely on the community's need**. For example, paramedics may provide immunizations in a high risk inner city population with low levels of vaccination program compliance, or provide some level of primary care to under-served rural areas with limited access to physician care. These expanded roles are not appropriate where community health needs are being met by existing mechanisms.

POTENTIAL ADVANTAGES OF EXPANDED SCOPE OF PRACTICE

- Hospitals are expensive and inefficient for non-emergency health conditions. Community health mobile medics can treat patients where they live at tremendous savings. Health care payers, in particular, are giving increased attention to the potential uses of professionals who are less expensive than physicians and registered nurses.⁸
- Many paramedics may find it appealing to have a slower pace of work, less stress and trauma, the opportunity to develop relationships with patients, and recognition for their many skills.⁹
- The added availability of a local referral system that operates through an expanded-scope paramedic could overcome the financial or geographical barriers that limit access to health care.¹⁰
- Primary care delivery may create another step in the career ladder, complete with higher pay and more respect.¹¹

POTENTIAL DISADVANTAGES OF EXPANDED SCOPE OF PRACTICE

- If handled within the confines of the emergency (9-1-1) response system, the demands placed on EMS providers by primary care may reduce their ability to respond to emergencies.¹²
- Without adequate planning and funding, expanded scope of care programs negatively impact busy urban and suburban EMS systems.
- EMS planners in heavily populated areas must consider how adding expanded-scope services would affect cycle time. Increasing the out-of-service time of any one unit could reduce service in a high volume EMS system.¹³
- A patient's outcome may be negatively affected if the assessment of a patient by a paramedic was handled incorrectly, or the patient failed to keep a follow-up appointment. This may subject the paramedic and his or her employer to increased potential for civil liability.
- Current paramedic curricula do not consistently address the knowledge and skills needed for out-of-hospital primary care. The new paramedic curriculum (DOT, revision expected 1998) is expected to include an **optional** expanded-scope section beyond the required minimum paramedic educational requirements.
- In some urban/suburban areas, managed care organizations are establishing small primary care clinics, usually staffed by a physician assistant or nurse practitioner. In these settings, there may be no economic advantage for deployment of expanded-scope paramedics as out-of-hospital providers of primary care.

ROADBLOCKS TO EXPANDED SCOPE OF PRACTICE

- **Funding**— The costs of training beyond the paramedic minimum may be very high. Additional lecture and clinical hours, as well as continuing education, are required.
- **Legal Issues** — Some states clearly define paramedic scope of practice to include or exclude expanded-scope skills. Other states do not clearly define the scope of practice statement. Legislation will be required at the federal and/or state level to support the expanded role paramedic, (See Appendix, Paramedic Expanded Scope of Practice - Rules Survey, for a list of the current status of such legislation in each state and the District of Columbia.)
- **Professional Organizations**— Concerns are that EMS primary care may encroach on the work of other professions (registered nurses, physicians) and the associated revenues may be obstacles. Out-of-hospital primary care could reduce the number of patients seen in hospitals and in physicians' offices. This could have negative economic impact for physicians and hospitals.
- **Paramedics** — Many paramedics may lack interest in out-of-hospital primary care.¹⁴ Many feel that providing primary care services conflicts with the objectives of providing emergency care.¹⁵
- **Insurers and Managed Care Organizations** — Expanded-scope providers must be able to show health care payers that out-of-hospital primary care are cost effective.¹⁶ To date, there has been no conclusive proof of generally applicable cost effectiveness.

-
- **Curricula** — To expand the scope of practice for paramedics, personnel must be trained intensively in patient assessment, geriatrics, pediatrics, and a broad range of underlying diseases. Such training could take months to master, and may not be sufficient to ensure patient safety.¹⁷
 - **Medical Community** — Proposals to utilize prehospital providers in non-traditional roles have generated a tremendous amount of interest in the medical community, including negative reactions. For any program to be successful, the program must be carefully integrated into the community's overall health care system and meet needs not addressed by the existing system.
 - **EMS Physicians** — Expanded-scope programs may pose challenges for those EMS physicians who serve as system medical directors. Medical directors must acquire new skills and shift efforts from in-hospital care to the prehospital environment. This will require EMS physicians to provide more oversight, direction, monitoring, and follow-up than ever before.
 - **Public Sector Cost Shifting** — If large managed care organizations (MCOs) shift new medical care responsibilities to the public sector, those MCOs must cover associated costs. An effective expanded-scope EMS system may be able to detect minor health problems before they become severe. It would be inappropriate for public sector EMS organizations to dilute essential public safety services to accommodate the economic interests of health care payers.

CONCLUSION

One simple conclusion can be drawn from all the periodicals, editorials, and field trials to date. Expanded scope of practice would be advantageous only where a community need has been clearly demonstrated. While the concept may appear to be cost-effective for the health care system on the whole, design and implementation must be based on local need and adequate support structures. EMS expanded-scope project designers must find the balance between the advantages, such as improved access to primary care for some citizens, and disadvantages such as the lack of appropriate medical direction and system follow-up.

The primary mission of an EMS system is to provide readily available, accessible, and cost-efficient prehospital emergency medical care. Expanded-scope programs should never be implemented if their implementation in any way compromises the integrity of the emergency response system.

ENDNOTES

- 1 NATIONAL HIGHWAY SAFETY ACT, 1966.
- 2 "EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC CURRICULUM, INSTRUCTOR'S LESSON PLANS," (AMEI), 1985, P. 4.
- 3 PARAMEDIC TEXTBOOK, MOSBY-YEAR BOOK, INC., 1994, P. 6.
- 4 DENNIS MURPHY, CHIEF OF SPRINGFIELD FIRE AND LIFE SAFETY, EMS INSIDER, SPECIAL BONUS SECTION, MAY 1994.
- 5 FLORIDA STATUTE, 401.411(G) FS.
- 6 GARZA, M., "EMS LEADERS EXPLORE EMS EXPANSION: THE SAND KEY CONFERENCE," EMS INSIDER, SPECIAL BONUS SECTION, MAY 1994.
- 7 STORMANT, S., DEPUTY CHIEF INTERVIEW, PHOENIX FIRE DEPARTMENT, FEBRUARY 10, 1997.
- 8 BELL, N., "A BIGGER UMBRELLA," EMERGENCY, JUNE 1994, P. 29.
- 9 IBID., P. 30.
- 10 HOLDSWORTH, N., "EXPANDED-SCOPE PARAMEDICS," JOURNAL OF EMERGENCY MEDICAL SERVICES, AUGUST 1994, P. 93.
- 11 BELL, N., "A BIGGER UMBRELLA," EMERGENCY, JUNE 1994, P. 30.
- 12 YAMEEN, J., "EXPANDED SCOPE OF PARAMEDIC PRACTICE," EMERGENCY, JUNE 1994, P. 65.
- 13 KUHR, S., "FOCUSING ON EXPANDED SCOPE", JOURNAL OF EMERGENCY MEDICAL SERVICES, JANUARY 1995, P. 129.
- 14 GARZA, M., "RETHINKING EMS: AFTER SAND KEY, THINGS WILL NEVER BE THE SAME," JOURNAL OF EMERGENCY MEDICAL SERVICES, MAY 1994, P. 106.
- 15 SWAN, T., "CAN EMS VOLUNTEERS DO MORE?," EMERGENCY, MAY 1994, P. 64.
- 16 YAMEEN, J., "EXPANDED SCOPE OF PARAMEDIC PRACTICE," EMERGENCY, JUNE 1994, P. 65.
- 17 DE LORENZO, ROBERT, MD., "MILITARY MEDIC," JOURNAL OF EMERGENCY MEDICAL SERVICES, APRIL 1996, P. 54.

GLOSSARY

Advanced Life Support (ALS) – All basic life support measures, plus invasive medical procedures including intravenous therapy, cardiac defibrillation, administration of medications and solutions, use of adjunctive ventilation devices, and other procedures which may be authorized by state law and performed under medical control.

Ambulance – A vehicle designed and operated for transportation of ill and injured persons, equipped and staffed to provide for first aid or life support measures to be applied during transportation.

Basic Life Support (BLS) – Generally limited to airway maintenance, ventilation (breathing) support, CPR, hemorrhage control, splinting of fractures, management of spinal injury, protection and transportation of the patient with accepted procedures.

Cardiac Arrest – A condition in which the hearts electrical impulses suddenly become chaotic.

Cross-Trained/Dual-Role (CT/DR) – An emergency service that allows personnel trained in emergency situations to perform to the full extent of their training, whether the situation should call for firefighting or medical intervention for a victim. This system type offers a greater level of efficiency than its single-role counterparts.

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

GLOSSARY

CONT'D

Defibrillation – The delivery of a very large electrical shock to a part of the chest/heart. Stops the abnormal activity and allows the heart to restart normally on its own. Defibrillation is required to reverse cardiac arrest and restore functional cardiac activity. It can be effective when applied soon after the onset of cardiac arrest.

Emergency Medical Services (EMS) – The provision of services to patients with medical emergencies. EMS has emerged as a field whose purpose is to reduce the incidence of preventable life-threatening and disabling injuries and acute illness whenever possible, and to minimize the physical and emotional impact of injuries and illnesses which do occur. The EMS field derives its origins and body of scientific knowledge from the related fields of medicine, public health, health care systems administration, and public safety.

EMS System – A comprehensive, coordinated arrangement of resources and functions which are organized to respond in a timely, staged manner to targeted medical emergencies, regardless of their cause and the patient's ability to pay, and to minimize their physical and emotional impact.

Scope of Education – The performance and learning objectives defined for each level of EMS provider.

Scope of Practice – Detailed parameters of various duties or services which may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it tends to represent the limits of what services an individual may perform.

Appendix 1.

Paramedic Expanded Scope of Practice-Rules Survey

State	Skills Permitted	Skills Prohibited	Not Addressed	Under Study
Alabama		X		
Alaska		X		
Arizona		X		
Arkansas		X		
California	X- Local Control			
Colorado		X		X
Connecticut		X		
Delaware		X		
Dist. Of Columbia			X	
Florida	X- Local Control			X
Georgia		X		X
Hawaii		X		
Idaho		X		
Illinois	X- Hospital setting			
Indiana	X- Local Control			
Iowa		X		
Kansas	X- Only during transport			
Kentucky		X		
Louisiana		X		
Maine		X		X
Maryland		X		
Massachusetts		X		
Michigan	X-Employer Controlled			
Minnesota	X- Local Control			
Mississippi		X		
Missouri		X		
Montana		X		
N. Carolina		X		
N. Dakota		X		
Nebraska		X		
Nevada		X		
New Hampshire	X			
New Jersey		X		
New Mexico	X- Local & State control			
New York	X-Regional Control			
Ohio			X	
Oklahoma		X		
Oregon		X		
Pennsylvania		X		
Rhode Island		X		
S. Carolina		X		
S. Dakota			X	
Tennessee		X		
Texas			X	
Utah		X		
Vermont		X		X- Interfacility
Virginia			X	
Washington		X		
West Virginia			X	
Wisconsin		X		
Wyoming		X		