POLICY: 552.51
TITLE: Optional Scope of Practice for Air Ambulance Providers

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SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Optional Scope of Practice for Air Ambulance Providers

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.206; 1797.214; 1797.218; and 1797.220. Title 22, California Code of Regulations, section 100146.

II. DEFINITIONS

A. **CAMTS**: Commission on Accreditation of Medical Transport Systems

B. **CAMTS ECC Level Certification**: CAMTS recognizes both the CCP-C and the FP-C for the *Emergency Critical Care (ECC)* accreditation level. *This CAMTS "ECC"* level also requires a qualified nurse partner and is required for programs participating in this optional scope - *see CAMTS 10th edition Accreditation Standard pg 3.4: http://69.89.31.68/~camtsorg/wp-content/uploads/2017/06/10th_Standards_Free_-_021017.pdf*

C. **CCP-C:** A "Critical Care Paramedic" is a paramedic educated and trained in critical care transport, whose scope of practice is in accordance to the standards prescribed in Title 22 - Division 9 - Chapter 4, holds a current certification as a CCP by the Board for Critical Care Transport Paramedic Certification (BCCTPC), has a valid license issued pursuant to Title 22 - Division 9 - Chapter 4, practices within a Qualified Transport Program, and is accredited by a LEMSA. The **CCP-C in training** must take the CCP-C exam within 6 months and pass the exam by the end of their first year with the Qualified Transport Program. See the following link for more information:
http://www.emsa.ca.gov/Media/Default/PDF/Chapter4Effctive2816.pdf

D. **Emergency Medical Services (EMS) Medical Director Association of California (EMDAC)**: Is an association which is advisory to the EMS Authority on issues of scope of practice (SOP).

E. **FP-C:** A "Certified Flight Paramedic" is a paramedic educated and trained in critical care transport and flight medicine, holds a current certification as an FP-C by the Board for Critical Care Transport Paramedic Certification (BCCTPC), has a valid license issued pursuant to Title 22 - Division 9 - Chapter 4, practices within a Qualified Transport Program, and is accredited by a LEMSA. The FP-C in training must take the FP-C exam within 6

months and pass the exam by the end of their first year with the Qualified Transport Program. See the following link for more information:
http://www.emsa.ca.gov/Media/Default/PDF/Chapter4Effctive2816.pdf
The FP-C examination consists of 125 questions and takes 2.5 hours to complete.

F. **FP-C in training:** These Paramedics have completed the Qualified Transport Program's initial academy training and are fully functional Paramedics for the program but have not yet completed their FP-C testing/certificate. The FP-C in training must take the FP-C exam within 6 months and pass the exam by the end of their first year with the Qualified Transport Program.

G. **Local EMS Agency (LEMSA):** The Agency designated by each County in accordance with the Health and Safety Code of the State of California that is responsible for local emergency medical services administration.

H. **Qualified Flight Paramedic:** A certified and LEMSA accredited EMT-P that meets the requirements for participating in this Unified Optional Scope. These Qualified FP-C or CCP-C paramedics have at least 3 years of critical care experience and have completed the Qualified Flight Program's initial academy training and fall into one of these categories: FP-C, or FP-in training, or CCP-C or CC- in training with additional education in flight and altitude physiology as specified in this policy, and are working for a Qualified Transport Program and are paired with a Qualified Transport Nurse as required in the "ECC level" of CAMTS 10th edition standards.

I. **Qualified Transport Program:** a ground or aeromedical transport program that has met the requirements to participate in this optional scope program by meeting CAMTS Emergency Critical Care (ECC) 10th edition level Accreditation (if aeromedical program) or equivalent and demonstrates the required training, education, competencies, QI and Medical Direction required.

J. **Qualified Transport Nurse:** A Registered Nurse with at least 3 years of critical care experience, who has completed the Qualified Transport Program training and is working toward the CEN, CCRN, CFRN or CTRN as required by the CAMTS ECC Accreditation. The Qualified Transport Nurse is employed by and practicing with the Qualified Transport Program. *(For aeromedical nurses, see page 3.5 CAMTS 10th edition Accreditation Standard: http://69.89.31.68/~camtsorg/wp-content/uploads/2017/06/10th_Standards_Free_-_021017.pdf)*

K. **Qualified Transport Program Medical Director:** The Qualified Transport Program Medical Director is Board certified or eligible in Emergency Medicine by American Board of Emergency Medicine or the American Board of Osteopathic Medicine, and if the Medical Director directs an aeromedical service, meets CAMTS ECC level requirements for Medical Director.

L. **Qualified Transport Program Physician:** A physician who is affiliated with the Qualified Transport Program as an associate or consultant, is not the Medical Director, but also is Board certified or eligible by an American Board of Medical Specialties board in emergency medicine or in the specialty appropriate for the scope of service (e.g, pediatrics, critical care) and for aeromedical service meets all the CAMTS requirements for Medical Director as identified in item 11 of this policy.

III. PURPOSE

This Unified Optional Scope provides a standardized scope of practice for qualified Paramedics who practice either on rotor or fixed wing aircraft or on ground ambulances. The goal for this optional scope is to allow a uniform practice environment for Qualified Transport Program teams and their patients that remains consistent throughout California and across regional boundaries and helps ensure that our patients receive the best critical care possible on both scene calls and interfacility transports.

IV. POLICY

A. Unified Paramedic Optional Scope of Practice items include:

1. Pediatric intubation
2. RSI (rapid sequence induction) medication administration including: sedatives, paralytics, analgesics, and induction agents
3. Video laryngoscopy (indirect laryngoscopy)
4. Supraglottic airway devices
5. Ventilator initiation, maintenance and management
6. Intraosseous (IO) access for adult and pediatric patients

B. **Qualified Transport Program Requirements for Participation in this Optional Scope**

1. The Aeromedical Transport Program must be CAMTS ECC level certified.
2. The Qualified Transport Program must provide enhanced training, education and competency verification consistent with the requirements of this optional scope, for CAMTS 10th edition ECC level, and as necessary for the FPC/CCP as indicated in this policy. Submission and verification of educational programs as specified in this policy is required.
3. The Qualified Transport Program must provide all 6 Unified Paramedic Optional Scope of Practice items, appropriate Quality Improvement (QI) and all LEMSA required metrics, providing a uniform report approved by EMDAC/SOP and delivered biannually to all LEMSAs.
4. The Program Medical Director must meet requirements as a “Qualified Transport Program Medical Director” must be board certified/ eligible in Emergency Medicine and which for flight programs includes CAMTS 10th edition ECC level requirements for the Medical Director.

C. **Qualified Paramedic Requirements for Participation in this Optional Scope**

1. The Qualified Paramedic must be employed by a Qualified Transport Program (and working with the program during any transports where these optional scope items are utilized).

2. The Qualified Paramedic must be partnered with a Qualified Transport Nurse, Qualified Program Medical Director or Qualified Program Physician during transports utilizing these optional scope items.

3. Be accredited by a LEMSA offering this optional scope

4. Must remain competent/proficient in these 6 optional scope procedures by passing the competency testing noted in this policy with the frequency required and noted here:
   a. Pediatric Intubation Quarterly
   b. Rapid Sequence Intubation Quarterly
   c. Video Laryngoscopy Quarterly
   d. Supraglottic Airway Quarterly
   e. Ventilator Management Annually
   f. Intraosseous Access Annually

5. Must have completed a minimum of 200 hours of training and all requisite training by the Qualified Transport Program as indicated in this policy and meet the requirements as outlined in definitions for one of the following:
   a. CCP-in training
   b. FPC-in training
   c. CCP
   d. FPC

D. Medical Control

Medical Control shall remain the primary responsibility of the LEMSA and is delivered in conjunction with the qualified transport program's policies and procedures when they are approved by the LEMSA:

1. Online Medical Control via direct conversation between the Qualified transport teams and Qualified transport program Medical Director (this would be permitted if described within the qualified transport program Medical Control Policy when the policy is approved by the LEMSA.)

2. Online Medical Control as per current regulation via direct access to base hospitals

3. Offline Medical Control through the Qualified Transport program policies and procedures when approved by the LEMSA (only items within the paramedic scope or approved optional scope).

4. Offline Medical Control through the policies, procedures, scope of practice and optional scopes of practice of the accrediting LEMSA.

5. During an interfacility transport Online Medical Control may be obtained from the sending or receiving physician if on duty at a designated base hospital.

E. Qualified Transport Program Medical Director

The Qualified Transport Program Medical Director will be required to be Board certified or eligible in Emergency Medicine, and for aeromedical programs, meet CAMTS ECC level Medical Director requirements – CAMTS 10th Edition

F. Quality Improvement Program

1. Collaborative process between EMDAC/SOP, LEMSAs, and the Qualified Transport Program for on-going quality Improvement (QI), data analysis, and performance improvement.

2. Provide EMDAC/SOP and LEMSAs with a standardized database report consistent with current national guidelines to be agreed upon in a collaborative process between EMDAC/SOP, LEMSAs and the Qualified Transport Programs.

3. Quality Improvement reporting will be delivered biannually and include all pertinent aspects of service and care surrounding the 6 items in this optional scope as well other critical care bundles

4. There will be QI reports submitted to the LEMSA and EMDAC/SOP on a scheduled basis (biannually), to include at minimum the following systemwide aggregate data:

    a. Pediatric intubation (frequency, success and adverse events).

        - Percent successful placement of ETI by age
            i. Numerator: # successful attempts = yes, Denominator: # of patients in whom ETI placement was attempted (defined as placement of a laryngoscope with intent of performing ETI)

        - Percent first-attempt success.
            i. Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom ETI placement was attempted

        - Percent of each complication (emesis, trauma, hypoxia, dislodgement) and of total complications.
            i. Numerator: # with complication = yes, Denominator: # of patients in whom ETI placement was attempted

        - Median time to insertion (if collected)

    b. RSI (rapid sequence induction) medication administration including: sedatives, paralytics, analgesics, and induction agents - Frequency of use, success rate by age, and adverse events) – as per section a. Pediatric intubation

    c. Supraglottic airways (SGA): Frequency as primary and rescue airway, success and adverse events).

        - Percent used as primary versus rescue airway

- Percent successful placement of SGA by age
  i. Numerator: # successful attempts = yes, Denominator: # of patients in whom SGA placement was attempted (defined as placement of a laryngoscope with intent of performing ETI)

- Percent first-attempt success.
  i. Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom SGA placement was attempted

- Percent of each complication (emesis, trauma, hypoxia, dislodgement) and of total complications.
  i. Numerator: # with complication = yes, Denominator: # of patients in whom SGA placement was attempted

- Median time to insertion (if collected)

d. Video laryngoscopy (indirect laryngoscopy): Frequency as primary and rescue airway, success, and adverse events as per ETI.

e. I/O (intraosseous): Frequency of use, overall success rate and adverse events

f. Ventilator initiation, maintenance and management: Frequency and adverse events

5. Data collection will be consistent with the EMDAC derived metrics for endotracheal intubation and supraglottic airway placement:

   a. Pediatric intubation, RSI and Video laryngoscopy
      1. Rescue device? – yes / no / not documented

         Rescue device is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.

      2. Successful placement? – yes / no / not documented

         Successful placement is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

      3. Number of attempts – numeric in integers / not documented

         Attempt is defined as insertion of the laryngoscope in the mouth with the purpose of ETI.

      4. Time to insertion *(optional)* – numeric in seconds / not documented

         Time to insertion is defined as the time from insertion of the laryngoscope into the mouth for the first attempt until the time of the first successful ventilation with minimal or no air leak.

      5. Complications
         - Regurgitation/emesis? – yes / no / not documented

Regurgitation/emesis is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.

- Bleeding/trauma? – yes / no / not documented

  Trauma/bleeding is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.

- Hypoxia? – yes / no / not documented

  Hypoxia is defined as any O_2 saturation $\leq$ 90% during or after placement in a patient previously normoxic prior to placement.

- Dislodgement? – yes / no / not documented

  Dislodgement is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved.

- Cardiovascular effects? – yes/ no/ not documented
  If yes,
  Hypotension yes/ no/ not documented
  Bradycardia yes/ no / not documented
  Cardiopulmonary arrest yes / no/ not documented

6. If dislodgement after placement, successful replacement? – yes / no / not documented / not applicable

   Successful replacement is defined the as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

b. Supraglottic airway:

1. Rescue device? – yes / no / not documented

   Rescue device is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.

2. Successful placement? – yes / no / not documented

   Successful placement is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

3. Number of attempts – numeric in integers / not documented

   Attempt is defined as insertion of the supraglottic airway device (SAD) into the mouth.

4. Time to insertion *(optional)* – numeric in seconds / not documented

   Time to insertion is defined as the time from insertion of the supraglottic airway device into the mouth for the first attempt until the time of the first successful ventilation with minimal or no air leak.

5. Complications
   - Regurgitation/emesis? – yes / no / not documented

     Regurgitation/emesis is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.

   - Bleeding/trauma? – yes / no / not documented

     Trauma/bleeding is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.

   - Hypoxia? – yes / no / not documented

     Hypoxia is defined as any O_2 saturation $\leq$ 90% during or after placement in a patient previously normoxic prior to placement.

   - Dislodgement? – yes / no / not documented

     Dislodgement is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved.

6. If dislodgement after placement, successful replacement? – yes / no / not documented / not applicable

   Successful replacement is defined the as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

G. Application by the LEMSA for Unified Scope of Practice for Qualified Transport Programs

1. LEMSA Medical Director desiring to approve use of the Unified Scope of Practice shall complete Local Optional Scope of Practice (LOSOP) Application and submit to the state of California EMS Authority through EMDAC's Scope of Practice Committee.

2. LEMSA Medical Director must specify if programs that qualified for the Unified Scope are Ground or Flight programs. All programs that have base operations within the

geographical footprint of a LEMSA that seek to utilize the Unified Scope must be approved under this guidance by that LEMSA and the EMDAC Scope of Practice Committee.

3. LEMSA Medical Director shall ensure that programs utilizing the Uniformed Scope of Practice meet the requirements as outlined in this guidance and that all approved programs submit data to the LEMSA and to EMDAC biannually.