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To: Ohio EMS providers, EMS medical directors, and partners in Ohio's healthcare delivery and medical transportation systems

From: Carol A. Cunningham, M.D., FAAEM
State Medical Director, Ohio Department of Public Safety, Division of EMS

Date: October 21, 2016

RE: Transport of Patients with Established Intravenous Access and the Ohio EMS Scope of Practice

On October 19, 2016, the State Board of Ohio Emergency Medical, Fire, and Transportation Services (EMFTS Board) amended the Ohio EMS scope of practice to allow emergency medical technicians (EMTs (formerly EMT-Basics)) to transport patients with central or peripheral intravenous (IV) access established if:

1) There is no IV infusion; **and**
2) The patient is being transported to sub-acute care (e.g. rehabilitation, nursing home, transitional care, assisted living facilities); **or** to a scheduled event (e.g. dialysis, doctor appointment, laboratory, radiology, outpatient procedure, rehabilitation); **or** is being discharged home.

While the associated regulatory language and education curricula are being developed, this amendment in the Ohio EMS scope of practice became **effective October 19, 2016**.

For the sake of clarity, the establishment of IV access is the placement of a catheter or a needle into a vein regardless of whether or not medications or fluids are administered through the device. A peripheral IV is a catheter or needle positioned in a vein where the tip of the device does not lie in the central circulation (e.g. inferior or superior vena cava, atrium of the heart). This includes saline locks and heplocks. A central IV is a catheter or needle positioned in a vein where the tip of the device lies in or traverses the central circulation (this includes peripherally inserted central catheters (PICC or PIC lines), Shiley central venous catheters (SCVC), and IV or dialysis catheters placed in the subclavian or femoral vein).

In addition, free-standing emergency departments and urgent care centers are acute care facilities. As such, this amendment to the Ohio EMS scope of practice does not apply to

patients who are being transported between these types of acute care facilities or transport from these types of acute care facilities to a hospital or emergency department. For these transports, an advanced EMT (AEMT) is required, at a minimum, for patients with a peripheral IV, and a Paramedic is required for patients with a central IV.

The only other scenarios where the EMFTS Board supports a variance in the Ohio EMS scope of practice are outlined in their position paper on the transport of patients with pre-existing medical devices or drug administrations. This document is available on the Ohio Department of Public Safety, Division of EMS website at http://www.ems.ohio.gov/about-papers.aspx. This position paper supports the transport of patients with pre-existing medical devices or drug administrations by all levels of Ohio EMS certifications in the prehospital setting (e.g. EMS runs initiated by 9-1-1) and for the emergent (i.e. disaster, mass casualty incident) interfacility transfer of patients. This does not include routine or scheduled interfacility transfers of patients nor does it include the transfer of patients out of an emergency department or hospital due to events such as emergency department overcrowding or physician convenience.

This amendment in the Ohio EMS scope of practice also presents a valuable opportunity for engagement with the partners in Ohio's healthcare delivery and medical transportation systems, in particular, hospital medical staff and EMS dispatchers. Per the federal Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, the transferring physician is responsible for several decisions including the determination of the appropriate level of care required during patient transport. Emergency medicine physicians are typically aware of the certification levels of EMS providers and their associated scopes of practice as EMS medicine is part of their core residency training requirements. However, a significant number of patient transfers are initiated by non-emergency physicians who have minimal to no knowledge of the various Ohio EMS certification levels or the parameters within the Ohio EMS scope of practice. In an effort to improve the alignment of appropriate resource allocation to patients requiring transport, EMS agencies may wish to engage with their dispatch agencies to ensure that essential information is acquired from the transferring facility at the time of the request. This information includes, but is not limited to, the method of airway management, the number and types of IV access established, the presence of an IV infusion, and a list of the medication(s) that are being infused. EMS agencies may also wish to engage with the medical staff of hospitals, free-standing emergency departments, urgent care centers, and sub-acute care facilities and serve as a resource of education for the Ohio EMS certification levels and the Ohio EMS scope of practice. As EMS is a vital sector of our healthcare system, these agencies are also essential members of our team.

As a resource to all parties involved, an updated Ohio EMS scope of practice matrix that reflects the EMFTS Board's amendment is now available on the Ohio Department of Public Safety, Division of EMS website at http://www.publicsafety.ohio.gov/links/ems_scope_practice.pdf. While this matrix provides a brief synopsis, I strongly encourage you to review the citations in chapter 4765 of the Ohio

Revised Code and the upcoming revised Ohio Administrative Code for complete information regarding the Ohio EMS scope of practice.

If you have any questions or concerns, please do not hesitate to contact me or a member of our staff at the Ohio Department of Public Safety, Division of EMS at (800) 233-0785. As always, thank you for your dedicated service to the residents and visitors of Ohio and to Ohio EMS!