

Dear Senators HEIDER, Souza, Jordan, and
Representatives WOOD, Packer, Chew:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Health and Welfare:

IDAPA 16.02.02 - Rules of the Idaho Emergency Medical Services (EMS) Physician Commission -
Proposed Rule (Docket No. 16-0202-1801).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 11/13/2018. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 12/12/2018.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4854, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee
FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen
DATE: October 24, 2018
SUBJECT: Department of Health and Welfare

IDAPA 16.02.02 - Rules of the Idaho Emergency Medical Services (EMS) Physician Commission - Proposed Rule (Docket No. 16-0202-1801)

Summary and Stated Reasons for the Rule

This rule updates the incorporation by reference to the Idaho EMS Physician Commission Standards Manual in order to include the most recent edition.

Negotiated Rulemaking / Fiscal Impact

Negotiated rulemaking was not conducted, as it was not considered feasible. There is no anticipated negative fiscal impact on the state general fund.

Statutory Authority

I.C. 56-1013A and 56-1023.

cc: Department of Health and Welfare
Frank Powell and Trinetta Middlebrook

*** PLEASE NOTE ***

Per the Idaho Constitution, all administrative rules must be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
16.02.02 – RULES OF THE IDAHO EMERGENCY MEDICAL SERVICES (EMS)
PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1801

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 17, 2018.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. The revision to these rules will ensure that the most recent edition of the manual has the force and effect of law.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year.

There is no anticipated fiscal impact to the state general fund related to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered on an ongoing basis throughout the year and at the quarterly meetings of the EMS Physician Commission.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2019-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format, but it is available upon request from Idaho EMS. Once the docket has been finalized and adopted, the manual will be available online at: www.emspc.dhw.idaho.gov.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2018.

Dated this 31st day of August, 2018.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0202-1801
(Only Those Sections With Amendments Are Shown.)

004. INCORPORATION BY REFERENCE.

The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~8~~⁹-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at www.emspc.dhw.idaho.gov or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID, 83712-8249, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ~~(7-1-18)~~()

INCORPORATION BY REFERENCE SYNOPSIS

In compliance with Section 67-5223(4), Idaho Code, the following is a synopsis of the differences between the materials previously incorporated by reference in this rule that are currently in full force and effect and newly revised or amended versions of these same materials that are being proposed for incorporation by reference under this rulemaking.

The following agency of the State of Idaho has prepared this synopsis as part of the proposed rulemaking for the chapter cited here under the docket number specified:

DEPARTMENT OF HEALTH AND WELFARE
IDAPA 16.02.02 – RULES OF THE EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN
COMMISSION
Proposed Rulemaking -- Docket No. 16-0202-1801

(Include a brief description that explains the differences between the version of the materials or documents that are currently incorporated by reference and the materials or documents that are being proposed for adoption in this rulemaking.)

(You may use the following table or write a brief summary of the differences)

Incorporated Document Version/URL	IDAPA Section Number	Current Version of Incorporated Document	Substantive Changes in New Incorporation by Reference Version
<u>EMSPC Standards Manual V. 2018-1</u>	16.02.02.004	Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2017-1 <i>(NOTE: when approved by the 2019 Legislature, the Standards Manual (Edition 2019-1) will go into effect on July 1, 2019.)</i>	See below for summary of the changes to the Idaho EMS Physician Commission "Scope of Practice" Standards Manual incorporated by reference in Section 004 of IDAPA 16.02.02, "Rules of the EMS Physician Commission." The changes for this incorporated manual were negotiated throughout the year with stakeholders and were finalized in the November 2018 meeting of the EMS Physician Commission. The text of the updated Standards Manual (<i>Edition 2019-1</i>) follows the summary. If you have further questions, please contact Wayne Denny, EMS Bureau Chief at (208) 334-4000.

Summary of Changes for Edition 2019-1

Effective date of new standards manual and scope of practice (page 15): July 1, 2019

Appendix A Changes:

- *Line 23: Hemorrhage Control – Wound Packing (X)*
- *Line 79: Hemorrhage Control – Wound Packing (X)*
- *Line 167: Hemorrhage Control – Wound Packing (X)*
- *Line 251: Hemorrhage Control – Wound Packing (X)*
- *Line 373: Hemorrhage Control – Wound Packing (X)*
- *Line 439: Ultrasound (3,OM)*



STATE OF IDAHO
EMS PHYSICIAN COMMISSION
STANDARDS MANUAL

Authority:

Idaho Code § 56-1013A, § 56-1016, and § 56-1017(1)

Rules for EMS Physician Commission Idaho Administrative Procedures Act 16.02.02

Edition 2019-1



EFFECTIVE JULY 1, 2019

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I. DEFINITIONS.

As promulgated by and in addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," the following terms are used in this manual as defined below:

Advanced Emergency Medical Technician (AEMT). A person who holds a current active license issued by the Bureau at the Advanced Emergency Medical Technician level and is in good standing with no restriction upon, or actions taken against, his license.

Affiliation. The recognition of an individual as a member or employee.

Bureau of Emergency Medical Services and Preparedness. The Bureau of Emergency Medical Services and Preparedness of the Idaho Department of Health and Welfare, hereafter referred to as "the Bureau."

Contemporaneous. Originating, existing, or occurring during the same period of time.

Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician.

Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice.

Critical Care Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and has successfully completed training objectives as set forth in the Critical Care Transport Curriculum Guide of the Bureau and who possesses a current active credential to provide Critical Care.

Critical Care Transport. The transportation of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer.

Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director.

Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel who are providing medical care.

Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following:

- a. Respond to a perceived need for medical care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury;
- b. Are prepared to provide interventions that are within the scope of practice as defined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”;
- c. Use an alerting mechanism to initiate a response to requests for medical care; and
- d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code.
- e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS.

Emergency Medical Services Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as “the Commission.”

Emergency Medical Responder (EMR). A person who holds a current active license issued by the Bureau at the First Responder or Emergency Medical Responder level and is in good standing with no restriction upon, or actions taken against, his license.

Emergency Medical Technician (EMT). A person who holds a current active license issued by the Bureau at the Emergency Medical Technician or Emergency Medical Technician-Basic level and is in good standing with no restriction upon, or actions taken against, his license.

EMS Agency. An organization licensed by the Bureau to provide emergency medical services in Idaho.

EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency.

Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code.

Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital.

Indirect (Off-Line) Supervision. The medical oversight provided by a physician to licensed EMS personnel who are providing medical care. The components of medical supervision include EMS system design, education, quality management, patient care guidelines, medical policies, and compliance.

License. A license issued by the Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met.

Licensed EMS Personnel. Individuals who possess a valid license issued by the Bureau.

Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury.

Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic.

Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision.

Medical Supervision Plan (MSP). The written document describing the provisions for medical supervision of licensed EMS personnel.

Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.”

Out-of-hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place.

Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and is in good standing with no restriction upon, or actions taken against, his license.

Physician. A person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, his license.

Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.”

II. EMS Physician Commission Standards Manual Authority

Idaho Code 56-1013A(1) empowers the EMS Physician Commission with statutory authority to establish standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance, and non-transport agencies licensed by the Bureau. Idaho Code 56-1017(1) specifically authorizes and directs the Commission to adopt appropriate rules defining the allowable scope of practice and acts and duties which can be performed by persons licensed by the department and the required level of supervision by a licensed physician.

IDAPA 16.02.02, "Rules of the EMS Physician Commission," Section 004 incorporate this EMS Physician Commission Standards Manual by reference. The purposes of this EMS Physician Commission Standards Manual are to establish the scope of practice of licensed EMS personnel and to specify the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure.

III. EMS Personnel Authority to Act

To provide emergency medical services, EMS licensed personnel must comply with Idaho Code and IDAPA 16.02.02, "Rules of the EMS Physician Commission." The policies of the EMS Physician Commission are documented in this Standards Manual.

Licensed EMS personnel who are representing an Idaho EMS agency and who possess a valid credential issued by that agency's EMS medical director may act and provide services in the out-of-hospital setting under the following conditions:

1. When participating in a planned deployment or agency sanctioned standby of personnel resources approved by the EMS medical director; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the EMS medical director; or
3. When participating in a training program approved by the Bureau or the EMS medical director.
4. When on duty, visibly display at all times identification specifying name and level of EMS licensure.

In addition, licensed EMS personnel may only provide out-of-hospital care when:

1. The patient care does not exceed the scope of practice as defined by this Standards Manual; and
2. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements" and
3. The patient care does not exceed the scope of practice approved by their EMS medical director and does not include assessments or interventions that have been specifically

prohibited by their EMS medical director.

Licensed EMS personnel who are representing a hospital or medical clinic and who possess a valid credential issued by the hospital or medical clinic supervising physician may act and provide services in the hospital and medical clinic setting under the following conditions:

1. When participating in a planned deployment or agency sanctioned standby of personnel resources approved by the hospital or medical clinic supervising physician; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the hospital or medical clinic supervising physician; or
3. When participating in a training program approved by the Bureau or the hospital or medical clinic supervising physician.

In addition, licensed EMS personnel may only provide hospital and medical clinic care when:

1. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, "Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements," or additional training approved by the hospital or medical clinic supervising physician and
2. The patient care does not exceed the scope of practice approved by their hospital or medical clinic supervising physician and does not include assessments or interventions that have been specifically prohibited by their hospital or medical clinic supervising physician.

IV. OUT-OF-HOSPITAL SUPERVISION

All Idaho-licensed EMS agencies, including hospital-based EMS agencies, must comply with the requirements described in this section. Hospital-based EMS agencies must comply with both the requirements described in this section and with the hospital and clinic supervision requirements described later in this Standards Manual when their licensed EMS personnel also have patient care duties in the hospital or clinic setting.

EMS Medical Director Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director.

1. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency.
2. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director.

The EMS medical director will have a written agreement with the EMS agency(s) that includes the following elements:

1. Identification of the EMS agency(s) for which he provides medical supervision.
2. Acknowledgement of the authority of the EMS medical director as established in Idaho statute and IDAPA 16.02.02, "Rules of the EMS Physician Commission."
3. An effective date.
4. An expiration date or a provision for automatic renewal upon mutual agreement.
5. Assurance of EMS medical director access to relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel.

The EMS medical director will provide the Bureau with documentation of the written agreement annually or upon request.

The EMS medical director must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.
4. The EMS medical director shall demonstrate appropriate training and/or expertise in adult and pediatric emergency medical services.
5. The EMS medical director for an air medical agency, in addition to the above requirements, must have training and experience in emergency medicine or critical care and have training in air ambulance operations that include flight physiology, stressors of flight, and air medical resource management.
6. If not previously completed, all current and new Medical Directors must complete mandatory EMSPC approved Medical Director education within one (1) year or be ABEM subspecialty board certified in EMS. Current EMSPC approved courses include: full NAEMSP National EMS Medical Director's Course and Practicum or the Guide for Preparing Medical Directors sponsored by the Critical Illness and Trauma Foundation. Additional educational courses may be approved upon request.

The EMS medical director is authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of an EMS medical director.
2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission and may not exceed the scope of practice established by the Commission.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the EMS medical director or the

Idaho EMS Bureau.

- a. Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

The EMS medical director is responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a “Good Samaritan” in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
4. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
5. Developing and implementing a program for continuous assessment and improvement of services by licensed EMS personnel under their supervision.
6. Reviewing and updating protocols, policies, and procedures at least every two (2) years.
7. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
8. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care, and procedures that are consistent and compatible with one another.
9. Designating other physicians to supervise licensed EMS personnel in the temporary absence of the EMS medical director.
10. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel. Such designated clinicians may only provide direct medical supervision when a designated physician is not present in the anticipated receiving health care facility. The following conditions must also be satisfied:

1. A written agreement between the designated Nurse Practitioner and the EMS medical director which describes the role and responsibilities of the designated Nurse Practitioner is required.
2. A written agreement between the designated PA and the EMS medical director which

describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required.

3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the EMS medical director.
4. The physician supervising the PA, as defined in IDAPA 22.01.03, Idaho Department of Health and Welfare, “Rules for the Licensure of Physician Assistants,” must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Out-Of-Hospital Setting.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented Medical Supervision Plan (MSP) that includes direct, indirect, on-scene, educational, and proficiency standards components. The EMS medical director is responsible for developing, implementing, and overseeing the MSP. However, non-physicians can assist the EMS medical director with the indirect medical supervision of licensed EMS personnel. The EMS medical director will submit the MSP to the Bureau upon request by the Bureau or the Commission. Medical Supervision Plans must be submitted within thirty (30) days of request. The Bureau must be notified of any changes in the MSP, including changes in designated clinicians, within thirty (30) days of the change(s).

At a minimum, the MSP must consist of the following elements:

A. Credentialing of licensed EMS personnel.

Credentialing is an EMS agency process by which licensed EMS personnel are authorized by the EMS medical director to provide medical care in accordance with a scope of practice that is established by the EMS medical director. The process for credentialing licensed EMS personnel is an extension of the “affiliating” of personnel and is consistent with contemporary EMS system design.

The process for credentialing will include the following:

1. Verification of Bureau licensure;
2. Affiliation to the EMS agency;
3. Review of the qualifications and proficiencies of the EMS provider, and all other EMS agency, hospital, and medical clinic affiliations.
4. Completion of an EMS agency orientation, as prescribed by the EMS agency, that includes:
 - a. EMS agency policies;
 - b. EMS agency procedures;
 - c. Medical treatment protocols;

- d. Radio communications procedures;
- e. Hospital/facility destination policies;
- f. Other unique system features.

Upon successful completion of the credentialing process, the EMS medical director may issue the EMS provider with a card, certificate, or other document which indicates explicit approval to provide patient care and specifically authorizes a scope of practice for the EMS provider.

- This credential should include a specific expiration date which may be the same date of expiration as the Bureau license.
- This credential will be sufficient evidence of “affiliation” for his or her license or renewal by the Bureau, if the dates are inclusive of the licensure period and the credential has not been withdrawn by the EMS medical director.

B. Indirect (off-line) medical supervision.

Indirect (off-line) supervision will include all of the following:

1. Written standing orders and treatment protocols for both adult and pediatric patients including direct (on-line) supervision criteria and approved medication formulary list;
2. Description of authorized optional psychomotor skills and patient care interventions, as defined by the Commission;
3. Initial and continuing education in addition to those required by the Bureau;
4. Methods of assessment and improvement;
5. Periodic assessment of psychomotor skill proficiency;
6. Provisions for medical supervision of and defining the patient care provided by licensed EMS personnel who are present for a multiple or mass casualty incident, disaster response, or other significant event involving response of licensed EMS personnel;
7. Defining the response when licensed EMS personnel discover a need for EMS while not on duty;
8. The credentialing of licensed EMS personnel for emergency response;
9. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s);
10. Triage, treatment, and transport guidelines;
11. Scene management for multiple EMS agencies anticipated to be on scene concurrently;
12. Criteria for determination of patient destination, including facility bypass criteria for Time Sensitive Emergencies;
13. Criteria for utilization of air medical services in accordance with IDAPA 16.01.03, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Agency Licensing Requirements,” Section 700-799;

14. Policies and protocols for patient refusal, “treat and release”, advanced directives by patients and physicians, determination of death, termination of resuscitation and other predictable patient non-transport scenarios;
15. Criteria for cancellation or modification of EMS response;
16. Equipment authorized for patient care;
17. Medical communications guidelines; and
18. Methods and elements of documentation of services provided by licensed EMS personnel.
19. Policies and protocols for the identification, treatment and transport of patients with ST-elevation myocardial infarction to ensure timely re-perfusion therapy.
20. Policy for recognition and utilization of bystander providers that are not credentialed by the local EMS system.
21. Patient Care Integration Agreement with other EMS agencies as appropriate as required by IDAPA 16.01.03.601 and IDAPA 16.01.03.602.

C. Direct (on-line) medical supervision.

Direct supervision may be accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians, who must be available twenty-four (24) hours a day seven (7) days a week. Provisions for direct supervision, including on-scene supervision, will be documented in the MSP which shall identify designated clinicians.

The EMS medical director will develop and implement procedures in the event of on-scene supervision by:

1. The EMS medical director or other physician(s) designated by the EMS medical director;
2. A physician with a pre-existing relationship with the patient; and
3. A physician with no pre-existing relationship with the patient who may or may not be present for the duration of treatment on scene or transportation.

Direct supervision of licensed EMS personnel by other persons is prohibited except in the manner described in the MSP.

Designated on-line physicians and clinicians shall have appropriate training and/or expertise in adult and pediatric emergency care.

D. Standards of supervision and training for students of state-approved training programs.

The EMS medical director, in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-

approved training programs, who have been placed for clinical practice and training. These standards will be defined, identified, and documented in the MSP.

EFFECTIVE JULY 1, 2019

V. HOSPITAL AND MEDICAL CLINIC SUPERVISION

Licensed EMS Personnel Responsibilities.

The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must:

1. When on duty, visibly display at all times identification specifying their level of EMS licensure.
2. Report such employment or utilization to the Bureau within thirty (30) days of engaging in such activity.

Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, as defined in this Standards Manual.

Hospital Supervising Physician and Medical Clinic Supervising Physician Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician.

1. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic.
2. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
3. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, who are defined in this Standards Manual.

The hospital supervising physician and medical clinic supervising physician must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.

The hospital supervising physician and medical clinic supervising physician are authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of a hospital supervising physician or medical clinic supervising physician.

2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission. If the authorized scope of practice exceeds the out-of-hospital scope of practice established by the Commission, the hospital supervising physician and/or medical clinic supervising physician must approve additional training to ensure competency in the expanded scope of practice. The Commission recognizes that hospital and medical clinic policies, state rules and the local community standard of care will influence the specific elements of any expanded scope of practice and the development of additional local oversight requirements.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and to withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the hospital supervising physician or medical clinic supervising physician or the Bureau.
 - o Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

The hospital supervising physician and medical clinic supervising physician are responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a “Good Samaritan” in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Approving additional training when the local scope of practice exceeds the out-of-hospital scope of practice established by the Commission.
4. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
5. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
6. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
7. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care and procedures that are consistent and compatible with one another.
8. Designating other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
9. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The hospital supervising physician or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel under the following conditions:

1. A written agreement between the designated Nurse Practitioner and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated Nurse Practitioner is required,
2. A written agreement between the designated PA and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required,
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician.
4. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Hospital and Medical Clinic Settings.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan (MSP). The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the MSP.

The MSP will include:

1. A credentialing process for licensed EMS personnel as defined by the hospital or medical clinic.
2. A current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel.
3. The hospital or medical clinic will submit such descriptions upon request of the Commission or the Bureau.
4. Provisions for direct medical supervision by designated clinicians and the identification of designated clinicians.

VI. BUREAU RESPONSIBILITIES.

The Bureau will provide:

1. Technical assistance to medical directors, hospital supervising physicians, medical clinic supervising physicians, and their administrators to develop appropriate Medical Supervision Plans.
2. The Commission with EMS agency Medical Supervision Plans upon request.
3. The Commission with the identification of EMS medical directors and their designated clinicians annually and upon request.

VII. EMS PHYSICIAN COMMISSION RESPONSIBILITIES.

The Commission will provide interpretation of the Rules of the Commission.

VIII. IDAHO AUTHORIZED SCOPE OF PRACTICE.

The Commission has approved the Scope of Practice for licensed EMS personnel, which is articulated in Appendix A. Appendix A lists specific psychomotor skills and patient care interventions and indicates the level of EMS licensure that may perform each skill or intervention. The EMS Medical Director, Hospital Supervising Physician, or Medical Clinic Supervising Physician must oversee a process to verify competency in all credentialed skills and interventions. The effective date of this Scope of Practice will be July 1, 2019.

It must be noted that not everyone is currently operating at the levels indicated by Xs in Appendix A and that it is only upon completion of required education, competency assessment, and endorsement or permission by their medical director that a provider can perform the procedures.

Appendix A implicitly defines both a “floor” and “ceiling” for each level of EMS licensure. Licensed EMS personnel must receive training and demonstrate competency in each skill and intervention that lies within their “floor.” Training for skills and interventions within the “floor” is based on curricula or specialized training approved according to IDAPA 16.01.05, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements.” Training and competency in skills and interventions within the “floor” are verified by examination and state EMS licensure according to IDAPA 16.01.05, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Education, Instructor, and Examination Requirements” and IDAPA 16.01.07, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Personnel Licensing Requirements.” Skills and interventions designated by an “X” in Appendix A are included in the “floor” for the specified level of EMS licensure.

Skills and interventions designated by “OM” in Appendix A may be authorized by the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician and are considered optional. These skills and interventions lie between the “floor” and “ceiling” of the specified level of EMS licensure. The EMS Medical Director, Hospital Supervising

Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills or interventions. Agencies must provide the minimum equipment required for their authorized OMs.

When an EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician desires to incorporate an OM, they must:

1. Report patient care response data to the Idaho Prehospital Electronic Record Collection System (PERCS) directly or by way of an Idaho validated export from a National EMS Information System (NEMSIS) compliant software application.
 - a. If an agency has not been able to obtain PERCS validation, they must report optional module usage on their annual agency renewal application. This method of reporting shall expire June 30, 2017.
2. Submit an addendum to their medical supervision plan to the Bureau that indicates which OM(s) they want to adopt.
3. Submit verification of credentialing to the Bureau prior to utilization of OM skills or interventions.

Psychomotor skills and patient care interventions that are not designated by either an “X” or “OM” in Appendix A fall outside the Commission’s established Scope of Practice for the specified level of EMS licensure and may not be performed by licensed EMS personnel at that level in the out-of-hospital setting. As such, Appendix A defines the “ceiling” for the specified level of EMS licensure.

Appendix A includes a CC Skills (Critical Care Skills) column that designates optional psychomotor skills and patient care interventions that may be performed by a Paramedic who receives additional critical care education and has successfully completed the Board for Critical Care Transport Paramedic Certification (BCCTPC) exam for Flight Paramedic (FP-C) or Critical Care Paramedic (CCP-C). A Paramedic must be appropriately credentialed by the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician before performing critical care skills. In addition, the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing education of critical care skills and interventions, and must take an active role in verifying proficiency in those skills and interventions since state EMS personnel licensing will not address critical care or optional skills and interventions.

The Commission has created additional requirements for certain psychomotor skills and patient care interventions that, if done improperly, represent a significant hazard to the patient. Additional standards may include but are not limited to on-line medical direction prior to performance of the skill or intervention, completion of specified training prior to credentialing, required elements for Patient Care Report documentation, required elements for performance assessment and improvement and/or compliance with a state-wide protocol or guideline. See

Appendices B through C. Skills and interventions with additional requirements are designated in Appendix A by a 1, 2, 3, 4, 5, etc. alongside the “X” or “OM”.

Emergency Medical Responder (EMR)

The primary focus of the Emergency Medical Responder, which prior to July 1, 2009 was known as a certified First Responder, is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.

Description of the Profession

The Emergency Medical Responder’s scope of practice includes simple skills focused on lifesaving interventions for critical patients. Typically, the Emergency Medical Responder renders on-scene emergency care while awaiting additional EMS response and may serve as part of the transporting crew, but not as the primary care giver.

In many communities, Emergency Medical Responders provide a mechanism to increase the likelihood that trained personnel and lifesaving equipment can be rapidly deployed to serious emergencies. In all cases, Emergency Medical Responders are part of a tiered response system. Emergency Medical Responders work alongside other EMS and health care professionals as an integral part of the emergency care team.

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

A major difference between the lay person and the Emergency Medical Responder is the “duty to act” as part of an organized EMS response.

In some systems, Emergency Medical Responders serve as a part of the crew on transporting EMS units; however, the Emergency Medical Responder is not intended to be the highest level caregiver in such situations. They must function with an EMT or higher level personnel during the transportation of emergency patients. The scope of practice model of an Emergency Medical Responder is limited to simple skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

After initiating care, the Emergency Medical Responder transfers care to higher level personnel. The Emergency Medical Responder serves as part of an EMS response system that ensures a progressive increase in the level of assessment and care.

Emergency Medical Technician (EMT)

The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Emergency Medical Technician's scope of practice includes basic skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In many communities Emergency Medical Technicians provide a large portion of the prehospital care. In some jurisdictions, especially rural areas, Emergency Medical Technicians provide the highest level of prehospital care. Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

Emergency Medical Technicians' scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

An Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Emergency Medical Technician has the knowledge of, and is expected to be competent in, all of the skills of the Emergency Medical Responder. A major difference between the Emergency Medical Responder and the Emergency Medical Technician is the knowledge and skills necessary to provide medical transportation of emergency patients.

The Emergency Medical Technician level is the minimum licensure level for personnel transporting patients in ambulances. The scope of practice is limited to basic skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight and limited training.

The Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Emergency Medical Technician is not prepared to make decisions independently regarding the appropriate disposition of patients. The Emergency Medical Technician serves as part of an EMS response system, assuring a progressive increase in the level of assessment and care. The Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Advanced Emergency Medical Technician (AEMT)

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

For many communities, Advanced Emergency Medical Technicians provide an option to provide high benefit, lower risk advanced skills for systems that cannot support or justify Paramedic level care. This is frequently the case in rural and volunteer systems. In some jurisdictions, Advanced Emergency Medical Technicians are the highest level of prehospital care. In communities which utilize emergency medical dispatch systems, Advanced Emergency Medical Technicians may function as part of a tiered response system. In all cases, Advanced Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Advanced Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

The Advanced Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Advanced Emergency Medical Technician has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder and Emergency Medical Technician. The major difference between the Advanced Emergency Medical Technician and the Emergency Medical Technician is the ability to perform limited advanced skills for emergency patients.

The Advanced Emergency Medical Technician is the minimum licensure level for patients requiring limited advanced care at the scene or during transportation. The scope of practice is limited to lower risk, high benefit advanced skills that are effective and can be performed safely

in an out-of-hospital setting with medical oversight and limited training.

The Advanced Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Advanced Emergency Medical Technician is not prepared to independently make decisions regarding the disposition of patients. The Advanced Emergency Medical Technician serves as part of an EMS response system assuring a progressive increase in the level of assessment and care. The Advanced Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Advanced Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Those AEMTs whose licensure is based on the Intermediate 85 curriculum and who have chosen not to complete either the EMT-2011 or the AEMT-2011 transition are expected to be competent in all the skills of the EMR and EMT with the exception of Pulse Oximetry, ATV non-intubated, aspirin, epi-auto injector, atropine sulfate & 2-Pralidoxime chloride auto-injector.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

Description of the Profession

The Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In some communities, Paramedics provide a large portion of the prehospital care and represent the highest level of prehospital care. In communities that utilize emergency medical dispatch systems, Paramedics may be part of a tiered response system. In all cases, Paramedics work alongside other EMS and health care professionals as an integral part of the emergency care team.

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

facility.

The Paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder, Emergency Medical Technician, and Advanced Emergency Medical Technician. The major difference between the Paramedic and the Advanced Emergency Medical Technician is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.

The Paramedic is the minimum licensure level for patients requiring the full range of advanced out-of-hospital care. The scope of practice is limited to advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

The Paramedic transports all emergency patients to an appropriate medical facility. The Paramedic serves as part of an EMS response system, ensuring a progressive increase in the level of assessment and care. The Paramedic may make treat and release decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

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

IX. EMS Proficiency and Performance Assessment Requirement.

Additional performance assessment requirements exist for advanced airway management including all intubation attempts and placements by any personnel affiliated with the EMS agency. The responsibility of the EMS medical director includes implementation of these requirements and EMS personnel compliance pursuant to IDAPA 16.02.02.300.05 and .06. The required data elements to be supplied by every EMS provider who attempts advanced airway management will be defined by the EMS Physician Commission. EMS providers will electronically submit the required data elements directly to the EMS Physician Commission starting January 1, 2010, in a manner established by the EMS Physician Commission. EMS providers will submit the required data elements contemporaneously with the completion of their patient care documentation. In the interest of evaluating aggregate performance, the EMS Physician Commission will compile and supply the EMS medical director with submitted data elements.

X. Idaho EMS Physician Commission Contact Information

EMSPhysiciancomm@dhw.idaho.gov

www.emspc.dhw.idaho.gov

Call Toll Free: 1-877-554-3367

Idaho EMS Physician Commission
2224 W. Old Penitentiary Road
PO Box 83720
Boise, Idaho 83720-0036
(208) 334-4000
Fax (208) 334-4015

XI. Idaho Bureau of EMS and Preparedness Contact Information

IdahoEMS@dhw.idaho.gov

www.idahoems.org

Call Toll Free: 1-877-554-3367

2224 W. Old Penitentiary Road
PO Box 83720
Boise, ID 83720-0036
(208) 334-4000
Fax (208) 334-4015

AIRWAY / VENTILATION / OXYGENATION		
1	Airway – Oral	X
2	Bag-Valve-Mask (BVM)	X
3	Cricoid Pressure (Sellick)	X
4	Finger Sweep	X
5	Head-tilt/chin-lift	X
6	Jaw-thrust	X
7	Jaw-thrust - Modified (trauma)	OM
8	Modified Chin Lift	X
9	Mouth-to-Barrier	X
10	Mouth-to-Mask	X
11	Mouth-to-Mouth	X
12	Mouth-to-Nose	X
13	Mouth-to-Stoma	X
14	Obstruction – Manual	X
15	Oxygen Therapy – Nasal Cannula	X
16	Oxygen Therapy – Non-rebreather Mask	X
17	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
18	Cardiopulmonary Resuscitation (CPR)	X
19	Defibrillation – Automated / Semi-Automated	X
20	Hemorrhage Control – Direct Pressure	X
21	Hemorrhage Control – Dressing	X
22	Hemorrhage Control – Tourniquet	X
23	Hemorrhage Control – Wound Packing	X
IMMOBILIZATION		
24	Cervical Stabilization – Cervical Collar	2,OM
25	Spinal Immobilization – Long Board	2,OM
26	Cervical Stabilization – Manual	X
27	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM
28	Extremity Stabilization - Manual	X
29	Extremity Splinting	2,OM
TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
30	Auto-Injector	X
31	Intramuscular (IM)	2,OM
MISCELLANEOUS		
32	Assisted Childbirth Delivery - Normal	X
33	Blood Pressure – Manual	X
34	Emergency Moves for Endangered Patients	X
35	Eye Irrigation	X
36	Taser Barb Removal	OM
MEDICATION FORMULARY		
37	Epinephrine (Adrenalin)	2,4,OM
38	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
39	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
40	Naloxone (Narcan)	3, SS
41	Oxygen	X
42	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards

OM=Optional Module

Levels of Medical Supervision

Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5
3, SS - State Statute 54-1733B	

AIRWAY / VENTILATION / OXYGENATION		
43	Advanced Airway devices not intended to be inserted into trachea	2,3,OM*~
44	Airway – Nasal	X
45	Airway – Oral	X
46	Bag-Valve-Mask (BVM)	X
47	CPAP	2, OM
48	Cricoid Pressure (Sellick)	X
49	Demand Valve – Manually triggered, flow restricted, ventilation	X
50	End Tidal CO ₂ Monitoring/Capnometry	2,3,OM~
51	Finger Sweep	X
52	Head-tilt/chin-lift	X
53	Jaw-thrust	X
54	Jaw-thrust - Modified (trauma)	X
55	Modified Chin Lift	X
56	Mouth-to-Barrier	X
57	Mouth-to-Mask	X
58	Mouth-to-Mouth	X
59	Mouth-to-Nose	X
60	Mouth-to-Stoma	X
61	Obstruction – Manual	X
62	Oxygen Therapy – Humidifiers	X
63	Oxygen Therapy – Nasal Cannula	X
64	Oxygen Therapy – Non-rebreather Mask	X
65	Oxygen Therapy – Partial Rebreather Mask	X
66	Oxygen Therapy – Simple Face Mask	X
67	Oxygen Therapy – Venturi Mask	X
68	Pulse Oximetry	X
69	CO Oximetry	2,4,OM
70	Suctioning – Tracheobronchial via advanced airway	2,OM
71	Suctioning – Upper Airway	X
72	Ventilators – Automated Transport (ATV) for non-intubated patients	X
CARDIOVASCULAR / CIRCULATION		
73	EKG - 12-lead data acquisition	2,OM
74	Cardiopulmonary Resuscitation (CPR)	X
75	Defibrillation – Automated / Semi-Automated	X
76	Hemorrhage Control – Direct Pressure	X
77	Hemorrhage Control – Dressing	X
78	Hemorrhage Control – Tourniquet	X
79	Hemorrhage Control – Wound Packing	X
80	Impedance Threshold Device (ITD)	OM
81	Mechanical CPR Device	X
IMMOBILIZATION		
82	Cervical Stabilization – Cervical Collar	X
83	Spinal Immobilization – Long Board	X
84	Cervical Stabilization – Manual	X
85	Spinal Immobilization – Seated Patient (KED, etc.)	X
86	Extremity Stabilization - Manual	X
87	Extremity Splinting	X
88	Extremity Splinting – Traction	X
89	MAST/PASG for Pelvic Immobilization Only	X
90	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
91	Intraosseous – Pediatric	2,OM
92	Intraosseous – Adult	2,OM
93	Peripheral – Initiation (includes External Jugular)	2,OM
94	IV Fluid infusion - Non-medicated	2,OM

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
95	Aerosolized (MDI)	X
96	Auto-Injector	X
97	Buccal	X
98	Intramuscular (IM)	2,OM
99	Intraosseous - Pediatric	2,4,OM
100	Intraosseous - Adult	2,4,OM
101	Nebulized (SVN)	X
102	Oral	X
103	Subcutaneous	2,OM
MISCELLANEOUS		
104	Assist with Prescribed Meds	X
105	Assisted Childbirth Delivery - Normal	X
106	Assisted Childbirth Delivery- Complicated	X
107	Blood Glucose Monitoring - Automated	2,4,OM
108	Blood Pressure – Manual	X
109	Blood Pressure – Automated	X
110	Emergency Moves for Endangered Patients	X
111	Eye Irrigation	X
112	Mechanical Patient Restraints	X
113	Rapid Extrication	X
114	Taser Barb Removal	OM
115	Venous Blood Sampling – Obtaining	2,OM
MEDICATION FORMULARY		
116	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
117	Activated Charcoal	X
118	Epinephrine (Adrenalin)	X
119	Glucagon	2,4,OM
120	Glucose (Oral)	X
121	Inhaled Beta Agonist (MDI)	X**2,OM
122	Inhaled Beta Agonist (SVN)	X**2,OM
123	Lidocaine - as an adjunct for IO fluid administration	4 OM
124	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
125	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
126	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
127	Naloxone (Narcan)	3, SS
128	Nitroglycerin - Sublingual	X**
129	Oxygen	X
130	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3
Requires EMSPC protocol	4
Just In Time Training	5
3, SS - State Statute 54-1733B	
~End Tidal CO2 Monitoring/ Capnometry must be included if the Supraglottic Airway is selected as an EMT-2011 2,3 OM	
* Adults Only	
** May carry and administer only if already prescribed	

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AIRWAY / VENTILATION / OXYGENATION		
131	Advanced Airway devices not intended to be inserted into trachea	X*
132	Airway – Nasal	X
133	Airway – Oral	X
134	Bag-Valve-Mask (BVM)	X
135	CPAP	2,OM
136	Cricoid Pressure (Sellick)	X
137	Demand Valve – Manually triggered, flow restricted, ventilation	X
138	End Tidal CO ₂ Monitoring/Capnometry	2,OM
139	Finger Sweep	X
140	Head-tilt/chin-lift	X
141	Jaw-thrust	X
142	Jaw-thrust - Modified (trauma)	X
143	Modified Chin Lift	X
144	Mouth-to-Barrier	X
145	Mouth-to-Mask	X
146	Mouth-to-Mouth	X
147	Mouth-to-Nose	X
148	Mouth-to-Stoma	X
149	Obstruction – Manual	X
150	Oxygen Therapy – Humidifiers	X
151	Oxygen Therapy – Nasal Cannula	X
152	Oxygen Therapy – Non-rebreather Mask	X
153	Oxygen Therapy – Partial Rebreather Mask	X
154	Oxygen Therapy – Simple Face Mask	X
155	Oxygen Therapy – Venturi Mask	X
156	Pulse Oximetry	2,OM
157	CO Oximetry	2,4,OM
158	Suctioning – Tracheobronchial via advanced airway	X
159	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
160	EKG - 12-lead data acquisition	2,OM
161	Cardiopulmonary Resuscitation (CPR)	X
162	Defibrillation – Automated / Semi-Automated	X
163	Hemorrhage Control – Direct Pressure	X
164	Hemorrhage Control – Dressing	X
165	Hemorrhage Control - Pressure Point	X
166	Hemorrhage Control – Tourniquet	X
167	Hemorrhage Control – Wound Packing	X
168	Impedance Threshold Device (ITD)	OM
169	Mechanical CPR Device	X
IMMOBILIZATION		
170	Cervical Stabilization – Cervical Collar	X
171	Spinal Immobilization – Long Board	X
172	Cervical Stabilization – Manual	X
173	Spinal Immobilization – Seated Patient (KED, etc.)	X
174	Extremity Stabilization - Manual	X
175	Extremity Splinting	X
176	Extremity Splinting – Traction	X
177	MAST/PASG for Pelvic Immobilization Only	X
178	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
179	Intraosseous – Pediatric	X
180	Intraosseous – Adult	OM
181	Peripheral – Initiation (includes External Jugular)	X
182	IV Fluid infusion - Non-medicated	X

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
183	Auto-Injector	X
184	Buccal	X
185	Intramuscular (IM)	2,OM
186	Intraosseous - Pediatric	2,4,OM
187	Intraosseous - Adult	2,4,OM
188	Oral	X
189	Subcutaneous	2,OM
MISCELLANEOUS		
190	Assist with Prescribed Meds	X
191	Assisted Childbirth Delivery - Normal	X
192	Assisted Childbirth Delivery- Complicated	X
193	Blood Glucose Monitoring - Automated	X
194	Blood Pressure – Manual	X
195	Blood Pressure – Automated	X
196	Emergency Moves for Endangered Patients	X
197	Eye Irrigation	X
198	Mechanical Patient Restraints	X
199	Rapid Extrication	X
200	Taser Barb Removal	OM
201	Venous Blood Sampling – Obtaining	X
MEDICATION FORMULARY		
202	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	OM
203	Activated Charcoal	X
204	Epinephrine (Adrenalin)	2,4,OM
205	Glucagon	2,4,OM
206	Glucose (Oral)	X
207	Inhaled Beta Agonist (MDI)	X**
208	Lidocaine - as an adjunct for IO fluid administration	4,OM
209	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
211	Nitroglycerin - Sublingual	X**
212	Oxygen	X
213	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5
3, SS - State Statute 54-1733B	
* Adults Only	
**may carry and administer only if already prescribed	

AIRWAY / VENTILATION / OXYGENATION		
214	Advanced Airway devices not intended to be inserted into trachea	X*
215	Airway – Nasal	X
216	Airway – Oral	X
217	Bag-Valve-Mask (BVM)	X
218	CPAP	2,OM
219	Cricoid Pressure (Sellick)	X
220	Demand Valve – Manually triggered, flow restricted, ventilation	X
221	End Tidal CO ₂ Monitoring/Capnometry	2,OM
222	Finger Sweep	X
223	Head-tilt/chin-lift	X
224	Jaw-thrust	X
225	Jaw-thrust - Modified (trauma)	X
226	Modified Chin Lift	X
227	Mouth-to-Barrier	X
228	Mouth-to-Mask	X
229	Mouth-to-Mouth	X
230	Mouth-to-Nose	X
231	Mouth-to-Stoma	X
232	Obstruction – Manual	X
233	Oxygen Therapy – Humidifiers	X
234	Oxygen Therapy – Nasal Cannula	X
235	Oxygen Therapy – Non-rebreather Mask	X
236	Oxygen Therapy – Partial Rebreather Mask	X
237	Oxygen Therapy – Simple Face Mask	X
238	Oxygen Therapy – Venturi Mask	X
239	Pulse Oximetry	X
240	CO Oximetry	2,4,OM
241	Suctioning – Tracheobronchial via advanced airway	X
242	Suctioning – Upper Airway	X
243	Ventilators – Automated Transport (ATV) for non-intubated patients	X
CARDIOVASCULAR / CIRCULATION		
244	EKG - 12-lead data acquisition	2,OM
245	Cardiopulmonary Resuscitation (CPR)	X
246	Defibrillation – Automated / Semi-Automated	X
247	Hemorrhage Control – Direct Pressure	X
248	Hemorrhage Control – Dressing	X
249	Hemorrhage Control - Pressure Point	X
250	Hemorrhage Control – Tourniquet	X
251	Hemorrhage Control – Wound Packing	X
252	Impedance Threshold Device (ITD)	OM
253	Mechanical CPR Device	X
IMMOBILIZATION		
254	Cervical Stabilization – Cervical Collar	X
255	Spinal Immobilization – Long Board	X
256	Cervical Stabilization – Manual	X
257	Spinal Immobilization – Seated Patient (KED, etc.)	X
258	Extremity Stabilization - Manual	X
259	Extremity Splinting	X
260	Extremity Splinting – Traction	X
261	MAST/PASG for Pelvic Immobilization Only	X
262	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
263	Intraosseous – Pediatric	X
264	Intraosseous – Adult	X
265	Peripheral – Initiation (includes External Jugular)	X
266	IV Fluid infusion - Non-medicated	X

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
267	Aerosolized (MDI)	X
268	Auto-Injector	X
269	Buccal	X
270	Inhaled - patient administered (nitrous oxide)	X
271	Intramuscular (IM)	X
272	Intranasal	X
273	Intraosseous - Pediatric	X
274	Intraosseous - Adult	X
275	IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X
276	Nebulized (SVN)	X
277	Oral	X
278	Subcutaneous	X
279	Sub-lingual	X
280	Topical	OM
MISCELLANEOUS		
281	Assist with Prescribed Meds	X
282	Assisted Childbirth Delivery - Normal	X
283	Assisted Childbirth Delivery- Complicated	X
284	Blood Glucose Monitoring - Automated	X
285	Blood Pressure – Manual	X
286	Blood Pressure – Automated	X
287	Emergency Moves for Endangered Patients	X
288	Eye Irrigation	X
289	Mechanical Patient Restraints	X
290	Rapid Extrication	X
291	Taser Barb Removal	OM
292	Venous Blood Sampling – Obtaining	OM
MEDICATION FORMULARY		
293	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
294	Activated Charcoal	X
295	Dextrose 50%	X
296	Dextrose, concentrated solutions	X
297	Epinephrine (Adrenalin)	X
298	Glucagon	X
299	Glucose (Oral)	X
300	Inhaled Beta Agonist (MDI)	X
301	Inhaled Beta Agonist (SVN)	X
302	Lidocaine - as an adjunct for IO fluid administration	4,OM
303	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
304	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
305	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
306	Naloxone (Narcan)	X
307	Nitroglycerin - Paste	OM
308	Nitroglycerin - Sublingual	X
309	Nitrous Oxide (Nitronox)	X
310	Oxygen	X
311	Vaccinations - at the request of the public health district if credentialed in IM administration	X

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
3, SS - State Statute 54-1733B	
* Adults Only	

Paramedic-2011

AIRWAY / VENTILATION / OXYGENATION		
Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
312	Advanced Airway devices not intended to be inserted into trachea	X
313	Airway – Nasal	X
314	Airway – Oral	X
315	Airway – Obstruction - removal of foreign body by direct laryngoscopy	X
316	Bag-Valve-Mask (BVM)	X
317	BiPAP	X
318	Chest Decompression – Needle	X
319	Chest Tube Placement	2,3,OM
320	Chest Tube – Monitoring & Management	X
321	CPAP	X
322	Cricoid Pressure (Sellick)	X
323	Cricothyrotomy – Needle/Percutaneous	X
324	Cricothyrotomy - Surgical	2,OM 3X
325	Demand Valve – Manually triggered, flow restricted, ventilation	X
326	End Tidal CO ₂ Monitoring/Capnometry	X
327	Finger Sweep	X
328	Gastric Decompression – NG Tube	X
329	Gastric Decompression – OG Tube	X
330	Head-tilt/chin-lift	X
331	Intubation – Digital	X
332	Intubation – Medication Assisted (non-paralytic)	X
333	Intubation – Medication Assisted (paralytics) (RSI)	2,3,OM
334	Intubation - Nasotracheal	X
335	Intubation - Orotracheal	X
336	Intubation – Retrograde	X
337	Jaw-thrust	X
338	Jaw-thrust - Modified (trauma)	X
339	Modified Chin Lift	X
340	Mouth-to-Barrier	X
341	Mouth-to-Mask	X
342	Mouth-to-Mouth	X
343	Mouth-to-Nose	X
344	Mouth-to-Stoma	X
345	Obstruction – Direct Laryngoscopy	X
346	Obstruction – Manual	X
347	Oxygen Therapy – Humidifiers	X
348	Oxygen Therapy – Nasal Cannula	X
349	Oxygen Therapy – Non-rebreather Mask	X
350	Oxygen Therapy – Partial Rebreather Mask	X
351	Oxygen Therapy – Simple Face Mask	X
352	Oxygen Therapy – Venturi Mask	X
353	PEEP – Therapeutic (>6cm H ₂ O pressure)	X
354	Pulse Oximetry	X
355	CO Oximetry	OM
356	Suctioning – Tracheobronchial via advanced airway	X
357	Suctioning – Upper Airway	X
358	Ventilators – Automated Transport (ATV) for non-intubated patients	X
359	Ventilators – Automated Transport (ATV)	X
360	Ventilators, Automated – Enhanced Assessment & Management	3X

Paramedic-2011

CARDIOVASCULAR / CIRCULATION		
Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
361	EKG - 12-lead data acquisition	X
362	EKG - 12-lead interpretation	X
363	EKG - 3-lead rhythm interpretation	X
364	Cardiopulmonary Resuscitation (CPR)	X
365	Cardioversion – Electrical	X
366	Carotid Massage	X
367	Defibrillation – Automated / Semi-Automated	X
368	Defibrillation – Manual	X
369	Hemorrhage Control – Direct Pressure	X
370	Hemorrhage Control – Dressing	X
371	Hemorrhage Control – Pressure Point	X
372	Hemorrhage Control – Tourniquet	X
373	Hemorrhage Control – Wound Packing	X
374	Impedance Threshold Device (ITD)	OM
375	IABP monitoring & management	3X
376	Invasive Hemodynamic Monitoring	3X
377	Mechanical CPR Device	X
378	Pericardiocentesis	2,3,OM
379	Pacing - Transcutaneous	X
380	Pacing - Transvenous & Epicardial – monitoring & management	3X
381	Pacing - Permanent/ICD	
IMMOBILIZATION		
382	Cervical Stabilization – Cervical Collar	X
383	Spinal Immobilization – Long Board	X
384	Cervical Stabilization – Manual	X
385	Spinal Immobilization – Seated Patient (KED, etc.)	X
386	Extremity Stabilization - Manual	X
387	Extremity Splinting	X
388	Extremity Splinting – Traction	X
389	MAST/PASG for Pelvic Immobilization Only	X
390	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
391	Arterial Line – Monitoring & Access Only	3X
392	Central Line – Placement	2,3,OM
393	Central Line – Monitor & Maintain Only	X
394	Intraosseous – Pediatric	X
395	Intraosseous – Adult	X
396	Peripheral – Initiation (includes External Jugular)	X
397	Umbilical - Initiation	2,3,OM
398	IV Fluid infusion - Non-medicated	X
399	IV Fluid infusion - Maintenance of Medicated Fluids	X

Paramedic-2011

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
400	Aerosolized (MDI)	X
401	Auto-Injector	X
402	Buccal	X
403	Endotracheal Tube (ET)	X
404	Inhaled - patient administered (nitrous oxide)	X
405	Intramuscular (IM)	X
406	Intranasal	X
407	Intraosseous - Pediatric	X
408	Intraosseous - Adult	X
409	IV Infusion	X
410	IV Piggyback	X
411	IV Programmable Volume Infusion Device	2, OM 3X
412	IV Push	X
413	IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X
414	Accessing Implanted Central IV Port	X
415	Nasogastric	X
416	Nebulized (SVN)	X
417	Oral	X
418	Rectal	X
419	Subcutaneous	X
420	Sub-lingual	X
421	Topical	X
MISCELLANEOUS		
422	Arterial Blood Sampling, Radial Site - Obtaining	
423	Assist with Prescribed Meds	X
424	Over-the-Counter Medications (OTC)	X
425	Assisted Childbirth Delivery - Normal	X
426	Assisted Childbirth Delivery- Complicated	X
427	Blood Chemistry Analysis	X
428	Blood Glucose Monitoring - Automated	X
429	Blood Pressure – Manual	X
430	Blood Pressure – Automated	X
431	Emergency Moves for Endangered Patients	X
432	Eye Irrigation	X
433	Eye Irrigation – Morgan Lens	X
434	Mechanical Patient Restraints	X
435	Rapid Extrication	X
436	ICP Monitoring	3X
437	Taser Barb Removal	OM
438	Urinary Catheterization	2,3,OM
439	Ultrasound	3, OM
440	Venous Blood Sampling – Obtaining	X

Paramedic-2011

MEDICATION FORMULARY		
Formulary	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
441 Medical Director Approved Medications	X	
442 Blood Products Administration		3X
443 Maintenance of Blood Administration	X	
444 Plasma Volume Expander Administration		3X
445 Thrombolytic Therapy Administration	X	
446 Vaccinations - at the request of the public health district if credentialed in IM administration	X	

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3
3, SS - State Statute 54-1733B	

EFFECTIVE JULY 1, 2019

Paramedic Non-RSI Statewide Intubation Standards

Topic	Requirements	Available Options
Patient Selection		
Adult / Peds	Unconscious w/ineffective respiration	
	Cardiac arrest	
	Apnea or agonal respirations	
	Conscious with ineffective respirations (Nasal intubations only)	
Equipment		
Laryngoscope blades	adult & ped blade sizes 2 different blade types	Macintosh Miller Video Laryngoscopes other blade types permissible
Continuous Pulse Oximetry	before, during & after intubation	
Rescue device	must have at least one available	LMA Combitube King LT bougie/flexguide
Tube placement	Mandatory continuous quantitative or waveform ETCO2.	quantitative or waveform ETCO2
Selection of tube size	based on patient age or size of 5th finger	Cuffed Sizes = 3.5 - 8.0 mm Uncuffed Sizes = 2.5 mm
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask Non-Rebreather Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth or insertion of tube through nares		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize additional methods to augment mandatory quantitative or waveform ETCO2	ETCO2 Epigastric sounds Breath sounds EDD chest rise tube misting Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		
All intubations, including RSI, must be reviewed by the Medical Director.		

Required Elements for Performance Assessment and Improvement

Monitoring		
100% chart review		
Intubation success rate	agency	
	provider	
1st attempt success rate	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

EMSPC RSI Statewide Standards

Topic	Requirements	Available Options
Patient Selection		
Adult /Peds	Patient requires intubation; AND is not flaccid, or has intact protective airway reflexes. Not a difficult airway	
Equipment		
Laryngoscope blades	adult & ped blade sizes 2 different blade types	Macintosh Miller Video Laryngoscope other blade types permissible
Medications	As per local EMS Medical Director	
Continuous Pulse Oximetry	before during and after intubation	
Rescue device	must have at least one available	LMA Combitube King LT other
Tube placement	Mandatory continuous quantitative or waveform ETCO2	Quantitative or waveform ETCO2
Selection of tube size	based on patient age or size of 5th finger	Cuffed Sizes = 3.5 - 8.0 mm Uncuffed Sizes = 2.5 mm
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask Non-Rebreather Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize additional methods to augment mandatory quantitative or waveform ETCO2	ETCO2 Epigastric sounds Breath sounds EDD chest rise tube misting Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		
All intubations, including RSI, must be reviewed by the Medical Director.		

Required Elements for Performance Assessment and Improvement

Monitoring		
100% chart review		
Intubation success rate	agency	
	provider	
1st attempt success rate	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

EMSPC Ventilator Standards

Definition

Automatic Transport Ventilator (ATV) Definition: volume control, pop-off valve to limit peak pressure, peak pressure alert/alarm

Provider may adjust: Rate, TV, FiO2 (target saturation of 95-99%)

Caution: Critical care transport services should be considered for inter-facility transport of patients with the following conditions:

- i. Simple volume control ventilation is not ideal for the patient.
- ii. Active titration of ventilator settings, recent or anticipated
- iii. Patient is at risk for displacement of an advanced airway or may be a difficult reintubation if extubated
- iv. Patient with monitoring or treatment needs that require more than one ALS provider or anticipate patient deterioration en route.

System Requirements:

- a. EMS agency medical director must approve any transport ventilator used by the EMS agency. A multimodal ventilator may be used by providers if only used in the volume control mode. The CPAP/BiPAP mode can be used on awake, non-intubated patients per the current scope of practice.
- b. EMS agency medical director must assure initial and ongoing competence (with each ventilator type used) for each individual EMS provider who will use mechanical ventilation.
- c. ALS services must have the capability of monitoring and recording continuous waveform capnography, pulse rate, respiratory rate, and blood pressure during mechanical ventilation. Recordings of these parameters must be documented for every patient treated with an ATV.
- d. EMS agency medical director review is required on all cases of ATV utilization.

Equipment

If utilizing ventilator, agency must have the ability to perform RSI.	Refer to Appendix C - RSI Standards
Medications	As per local EMS Medical Director
Continuous Pulse Oximetry	
Suction device	per minimum EMS Bureau equipment list
Bag Valve Mask	per minimum EMS Bureau equipment list
Oxygen	per minimum EMS Bureau equipment list
ALS services - monitoring and recording of capnography, pulse rate, respiratory rate, and blood pressure	

Training

Medical Director must ensure initial and ongoing provider competence with each type of ventilator utilized.

PCR Documentation

Providers must document use of an ATV.

All uses and documentation of an ATV must be reviewed by the Medical Director.

Inter-facility Transports:

- Inter-facility transports are performed on a regular basis. The following information is required when performing these transports:
 1. Signed doctor's orders for treatment to be provided en-route outside agency protocols.
 2. Signed consent of transport by patient, or designee, and doctor.
 3. Patient face sheet to include insurance information and emergency contact information.
 4. Nurse's notes to include medication list, allergies, vital signs and POST/DNR/Living Will forms (may be faxed to receiving institution).
 5. Doctor's notes to include diagnosis, preliminary or otherwise, and treatment plan, if appropriate (may be faxed to receiving institution).
 6. Verbal report from the Physician or Nurse.
 7. Other items as needed. (i.e.: X-rays, CT films, labs, EKG's, etc.)
 - **Exception:** Nursing home transports (either to or from the nursing home) will generally have a condensed version of this information.
- Crews are determined by the expected needs of the patient. Transports can be staffed by any level of provider, provided that the needed patient care falls within their scope of practice.
 - i. Critical care transports require a minimum of one certified critical care provider and one additional paramedic or RN in the patient compartment. Special consideration may be given for the second provider based on a specific specialized patient need. (Certified critical care providers must have one of the following credentials: FP-C, CCP-C, CFRN, CTRN, or CCRN/CEN with additional critical care credentialing.)
 - ii. Non-critical care agencies utilizing hospital-based RNs or other providers must assure they have appropriate out-of-hospital transport education, affiliation, or agency agreement and equipment necessary. These providers' education and clinical skill capability must match patient anticipated transport needs (i.e. advanced airway management, vent management, cardiac monitoring, and or equipment).
 - iii. Specialty personnel accompanying the patient will be responsible to advise the EMS crew in their areas of expertise. Specialty personnel will also be responsible for administration and/or use of their medications and/or equipment.
- Complete appropriate documentation and billing form as outlined by current practices/procedures for all inter-facility transports.
- All inter-facility transfers should be included in agency QA/QI process.

Transport Decision Matrix:

The matrix (located on the following page) should be utilized for determining level of care for interfacility transfers. The "X" indicated the minimum level of licensure to perform the transport. Decisions should be made both on the need and the potential need of the patient being transferred.

Equipment or Care Required	BLS/ILS	ALS	CC
Patient Type:			
Transport with Air Medical crew where responsibility for patient care lies solely on the Air Medical crew.	X		
Stable patient. Requires no special care. May have NG tube, Foley Catheter, gastrostomy tube, or patient controlled device that requires no intervention from transporting personnel.	X		
Stable patient. Requires cardiac monitoring or may need paramedic level intervention. No reasonable expectation that the patient condition will deteriorate.		X	
Stable patient requiring care outside the paramedic scope of practice. Patient who is stable but whose condition has a reasonable expectation of deteriorating. Unstable patient			X X X
Airway/Breathing Interventions:			
Oxygen by mask or cannula	X		
Basic vent management (refer to Ventilator Standards)		X	
Enhanced vent management			X
IV Access/Medication Administration:			
Saline lock without additives and not requiring access or flush en route	X		
Saline Lock without additives. Peripheral IV without additives (D10W, Normal Saline, or Lactated Ringers acceptable).	OM/X		
Peripheral IV with any drug approved by Agency Medical Director - administered without an IV pump		X	
Any Medical Director approved formulary medication that requires an IV pump.		OM	X
IV infusion of any drug outside Medical Director approved ALS formulary.			X
Blood products maintenance		X	
Blood products initiation			X
Central venous access device (capped)	X		
Central venous access device with fluids infusing		X	
Arterial access device			X
Pulmonary artery line in place			X
Other Devices:			
Temporary venous pacemaker			X
Chest tube without suction		X	
Chest tube with suction			X

*Time - benefit of immediate/expeditious transfer outweighs risk of delay in transport by recommended level