

DRAFT #1: January 28, 2019

The legal authority for EMS personnel to practice is established by State legislative action and EMS Rules. Licensure authority prohibits anyone from practicing a profession unless they are licensed and authorized by the State, regardless of whether or not the individual has been certified by a nongovernmental or private organization (NREMT).

“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 individuals that are licensed within that State. In general, scopes of practice focus on activities that are regulated by law (for example, starting an intravenous line, administering a medication, etc.). This includes technical skills that, if done improperly, represent a significant hazard to the patient and therefore must be regulated for public protection. Scope of practice establishes which activities and procedures that would represent illegal activity if performed without a license and restricts the use of professional titles to persons that are authorized by the state. In addition to drawing the boundaries between the professionals and the layperson, scope of practice also defines the boundaries among professionals, creating either exclusive or overlapping domains of practice” (National EMS Scope of Practice Model, 2018).

An individual may only perform a skill or role for which that person is:

EDUCATED (has been trained to perform the skill or role), **AND**
CERTIFIED (has demonstrated competence in the skill or role), **AND**
LICENSED (has legal authority issued by the State to perform the skill or role), **AND**
CREDENTIALLED (has been authorized by medical director to perform the skill or role).

Scope of Practice versus 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 not 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. See National EMS Scope of Practice Model (2018) for a full explanation of these distinctions.

The 2018 National EMS Scope of Practice model defines the various levels of EMS licensure; their education requirements, primary role, type of educational setting (vocational, technical, or academic), the amount of critical thinking and level of supervision required.

The *Scope of Practice Model* and *Education Standards* assume a progression of the three domains of learning (cognitive, affective, and psychomotor) that affects EMS practice from the EMT through the Paramedic level. **Licensed personnel at each level are responsible for all knowledge, judgments, and skills at their level and all levels preceding their level.** The *Scope of Practice Model* also assumes that EMS personnel not only receive requisite knowledge, but they can comprehend data, apply knowledge, analyze and synthesize information, and evaluate the outcomes of their actions.

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 *Education Agenda*, **the responsibility for determining the knowledge necessary to safely perform skills, tasks, and roles falls to the EMS educators.**

Scope of Practice for Special Populations

EMS personnel are expected to provide culturally and linguistically competent care and meet the urgent health care needs of all patients with consideration to age, race, gender, cultural, religious, and ethnic considerations consistent with their defined scope of practice. Recognized special populations include, but may not be limited to, children, older patients, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) patients, bariatric patients, patients with disabilities, and patients with limited access to health care due to geographic, demographic, socioeconomic, or other reasons.

Specialty Care Delivered by Licensed EMS Personnel

Specialization of EMS personnel occurs in response to an identified need for an expanded body of knowledge and skills that are best served by a formal supplemental educational and credentialing process. In many instances throughout health care the development and oversight of specialty recognition is lead through specialty boards and implemented in conjunction with State regulators. Specialty recognition, credentialing, or endorsement is the outcome of a formally defined process and mechanism for actively assessing that an individual possesses and has mastered a unique body of knowledge over and above entry-level cognitive, affective, and psychomotor domains of learning and that they can apply this knowledge and related skill set to improve care provided for patients. Integration of specialty care requires appropriate

educational preparation, a rigorous certification process, integration with State scope of practice and licensure regulations, and local credentialing by the EMS MD and EMS agency.

States often approach specialization by enacting scope of practice regulations that allow for additional practice, often called an endorsement, in addition to an existing license level. This allows cooperation with non-governmental specialty boards. EMS specialty care endorsements recognized in Illinois: Mobile Integrated Healthcare Community Paramedic; Critical Care, and Flight Paramedic.

This document offers an “at-a-glance” view of the Scope of Practice for Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT)/EMT-Intermediates (EMT-Is), and Paramedics as approved by IDPH after input and collaboration with state EMS MDs. The definitions of each level of licensure are found in Section 515.100 Definitions of the EMS Administrative Code (Rules). This list is no finite as it does not include all skills expected of an EMS provider such as patient assessment, vital signs..

In accordance with Section 515.330 of the EMS Rules, the EMS MD must “develop and authorize written standing orders (treatment protocols, standard operating procedures) and certify that all involved personnel will be knowledgeable and competent in emergency care.” Performance of services outlined in this document and in the aforementioned code sections, shall only be performed if the EMR, EMT, AEMT/EMT-I, and Paramedic have received education and competency measurement as part of entry-level courses or through subsequent education approved by IDPH and the EMS Medical Director with jurisdiction over that EMS professional’s practice.

An individual EMS MD may limit or require that providers obtain on-line medical control approval before initiating certain interventions. Each System will need to tailor and revise protocols to fit their region and System practice, but must ensure that they remain within the National and State approved scopes of practice.

EMS medical directors are not permitted to expand the scope of practice for EMS providers unless under a State-approved trial or research study, but may provide clarifications or limitations on services that are permitted. A System must submit a research proposal or Pilot Project proposal to IDPH before expanding the scope of practice for any EMS personnel. IDPH will review the proposal but is not obligated to approve the proposed study nor accept any recommendation to amend the scope of practice.

LEGEND:

NTL– National Scope of Practice

I – Illinois amended curriculum for initial education, must teach concepts even if not included in local protocols

I* - Not in national scope, optional by IDPH; EMS MD-approved training required; optional to incorporate into practice

No.	I. Airway, Ventilation, Oxygenation	EMR	EMT	AEMT	Paramedic
1	Airway - nasal	I	NTL	NTL	NTL
2	Airway - oral	NTL	NTL	NTL	NTL
3	Airway - supraglottic			NTL	NTL
4	Bag-valve-mask (BVM)	NTL	NTL	NTL	NTL
5	CPAP [BiPAP, PEEP (I)]		NTL	NTL	NTL
6	Chest decompression - needle			I	NTL
7	Chest tube placement – assist only				NTL
8	Chest tube – monitoring and management				NTL
9	Cricothyrotomy (needle and surgical)				NTL
10	End tidal CO ₂ monitoring and interpretation of waveform capnography		I	NTL	NTL
11	Gastric decompression – NG or OG tube				NTL
12	Monitoring of NG/OG tube already in place		I	I	NTL
13	Head tilt – chin lift	NTL	NTL	NTL	NTL
14	Endotracheal intubation and extubation			I	NTL
15	Rapid sequence intubation using paralytic agents				I
16	Jaw-thrust	NTL	NTL	NTL	NTL
17	Mouth-to-barrier	NTL	NTL	NTL	NTL
18	Mouth-to-mask	NTL	NTL	NTL	NTL
19	Mouth-to-mouth	NTL	NTL	NTL	NTL
20	Mouth-to-nose	NTL	NTL	NTL	NTL
21	Mouth-to-stoma	NTL	NTL	NTL	NTL
22	Airway obstruction – dislodgement by direct laryngoscopy			I	NTL

23	Airway obstruction – manual dislodgement technique	NTL	NTL	NTL	NTL
24	Airway obstruction – removal by Magill forceps			I	NTL
25	Oxygen therapy - humidifiers		NTL	NTL	NTL
26	Oxygen therapy – Nasal cannula	NTL	NTL	NTL	NTL
27	Oxygen therapy – High flow nasal cannula				NTL
28	Oxygen therapy – Non-rebreather mask	NTL	NTL	NTL	NTL
29	Oxygen therapy – Partial rebreather mask		NTL	NTL	NTL
30	Oxygen therapy – Simple face mask		NTL	NTL	NTL
31	Oxygen therapy – Venturi mask		NTL	NTL	NTL
32	Pulse oximetry	I	NTL	NTL	NTL
33	Ventilation with a flow-restricted oxygen- powered device		I*	I*	I*
34	Transport ventilator with adjustments beyond rate and tidal volume				I*
35	Suctioning – Upper airway	NTL	NTL	NTL	NTL
36	Suctioning – tracheobronchial of an intubated patient		I	NTL	NTL
37	Suctioning - stoma			I	NTL
38	Tracheostomy tube replacement through a stoma			I	NTL
II. Skill – Cardiovascular / Circulation					
39	Cardiopulmonary resuscitation (CPR)	NTL	NTL	NTL	NTL
40	Cardiac monitoring – 12 lead ECG acquisition and transmission		NTL	NTL	NTL
41	Cardiac monitoring – 12 lead ECG interpretation				NTL
42	Cardiac monitoring ECG rhythm monitoring			I	NTL
43	Cardioversion - electrical			I	NTL
44	Defibrillation – automated/semi-automated	NTL	NTL	NTL	NTL
45	Defibrillation - manual			I	NTL
46	Hemorrhage control – direct pressure	NTL	NTL	NTL	NTL
47	Hemorrhage control – tourniquet	NTL	NTL	NTL	NTL
48	Hemorrhage control – wound packing (hemostatic gauze/agents)	NTL	NTL	NTL	NTL
49	Mechanical CPR device		NTL	NTL	NTL
50	Targeted temperature mgt (therapeutic hypothermia)				I*
51	Telemetric monitoring devices/transmission of clinical data, including video data		NTL	NTL	NTL
52	Transcutaneous pacing			I	NTL
53	Transvenous cardiac pacing – monitoring and maintenance				NTL
III. Skill – Splinting, Spinal Motion Restriction (SMR), and Patient Restraint					
54	Cervical collar	NTL	NTL	NTL	NTL
55	Long spine board [scoop stretcher (I)]	I	NTL	NTL	NTL
56	Manual cervical stabilization	NTL	NTL	NTL	NTL
57	Seated spine motion restriction (KED, etc.)		NTL	NTL	NTL
58	Extremity stabilization - manual	NTL	NTL	NTL	NTL
59	Extremity splinting	NTL	NTL	NTL	NTL
60	Splint - traction		NTL	NTL	NTL
61	Mechanical patient restraint		NTL	NTL	NTL
62	Emergency moves for endangered patients	NTL	NTL	NTL	NTL
63	Protective equipment (helmet) removal			I	NTL
IV. Skill – Medication Administration – Routes					
64	Aerosolized/nebulized	I	NTL	NTL	NTL
65	Endotracheal tube			I	NTL
66	Inhaled	I	NTL	NTL	NTL
67	Intradermal				NTL
68	Intramuscular		I	NTL	NTL
69	Intramuscular – auto-injector	NTL	NTL	NTL	NTL
70	Intranasal			NTL	NTL

71	Intranasal – unit-dosed, premeasured	NTL	NTL	NTL	NTL
72	Intraosseous			NTL	NTL
73	Intravenous			NTL	NTL
74	Mucosal/sublingual		NTL	NTL	NTL
75	Nasogastric				NTL
76	Oral	I	NTL	NTL	NTL
77	Rectal			I	NTL
78	Subcutaneous			I	NTL
79	Topical				NTL
80	Transdermal				NTL
V. Medical Director Approved Medications					
81	Autoinjector epinephrine for anaphylaxis (supplied and carried by the EMS Agency and/or patient's own)	I	NTL	NTL	NTL
82	Auto-injector antidotes for chemical/hazardous material exposure	NTL	NTL	NTL	NTL
83	Auto-injector opioid antagonist (naloxone) use for suspected opioid overdose	NTL	NTL	NTL	NTL
84	Immunizations/vaccinations in an approved program			NTL	NTL
85	Inhaled-beta agonist/bronchodilator and anticholinergic for dyspnea and wheezing		NTL	NTL	NTL
86	Inhaled (nebulized) albuterol for dyspnea and wheezing	I			
87	Inhaled – monitoring patient administered (i.e. nitrous oxide)			NTL	NTL
88	Intranasal – opioid antagonist for suspected opioid overdose	NTL	NTL	NTL	NTL
89	Intranasal glucagon		I	NTL	NTL
90	Intravenous			NTL1	NTL
91	Intramuscular glucagon, naloxone, epinephrine		I	NTL	NTL
92	Maintain an infusion of blood or blood products				NTL
93	Oral aspirin for chest pain of suspected ischemic origin	I	NTL	NTL	NTL
94	Oral diphenhydramine		I	I	NTL
95	Oral glucose for suspected hypoglycemia	I	NTL	NTL	NTL
96	Oral ondansetron		I	I	NTL
97	Oral over the counter (OTC) analgesics for pain or fever		NTL	NTL	NTL
98	OTC medications, oral and topicals				NTL
99	Parenteral analgesia for pain			NTL	NTL
100	Sublingual nitroglycerin for chest pain of suspected ischemic origin – limited to patient's own prescribed medication		NTL		
101	Sublingual nitroglycerin for chest pain of suspected ischemic origin		I	NTL	NTL
102	Thrombolytics				NTL
103	Additional medications approved for AEMT/EMT-I administration by appropriate routes: adenosine, amiodarone, atropine sulfate, benzodiazepines, dexamethasone, diphenhydramine; fentanyl, furosemide, Isoetharine, ketorolac, lidocaine HCl 2%, metaproterenol, methylprednisolone, morphine sulfate, ondansetron, promethazine, salmeterol, terbutaline, triamcinolone			I*	
104	Medications approved for paramedic administration based on National Scope of Practice Model, National Model EMS Guidelines and/or IDPH: acetazolamide, acetaminophen, acetylcysteine, activated charcoal, adenosine, amiodarone, aspirin, atropine sulfate, antibiotics, benzodiazepines, calcium chloride, calcium gluconate, cimetidine, cyanide antidotes, dextrose 10% &/or 50%, diltiazem, diphenhydramine, dopamine, droperidol, epinephrine 1mL/1 mL and 1 mg/10mL; etomidate, famotidine, fentanyl, furosemide, glucagon, haloperidol, helium gas mixture, heparin, hydralazine, hydromorphone, ibuprofen, ipratropium, isoetharine, ketamine, ketorolac, labetalol, lidocaine 2%, magnesium sulfate, metaproterenol, metoclopramide, morphine sulfate, naloxone, nifedipine, nitrous oxide, norepinephrine, NTG, olanzapine, ondansetron, oxymetazoline, potassium iodide, potassium chloride, procainamide, prochlorperazine, sildenafil, sodium bicarbonate, steroids, tetracaine ophthalmic solution, tadalafil, terbutaline, tranexamic acid (TXA), triamcinolone, verapamil; ziprasidone, vaccinations in an approved program. Paralytics: RSI should be reserved for specialized providers operating within a comprehensive program with ongoing training and quality assurance measures.				I

VI. Skill – IV Initiation/Maintenance Fluids					
105	Access indwelling catheters and implanted central IV ports				NTL
106	Central line monitoring				NTL
107	Intraosseous – initiation, peds and adult			NTL	NTL
108	Intravenous access			NTL	NTL
109	Intravenous initiation - peripheral			NTL	NTL
110	Intravenous – maintenance of non-medicated IV fluids			NTL	NTL
111	Intravenous – maintenance of medication IV fluids				NTL
VII. Skill – Miscellaneous					
112	Assisted delivery (childbirth)	NTL	NTL	NTL	NTL
113	Assisted complicated delivery (childbirth)		NTL	NTL	NTL
114	Blood chemistry analysis			I	NTL
115	Blood pressure automated		NTL	NTL	NTL
116	Blood pressure - manual	NTL	NTL	NTL	NTL
117	Blood glucose monitoring	I	NTL	NTL	NTL
118	Eye irrigation	NTL	NTL	NTL	NTL
119	Eye irrigation – hands free irrigation using sterile eye irrigation device		NTL	NTL	NTL
120	Patient transport		NTL	NTL	NTL
121	Venous blood sampling			NTL	NTL

1 Limited to analgesia, anti-nausea/antiemetic, dextrose, epinephrine, glucagon, naloxone, and others defined by state/local protocol.

Portable Technologies

Exponential improvements and availability of portable technologies, such as left ventricular assist devices (LVAD), patient controlled analgesia pumps, transport ventilators, etc., creates complex challenges for education and credentialing that did not exist a decade ago. Such patient care needs may be encountered by all levels of personnel in community and 9-1-1 settings and also with patients originating in health care facilities during transfers. Even when the patient's condition would not require EMS interaction with a device or intervention during transport, the variability of circumstances under which EMS delivery systems will likely encounter these patients steered the *Expert Panel* away from a call for specific levels of EMS personnel to be qualified in managing complex technologies, including non-invasive diagnostic equipment (e.g. Ultrasound.) The actions of EMS personnel with regard to portable equipment and technologies have intentionally been left to local medical director credentialing.

Caveats on the National EMS Scope of Practice Model - September 2018

This document was produced by the National Association of State EMS Officials with support from the US Department of Transportation, National Highway Traffic Safety Administration (NHTSA), Office of Emergency Medical Services (OEMS) through Contract DTNH2216C00026, with supplemental funding from the Health Resources and Services Administration (HRSA) Emergency Medical Services for Children Program. It will be used to revise the National EMS Education Standards, national EMS certification exams, and national EMS educational program accreditation.

The Interpretive Guidelines included in the National Scope of Practice document are intended to illustrate the kinds of skills and interventions personnel at various levels are educated, certified, licensed and otherwise qualified to do. This does not mean that every person at a particular level will routinely do every skill on the Interpretive Guideline list. One example of this is the obtaining and transmitting 12 lead electrocardiograms (ECG) at the EMT level. The *Expert Panel* recognized the strong research evidence to support the value of this skill for improving patient outcomes, especially in rural settings, however some systems have readily available paramedics and EMT's might not be used to provide this technology in such systems. The *Expert Panel* also recognized that the cost of technology might be prohibitive for some EMT level agencies. Accordingly, this is one example of a skill on which EMTs (and other levels of EMS personnel) will routinely be educated and tested but that preparation does not imply that the technology must or even should be available in every practice setting where EMTs function. In other words, such a task should be valued/permitted but not required if the necessary equipment/resources are not available to personnel.

States maintain the regulatory flexibility to permit licensees to exceed the Practice Model but they do so along with the need to develop learning objectives, educational content, competency measures, and a credentialing process to ensure safe practice. As an example, some States allow licensed EMTs to draw up a unit dose of epinephrine for IM injection to treat anaphylaxis from a single or multi-dose vial although this activity is dependent on strict oversight by a physician medical director and is not permitted in all jurisdictions.