**Question**: In reference to the medications used by EMS, which statement best describes your state?

1. The state/region/county government does not establish a required medication list, each medical director determines what medications may be carried;
2. The state government identifies a list of medications that may be carried;
3. The state/region/county government identifies a list of medications that must be carried;
4. The state/region/county government identifies a hybrid list of medications and alternatives that must be carried;
5. Other: Please explain.

| | State | #1 | #2 | #3 | #4 | #5 | |
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| **1** | AK | | **X** | | | | Alaska is currently in the process of revising our scope. We have taken the approach of permissive versus prescribed. We are also discussing listing classes of drugs in some cases vs listing specific drugs. For example benzodiazepines versus valium or versed. The state publishes the list that EMS may carry. If they want to go beyond that we have a special skills process that the agency can go through and justify the additional meds or skills. |
| **2** | NM | | **X** | | | | We have a scope of practice that serves as a menu from which MD's can choose what goes on their trucks. They can adapt all or part of the scope, but not exceed. In cases of shortage, we can do quick changes/additions for alternatives when possible. |
| **3** | MI | | | | **X** | | I have attached our medication shortage and substitution protocols that we have recently distributed. The issue of shortages previously mandated emergency protocols regularly to allow for new medications to be added. Please feel free to contact us if you have any questions. |
| **4** | NE | | **X** | **X** | | | The EMS Board is required to develop statewide protocols. These protocols have a listing of medications that should be used; however, each PMD has the authority in regulation to approve medications for the paramedic level. The medications at the other levels (EMT, AEMT, EMT-I) are spelled out in regulation and cannot be modified by the PMD.<br>Here is a link to the regulations: http://dhhs.ne.gov/publichealth/Licensure/Documents/EMS172-11.pdf<br>Note: these are in the process of being updated so this may change within a year. |
| **5** | MT | | **X** | | | | The medical board describes medications in state protocols (that sets the scope for every provider), but the medical director has latitude to make accommodations within that scope. Medical directors can also request modified protocols beyond the scope of the state protocols. |
| **6** | NV | **X** | | | | | |
| **7** | NY | | **X** | | | | The region develops ALS protocols and submits to our State EMS Council for review and approval. Our State EMS Council has also developed an "alternative formulary" that we have published. This can be used during medication shortages. https://www.health.ny.gov/professionals/ems/pdf/13-04.pdf |
| **8** | TN | | | | | X | We have required drugs and classifications in some areas with substitution by Medical Directors for therapeutic equivalent but the drugs are not listed in our rules. We have a rule that requires medication and equipment in a board approved Ambulance Equipment and specifications List. This list is reviewed annually by our clinical issues committee than presents recommendations to the board for any changes . This allows us to move forward with evidence based guidelines for best field treatments and equipment that can be changed easier and faster than going through rule making. We do have a public comment time before the board on any recommended changes being presented to the board. Changes are always adopted in September each year and not required until July 1 of following year. If a large expense a longer time will be given before requirement. |
| **9** | TX | **X** | | | | | |
| **10** | DC | | | | | X | We require a minimum list of medications that must be carried, but each agency medical director has the option to add more if he/she sees fit |
| **11** | NC | | | | | X | North Carolina does not have any of its scope of practice/formulary for medications in NC Administrative Code, but references supplemental document housed by stakeholder group (NC College of Emergency Physicians). This allows for us to keep these documents in a living format to ensure they are updated. Both the supplemental document and the over-arching document approved by the NC Medical Board do not contain a lot of specific medications, but more classifications of medications to allow flexibility by the local system medical director (anti-emetic, NSAIDs, etc.). Hope this makes sense. |

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| **12** | KS | | | **X** | | | Our regulations state that each service shall carry the equipment and medications necessary to execute their approved medical protocols (we do not mandate a specific listing of equipment or medications, but their list is reported to us by each service annually and we hold them to it – no changes can be done to this list without providing us the new listing and the updated protocol).<br>Currently, in Kansas, medical protocols can only be approved by 3 methods in Kansas: 1) Local component medical society; 2) Hospital medical staff of a facility the ambulance service transports; and 3) In the absence of 1 and 2, the State's Medical Advisory Council (MAC). Our Medical Advisory Council is specific to EMS Medical Directors within the state.<br><br>I attached our guidance document we approved late last year to let services know how we are going to interpret our rules and regulations as it pertains to drug shortages and compliance with state law. The 3rd scenario in this document appears to be the most applicable to your question/initiative. |
| **13** | AL | | | **X** | | | #3 although some are required and some are optional |
| **14** | OK | | **X** | | | X | The Department has a standard state protocol with formulary. The formulary has some alternatives when medications are unavailable.<br>Agencies can adopt the state protocol and alternative medications or submit their own protocol for approval.<br>When the protocol is approved, the agency is required to maintain the medications or identified alternatives. |
| **15** | SD | **X** | | | | | South Dakota does not stipulate what medications an ambulance must or may carry. We do focus on the level specific scope of practice and allow the local medical director to dictate what his/her crews can administer. |
| **16** | IL | **X** | | | | | |
| **17** | CO | | **X** | | | | |
| **18** | VA | | **X** | | | | See Virginia's formulary at:<br>**http://www.vdh.virginia.gov/content/uploads/sites/23/2016/05/ScopeOfPractice-Formulary.pdf**<br>We anticipate an update in May, 2018. The State identifies Scope of Practice Formulary as practice maximums and therefore educational minimums. As such, the state does not specifically dictate which of the medications an ambulance is to carry. The actual practice is then defined locally by the agency's operational medical director. We based the category listed on the Core Content document. |
| **19** | NJ | | | | | **X** | We have traditionally has a short mandatory list and a long permissive list (~60) of drugs in regulation. For the past year, we have been moving (by waiver) to CLASSES of medication, e.g., from "Morphine Sulfate" to "Narcotic Analgesic". This generally works really well, except when the acceptable alternatives are a different class, e.g., Beta Blockers and Slow Calcium Channel Blockers for rapid atrial fibrillation.<br>We require all clinical waivers to include a peer-reviewed evidence base and our Director and physician partner to perform a Level of Evidence/Quality of Evidence analysis to ensure that it reaches Class lla/Level B. |
| **20** | **RI** | | | **X** | | | |
| | | **4** | **8** | **4** | **1** | **5** | |