



2019 Revision to the National EMS Scope of Practice Model Talking Points for State EMS Officials April 2019

- ❖ State policymakers play a critical and longstanding role in occupational licensing policies, dating back to the late 19th century when the U. S. Supreme Court decision in *Dent v. West Virginia*¹ established States' rights to regulate certain professions.
- ❖ Since the legal authority to practice can be obtained only from the State, the State licensure process provides a means for States to pursue unlawful practice by unlicensed individuals. This affords title protection to EMS personnel that comply with State regulations, and protection of the public from individuals who have not met minimum standards.
- ❖ Licensure authority prohibits anyone from practicing a profession unless they are licensed and authorized by the State, regardless of whether the individual has been certified by a nongovernmental or private organization.
- ❖ Regardless of what descriptive title is used by a state agency, if an occupation has a statutorily or regulatorily defined scope of practice and only individuals authorized by the state can perform those functions and activities, the authorization has the legal effect of a license.²

The National EMS Scope of Practice Model (*"Scope of Practice Model"*) was first published by the National Highway Traffic Safety Administration (NHTSA) in 2007 with primary leadership from NASEMSO.

- ❖ The *Scope of Practice Model* is a consensus-based document that was developed to improve the consistency of EMS personnel licensure levels and nomenclature among States; it does not have regulatory influence unless adopted by the State.
- ❖ The *Scope of Practice Model* was revised in 2018 using a multi-disciplinary nationwide stakeholder process. It describes a progression of knowledge and skills among multiple levels of EMS personnel based on the best available research, expert consensus, and multiple national reviews. The model continues to provide nationally standardized titles and descriptions for EMS practitioners.
- ❖ Core to this document and the practice of every licensed health professional is compliance with four domains intended to serve the legal and ethical obligation of States to ensure the public is protected from unqualified individuals.

- ❖ An individual may only perform a skill or role for which that person is:
 - **EDUCATED** (has been trained to perform the skill or role), **AND**
 - **CERTIFIED** (has demonstrated competence in the skill or role), **AND**
 - **LICENSED** (has legal authority issued by the State to perform the skill or role), **AND**
 - **CREDENTIALLED** (has been authorized by their medical director to perform the skill or role).

- ❖ The *Scope of Practice Model* describes “entry-level” expectations: the minimum practice requirements in advance of gaining field experience prior to supervised or individual work experience at the levels of an Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), or Paramedic.

- ❖ The list of psychomotor skills that appear as interpretive guidelines is neither prescriptive nor finite. States and their medical directors maintain the legal authority to establish their scope of practice and are encouraged to use the *National EMS Scope of Practice Model* as a foundation/framework.

- ❖ The concept that EMS personnel are somehow practicing “under the physician’s license” is not accurate. The umbrella of physician supervision and collaboration can never be used to replace the certification, scope of practice, and individual responsibility of licensed EMS personnel. EMS personnel hold their own license and the relevant State authority can restrict or remove that license to stop incompetent or dangerous practice.

- ❖ The *Scope of Practice Model* document is not simply a list of psychomotor skills; it addresses several considerations related to an EMS scope of practice that are important to digest and understand. Users are strongly encouraged to read the Model *in its entirety*.

- ❖ Implications for States that exceed the *Scope of Practice Model* include:
 - Texts and publisher-created support materials may not include the State added content.
 - The National EMS Certification exams may not cover the content added by the State.
 - The State would need to ensure an orientation process and verification of competency for persons who transfer into the State from another location that may not have included the additional content.
 - The additional material creates some element of confusion about what would be allowed when there is a mobilization of resources for an event requiring an EMS response among multiple states.

- ❖ Download the **2019 National EMS Scope of Practice Model** at ems.gov.

Summary of Recommendations from the 2019 Scope of Practice Model Revision:

1. The *Expert Panel* considered the evidence related to the value of National EMS Program Accreditation towards student and patient outcomes and encourages collaboration among stakeholder groups for full implementation of national EMS program accreditation at the AEMT level by 2025.
2. The *Expert Panel* strongly supports the national call for the elimination of barriers for all professions to practice to the full extent of their education, training, and competence with a focus on collaborative teamwork to maximize and improve care throughout the health care system³.
3. The *Expert Panel* considered several tasks that should be taught and can be valued/permitted at the EMT level but not required if the necessary equipment, resources, and oversight to complete the task are not available to personnel. (Examples may include blood glucose monitoring and the obtaining and transmitting 12 lead electrocardiograms.)
4. With regards to tasks that are routinely performed by members of the lay public, the *Expert Panel* maintains that licensed individuals are accountable at a higher level for the medical care they provide as well as the maintenance and calibration of medical equipment used during a patient encounter. (It is also important to note that the use of blood testing devices by EMS personnel invokes the federal-level Clinical Laboratory Improvement Amendments⁴ [CLIA] to the Public Health Services Act.)
5. Considering the education, certification, licensing, and credentialing processes pertaining to EMS practice, the *Expert Panel* reaffirms that while an EMR may be used to assist patient care in an ambulance, an EMT (or higher level personnel) must be physically present in the patient compartment and assume responsibility for the delivery of care during transport.
6. The mechanical task of opening bottles or providing a drink of water aside, aid associated with placing a tablet in the patient’s mouth, activating an inhaler, or delivering a dose of medication via autoinjector is clearly an act of medication administration. Administration of medication requires a thorough understanding of related pharmacology and safe administration practices. References to “assist patients in taking their own prescribed medications” have been identified as confusing by educators and practitioners and the *Expert Panel* has advised they be removed from the *Practice Model and National EMS Education Standards*.

¹ Dent v. West Virginia, 129 U.S. 114 (1889) at <https://cdn.loc.gov/service/ll/usrep/usrep129/usrep129114/usrep129114.pdf>

² National Registry of Emergency Medical Technicians. *Legal Differences Between Certification and Licensure* at https://www.nremt.org/rwd/public/document/certification_licensure

³ Institute of Medicine of the National Academies (2010) *The Future of Nursing Focus on Scope of Practice*. Washington, DC. at <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf>

⁴ 42 CFR 493, *Laboratory Requirements* (2011) at <https://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap6A-subchapII-partF-subpart2-sec263a.pdf> See also, www.cms.gov/CLIA.