# Change Notice 1.0
## 2007 National EMS Scope of Practice Model

June 5, 2017

**Recommendation:** The following changes, which form a part of the National EMS Scope of Practice Model (February 2007) DOT HS 810 657, are recommended by the National Association of State EMS Officials (NASEMSO) for immediate implementation by all EMS agencies.

<table>
<thead>
<tr>
<th>Page</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.</td>
<td>Add: <em>Administer an opioid antagonist to a patient suspected of opioid overdose.</em></td>
</tr>
<tr>
<td>30.</td>
<td>Add: <em>Unit-dose, premeasured, intranasal or autoinjector.</em></td>
</tr>
<tr>
<td>30.</td>
<td>Add: <em>Opioid antagonist</em></td>
</tr>
</tbody>
</table>

**Background:** The National Association of State EMS Officials (NASEMSO) and a subject matter expert panel that included representatives of several national EMS organizations considered the following questions to facilitate urgent changes to the 2007 National EMS Scope of Practice Model (Model) to add the administration of opioid antagonists to the Emergency Medical Responder and Emergency Medical Technician scopes of practice:

1. Is there evidence that the procedure or skill is beneficial to public health?
2. What is the clinical evidence that the new skill or technique as used by EMS practitioners will promote access to quality healthcare or improve patient outcomes? (The base of evidence should include the best available clinical evidence, clinical expertise, and research.)

**Discussion:** NASEMSO engaged the services of a board certified emergency physician and researcher to lead a systematic review of literature to review the available evidence. An administrative team comprised of the project leadership established the following PICO questions:

(P) For adults with opiate/opioid toxicity in the prehospital environment, (I) does administration of naloxone (intramuscular or intranasal) by ALS (paramedics/EMT-I/AEMT) responders (C) compared to bystanders, law enforcement or BLS (EMT-B/EMT/EMR) (O) improve patient mental and respiratory status?
This PICO question evaluated all data from 1980 to the date of the search.

**RESULTS OF SYSTEMATIC REVIEW OF LITERATURE:** The search terms were exploded and are as follows: Search 1: “ambulance” OR “emergency medical services” OR “prehospital care” OR “mobile health units” OR “paramedic” AND “naloxone” OR “narcan” OR “opiate antagonist”; Search 2: “bystander” OR “law enforcement” OR “rescue personnel” OR “untrained” AND “naloxone” OR “narcan” OR “opiate antagonist”. Additionally, review articles were hand searched for relevant papers. Inclusion criteria used for the evaluation of this search were manuscripts that satisfied the PICO question, were published in English, in peer-reviewed journals, and whose subjects were human (no basic science or animal models). Exclusion criteria included: studies that did not specifically compare ALS (paramedics/EMT-I/AEMT) responders to bystanders, law enforcement or BLS (EMT-B/EMT/EMR), studies not in the prehospital setting, and studies that examined perceptions of responders only (no clinical patient outcomes). Utilizing a comprehensive search strategy, a total of 850 articles were extracted. After independent evaluation by two reviewers, no manuscripts satisfied inclusion. No publications evaluated satisfied the stated PICO question concerning naloxone use between these groups. We suggest that this finding is not unusual or unreasonable due to the fact that the administration of opioid antagonists at the EMR and EMT levels is not currently supported in the (2007) Model, creating a barrier to the use of naloxone by these providers.

**DISCUSSION:** Naloxone is a medication approved by the Food and Drug Administration (FDA) to reverse overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. While we were not able to determine broad patient outcomes related to BLS (EMT and EMR) administration compared to ALS practitioners, NASEMSO also considered expert medical opinion, patient care outcomes identified by consensus panels, available research on the use of naloxone administration by lay bystanders, and the outcomes of state/regional demonstration projects in an attempt to inform a recommendation. We considered the safety of the drug and relative inability to do harm, the potential lifesaving benefits for opiate overdose patients, the availability of unit dose packaging, the relatively clear indications for use of the drug, the response to the rising problem of opiate overdoses nationwide, the ease of training BLS practitioners to use the drug safely and effectively, the minimal background in patient assessment, pharmacology, pathophysiology, airway management, etc. to use this drug. We conclude that the benefits outweigh the risks of incorporating opioid antagonist administration into the scope of practice at the EMR and EMT level for patients with suspected opioid overdose.

EMRs and EMTs shall only undertake the practice if they possess the necessary educational preparation, experience and knowledge to properly administer an opioid antagonist via unit-dose, premeasured, intranasal or autoinjector routes. The execution of the procedures shall include the identification and discrimination of expected and unexpected human responses and the post-treatment management of administering opioid antagonists to EMS patients with suspected opioid overdose.