EMS

EMERGENCY MEDICAL SERVICES

THE NATIONAL EMS SCOPE OF PRACTICE MODEL:

Freedom within Limits

DRAFT 2.0
For review and comment.
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Introduction to Draft 2.0

On behalf of the *National EMS Scope of Practice Model* Task Force (SOP Task Force), I am pleased to present Draft 2.0 of the *National EMS Scope of Practice Model (Model)*. The creation of the *Model* is an important step in the implementation of the *EMS Education Agenda for the Future: A Systems Approach*.

Thank you to everyone who took the time to comment on Draft 1.0 of the *Model.* The review of Draft 1.0 was an opportunity for the EMS community to shape its own future. In that regard, it was an overwhelming success. Thousands of letters were received from people and organizations representing all segments of our nation's EMS system. We heard from urban and rural providers, fire departments and private services, hospitals, community leaders, physicians, educators, and private citizens. Some comments we received helped to validate the work of the SOP Task Force. Other comments were useful in redirecting our approach. While not all of the suggestions received were included in the final version, each was considered and contributed to an understanding of how the *Model* will serve the Nation.

Many of the comments received addressed implementation issues. The SOP Task Force is acutely aware that the *Model* is not a stand-alone document, but can only work when it is integrated into a much broader system of public protection. As that integration occurs, issues in the areas of finance, workforce, public policy, medical oversight, education, and others must be addressed. While it is not officially within the charge to the SOP Task Force to implement the *Model*, Draft 2.0 has been crafted in a way that will address some of the implementation concerns. The National Highway Traffic Safety Administration (NHTSA) and its federal partners are committed to assure a smooth transition.

From the broad array of comments received, a few significant themes emerged and that are addressed in Draft 2.0. The themes include:

- Retention of a proposed Emergency Medical Technician (EMT) level with a skill set fairly close to the US DOT 1994 EMT-Basic: National Standard Curriculum.
- Inclusion of a level of licensure between the EMT and Paramedic, proposed to be titled as "Advanced EMT".
- Support for the names of the various levels of EMS licensure as proposed in Draft 1.0.
- Addressing implementation issues specific to the development of the *Model*.
- Clarification of the purpose of the *Scope of Practice Model* and its relationship to state-established scopes of practice for EMS personnel licensure.

Widely varying comments were received on the proposed Advanced Practice Paramedic (APP) level. Some reviewers felt the level was a visionary addition to the hierarchy of EMS professional development. Others saw no need for the creation of the APP or felt it would not be affordable or feasible. Still others embraced the concept of an APP but had suggestions for revising various pieces of the vision. In an effort to give this subject the full and legitimate consideration it deserves, the SOP Task Force has elected to put

further development of the APP level on hold. NHTSA has agreed to address the concept of the APP level in another forum to assure the concept receives the thoughtful attention of the EMS, public health, medical, allied health, and nursing communities.

While the SOP Task Force is pleased with the progress that Draft 2.0 represents, there is still more work to do. Again, we ask for the help of the national EMS community in providing your thoughts and comments on this draft. From now until June 1, 2005, we invite you to submit your written comments on Draft 2.0 to:

EMS National Scope of Practice Model Project
c/o NASEMSD
201 Park Washington Court
Falls Church, VA 22046-4527

On June 12-15, 2005, there will be a National Review Team (NRT) meeting in the Washington, DC area to provide an opportunity for the EMS community and key stakeholders to share their comments and opinions with the SOP Task Force. There will be an "open mike" session during the first day, an opportunity for the SOP Task Force to hear from invited members representing the key national EMS organizations on the second day, and the SOP Task Force will wrap up the meeting the last two days by considering and deliberating all of the written and presented comments on Draft 2.0. More information on the expectations for the June meeting will be posted on the *National EMS Scope of Practice Model* project web site soon. Invitations to the June 2005 NRT meeting will be mailed to the key national EMS organizations in the coming weeks.

For more information about the progress of project, to see the latest draft of the document, or to learn more about the plans for the National Review Team meeting in June 2005, please visit the project web site at: http://www.emsscopeofpractice.org.

Dan Manz, Principal Investigator

The National EMS Scope of Practice Model
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The Vision

Emergency Medical Services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and it will be integrated with other health care providers and public health and safety agencies. It will improve community health and result in a more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net.

Emergency Medical Services: Agenda for the Future
1996, National Highway Traffic Safety Administration

Executive Summary

Will be developed from the final draft.

Introduction

Emergency Medical Services (EMS) personnel treat nearly 20 million patients a year in the United States. Many of these patients have complicated medical or traumatic conditions that require considerable knowledge, skill, and judgment to be treated effectively in the out-of-hospital setting. Some are critically ill or injured, and the proper care can literally make the difference between life and death. For most patients, their crisis may not be a matter of life or death, but it is no less significant to them and their family. High quality out-of-hospital emergency care is an important part of the United States health care system.

As of 2003, there were 840,669 certified out-of-hospital care personnel in the United States (Lindstrom and Losavio 2004), and the nation's annual expenditure for EMS topped $6.75 billion (Sayer, Brown et al. 2001). Emergency Medical Services are diverse and complex systems. Until now, there has not been a national system to aid states in the evolution of their EMS personnel scopes of practice and licensure. In 1996, there were at least 44 different levels of EMS personnel certification in the US (National Highway Traffic Safety Administration 1996), and it is presumed that the number has increased since that time. This patchwork of EMS personnel certifications has created considerable problems, including but not limited to:

- Public confusion
- Reciprocity challenges
- Limited professional mobility
- Difficulty in implementing telemedicine programs
- Decreased efficiency due to duplication of effort

The *EMS Education Agenda for the Future: A Systems Approach (2000)* identified the need to establish a National EMS Scope of Practice Model as one of five components of an integrated, systematic approach to regulation of EMS education, certification, and licensure. This system will help ensure safe and effective patient care to those who need out-of-hospital emergency care. It relies on a "hand-in-glove" relationship between competency certification and professional licensure. The development of the *National EMS Scope of Practice Model* is part of the continued commitment to realize the vision of the *EMS Agenda for the Future* and the *EMS Education Agenda for the Future.*

The authors of the *National EMS Scope of Practice Model* recognize the responsibility of the state regulatory process to protect the public. As part of that responsibility, states have the authority to establish the scopes of practice for EMS personnel within their state.

This model is not intended to force standardization or imply a "one size fits all" solution. It is a tool for states to use that will encourage national consistency.

The *National EMS Scope of Practice Model* supports a system of licensure common in other allied health professions. Such a system offers the following benefits:

- Establish national standards for the entry level psychomotor skills and knowledge for EMS personnel
- Improve consistency among States' scopes of practice
- Facilitate reciprocity
- Improve professional mobility
- Promote consistency of EMS personnel titles
- Improve the name recognition and public understanding of EMS personnel.

A traditional health care licensure system supports the fundamental responsibility of a professional community— to protect the public. The licensure of EMS personnel is part of an integrated and comprehensive system to improve patient care and safety.

The challenge facing the EMS community is to develop a national system that is flexible enough to enable reasonable local variation, while still establishing national standards for EMS personnel licensure levels. Emergency care must be responsive at the state and local level and this document recognizes the need for freedom within limits.

History of Occupational Regulation in EMS

The development of modern civilian Emergency Medical Services (EMS) stems largely from lessons learned in providing medical care to soldiers injured in military conflict. Building on these lessons, a number of rescue squads and ambulance services emerged in the civilian sector. While well intentioned, most of these personnel were untrained, poorly equipped, unorganized, and unsophisticated. The systems were unregulated, and no standards existed. By the 1960s, prehospital care in the US had evolved into a patchwork of well intentioned but uncoordinated efforts. This all changed in the mid-sixties.

In 1960, the President's Committee for Traffic Safety recognized the need to address "Health, Medical Care and Transportation of the Injured" to reduce the nation's highway fatalities and injuries.

In 1966, the National Academy of Sciences published a report entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*. This report quantified the magnitude of traffic-related death and disability while vividly describing the deficiencies in prehospital care in the United States. The "white paper" made a number of recommendations regarding ambulance systems, including a call for ambulance standards, state-level policies and regulations, and adopting methodology for providing consistent ambulance services at the local level (National Academy of Sciences National Research Council 1966).

The Highway Safety Act of 1966 required each State to have a highway safety program which complied with uniform Federal standards, including "emergency services." This provided the impetus for the National Highway Traffic Safety Administration's (NHTSA's) early leadership role in EMS system improvements. Initial NHTSA EMS efforts were focused on improving the education of prehospital personnel such as the writing of the National Standard Curricula. Funding was also provided to assist states with the development of state EMS Offices. Subsequent NHTSA efforts were oriented toward comprehensive EMS system development and included, for instance, model state EMS legislation (Weingroff and Seabron).

The genesis of state EMS systems can also be traced to the early 1970s, when an unprecedented level of funding from the federal government and the Robert Wood Johnson Foundation prompted the establishment of regional EMS systems and demonstration projects throughout the country. The Emergency Medical Services Systems Act of 1973, enacted by Congress as Title XII of the Public Health Service Act, yielded eight years and over $300 million of investment in EMS systems planning and implementation. The availability of EMS personnel and their training were two components that states were required to focus on, resulting in the first generation of legislation and regulation of EMS personnel levels (National Highway Traffic Safety Administration 1996).

One function of state EMS offices was to ensure the competence of EMS personnel functioning in that state. Occupational licensure represents the most rigorous form of protecting the public from incompetent practitioners. In some states, however, there was legislative backlash resulting from a large increase in the requests for licensure of allied health professionals in the late 1960s (Shimberg 2000). In general, certification does not offer the same degree of public protection, nor the same due process protections, as licensure. Unfortunately, the term 'certification' has come to have multiple connotations in EMS, and a meaning different from that of other disciplines, causing confusion and inconsistency at the national level.

By 1990, EMS in the United States had enjoyed many successes. Not only did EMS systems grow, but EMS became a career and volunteer activity for hundreds of thousands of talented, committed, and dedicated individuals. Emergency medical care was available to virtually every citizen in the country by simply dialing 9-1-1 from any telephone. Despite this progress, EMS was impacted by a number of factors in the broader health care system.

In 1992, the need for a long-term strategic direction was recognized by the National Association of EMS Physicians and the National Association of State EMS Directors, and the *EMS Agenda for the Future* was initiated with support from the National Highway Traffic Safety Administration (NHTSA) and the Maternal and Child Health Bureau of the Heath Resources and Services Administration (HRSA). Published in 1996, the *EMS Agenda for the Future* proposed a bold vision for greater integration of EMS into the US health care system.

In 1993, *The National Emergency Medical Services Education and Practice Blueprint* was released to the EMS community. The *Blueprint* defined an EMS educational and training system that would provide both the flexibility and structure needed to guide the development of national standard training curricula and guide the issuance of licensure/ certification by the individual states.

In 1998, the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation published *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (Finocchio, Dower et al. 1998). The report recommended that a national policy advisory board develop standards, including model legislative language, for uniform scopes of practice authority for the health professions. The report emphasized the need for states to enact and implement scopes of practice that are nationally uniform and based on the standards and models developed by the national policy advisory body.

Demonstrating their commitment to the *EMS Agenda*, in 1998 NHTSA and HRSA jointly supported a two year project to develop an integrated system of EMS regulation, education, certification, licensure, and educational program accreditation. The result was the *EMS Education Agenda for the Future: A Systems Approach*, which recognized the need for a variety of integrated and coordinated initiatives to meet the needs of the current EMS system while moving toward the vision proposed in the *EMS Agenda for the Future*. The model described in the *EMS Education Agenda* called for a more traditional approach to licensing EMS personnel.

The Role of State EMS Offices

Each State has the statutory authority and responsibility to regulate EMS. Since the early 1970s, the States have assumed a major leadership role in EMS and have served a vital role in the development and support of emergency medical systems in this country.

A coordinated national EMS system is in the best interest of states, EMS personnel, and the public. State EMS offices, while working in cooperation with their stakeholders, should implement Scope of Practice regulations that are as close as possible to those in the *National EMS Scope of Practice Model*. This will help with professional recognition of EMS personnel, facilitate reciprocity, decrease confusion, and enable the development of high quality support systems to the benefit of the entire system.

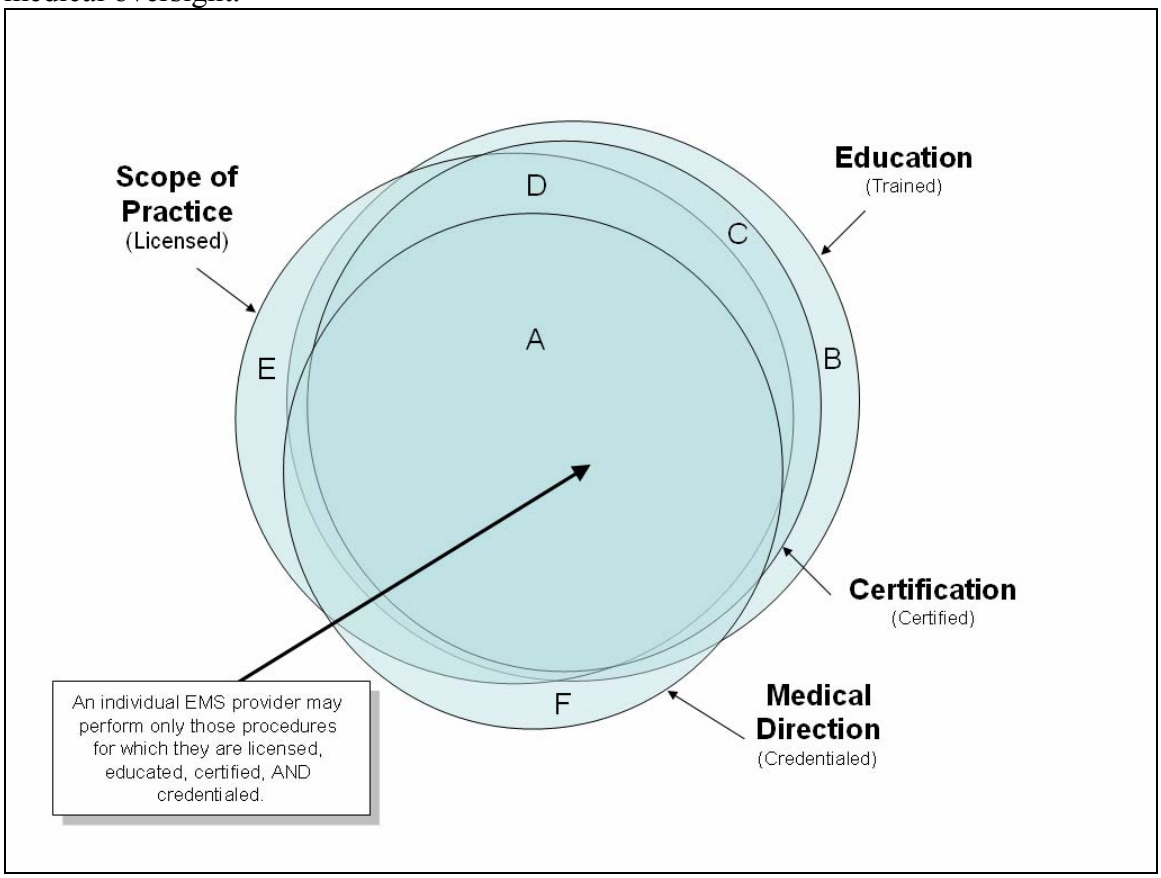
The Interdependent Relationship Between Training, Certification, Licensure, and Credentialing

The *National EMS Scope of Practice Model* establishes a suggested framework that ultimately determines what an individual with a state license as an EMS professional is authorized to perform on a given day in a given EMS system. In short, an individual may only perform a skill which the individual has been:

- Trained in (has been educated to perform the skill), AND
- Certified (has demonstrated competence), AND
- Licensed (has legal authority issued by the State), AND
- Credentialed (has medical oversight).

This relationship is represented graphically in fig. 1.

Fig 1: The Relationship between the education, certification, scope of practice, and medical oversight.



"A" represents skills and roles for which an individual has been trained, certified, and licensed by a state, and has also received medical direction. This is the only acceptable region of performance, as it entails four overlapping and mutually dependent levels of public protection: education, certification, licensure, and credentialing.

"B" represents skills and roles for which an individual has received education, but is neither certified, licensed, nor has medical direction. For example, an EMT in a paramedic class is taught advanced skills; despite being trained, the EMT cannot perform those skills until such time that he is certified, licensed and has medical direction to do so.

"C" represents skills and roles that have been taught and certified, but are not part of the state license and local medical direction. For example, a Paramedic is trained and certified in needle cricothyrotomy. Should he be functioning in a state in which that skill is prohibited for Paramedics, it would now be out of his scope of practice.

"D" represents skills and roles for which an individual is trained, certified, and licensed, but has no medical direction. For example, an off duty Paramedic arriving at the scene of an incident outside of his jurisdiction usually has no medical direction to perform advanced skills. In this case, performing an advanced skill would represent a violation of his scope of practice.

"E" represents skills or roles that the state has authorized but which also require local entities to assure the training, verify competence, and provide medical direction. For example, rapid sequence intubation (RSI) in some states is legally permitted, but usually not taught as part of the initial education, nor is it part of the certification process, and most medical directors do not credential individuals to perform RSI. Some individuals (for example, flight paramedics) may perform RSI; however, the local medical director assumes responsibility for training, competency verification, and medical direction.

"F" represents skills or roles which a medical director wants an individual to perform but he has not been trained, certified, nor licensed. There is considerable state-to-state variability in dealing with this situation. Some states have regulatory mechanisms that enable a physician to assume complete responsibility for the performance of skills and roles performed by an individual. Some states have regulations that prohibit licensed individuals from functioning beyond their scope of practice, and may take action against their licensure, even if the individual had medical direction to perform that skill or role.

These four circles represent overlapping and complementary forms of public protection. Individuals should not perform any role for which they are not trained, certified, licensed, AND credentialed.

The Relationship Between The National EMS Scope of Practice Model and a State's Scope of Practice

Defining a health care professional's scope of practice is a state regulatory function. The *National EMS Scope of Practice Model* was developed to improve the consistency of EMS personnel levels and nomenclature among states. It is a consensus document with no regulatory authority.

The *National EMS Scope of Practice Model* identifies the psychomotor skills and knowledge necessary for the entry level competence of each nationally identified level of EMS licensure. This model will be used to develop national EMS education standards, national EMS certification exams, and national EMS educational program accreditation. Under this model, to be eligible for state licensure, EMS personnel must be verifiably competent in the entry level knowledge and skills needed to ensure safe and effective practice at that level. This competence is assured by completion of a nationally accredited educational program and national certification.

These standards should also be used by the states to develop their own scope of practice legislation and regulation. State scopes of practice may be more specific than those included in this model and clearly identify both the entry level and maximum skills and roles of each level of EMS licensure in the state.

While each state has the right to establish its own scope of practice for each EMS level, staying as close to this model as possible facilitates reciprocity, standardizes professional recognition, and decreases the necessity of each state developing its own education and certification materials. The educational standards, national certification, educational program accreditation, and publisher developed instructional support materials provide states with infrastructure support for each nationally defined EMS licensure level.

States may opt to include skills from the next higher level, but should do so with caution and purpose. The adoption of skills and roles beyond those proposed in this model will erode national consistency, interstate mobility, and legal recognition for EMS personnel. Additionally, content in future national EMS education standards, national certification examinations, and curriculum-focused aspects of national accreditation standards will not include those skills. States including skills beyond entry level assume full responsibility for the development and implementation of their own educational content, certification materials, quality assurance procedures, and credentialing resources. It is suggested that states only add skills from the next level (i.e. they should not "skip levels").

Some States permit licensed EMS personnel to perform skills and roles beyond the entry level as they gain knowledge, additional education, experience, and (possibly) additional certification. Care must be taken to consider the level of cognition necessary to perform a skill safely. Particularly problematic skills are those that appear to be simple to perform, but require considerable clinical judgment for an individual to know when they should, and should not, be performed.

If permitted by an individual state, additional skills or roles should be drawn from the next level of EMS licensure. "Skipping levels" represents a large increase in cognitive complexity and patient risk and should therefore be avoided. States who choose to adopt skills and roles beyond these standards must assume all responsibility for assuring that personnel are trained and competent in the additional skills and roles; they are not part of the national model. The *National EMS Scope of Practice Model* does not describe the method that may be used to verify added competencies.

Scope of Practice

Scope of practice is a legal description of the distinction between licensed health care personnel and the lay public and among different licensed health care professionals. It describes the authority, vested by a state, in licensed individuals practicing within that state. Scope of practice establishes which activities and procedures that, if performed without licensure, represent illegal activity. In addition to drawing the boundaries between the professional and the lay person, scope of practice defines the boundaries among professionals, creating either exclusive or overlapping domains of practice.

> Scope of Practice is a description of what a licensed individual legally can, and cannot, do.

Scope of practice does not define every activity of a licensed individual (for example, lifting and moving patients, taking a blood pressure, direct pressure for bleeding control, etc). In general, scopes of practice focus on activities that are regulated by law (for example, starting an intravenous line, use of the pneumatic antishock garment, administering a medication, etc.). This includes technical skills that, if done improperly, represent a significant hazard to the patient and therefore must be kept out of the hands of the untrained. Scopes of practice typically do not regulate non-medical tasks or non-invasive tasks with no physiological/clinical implications.

Scope of Practice vs. Standard of Care

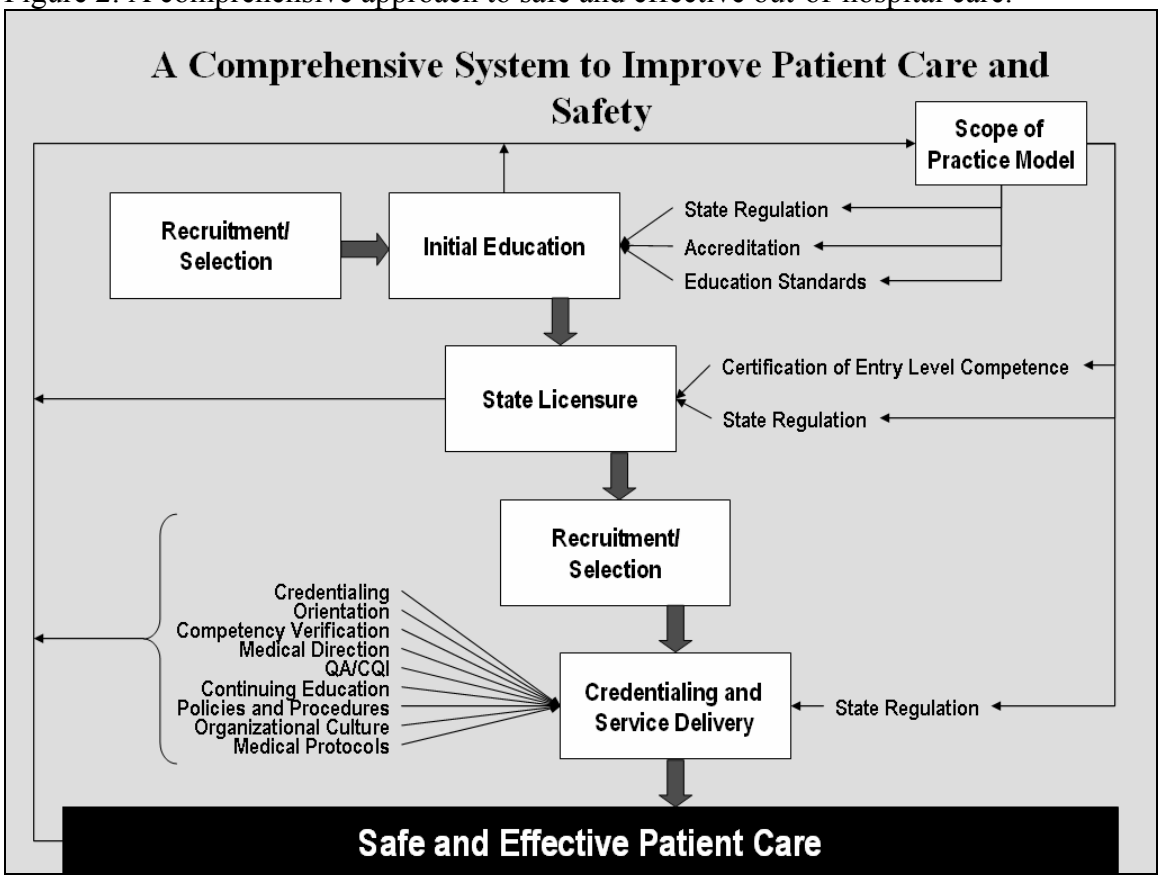
Scope of practice does not define a standard of care, nor does it define what should be done in a given situation (i.e., it is <u>not</u> a practice guideline or protocol). It defines what is legally permitted to be done by some or all of the licensed individuals at that level, not what must be done.

	Scope of Practice	Standard of Care
Purpose	Deals with the question, "Are you/were you *allowed* to do it?"	Deals with the question, "Did you do the right thing and did you do it properly?"
Legal implications	Act of commission is a criminal offense	Acts of commission or omission may lead to civil liability
Variability	May vary from individual to individual. Does not vary based on circumstances.	Situational, depends on many variables
Defined by	Established by statute, rules, regulations, president, and/or licensure board interpretations	Determined by scope of practice, literature, expert witnesses, and juries
Miscellaneous	It is difficult to regulate knowledge through scope of practice.	Used to evaluate professional judgment

Scope of Practice as Part of a Comprehensive Approach to Safe and Effective Out-of-Hospital Care

Scope of practice is only one part of health care regulation, and regulation is only one component of a comprehensive approach to improved patient care and safety. Safe and effective EMS care is the cumulative effect of a cascade of thousands of individual decisions involving every level of EMS leadership, supervision, management, and regulation. Safe and effective patient care is the shared responsibility of everybody within the EMS system, and must be our collective first priority. Safe and effective care cannot be accomplished through any single activity, but is best accomplished with an integrated system of checks and balances. All components of the comprehensive approach to safe and effective patient care are mutually supportive and dependent. Figure 2 illustrates the interconnected nature of many of the components of a comprehensive system.

Figure 2: A comprehensive approach to safe and effective out-of-hospital care.



Scope of Practice for Special Populations

EMS professionals are expected to meet the urgent health care needs of all patients, regardless of age or co-morbidity, consistent with their defined scope of practice. Recognized special populations include, but may not be limited to, children, elders,

patients with disabilities, and patients with limited access to health care due to geographic, demographic, socioeconomic, or other reasons.

Scope of Practice during Disasters, Public Health Emergencies, and Extraordinary Circumstances

It is virtually impossible to create a scope of practice that takes into account every unique situation, extraordinary circumstance, and possible practice situation. This is complicated by the fact that EMS personnel are an essential component of disaster preparedness and response. In many cases, EMS personnel are the only medically trained individuals at the scene of a disaster when other health care resources may be overwhelmed. This document cannot account for every situation, but rather is designed to establish a system that works under normal circumstances. It is assumed that the scope of practice of EMS personnel may be modified or changed in times of disaster or crisis with proper education, medical oversight, and quality assurance to reasonably protect patient safety.

The Risk of Role Creep

A significant risk to patient safety occurs when EMS personnel are placed into situations and roles for which they are not experientially or educationally prepared. There are numerous political, economic, social, and cultural reasons why personnel are pressured into functioning beyond their intended role. Role creep demonstrates a lack of appreciation for safety of the public and the consequences of such actions.

It is the shared responsibility of medical oversight, clinical and administrative supervision, regulation, and quality assurance to ensure that EMS personnel are not placed in situations where they will be tempted to exceed the scope of their practice. In many cases, the pressure can be extraordinary. For the protection of the public and to ensure patient safety, regulation must exist to prevent the tendency of the roles of EMS personnel to creep from their original intent.

How to Use This Document

This model serves as a guide for State EMS Offices that are statutorily responsible for regulating EMS in their respective jurisdictions. The vision of the *National EMS Scope of Practice Model* is to standardize EMS personnel licensures nationwide.

States are strongly encouraged to adopt the licensure levels for EMS personnel identified by the *National EMS Scope of Practice Model* to strengthen the national EMS system. The benefits of the adoption of standard skills and interventions by states, as proposed in

the model, include consistency, improved patient safety, increased interstate mobility, and better legal/public recognition of EMS personnel.

As a relatively young discipline, EMS has a limited research base making evidence based decision making challenging. This project was guided by research whenever possible. This project utilized state survey data, the National EMS Core Content, state EMS office and medical director surveys, the national EMS practice analysis, the National EMS Information System (NEMSIS) pilot project data, the Longitudinal EMT Attributes and Demographics Study (LEADS), and peer reviewed literature.

In addition, this model was influenced by extensive literature review of other professions, systematic analysis of policy documents regarding health care licensing and patient safety, invited presentations by other allied health credentialing bodies, and cross-professional and international comparative analysis.

Statistical analysis and research on patient safety, scope of practice, and EMS personnel competency must become a priority among the leadership of national associations, federal agencies, and research institutions. When this data collection, subsequent analysis, and scientific conclusions are published and replicated, later generations of the *National EMS Scope of Practice Model* and interpretive guidelines should be driven by those findings.

The authors of the *National EMS Scope of Practice Model* recognize the right of any State to deviate from this document. States choosing to exercise that right should do so fully understanding the need to develop and implement their own state-specific educational content, program approval, certification examinations, and credentialing processes.

Overview of the EMS Profession

This model defines the practice of EMS personnel. EMS personnel are unique health care professionals in that they provide medical care and transportation in an out-of-hospital setting with medical oversight. EMS personnel are not independent practitioners. While the practice is not independent, it is relatively unsupervised and often has little backup. Therefore, EMS personnel must be able to exercise considerable judgment, problem-solving, and decision-making skills.

Most EMS personnel work in emergency medical services that respond to emergency calls. Emergency response is typically a local government function (or contracted by local government to a private entity). In most communities, citizens call 9-1-1 when they need emergency medical care, and the appropriate EMS resources are dispatched. In the case of emergency calls, EMS personnel are unique in that they typically have a "duty to act." Many EMS personnel provide transportation services for patients requiring medically supervised transportation, either exclusively or in addition to emergency

response. These "scheduled transports" generally do not fall under the "duty to act" responsibility of emergency response.

EMS personnel generally practice emergency medicine out of the hospital. They respond and provide care to the patient in the setting in which the patient became ill or injured, including the home, field, work, industrial, and recreational settings. In some cases, EMS personnel "stand-by" at mass gatherings or high-risk activities.

Emergency Medical Services are a local function and organized in a variety of ways. Common models are municipal government (fire-based or third-service) or a contracted service with a private (profit or not-for-profit) entity. EMS personnel also can be categorized in a variety of ways. Higher level personnel tend to be paid (either full- or part-time), while lower levels have higher percentages of volunteer or partially paid personnel.

EMS provides out-of-hospital medical care to those with perceived urgent needs. It is a component of the overall health care system. EMS delivers care as part of a system intended to attenuate the morbidity and mortality associated with sudden illnesses and injury. The positive effects of EMS care are enhanced by linkages with other community health resources and integration within the health care system.

EMS Personnel Licensure Levels

During the first forty years of EMS system development, the National Standard Curricula (NSC) provided the only national guidance for States in developing scope of practice legislation. Unfortunately, the NSC provided little opportunity for reasonable and necessary state flexibility. The National EMS Scope of Practice Model will enable states to develop scopes of practice that are flexible enough to accommodate reasonable variation while enabling State and local EMS systems the ability to respond to local factors (such as funding, local health care resources, urban/rural/frontier settings, and workforce considerations-volunteer, part-time, and career EMS personnel.)

This document, as one of five components of the *EMS Education Agenda for the Future: A Systems Approach*, is a model for state EMS system regulatory functions as they continue to refine their scopes of practice. This model recognizes the utility of standardization of levels of licensure within and across states as well as states' ability to authorize adjustments at the regional or local level based on a variety of factors (such as medical oversight, local EMS agency capacity, etc.). The ultimate goal of adopting this model, and the other components of the *EMS Education Agenda for the Future: A Systems Approach*, is to enhance patient care, ensure patient safety, facilitate reciprocity, and decrease confusion for the public and EMS personnel.

In reality, only a few licensure levels are practical. The support of the educational infrastructure (developing educational standards, national accreditation, national certification, continued competency requirements, etc.) requires a tremendous

expenditure of resources and is only viable if there are a finite number of levels. Therefore, the challenge is to create a system that meets the diverse needs of the country, while keeping the number of licensure levels as small as possible.

For the purpose of this model, a new licensure level represents a substantial difference in:

- Skills
- Practice environment
- Knowledge
- Qualifications
- Services provided
- Needs
- Risk
- Level of supervisory responsibility
- Amount of autonomy
- Judgment/critical thinking/decision making.

Specialty certifications are used to accommodate smaller differences in some or all of the above.

Emergency Medical Responder (EMR)

The primary focus of the Emergency Medical 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.

Educational Requirements: Eligibility for licensure at this level requires successful completion of an approved Emergency Medical Responder training program.

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 care in a patient transport situation. 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.

Educational Requirements: Eligibility for licensure at this level requires successful completion of an approved Emergency Medical Technician course.

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 care in a patient transport situation. 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.

Educational Requirements: Eligibility for licensure at this level requires successful completion of an approved Advanced Emergency Medical Technician course.

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 care in a patient transport situation. 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.

Educational Requirements: Because of the amount of complex decision making, eligibility for licensure requires successful completion of a nationally accredited Paramedic program at the Certificate or Associates Degree level.

EMS Personnel Scope of Practice Models

EMS skills and knowledge represent a continuum of complexity and risk. As the licensure level increases, the knowledge required to practice safely, the skill complexity (the difficulty in acquiring and maintaining skill competency), and the potential for harm increase. Communities must assess their needs and the resources they are willing and able to invest in out-of-hospital emergency care.

The primary role of each EMS licensure level is outlined in the 'Description of the Profession' section. The language in the 'Description of the Profession' and 'Psychomotor Skills' sections may be helpful to states as they integrate the *National EMS Scope of Practice Model* into their laws or administrative regulations.

The 'Psychomotor Skills' section describes categories of skills associated with entry level competence at each licensure level. The 'Psychomotor Skills' sections do not reference specific pieces of equipment or procedures, but rather, are written with more explanatory language. This is intended to minimize the need for changes to the *EMS Scope of Practice Model* as technology and medical science evolve. This approach also allows states some degree of latitude in how detailed they choose to be in defining specific psychomotor skills and procedures that will be allowed by the state for licensed EMS personnel.

Because of the general language used in writing the 'Psychomotor Skills' section, interpretive guidelines (Appendix A) provide additional clarification and direction. The interpretive guidelines will serve as the basis for developing *National EMS Education Standards* and *National EMS Certification* tests. The interpretive guidelines are not intended to be all inclusive of every skill that a State may allow to be performed at an EMS licensure level

Emergency Medical Responder (EMR)

Description of the Profession

The Emergency Medical Responder's model 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 model 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 rescuer and the Emergency Medical Responder is the duty to respond as part of an organized EMS response.

In some systems, the Emergency Medical Responder may serve as a part of the staffing of transporting EMS units; however the EMR is not intended to be the highest level caregiver in such situations. They must be functioning with an EMT or higher during the

transportation of emergency patients. The scope of practice of an EMR 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 trained 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.

Psychomotor Skills

The following are the entry level psychomotor skills of the EMR:

- Airway and Breathing
  - Insertion of airway adjuncts intended to go into the oropharynx
  - Use of positive pressure ventilation devices such as the bag-valve-mask.
  - Suction of the upper airway
  - Supplemental oxygen therapy
- Pharmacological interventions
  - Use of unit dose auto-injectors for the administration of life saving medications intended for self or peer rescue in hazardous materials situations (MARK I, etc.)
- Medical/Cardiac Care
  - Use of an automated external defibrillation

The following are not entry level psychomotor skills of the EMR:

- Any skill specifically identified as an entry level skill for a higher level
- The administration or assistance of any medication other than oxygen or auto-injected medication for self or peer rescue

Emergency Medical Technician (EMT)

Description of the Profession

The Emergency Medical Technician's model 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 are 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 model 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 and is expected to be competent in all of the skills of lower levels. The 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 staffing for transporting 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 patients to an appropriate medical facility. The Emergency Medical Technician is not prepared to independently make decisions 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.

Psychomotor Skills

The following are the entry level psychomotor skills of the EMT:

- Airway and Breathing
  - Insertion of airway adjuncts intended to go into the oropharynx or nasopharynx.
  - Use of positive pressure ventilation devices such as manually triggered ventilators and automatic transport ventilators.
- Pharmacological Interventions
  - Assist patients in taking their own prescribed mediations
  - Administration of the following over-the-counter medications with appropriate medical oversight:
    - Activated charcoal for suspected oral ingestion
    - Oral glucose for suspected hypoglycemia
    - Oral analgesics for pain relief
    - Aspirin for chest pain of suspected ischemic origin
- Trauma Care
  - Application and inflation of the pneumatic anti-shock garment (PASG)

The following are not entry level psychomotor skills of the EMT:

- Any skill specifically identified as a entry level skill for a higher level
- Insertion of an airway adjunct intended to go deeper than the oropharynx.
- Monitoring an intravenous (IV) infusion
- Administration of prescription medications

Advanced Emergency Medical Technician

Description of the Profession

The Advanced Emergency Medical Technician's model 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' model scope of practice includes basic, limited advanced and pharmacological 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 lower levels. The major difference between the Advanced Emergency Medical Technician and the Emergency Medical Technician is the ability to perform limited advanced skills and provide pharmacological interventions to emergency patients.

The Advanced Emergency Medical Technician is the minimum staffing 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 patients to an acute care 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.

Psychomotor Skills

The following are the entry level psychomotor skills of the AEMT:

- Airway and Breathing
  - Insertion of airways that are NOT intended to be placed into the trachea
  - Tracheobronchial suctioning of an already intubated patient
  - Ventilation of an already intubated patient
- Assessment
- Pharmacological Interventions
  - Establish and maintain a peripheral IV
  - Administer (non-medicated) IV fluid therapy
  - Administer sublingual nitroglycerine to a patient experiencing chest pain of suspected ischemic origin
  - Administer subcutaneous epinephrine to a patient in anaphylaxis
  - Administer intramuscular glucagon to a hypoglycemic patient
  - Administer intravenous D50 to a hypoglycemic patient
  - Administer inhaled beta agonists to a patient experiencing difficulty breathing and wheezing
  - Administer a narcotic antagonist to a patient suspected of narcotic overdose.
  - Assist a patient in the self-administration of nitrous oxide for pain relief

The following are not entry level psychomotor skills of the AEMT:

- Any skill specifically identified as a entry level skill for a higher level
- Endotracheal intubation
- IV medications, other than D50 and narcotic antagonist
- Administration of any scheduled medications
- Insertion of an esophageal obturator airway (EOA) or esophageal gastric tube airway (EGTA)

Paramedic

Description of the Profession

The Paramedic's model 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 many communities, Paramedics provide a large portion of the prehospital care and represent the highest level of prehospital care. In some 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 part of an integral part of the emergency care team.

The Paramedic's model 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 lower levels. The major difference from the Advanced Emergency Medical Technician is the Paramedic's 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, and require significant background knowledge in basic and applied sciences.

The Paramedic is the minimum staffing 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 patients to an appropriate medical facility. The Paramedic is not prepared to independently refer patients. 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 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, Paramedics often perform medical transport services of patients requiring care within their scope of practice.

Psychomotor Skills

The following are the entry level psychomotor skills of the Paramedic:

- Airway and Breathing
  - Perform endotracheal intubation using a variety of techniques
  - Perform percutaneous cricothyrotomy
  - Decompress the pleural space
  - Perform gastric decompression
- Pharmacological Interventions
  - Insert an intraosseous cannula
  - Enteral and parenteral administration of approved prescription medications
  - Access indwelling catheters and implanted central IV ports for fluid and medication administration
  - Administer medications by IV infusion
  - Maintain an infusion of blood or blood products
- Medical/Cardiac Care
  - Perform cardioversion, manual defibrillation, and transcutaneous pacing

The following are not entry level psychomotor skills of the Paramedic:

- Tube thoracostomy
- The initiation of blood or blood product administration

Knowledge

Typically, scope of practice refers to the tasks and roles that licensed personnel are legally authorized to perform. In general, it does not describe the requisite knowledge necessary to perform those tasks and roles competently. As outlined in the *EMS Education Agenda for the Future*, the major responsibility for determining the knowledge necessary to safely perform tasks and roles falls to educators. The authors of the Scope of Practice offer the following schema to provide guidance to the presumed depth and breadth of cognitive material envisioned for each level of EMS licensure.

	Emergency Medical Responder	EMT and AEMT	Paramedic
Critical	Simple	Fundamental	Complex
Emergent		Simple	Fundamental
Lower Acuity			Simple

Simple, fundamental, and complex refer to a progressive increase in the depth of coverage in each respective topic area. Critical, emergent, and lower acuity refer to the acuity levels assigned to "Conditions and Components" in Appendix 2 of the *National Core Content: The Domain of EMS Practice*. Applying this matrix, the Emergency Medical Technician would possess fundamental knowledge of all the Patient Complaints, Presenting Signs and Symptoms, and Disorders denoted as critical, and simple knowledge of those denoted as emergent.

It is recognized that the terms used above are inherently subjective. Clearly, two equally qualified experts will have different interpretations as to exactly what is "fundamental," what is "complex," and what is the difference. Obviously, the judgment of experts will be needed to come to consensus as Educational Standards are developed. This matrix is included to provide general guidance, and we trust that the development and review process will resolve the majority of the differences of opinion.

Specializations

In some cases, specialty certifications may be used to respond to local needs for flexibility or to recognize continuing education. Specialty certifications may evolve to accommodate subtle differences in skills, practice environment, knowledge, qualifications, services provided, needs, risk, level of supervisory responsibility, amount of autonomy and/or judgment/critical thinking/decision making.

It is beyond the purview of this project to define the wide array of possible specialty certifications that might exist now or in the future. However, a premise of this document is that *specialty certifications must not be used to change the scope of practice of an individual.*

Implementation

The *National EMS Scope of Practice Model* represents an important step in the maturation of Emergency Medical Services as a profession. The model is evolutionary, not revolutionary. It is intended to be implemented deliberately and incrementally, over time. Depending on the magnitude of the change required at the state level, it is expected that individual state scopes of practice will begin to reflect this document in 2008-2010.

Implementing the *National EMS Scope of Practice Model* will require consideration of: funding, reimbursement, transition courses, grandfathering of current providers, the development of educational and instructional support materials, workforce issues, labor negotiations, impact on volunteerism, etc.

The National Highway Traffic Safety Administration is committed to realizing the vision of the *EMS Agenda for the Future*. Full implementation of the *EMS Education Agenda for the Future: A Systems Approach* is an important component of achieving this goal. NHTSA will continue to support the national EMS community in its effort to facilitate the implementation of the Education Agenda and all of the remaining components.

Appendix A: Interpretive Guidelines

The interpretive guidelines are used to help guide the users of this document by providing additional insight into the discussions and deliberations that revolved around the decisions of the Scope of Practice Task Force. These interpretive guidelines represent the collective opinions of the Scope of Practice team in March 2005.

The interpretive guidelines are included to allow future users to apply similar methodology in deciding the appropriateness of new interventions at each provider level. *They are illustrative, and NOT all inclusive.*

The interpretive guidelines are intended to guide the development of National EMS Education Standards, National EMS Certification, and National EMS Education Program Accreditation. The interpretive guidelines will also assist state regulatory agencies in developing and further refining their administrative or legislative rules. *These guidelines are not intended to appear in practice acts.*

Airway and Breathing Entry Level Psychomotor Skills

Emergency Medical Responder	Emergency Medical Technician	Advanced EMT	Paramedic
Oral airway BVM Sellick's Maneuver Head-tilt chin lift Jaw thrust Modified chin lift Mouth to barrier Mouth to mask Mouth to mouth Mouth to nose Mouth to stoma Obstruction–manual Oxygen therapy Nasal cannula Non-rebreather face mask Upper airway suctioning	Humidifiers Partial rebreathers Venturi mask Manually Triggered Ventilator (MTV) Automatic Transport Ventilator (ATV) Oral and Nasal airways	Esophageal-Tracheal Multi-Lumen Airways	BiPAP/CPAP Needle chest decompression Chest tube monitoring Percutaneous cricothyrotomy $ETCO_2$/Capnography NG/OG tube Endotracheal intubation Non-paralytic, pharmacologically assisted intubation (without paralytics) Nasotracheal intubation Airway obstruction removal by DL PEEP

Assessment Entry Level Psychomotor Skills

Emergency Medical Responder	Emergency Medical Technician	Advanced EMT	Paramedic
Manual BP	Pulse oximetry Manual and auto BP	Blood glucose monitor	EKG interpretation Interpretive 12 Lead Blood chemistry analysis

Pharmacological Intervention Entry Level Psychomotor Skills

Emergency Medical Responder	Emergency Medical Technician	Advanced EMT	Paramedic
<u>Tech of Med Administration</u> -Unit dose auto-injectors for self or peer care	<u>Assisted Medications</u> -Assisting a patient in administering his/her own prescribed medications, including auto-injection <u>Tech of Med Administration</u> -Buccal -Oral <u>Administered Meds</u> -MD-approved over-the-counter medications (activated charcoal, oral glucose, oral analgesics, ASA for chest pain of suspected ischemic origin)	Peripheral IV insertion IV fluid infusion <u>Tech of Med Administration</u> -Aerosolized -Subcutaneous -Intramuscular -Nebulized -Sublingual -Intranasal -IV push of D50 and narcotic antagonist only <u>Administered Meds</u> -SL Nitroglycerine for chest pain of suspected ischemic origin -SQ epinephrine for anaphylaxis -IM glucagon and IV D50 for hypoglycemia -Inhaled beta agonist for dyspnea and wheezing -Narcotic antagonist -Nitrous oxide for pain relief	Central line monitoring IO insertion Venous blood sampling <u>Tech of Med Administration</u> -Endotracheal -IV (push and infusion) -NG -Rectal -IO -Topical -Accessing implanted central IV port <u>Administered Meds</u> -MD-approved medications -Maintenance of blood administration -Thrombolytics initiation

Emergency Trauma Care Entry Level Psychomotor Skills

Emergency Medical Responder	Emergency Medical Technician	Advanced EMT	Paramedic
Cervical collar Manual stabilization Extremity splinting Eye irrigation Rapid extrication Direct pressure Hemorrhage control	Spinal immobilization Seated spinal immobilization Long board Traction splinting Mechanical pt restraint Tourniquet MAST/PASG		Morgan lens

Medical/Cardiac Care Entry Level Psychomotor Skills

Emergency Medical Responder	Emergency Medical Technician	Advanced EMT	Paramedic
CPR AED Assisted normal delivery	Mechanical CPR Assisted complicated delivery		Cardioversion Carotid massage Manual defibrillation TC pacing

Definitions

Academic—Based on formal education; scholarly; conventional.

Academic institution—A body or establishment instituted for an educational purpose and providing college credits or awarding degrees.

Accreditation—The granting of approval by an official review board after specific requirements have been met. The review board is non-governmental and the review is collegial and based on self-assessment, peer assessment, and judgment. The purpose of accreditation is public accountability.

Advanced Level Care—Care that has greater potential risk to the patient if improperly or inappropriately performed, is more difficult to attain and maintain competency in, and requires significant background knowledge in basic and applied sciences. These include invasive and pharmacological interventions.

Certification—The issuing of certificates by a private agency based upon standards adopted by that agency that are based upon competency.

Continuing education—The continual process of life-long learning.

Competence—The application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare. (National Council of State Boards of Nursing 1996)

Core content—The central elements of a professional field of study. The core content does not specify the course of study.

Credentialing agency—An organization that certifies an institution's or individual's authority or claim of competence for a course of study or completion of objectives.

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

Educational affiliation—An association with a learning institution (academic), the extent to which can vary greatly from recognition to integration.

Entry Level Competence—The level of competence expected of an individual who is about to begin a career. Entry level competence is sometimes defined as the minimum competence necessary to practice safely and effectively.

EMS System—Any specific arrangement of emergency medical personnel, equipment, and supplies designed to function in a coordinated fashion. May be local, regional, state, or national.

Licensure—The act of a state granting an entity permission to do something that the entity could not legally do without such permission. Licensing is generally viewed by legislative bodies as a regulatory effort to protect the public from potential harm. In the health care delivery system, an individual who is licensed tends to enjoy a certain amount of autonomy in delivering health care services. Conversely, the licensed individual must satisfy ongoing requirements that ensure certain minimum levels of expertise. A license is generally considered a privilege and not a right.

National EMS Core Content—The document that defines the domain of out-of-hospital care.

National EMS Education Program Accreditation—The accreditation process for institutions that sponsor EMS educational programs.

National EMS Education Standards—The document that defines the terminal objectives for each EMS licensure level.

National EMS Scope of Practice Model—The document that defines scope of practice for the various levels of EMS personnel.

Outcome—The short-, intermediate-, or long-term consequence or visible result of treatment, particularly as it pertains to a patient's return to societal function.

Practice analysis—A study conducted to determine the frequency and criticality of the tasks performed in practice.

Registration—A listing of individuals who have met the requirements of the registration service.

Registration agency—Agency traditionally responsible for the delivery of a product used to evaluate a chosen area. States may voluntarily adopt this product as part of their licensing process. The registration agency is also responsible for gathering and housing data to support the validity and reliability of their product.

Regulation—Either a rule or a statute that prescribes the management, governance, or operating parameters for a given group; tends to be a function of administrative agencies to which a legislative body has delegated authority to promulgate rules/regulations to "regulate a given industry or profession." Most regulations are intended to protect the public health, safety, and welfare.

Scope of practice—Defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it represents the limits of services an individual may legally perform.

Testing agency—Agency traditionally responsible for delivering a contracted examination. The responsibility of interpreting the results and defending the validity of those judgments is placed on the contractor.

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