August 31, 2021

The Honourable Adrian Dix
Minister of Health
Room 337 Parliament Buildings
Victoria BC  V8V 1X4

Dear Minister Dix:

On July 14, 2021 you directed the Emergency Medical Assistants Licensing Board (the "Board") to provide recommendations on the expansion of firefighter scope of practice changes by September 6, 2021. The Board is pleased to have this opportunity to improve EMA services in BC and provide the attached submission for your consideration.

In response to events following the latest heat wave and in recognition of the role First Responders have in supporting EMS in BC, the Board has undertaken a review of scope of practice with the intent of finding opportunities where First Responders can provide time-sensitive care and support the efficient delivery of ambulance services by BCEHS. The Board is confident that the scope changes in the attached support the Office of the Auditor General's *Access to Emergency Health Services* report recommendation of improved coordination of patient care and reflects current medical standards.

The Board is extremely appreciative of this opportunity to provide these recommendations, many of which address long-standing gaps in first responder services. We look forward to continued dialogue on reformation of paramedic and first responder regulatory oversight and are available to support you with any further steps in this process.

Sincerely,

Ryan Sinden
Chair
Emergency Medical Assistants Licensing Board

## Glossary of Acronyms & Terms

### Terminology

Board – refers to the EMA Licencing Board
ACP – Advanced Care Paramedic
CAF – Canadian Armed Forces
CBRNe – refers to a chemical, biological, radiological, nuclear and explosives (CBRNE) event
CCP – Critical Care Paramedic
EMA – Emergency Medical Assistant
EMS – Emergency Medical Services
EMA FR – EMA First Responder
EMR – Emergency Medical Responder
EPI - Epinephrine
ITT – Infant Transfer Team
PCP – Primary Care Paramedic
PII – Paramedics in Industry
Schedule 1 or 2 – refers to the Scope of Practice Schedules in the EMA Regulation
SoP – Scope of Practice

### Employers

BCEHS – British Columbia Emergency Health Services
PII – Paramedics in Industry (Dr. Allan Holmes)
TEAAM - Technical Evacuation Advanced Aero Medical Society (Dr. Allan Holmes)

### Training Institutions

BCEHS – British Columbia Emergency Health Services
COTR – College of the Rockies
JIBC – Justice Institution of British Columbia
OHM – OHM Medical Services

### Associations

APBC – Association of Paramedics of British Columbia
BCPFFA – British Columbia Professional Fire Fighters Association
FCABC – Fire Chief's Association of British Columbia

# EMA Licensing Board – Proposed EMA Regulation Amendments

| Item # | Licence Category | Current State | Proposed skill addition | Describe Benefit to Patient Care | Agency Support |
|---|---|---|---|---|---|
| 1 | | The Board does not have the ability to restrict a licence | **Part 2 8 (2)**<br>**Categories of a Licence**<br>Add: the ability for the Board to restrict a licence | As is noted in several recommended scope changes below, the Board requires the ability to restrict a licence prior to the implementation of any scope changes. All scope changes at lower licence levels impact all subsequent licence levels, necessitating the need for the Board to have the regulatorily authority to restrict licenses as needed until educational and examination requirements have been met. As further clarified in Appendix C, the Board does not currently have this authority. | |
| 2 | FR | | Move "ventilation using pocket mask and bag/valve/mask devices" **from Schedule 2 to Schedule 1** | Moving core competencies of basic FR skills to Schedule 1. This ensures all FRs are licensed to provide fundamental life support services. | |
| 3 | FR | | Move "use of airway management techniques including oropharyngeal airways, ~~oral~~ suction devices and oxygen-supplemented mask devices to assist ventilation **from Schedule 2 to Schedule 1**<br>**Remove "oral"** | Moving core competencies of basic FR skills to Schedule 1. This ensures all FRs are licensed to provide fundamental life support services. | |
| 4 | FR | | Move "administration of oxygen" **from Schedule 2 to Schedule 1** | Moving core competencies of basic FR skills to Schedule 1. This ensures all FRs are licensed to provide fundamental life support services. | |

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| 5 | FR | | Move "use of an automatic or semi-automatic external defibrillator" **from Schedule 2 to Schedule 1** | Moving core competencies of basic FR skills to Schedule 1. This ensures all FRs are licensed to provide fundamental life support services. | |
| 6 | FR | Currently not able to assist patients with medications | **Schedule 2**<br>Assist patient with own prescribed medication<br>Add definition of "assist" and "administration" to glossary | Allows FR to assist patients in management of pre-existing condition at the behest of the patient | OHM<br>BCEHS |
| 7 | FR | Currently, FRs can administer oxygen. FRs are not permitted to monitor blood oxygen levels. | **Schedule 2**<br>Add: pulse oximetry and CO-oximetry<br><br>Remove pulse oximetry from EMR SOP | The addition of pulse oximetry to FR scope would permit more thorough assessment of patients' oxygenation status as well as the effectiveness of FR interventions.<br><br>CO-oximetry is a crucial tool when evaluating patients or firefighters who may have been exposed to elevated levels of carbon monoxide. | FCABC<br>BCPFFA<br>BCEHS (PO)<br>R. Lyster (PCP) |
| 8 | FR | Glucometry is currently <u>not</u> in the FR SoP | **Schedule 2**<br>Glucometry | Evaluation of a patient's capillary blood sugar level is important in the assessment and in guiding the appropriateness of intervention. This is especially important when patients suffer from an episode of hypoglycemia or an "insulin reaction". | FCABC<br>BCPFFA |

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| 9 | FR | EpiPen without consult is currently <u>not</u> in the FR SoP | **Schedule 2**<br>Intramuscular epinephrine by auto-injector<br><br>***<u>Requires Board ability to restrict licenses</u>*** | During a severe anaphylactic reaction, timely administration may be lifesaving. The use of an epinephrine auto-injector can temporize this medical emergency to provide time for advanced medical practitioners to arrive and administer further critical care medications and airway management. | FCABC<br>BCPFFA<br>APBC – EMR only |
| 10 | FR | It is unclear if Pelvic Binding is included in the current scope of practice under Basic Wound Management | **Schedule 1**<br>Remove "basic wound and fracture management"<br><br>Add "wound management not requiring tissue puncture or indentation."<br>Add: fracture management<br>Remove "emergency fracture management/ immobilization" from EMR | Rapid, appropriate wound management is foundational to patient survival from traumatic injuries, especially hemorrhage.<br><br>Appropriate fracture management lessens pain, complications, and disability following fractures. | FCABC<br>BCEHS |
| 11 | FR/EMR | Lift, load, extricate, and evacuate, is <u>not</u> currently in the FR SoP | **Schedule 1**<br>Add "lift/load and extricate/evacuate" to FR scope.<br><br>Amend EMR Schedule 1 to read "Patient transportation" after removing above wording. | FRs are often required to assist with loading or to evacuate patients from austere environments to areas where BCEHS can access. FRs are often principally involved in extrication of patients from hazardous environments such as motor vehicle collision scenes and steep slope rescues. | FCABC<br>BCPFFA<br>BCEHS (extrication and evacuation only) |

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| 12 | FR | Procoagulants are <u>not</u> currently in the FR SoP | **Schedule 2**<br>Add: Topical administration of procoagulants and antifibrinolytics<br>Not added to med list<br>Need to ensure language adds topical as a medication route then which medications are mandated by licence level | Modern hemorrhage control techniques are a critical foundational skill. This adds a valuable tool for major hemorrhage control to the EMA tool chest. | FCABC<br>BCPFFA<br>JIBC |
| 13 | FR | FR/EMR cannot currently provide a Narcotic Antagonist except under Provincial Health Order. | **Schedule 2**<br>Add intramuscular / intranasal administration of opioid antagonist | FRs play a pivotal role in the early reversal of opiate overdoses. Early administration of naloxone saves lives and reduces disability. | FCABC<br>BCPFFA<br>BCEHS<br>COTR -EMR only |
| 14 | FR | Blood Pressure measurement is <u>not</u> currently in the FR SoP | **Schedule 2**<br>Add non-invasive blood pressure measurement | Provides an indication of the patient's current cardiovascular state and their trajectory. This is valuable to guiding subsequent interventions, timeliness of interventions, and appropriate resource allocation | JIBC<br>FCABC<br>BCPFFA |
| 15 | FR | Not authorized for FR | **Schedule 2**<br>Intramuscular anti-hypoglycemic agent<br>***<u>Requires Board ability to restrict licenses</u>***<br>Remove from PCP | Provides an effective option for treating low blood-sugar that does not create concerns for aspiration for obtunded (lethargic) patients. | BCEHS<br>JIBC |

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| 16 | EMR (included as EPI in FR above) | Epinephrine is **not** currently a medication in the EMR SoP | **Schedule 2**<br>Add: Epinephrine<br><br>Include Intramuscular for Schedule 2 route | During severe anaphylaxis, timely administration may be lifesaving. | BCPFFA |
| 17 | EMR | Salbutamol is <u>not</u> currently a medication in the EMR SoP | **Schedule 2**<br>Add administration of bronchodilator, inhaled or nebulized<br>Aligns with Alberta (AIT) | This medication would provide life-saving symptom relief from asthma and other constrictive airway diseases. | FCABC<br>BCPFFA<br>BCEHS |
| 18 | EMR | | **Schedule 2 2(a):**<br>Reads:<br>"maintenance of intravenous lines without medications or blood products while transporting persons between health facilities"<br>Should read:<br>"maintenance of intravenous lines without medications or blood products" | Allows for transport to a facility rather than just between facilities if a higher level of EMA has established an IV (e.g., In a multi-casualty situation) | |

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| 19 | PCP | Blood collection – currently an endorsement | **Part 1:**<br>Move IV from Schedule 2 to Schedule 1<br>**Part 2:**<br>**Schedule 1**<br>**Add:** Collection of venous blood samples (with IV endorsement)<br>***Requires Board ability to restrict licenses*** | **Part 1:**<br>Most PCPs are currently "IV endorsed". Current PCP treatment guidelines for many conditions include the establishment and use of intravenous access. Current National standard.<br>**Part 2:**<br>Ability to provide preventive care and meet industrial standards as it relates to medical surveillance | PII |
| 20 | PCP | Needle thoracentesis is currently not in the PCP SoP | **Schedule 1**<br>Needle Thoracentesis<br><br>Remove from ACP | Time-dependent life-saving procedure associated with decreased mortality rate in blunt traumatic cardiac arrest. This reflects best practice across the country (including CAF). | JIBC<br>APBC<br>TEAAM |
| 21 | PCP | Intraosseous initiation and maintenance are not currently in the PCP SoP | **Move from ACP to PCP**<br>**Schedule 2**<br>"initiation and maintenance of intraosseous needle cannulation"<br>Remove from ACP. | An important second-line vascular access maneuver when the establishment of peripheral IV lines fail or are unavailable. Provides a rapid access route for the administration of fluids, medications and/or blood products. Reduced risk of high-risk sharps errors. Ease of access in pediatric cardiac arrests where IV is empirically challenging.<br>This reflects best practice for PCPs across the country (including CAF). | JIBC<br>APBC<br>TEAAM |

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| 22 | PCP | Point of Care Testing is currently not in the PCP SoP | **Schedule 1**<br>Point-of-care testing | Point of care technology (portable testing equipment) is evolving rapidly. Generic wording allows for utilization of these new technologies as appropriate for each EMA skill level (PCP to CCP) to assess, triage and manage patients more safely and effectively. Point-of-care testing provides immediate "snapshot" diagnostic information.<br><br>Supports current point-of-care testing practices such as portable ultrasound use by CCPs; improves early recognition of critical illness/injury such as sepsis and major trauma. | JIBC<br>BCEHS<br>APBC<br>TEAAM |
| 23 | PCP | Not currently in the PCP SoP | **Schedule 1**<br>Manual defibrillation<br><br>Remove from ACP & ITT | Supports PCPs in operation of equipment being deployed across the province to support interfacility transfers. Results in less time off the chest in cardiac arrest thereby increasing survival rates. | BCEHS<br>APBC |
| 24 | PCP | Not currently in the PCP SoP | **Schedule 1**<br>Capnography | Verify placement of airway devices and patency of ventilation. Access to capnographic monitoring equipment is improving with many current monitoring devices including this functionality as well. | BCEHS<br>APBC |
| 25 | PCP | Not currently in the PCP SoP | **Schedule 1**<br>Change PCP 3 (d) from "maintenance of intravenous lines using intermittent infusion devices, including saline locks and IV pumps."<br>To: "maintenance of intravenous lines including the use of infusion devices and saline locks." | Supports PCP during interfacility transfers. Current wording is unclear and leads to confusion as to what is in scope and what is not. | BCEHS<br>APBC |

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| 26 | PCP | Anti-pyretic medication is not currently in the PCP SoP | **Schedule 1**<br>Add: anti-pyretic | Increased scope for management of febrile patient. | JIBC<br>APBC |
| 27 | PCP | Steroid is not currently in the PCP SoP | **Schedule 2**<br>Add: Corticosteroids | Used for management of Addisonian Crisis – A life-saving procedure, and the early management of other acute inflammatory conditions. | JIBC<br>BCEHS<br>APBC |
| 28 | PCP | Not able to perform certain diagnostic tests | **Schedule 2**<br>Add ability to take "microbiology swabs of dermal and mucosal sites for the diagnosis of communicable diseases" | Ability to obtain samples to diagnose and treat communicable diseases at site.<br>These EMAs are already skilled in invasive oropharyngeal airway procedures. | PII – Dr Holmes |
| 29 | ACP | Limited use of medications | **Move from Schedule 2 to Schedule 1 and change 2.4(b) to:**<br>"administration of drug therapy on consultation with a medical practitioner who is designated by an employer as a medical oversight advisor"<br><br>Terminology change from Transport Advisor "to "medical oversight advisor" as TA is vague and not all EMA care involves transport. | Many existing ACPs and all new graduates currently have this endorsement. Allows flexibility in modifying prehospital and interfacility medication administration. Provides for future implementation of medication treatment options as medical best-practice evolves. Provides clear medical oversight. | JIBC |

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| 30 | ACP | Not currently in the ACP SoP | **Schedule 2**<br>Add: "Subcutaneous application of local anesthetic"<br><br>**Schedule 2**<br>Add "invasive wound management" | Required to support invasive wound care e.g., Stitching of wounds; allows regional nerve blocks as alternative to general analgesia | BCEHS<br>APBC |
| 31 | ACP | Not currently in the ACP SoP | **Schedule 2**<br>Add: "Finger thoracostomy" | Permits emergent treatment of a suspected tension pneumothorax as an alternative to needle thoracocentesis when this initial maneuver fails. | BCEHS<br>APBC |
| 32 | CCP | Not currently in the CCP SoP | **CCP SOP**<br>Add: "Chest tube insertion" | Supports rural and remote health by optimizing patient safety during interfacility transfers. Allows life-saving procedure to be performed on critically injured patients. | BCEHS<br>APBC |
| 33 | CCP | Not currently in the CCP SoP | **CCP SOP**<br>Add: "initiation of central venous line" | Supports rural and remote health by optimizing patient safety during interfacility transfers | BCEHS<br>APBC |
| 34 | CCP | Not currently in the CCP SoP | **CCP SOP**<br>Add: Escharotomy | Improves ventilation of patients with restrictive or circumferential burns. A life-saving procedure | BCEHS<br>APBC |
| 35 | CCP | Not currently in the CCP SoP | **CCP SOP**<br>Add: Esophageal manometry | Allows optimization of mechanical ventilation strategies without potentially injuring lung tissue. Supports rural and remote health by optimizing patient safety during interfacility transfers | BCEHS<br>APBC |

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| 36 | CCP | Not currently in the CCP SoP | **CCP SOP**<br>Pericardiocentesis | Provides definitive management for pericardial tamponade during resuscitation. A life-saving procedure | BCEHS<br>APBC |

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| 37 | FR | Not currently in the FR SoP | **Schedule 2**<br>Add: Oral analgesia | Relieves pain and improves patient experience. | BCEHS<br>JIBC |
| 38 | FR | ASA for Acute Coronary Syndrome is not currently in the FR SoP | **Schedule 2**<br>Add: administer ASA<br>NOTE: once Cardiac Services BC develops a province-wide Acute Coronary Syndrome guideline | FRs would have access to a medication to help minimize damage to the heart of a patient experiencing Acute Coronary Syndrome. ASA is commonly recommended by ambulance dispatch to patients experiencing chest pain and may not have access to it. | FCABC<br>BCPFFA |
| 39 | PCP | Narcotic analgesic is not currently in the PCP SoP | **Schedule 2**<br>Add: Opioid analgesic | Increased prehospital analgesic options for PCP – provide better management of pain in patients of all categories. Better clinical model for management of both medical & trauma patients. | JIBC<br>BCEHS<br>APBC |
| 40 | PCP | Nerve agent antidotes is not currently in the PCP SoP | **Schedule 2**<br>Add: chemical and biological agent counter measures | Potentially no direct patient benefit – nerve agents would typically be used for crew evacuation strategies in a CBRN*e* incident. Secondary benefit to patients would be an increase in crews available in warm / cold zones. | JIBC<br>BCEHS<br>APBC |
| 41 | ACP | Available in schedule 2 | **Schedule 2**<br>Change Mechanical ventilation to "Automated Mechanical Ventilation"<br>**CCP Add:** Mechanical ventilation management and strategy development | Facilitation of more effective ventilation during transport or when operating with a smaller team.<br>Allows for more consistent ventilation<br>Clarifies difference between use of prehospital emergency ventilation devices as appropriate at the ACP level and management of complex ICU patients which are the focus of CCP care. | JIBC<br>TEAAM |

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| 42 | ACP | Not currently in the ACP SoP | **Schedule 1**<br>Add: “joint dislocation reduction” | Effective pain management without relying on analgesics.<br>Would not reduce conveyance as patient would need x-ray to confirm placement | JIBC |
| 43 | ACP | Not currently in the ACP SoP | **Schedule 2**<br>Add “Invasive wound care” in consultation with a medical practitioner who is designated by an employer as a medical oversight advisor | Allows paramedics to perform minor wound management in out-of-hospital settings | BCEHS<br>APBC |

## Non-Scope Regulation Recommendations

In lieu of regulatory changes, the Board and branch make changes via policy and process to improve the service delivery of licensure and examinations. Without amendments to the regulation there are limited opportunities for additional improvements. The branch has identified regulatory amendments/additions, which can be completed via ministerial order that would improve service delivery to EMAs and enhance the Licensing Board's ability to protect the public.

### Licence Restrictions

The Board does not have the regulatory authority to restrict a licence. The authority to set conditions is "subject to the regulations" and because the regulations state that all licence holders in the category may provide all services for that category, there is no authority to restrict. The Board does not have the authority, upon registration, to impose terms or conditions on an EMA's licence which would have the effect of limiting the services that an EMA is authorized to provide pursuant to the regulations. The authority to restrict practice is crucial to the safe and effective implementation of scope of practice changes from this recommendation process.

### Timelines

Specific timelines in the regulation are either silent or overly restrictive. For example, when an applicant completes Board examinations, there is no timeline as to when they must apply for a licence and no ability for the Board to refuse a licence after years without practice, which poses a risk to patient safety. Other health professions regulatory bodies can assess currency of practice in the context of eligibility to practice. However, there is a 12-month post certificate timeline for completing examinations, which does not allow for extenuating circumstances, including pandemic-related barriers.

The timelines set out for a non-student, short-term license is in 30-day increments to a maximum of one year. This is administratively cumbersome for both the EMA and the branch.

Student licenses may be issued for a maximum of two years which creates risks to students that may need to defer their ACP training due to extenuating circumstances.

A licence issued under extraordinary circumstances such as a mass casualty disaster may only be issued for a maximum of 60 days, and only at the request of the Corporation.

These long-standing issues would require adjustments to timelines under a ministerial order but would have significant impact on individual EMAs and in the case of extenuating circumstance, ensure the Board can react quickly in mass casualty events.

## Continuing Competence/Term of a Licence

Continuing Competence is an annual requirement for all EMAs above the First Responder level. The process is especially onerous for EMAs and the branch using a legacy system and for the Board in processing EMAs who are in shortfall. The Continuing Competence program has an annual expense of approximately $14k in registered mail costs required by the regulation. Continuing Competence can be comprised of both education and patient contact credits. The branch has no authority to review or confirm patient contacts due to patient confidentiality.

First responders complete licence renewal examinations once every three years. If First Responders were brought under the Continuing Competence program, their regularly scheduled training events could be used as continuing education credits. This would better support rural and remote volunteer departments which encounter considerable logistical and financial obstacles to the current license renewal process. A Continuing Education program that was required on a three-year licence cycle instead of annually, would streamline the process for both EMAs and the branch. This would require a licence term of three years for all licence categories (from five currently for those above First Responder) and proof of Continuing Education would be required at the time of licence renewal. This would evenly distribute the Continuing Education requirements over 36 months, making the program more manageable operationally and reducing the number of EMAs in shortfall leading to disciplinary action by the Board. The Board currently processes 400-700 EMAs in shortfall annually at considerable expense. As the scope of practice for First Responders expands, there should be a corresponding increase in professional obligation to ensure continuing competency in those skills. This would be consistent with professional regulation of other health care professionals.

The Board does not currently have the authority to issue a non-practicing licence. A non-practicing licence is permitted by paramedic regulators in other Canadian jurisdictions and in other BC health professions. The ability to inactivate a licence without punitive action would benefit EMAs who are on medical, parental, and other types of leaves and while working in administrative roles. This is particularly relevant for those undergoing long-term treatments including for cancer and for those who are recovering from PTSD. EMAs are more likely to report to the Board that they are unfit to practice if an opportunity to maintain their licence without disciplinary action were available.

## Training

The Board's authority to assess EMA training programs is limited to the phrase "recognized by the licensing board" found in Part 2, 2(c)(i) of the EMA Regulation. Over time, the Board has defined program recognition in various ways including requiring accreditation briefly, until a legal opinion advised that this fettered the Board's authority. The Board has limited regulatory authority to rigorously assess program prerequisites, curriculum, evaluation methods, length of programs, and the extent to which each program component is delivered, learned and assessed, nor is there authority to audit programs to ensure consistency between cohorts and across recognition periods.

Board legal advice has determined that the EMA Regulation allows limited regulatory authority as compared to the complexity of the *Health Professions Act*, and the term "recognize" appears to have been used intentionally to limit the authority of the Board (i.e., vs. "approve"). The Board presumes at law, to have the powers necessary to recognize a training program for the purposes of licensing EMAs, and those powers are limited to that statutory mandate. For example, the Board does not govern the profession or regulate or licence training providers themselves. The Board does not have the authority to approve, suspend, or monitor training programs post recognition and until the program is due for re-recognition including in instances where allegations of inadequate or inappropriate training occur. The standard in other health professions includes the ability to approve, suspend and monitor training programs that lead to licensure.

## Registry

Section 14(1) of the EMA Regulation mandates that the Board registry and rules must be open to the public for inspection at the office of the Board during business hours and Section 14(2) gives the Board the discretion to refuse access in specific circumstances. The Board has obtained a legal opinion which advised that an online registry is open to the public 24/7 whereby access cannot be refused and therefore does not meet the requirements of Section 14(2). The regulation prevents the Board from moving to an online registry.

Online registries enable employers, other jurisdictions, and the public to verify good standing, licence terms and conditions and disciplinary action on demand and is in alignment with current health profession standards including paramedic regulators across Canada.