



## LEGAL INTERVENTIONS TO REDUCE OVERDOSE MORTALITY: EMERGENCY MEDICAL SERVICES NALOXONE ACCESS

### Background

Fatal drug overdoses have increased more than six-fold in the past three decades, and now claim the lives of over 36,000 Americans every year.<sup>1</sup> Opioid overdose is reversible through the timely administration of the medication naloxone and the provision of ancillary emergency care. Although naloxone is a prescription medicine, it is not a controlled substance and has no abuse potential.<sup>2,3,4</sup> [Over 25 states](#) have modified law and policy to make it easier for laypeople to access naloxone, with more making this change every year.<sup>5</sup> Published research suggests that increased bystander naloxone access reduces overdose death rates, but naloxone access programs currently cover only a small fraction of the country.<sup>6,7,8,9</sup> Thus, Emergency Medical Services (EMS) remain a crucial source for emergency naloxone administration.

### EMS Naloxone Access

The National Highway Traffic Safety Administration (NHTSA), the lead federal agency in providing guidance and coordination to the EMS community, recognizes four EMS provider levels. By increasing level of training, these are Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic.<sup>10</sup> NHTSA has created a National EMS Scope of Practice Model that lists the minimum skills responders at each level should possess. Under these guidelines, “administration of an opioid antagonist” is a necessary skill for paramedics and AEMTs, but not for EMTs and EMRs. While states are free to set their own standards, most are moving to align their provider levels and scopes of practice with the NHTSA model.

Nationwide, EMTs outnumber AEMTs and paramedics combined by a factor of approximately three-to-one<sup>11</sup>, and EMRs are more numerous still. Many rural and underserved areas such as tribal lands are served largely by EMTs and EMRs, and even in better-served areas these responders are often the first on scene.<sup>10,12</sup> Therefore, authorizing these trained responders to administer naloxone may reduce time to overdose rescue, possibly decreasing morbidity and mortality.

To determine the current state of EMS naloxone administration authority, we systematically reviewed all relevant laws and regulations for the 50 states, the District of Columbia, Guam, and Puerto Rico in effect as of September 1, 2014. For jurisdictions with statewide naloxone administration protocols, we also cataloged the required or recommended initial IV naloxone dose specified in the protocols to determine the level of variance in dosing between states. We found that, as of September, 2014, all states permit paramedics to administer naloxone and all but one (MS) permit AEMTs or the state’s equivalent intermediate-level EMS providers to do so. Twenty-four permit EMTs and 13 permit EMRs to administer the medication (Table 1). The corresponding numbers for EMTs and EMRs as of November 2013 were 12 and 3 respectively, a testament to the rapid uptake of this scope of practice change.<sup>13</sup> Our research also documented wide variation in naloxone dosing policies, suggesting the need for evidence-based research in this area (Table 2).

Given the evidence that EMT and EMR personnel can successfully administer naloxone, and the growing number of states choosing to expand access to naloxone, NHTSA and state policymakers may wish to modify EMR and EMT scopes of practice to permit the administration of naloxone under medical direction. Such changes would likely reduce the time to naloxone administration, possibly reducing opioid overdose morbidity and mortality.

**Table 1. Naloxone administration authority by Provider level**

|                             | <b>EMR</b><br>n = 43 | <b>EMT</b><br>n = 53 | <b>EMT-I*</b><br>n = 29 | <b>AEMT*</b><br>n = 36 | <b>Paramedic</b><br>n = 53 |
|-----------------------------|----------------------|----------------------|-------------------------|------------------------|----------------------------|
| Number (%) of jurisdictions | 13 (30%)             | 24 (45%)             | 24 (83%)                | 36 (100%)              | 3 (100%)                   |

\* As some states license or certify two levels of intermediate/advanced EMS providers, these numbers sum to >53

**Table 2. Initial Adult IV naloxone dosage in jurisdictions with statewide protocols (n = 33)**

|                             | Dosage (mg) |                |          |            |                |          |               |
|-----------------------------|-------------|----------------|----------|------------|----------------|----------|---------------|
|                             | <b>0.4</b>  | <b>0.4 – 2</b> | <b>1</b> | <b>0.5</b> | <b>0.1 – 2</b> | <b>2</b> | <b>.4 - 4</b> |
| Number (%) of jurisdictions | 5 (15%)     | 14 (42%)       | 2 (6%)   | (3%)       | 1 (3%)         | 9 (27%)  | 1 (3%)        |

**Figure 1. EMS naloxone administration authority by provider level**

| Jurisdiction                    | Paramedic            | Intermediate* | EMT | EMR |
|---------------------------------|----------------------|---------------|-----|-----|
| All Existing Levels (19)        | California           |               |     | N/A |
|                                 | Colorado             |               |     | N/A |
|                                 | Connecticut          |               |     |     |
|                                 | Delaware             |               | N/A | N/A |
|                                 | Georgia              |               |     | N/A |
|                                 | Illinois             |               |     |     |
|                                 | Indiana              |               |     |     |
|                                 | Louisiana            |               |     |     |
|                                 | Massachusetts        |               |     |     |
|                                 | Maryland             |               |     |     |
|                                 | North Carolina       |               |     |     |
|                                 | New Hampshire        |               |     |     |
|                                 | New Jersey           |               | N/A | N/A |
|                                 | New Mexico           |               |     |     |
|                                 | New York             |               |     |     |
|                                 | Ohio                 |               |     |     |
|                                 | Oklahoma             |               |     |     |
|                                 | Rhode Island         |               |     | N/A |
|                                 | Vermont              |               |     |     |
| All Except EMR (5)              | District of Columbia |               |     |     |
|                                 | Missouri             |               |     |     |
|                                 | Minnesota            |               |     |     |
|                                 | Montana              |               |     |     |
|                                 | Utah                 |               |     |     |
| Intermediate and Paramedic (25) | Alaska               |               |     |     |
|                                 | Alabama              |               |     |     |
|                                 | Arkansas             |               |     | N/A |
|                                 | Arizona              |               |     |     |
|                                 | Guam                 |               |     |     |
|                                 | Iowa                 |               |     |     |
|                                 | Idaho                |               |     |     |
|                                 | Kansas               |               |     |     |
|                                 | Kentucky             |               |     |     |
|                                 | Maine                |               |     |     |

| Jurisdiction  |                | Paramedic | Intermediate* | EMT | EMR |
|---|----------------|-----------|---------------|-----|-----|
|   | Michigan       |           |               |     |     |
|   | North Dakota   |           |               |     |     |
|   | Nebraska       |           |               |     |     |
|   | Nevada         |           |               |     |     |
|   | Oregon         |           |               |     |     |
|   | Pennsylvania   |           |               |     |     |
|   | South Carolina |           |               |     |     |
|   | South Dakota   |           |               |     | N/A |
|   | Tennessee      |           |               |     |     |
|   | Texas          |           |               |     |     |
|   | Virginia       |           |               |     |     |
|   | Washington     |           |               |     |     |
|   | Wisconsin      |           |               |     |     |
|   | West Virginia  |           |               |     |     |
|   | Wyoming        |           |               |     |     |
| Paramedic Only (4)  | Florida        |           | N/A           |     | N/A |
|   | Hawaii         |           | N/A           |     |     |
|   | Mississippi    |           |               |     |     |
|   | Puerto Rico    |           | N/A           |     | N/A |
| <p>*Includes AEMT and state-equivalent Intermediate level</p> <p>● = Within scope   ● = Not within scope   N/A = Level does not exist</p> |                |           |               |     |     |

# EMS Naloxone Administration by Provider Level



## Paramedic only

In these four jurisdictions, paramedics are the only tier of EMS provider authorized to administer naloxone. (FL, HI, MS, Puerto Rico\*)



## Intermediate & Paramedic

In these 25 jurisdictions, AEMT, EMT-I and Paramedics carry naloxone. This is also what is currently authorized at the national level. (AK, AL, AR, AZ, Guam\*, IA, ID, KS, KY, ME, MI, ND, NE, NV, OR, PA, SC, SD, TN, TX, VA, WA, WI, WV, WY)



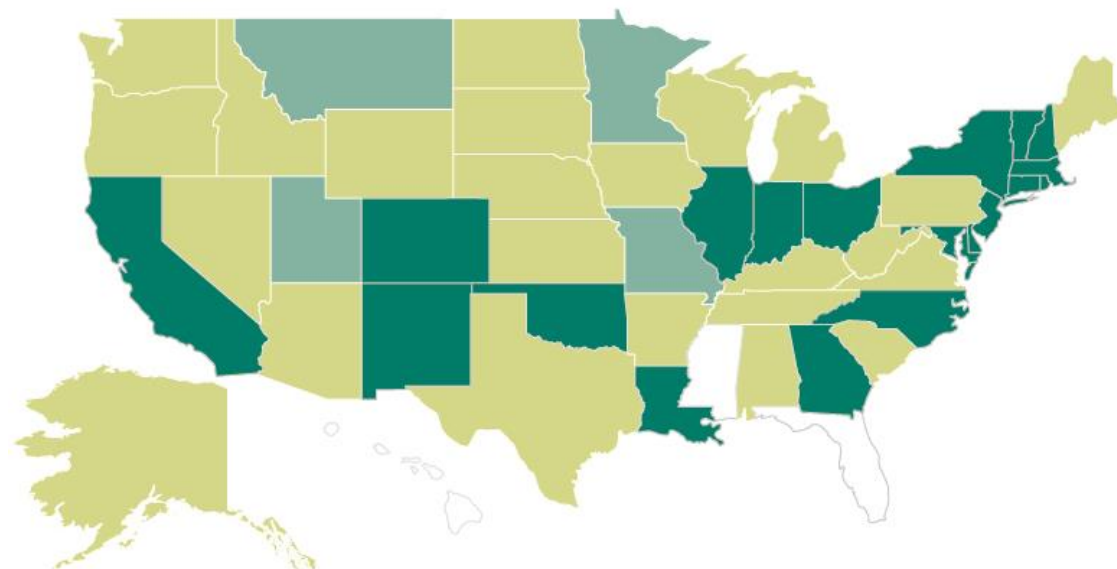
## All except EMR

In these five jurisdictions, all EMS personnel levels, with the exception of EMR, carry naloxone. (DC\*, MO, MN, MT, UT)



## All levels

In these 19 jurisdictions, all EMS levels carry naloxone. (CA, CO, CT, DE, GA, IL, IN, LA, MA, MD, NC, NH, NJ, NM, NY, OH, OK, RI, VT)



As of September 1, 2014

\* Not shown on map

Administration of Naloxone by EMS Personnel – Authority and Protocol  
As of September 1, 2014

|           | EMR  | EMT  | AEMT                                    | EMT-I  | Paramedic   | Protocol*   |
|-----------|--|--|---|--|---|---|
| <b>US</b> | Not within scope of practice. <sup>14</sup>              | Not within scope of practice. <sup>15</sup>                | Within scope of practice. <sup>16</sup> | Being phased out. For states still referencing this level, within scope of practice. <sup>17</sup> | Within scope of practice. <sup>18</sup>                                       | <p>While the National Highway Transportation Safety Administration maintains a National Scope of Practice Model, it is advisory and does not contain naloxone administration protocols.<sup>19</sup></p> <p><u>Adult:</u><sup>20</sup><br/>0.4-2 mg IV/IM/SC every 2 to 3 minutes. If no response observed after 10 mg, the diagnosis of opioid-induced or partial opioid induced toxicity should be questioned.</p> <p><u>Children:</u><sup>21</sup><br/>0.01 mg/kg IV/IM/SC. If ineffective, a subsequent dose of 0.1 mg/kg body weight may be administered.</p> <p><u>Neonates:</u><sup>22</sup><br/>0.01 mg/kg IV/IM/SC. Dose may be repeated in accordance with adult administration guidelines for postoperative opioid depression.</p> |
| <b>AK</b> | [ETT]<br><br>Not within scope of practice. <sup>23</sup> | [EMT-I]<br><br>Not within scope of practice. <sup>24</sup> | N/A                                     | [EMT-II & EMT -III]<br>Within scope of practice under medical direction. <sup>25</sup>             | [MICP] <sup>26</sup><br><br>Within scope of practice under medical direction. | <p><u>Adult:</u><sup>27</sup><br/>.4—2 mg slow IVP or IM if no IV access. Preferable patient not awakened in the field; only administer enough to reverse respiratory depression or hypotension.</p>  |
| <b>AL</b> | Not within scope of practice. <sup>28</sup>              | Not within scope of practice. <sup>29</sup>                | Within scope of practice. <sup>30</sup> | Within scope of practice. <sup>31</sup>  | Within scope of practice. <sup>32</sup>                                       | <p><u>Adult:</u><sup>33</sup><br/>2 mg IV/IN every 3 minutes, maximum dose 8 mg. If desired, start by giving 0.5 mg and titrate to effect.</p> <p><u>Pediatric:</u><br/>&lt;5 years: 0.1 mg/kg IV/IN.<br/>&gt;5 years or 20 kg: 2 mg IV/IN.</p>   |

|    | EMR   | EMT  | AEMT  | EMT-I                                   | Paramedic   | Protocol*  |
|----|---|--|---|---|---|--|
| AR | N/A <sup>34</sup>                           | Not within scope of practice. <sup>35</sup>  | Within scope of practice if trained in use and credentialed by EMS agency medical director. <sup>36</sup> | N/A                                     | Within scope of practice if trained in use and credentialed by EMS agency medical director. <sup>37</sup> | Authority to develop protocols delegated to Medical Director of a licensed EMS provider. Medical Director may limit but not expand EMS personnel scope of practice. <sup>38</sup> Arkansas maintains a BLS sample protocol but no model ALS protocol. <sup>39</sup>  |
| AZ | Not within scope of practice. <sup>40</sup> | Not within scope of practice. <sup>41</sup>  | N/A   | Within scope of practice. <sup>42</sup> | Within scope of practice. <sup>43</sup>   | <p><u>Adult:</u><sup>44</sup></p> <ul style="list-style-type: none"> <li>- IV, IM, inject SL, SC, ET: 2 mg initial bolus IV or ET, may repeat every 2 minutes as necessary, titrate to effect.</li> <li>- Intranasal: 1 mg each nostril using a Mucosal Atomizer Device for a total of 2 mg. May repeat every 2 minutes as necessary. Titrate to effect.</li> <li>- Continuous IV Infusion: 2/3 of the initial bolus/hr (bolus that it took to reverse) administered as a continuous infusion; i.e., if 2 mg Narcan resulted in opioid reversal initially, then it can be maintained by continuous infusion of 1.4 mg/hr. Put 1.4 mg Narcan in 250 ml NS and run at 250 ml/hr. A repeat IV bolus of 2 the initial bolus administered 15 minutes after the initial bolus is recommended.</li> </ul> <p><u>Pediatric:</u></p> <ul style="list-style-type: none"> <li>&lt; or equal to 5 years or &lt; 20 kg: 0.1 mg/kg IV, ET, inject SL, SC, IO (includes neonate)</li> <li>&gt; or equal to 5 years or &gt; 20 kg: 2 mg IV, ET, inject SL, SC or IO</li> </ul> |
| CA | N/A <sup>45</sup>                           | Within scope of practice, if training completed and competency demonstrated. <sup>46</sup> | Within scope of practice. <sup>47</sup>   | N/A                                     | Within scope of practice. <sup>48</sup>   | No state protocols; authority delegated to local EMS agency medical director. <sup>49</sup>  |

|           | EMR  | EMT   | AEMT   | EMT-I                                   | Paramedic   | Protocol*  |
|-----------|--|---|--|---|---|--|
| <b>CO</b> | N/A <sup>50</sup>                                      | [EMT & EMT-IV]<br>Within scope of practice. <sup>51</sup>                                       | Within scope of practice. <sup>52</sup>                | Within scope of practice. <sup>53</sup> | Within scope of practice. <sup>54</sup>                                       | No state protocols; authority delegated to medical director. <sup>55</sup>   |
| <b>CT</b> | Within scope of practice (IN & AI only). <sup>56</sup> | Within scope of practice (IN & AI only). <sup>57</sup>  | Within scope of practice (IN & AI only). <sup>58</sup> |   | Within scope of practice. <sup>59</sup>                                       | No central state protocols. <sup>60</sup> Statutory guidance for Connecticut is addressed with a general scope of practice clause <sup>61</sup> and more thoroughly defined under mobile intensive care sections. <sup>62</sup>  |
| <b>DE</b> | N/A <sup>63</sup>                                      | Within scope of practice if operating under an approved pilot protocol (IN only). <sup>64</sup> | N/A <sup>65</sup>                                      | N/A                                     | Within scope of practice. <sup>66</sup>                                       | <u>Adult:</u><br>BLS <sup>67</sup> : 1mg naloxone IN. If no improvement after two minutes, second does may be given in opposite nares.<br>ALS <sup>68</sup> :<br>.4 – 2 mg naloxone IV, IN or IM.<br><u>Pediatric.</u> <sup>69</sup><br>.1 mg/kg naloxone IV, IN, or IM (maximum dose is 2 mg).<br>Not indicated for newborns suspected of narcotic induced apnea. |
| <b>FL</b> | N/A <sup>70</sup>                                      | Not within scope of practice. <sup>71</sup>   | N/A <sup>72</sup>                                      | N/A                                     | Within scope of practice. <sup>73</sup>                                       | No state protocols; authority delegated to Medical Director of BLS or ALS service provider to develop protocols. <sup>74</sup>   |
| <b>GA</b> | N/A <sup>75</sup>                                      | Within scope of practice, auto-injector or intranasal only. <sup>76</sup>                       | Within scope of practice. <sup>77</sup>                | Within scope of practice. <sup>78</sup> | [Cardiac technician and paramedic]<br>Within scope of practice. <sup>79</sup> | <u>Adult:</u><br>0.4-2 mg IV, IO, ET, IM, may repeat at 2-3 minute intervals.<br><u>Pediatric:</u><br>Initial dose of 0.01mg/kg IV/IO, if no clinical improvement: administer 0.1mg/kg IV/IO. Maximum dose of 2mg. <sup>80</sup>   |



|           | EMR  | EMT   | AEMT   | EMT-I  | Paramedic   | Protocol*   |
|-----------|--|---|--|--|---|---|
| <b>HI</b> | [First responder] <sup>81</sup><br>Not within scope of practice. <sup>82</sup> | [EMT-Basic]<br>Not within scope of practice. <sup>83</sup>    | N/A <sup>84</sup>  | N/A  | [EMT-Paramedic / Mobile Intensive Care Technician]<br>Within scope of practice. <sup>85</sup> | Approved for adults only.<br><u>Adult:</u><br>Approved for respiratory depression or difficulty after administration of pain medicine: <sup>86</sup> <ol style="list-style-type: none"> <li>Administer 0.5 mg IV and repeat as needed up to a total dose of 2.0 mg.</li> <li>If IV has been lost, administer 2 mg IN (must use 1 mg/ml concentration when giving IN).</li> </ol> For altered mental status with blood glucose greater than or equal to 70 mg/dl: <sup>87</sup> <ol style="list-style-type: none"> <li>Administer 2 mg IN. Must use 1 mg/ml concentration when administering intranasal.</li> </ol> OR <ol style="list-style-type: none"> <li>Administer IV in increments of 0.5 mg up to 2 mg total.</li> </ol> If not improved and no IV, give Naloxone 2 mg IM. |
| <b>IA</b> | Not within scope of practice. <sup>88</sup>                                    | Not within scope of practice. <sup>89</sup>                   | Within scope of practice (IM or IVP only). <sup>90</sup> | Not within scope of practice. <sup>91</sup>          | Within scope of practice. <sup>92</sup>   | <u>Adult:</u> <sup>93</sup><br>- Altered Mental Status: Administer 1 mg IV. If no response, may repeat in 3 minutes.<br>- Pain Control: Administer 1 mg IV for respiratory depression from narcotics. May repeat once if needed.<br><u>Pediatric.</u> <sup>94</sup><br>Altered Mental Status: Administer 0.1 mg/kg IV up to maximum dose of 2.0 mg per dose.  |
| <b>ID</b> | [EMR-2011]<br><br>Not within scope of practice. <sup>95</sup>                  | [EMT-2011]<br><br>Not within scope of practice. <sup>96</sup> | [AEMT-2011]<br>Within scope of practice. <sup>97</sup>   | [AEMT-85]<br>Within scope of practice. <sup>98</sup> | [Paramedic-2011]<br>Within scope of practice. <sup>99</sup>                                   | <u>Adult:</u> 0.4-2mg IM/IN <sup>100</sup><br><u>Pediatric:</u> 0.1mg/kg IM/IN; max 2mg)  |

|           | EMR   | EMT   | AEMT   | EMT-I                                    | Paramedic                                | Protocol*  |
|-----------|---|---|--|--|--|--|
| <b>IL</b> | Within scope of practice if contained in approved System Program Plan. <sup>101</sup> | Within scope of practice if contained in approved System Program Plan. <sup>102</sup> | N/A  | Within scope of practice. <sup>103</sup> | Within scope of practice. <sup>104</sup> | Although IL generally follows the national model, EMS systems have the authority to develop protocols in a system program plan that is submitted to and approved by the Illinois Department of Public Health. <sup>105</sup>   |
| <b>IN</b> | Within scope of practice. <sup>106 107</sup>  | [EMT] Within scope of practice. <sup>108</sup>  | [Currently transitioning from EMT-I to AEMT]<br><br>Within scope of practice. <sup>109</sup> | N/A                                      | Within scope of practice. <sup>110</sup> | Authority to develop protocols is delegated to the Indiana EMS Commission <sup>111</sup> and local EMS medical directors. <sup>112</sup>   |
| <b>KS</b> | Not within scope of practice. <sup>113</sup>  | Not within scope of practice. <sup>114</sup>  | Within scope of practice. <sup>115 116</sup>   | N/A                                      | Within scope of practice. <sup>117</sup> | No state protocols; authority to develop protocols is delegated to “the county medical society or, if there is no county medical society, the medical staff of a hospital to which the ambulance service primarily transports patients.” <sup>118</sup>  |
| <b>KY</b> | Not within scope of practice. <sup>119</sup>  | Not within scope of practice. <sup>120</sup>  | Within scope of practice. <sup>121</sup>   | N/A                                      | Within scope of practice. <sup>122</sup> | Medical directors for individual ambulance services have the authority to develop protocols, with the approval of the Kentucky Board of Emergency Medical Services. However, the Commonwealth has published model protocols. <sup>123</sup><br><br><u>Adult:</u> 0.4 – 2.0 mg IV, IM, SC, nasal via atomizer, or ET (diluted); min. recommended = 2.0 mg; repeat at 5 minute intervals to 10 mg maximum dose. (Medical Control may request higher amounts). Infusion: 2 mg in 500 ml of D5W (4 mcg/ml), infuse at 0.4 mg/hr (100 ml/hour).<br><u>Pediatric:</u> 0.1 mg/kg/dose IV, IM, SC, ET (diluted); maximum of 0.8 mg; if no response in 10 minutes, administer an additional 0.1 mg/kg/dose. |

|           | EMR   | EMT   | AEMT                                     | EMT-I  | Paramedic                                | Protocol*  |
|-----------|---|---|--|--|--|--|
| <b>LA</b> | [Licensed EMR] <sup>124</sup><br><br>Within scope of practice. <sup>125</sup>             | Within scope of practice. <sup>126</sup>                            | Within scope of practice. <sup>127</sup> | N/A  | Within scope of practice. <sup>128</sup> | No state protocols; authority to develop protocols is delegated to the Bureau of Emergency Medical Services, <sup>129</sup> which has in turn promulgated rules requiring EMS service providers to (1) adopt protocols that have been established by a parish or medical component society, or (2) in a parish where protocols have not been adopted by the parish, develop protocols to be approved by the parish or component medical society. <sup>130</sup>  |
| <b>MA</b> | [EMS First Responder] Within scope of practice (IN or auto-injector only). <sup>131</sup> | Within scope of practice (IN or auto-injector only). <sup>132</sup> | Within scope of practice. <sup>133</sup> | Within scope of practice (IN or auto-injector only). <sup>134</sup>  | Within scope of practice. <sup>135</sup> | <u>Adult:</u> <sup>136</sup><br>- First responder, EMT, EMT-Intermediate: 2mg via IN or 0.4mg via auto-injector (IM). If no response after 3-5 minutes, give 2 <sup>nd</sup> dose.<br>- AEMT/Paramedic: 0.4-2mg IV/IO/IM/IN. <sup>137</sup> May be repeated as indicated.<br><u>Pediatric:</u> 0.1mg/kg to 20kg, then 2mg.   |
| <b>MD</b> | Within scope of practice (IN only). <sup>138</sup>  | Within scope of practice (IN only). <sup>139</sup>                  | N/A                                      | [Cardiac Rescue Technician] Within scope of practice. <sup>140</sup> | Within scope of practice. <sup>141</sup> | <u>Adult:</u><br>- BLS: 2mg IN (one mg per nostril) <sup>142</sup><br>- ALS: 0.4 – 2 mg IVP/IM/IN (if delivery device is available divide administration of the dose equally between the nostrils to a maximum of 1 mL per nostril); titrate to adequate respiratory effort.<br><br><u>Pediatric</u> <sup>143</sup> :<br>- BLS: 28 days to 8 years: 0.8 to 1 mg IN 8 years to adult: follow adult protocol<br>- ALS: 0.1 mg/kg SLOW IVP/IO/IM/IN (if delivery device is available; divide administration of the dose equally between the nostrils to a maximum of 1 mL per nostril). Maximum dose 0.4-2mg. |

|           | EMR  | EMT  | AEMT  | EMT-I  | Paramedic                                | Protocol*   |
|-----------|--|--|---|--|--|---|
| <b>ME</b> | Not within scope of practice. <sup>144</sup>   | Not within scope of practice. <sup>145</sup>         | Within scope of practice. <sup>146</sup>                                  | N/A  | Within scope of practice. <sup>147</sup> | <u>Adult:</u> <sup>148</sup><br>0.1 – 2 mg IV/IO/IM or intranasal (may opt to give 2 mg as starting dose if using intranasal route) titrate to improve respiratory drive.<br><u>Pediatric:</u><br>If <20 kg give 0.1 mg/kg; Never administer to a neonate.  |
| <b>MI</b> | [Medical First Responder] <sup>149</sup><br><br>Not within scope of practice. <sup>150</sup> | Not within scope of practice. <sup>151</sup>         | [EMT-Specialist/Advanced]<br><br>Within scope of practice. <sup>152</sup> | N/A  | Within scope of practice. <sup>153</sup> | <u>Adult:</u> <sup>154</sup><br>2 mg IV slowly, titrating to improve respiratory status or IM, repeat as needed every 2 – 3 minutes.<br><u>Pediatric:</u> <sup>155</sup><br>Up to 0.1 mg/kg (maximum dose 2 mg) IV slowly, titrating to improve respiratory status or IM; repeat as needed.                         |
| <b>MN</b> | Not within scope of practice. <sup>156</sup>   | Within scope of practice. <sup>157</sup>             | Within scope of practice. <sup>158</sup>                                  | N/A  | Within scope of practice. <sup>159</sup> | No statewide protocols; responsibility for establishing falls to the Medical Director. <sup>160</sup>   |
| <b>MO</b> | [First responder] <sup>161</sup><br><br>Within scope of practice. <sup>162</sup>             | [EMT-B]<br>Within scope of practice. <sup>163</sup>  | N/A   | Within scope of practice. <sup>164</sup>     | Within scope of practice. <sup>165</sup> | No statewide protocol; medical directors are required, in cooperation with the ambulance service administrator, to develop, implement and annually review medical and treatment protocols for medical, trauma and pediatric patients. <sup>166</sup>  |
| <b>MS</b> | [Medical First Responder] <sup>167</sup><br><br>Not within scope of practice. <sup>168</sup> | Not within scope of practice. <sup>169</sup>         | N/A   | Not within scope of practice. <sup>170</sup> | Within scope of practice. <sup>171</sup> | No statewide protocols; protocols must be developed by each EMS provider's off-line Medical Director. <sup>172</sup>  |
| <b>MT</b> | Not within scope of practice. <sup>173</sup> , <sup>174</sup>                                | Within scope of practice (IM/IN only) <sup>175</sup> | Within scope of practice. <sup>176</sup>                                  | N/A <sup>177</sup>                           | Within scope of practice. <sup>178</sup> | The Montana Board of Medical Examiners has authority, after consultation with others, to adopt rules re: the administration of drugs by EMTs. <sup>179</sup><br><br><u>Adult:</u> <sup>180</sup><br>- EMTs: 0.4 mg (IM/IN). If no response after 2 minutes, repeat dose once. Additional doses require consultation |

|           | EMR  | EMT  | AEMT                                     | EMT-I   | Paramedic                                | Protocol*  |
|-----------|--|--|--|---|--|--|
|           |  |  |  |   |  | with the medical director.<br>- AEMTs/Paramedics: 0.4 – 4 mg (IV/ET/IM/IN/IO) (be aware that the patient may become belligerent or hostile and may need restraint).<br><u>Pediatric:</u><br>0.1 mg/kg (IV/ET/IM/IO), max 2 mg; or (IN) 0.2 mg/kg, ½ dose each side.  |
| <b>NC</b> | [Medical Responder]<br><br>Within scope of practice (IN only) <sup>181</sup> | Within scope of practice (IN only). <sup>182</sup> | N/A                                      | Within scope of practice. <sup>183</sup>  | Within scope of practice. <sup>184</sup> | Treatment protocols developed by the North Carolina College of Emergency Physicians must be adopted by local EMS systems. <sup>185</sup> Protocols may be modified by local EMS systems if approved by the OEMS Medical Director. <sup>186</sup><br><br><u>ALS:</u><br><u>Adult:</u> <sup>187</sup><br>0.4-2.0 mg IV/IO/IM/IN/ETT bolus titrated to patient's respiratory response.<br><u>Pediatric:</u><br>0.1 mg/kg IV/IO/IN/IM/ETT (max 2 mg); repeat as per protocol (specific protocols provided for various heights, weights, and ages of children). |
| <b>ND</b> | Not within scope of practice. <sup>188</sup>                                 | Not within scope of practice. <sup>189</sup>       | Within scope of practice. <sup>190</sup> | EMT-I85: Not within scope of practice.<br><br>EMT-I99: Within scope of practice. <sup>191</sup> | Within scope of practice. <sup>192</sup> | Protocols vary by patient presentation.<br><br><u>Adult:</u><br>- Altered Mental Status <sup>193</sup> : If opiate overdose is suspected administer Narcan 2 mg IV. May repeat every 5 minutes.<br>- Overdose <sup>194</sup> : If patient has depressed respirations, administer Narcan 2 mg IV. If no response repeat dose up to a maximum of 4 mg.<br><u>Pediatric:</u><br>- Altered Mental Status <sup>195</sup> : If opiate overdose is suspected administer Narcan 0.05 – 0.1 mg/kg IV. May repeat every 5 minutes x 2.                               |

|           | EMR  | EMT  | AEMT  | EMT-I                                    | Paramedic                                | Protocol*   |
|-----------|--|--|---|--|--|---|
|           |  |  |   |  |  | - Overdose <sup>196</sup> : If patient has depressed respirations administer Narcan 0.1 mg/kg IV.   |
| <b>NE</b> | Not within scope of practice. <sup>197</sup>         | Not within scope of practice. <sup>198</sup>               | Within scope of practice. <sup>199</sup>              | Within scope of practice. <sup>200</sup> | Within scope of practice. <sup>201</sup> | Per Model State Protocols. <sup>202</sup><br><br><u>Adult:</u> <sup>203</sup><br>0.4 – 2 mg (IV/IO/MAD)<br><u>Pediatric:</u><br>0.1 mg/kg to a max of 2 mg (IV/IO/MAD)  |
| <b>NH</b> | Within scope of practice(IN only) <sup>204 205</sup> | Within scope of practice( IN nly) <sup>206</sup>           | Within scope of practice. IV/IM or IN. <sup>207</sup> | Within scope of practice. <sup>208</sup> | Within scope of practice. <sup>209</sup> | Varies depending on patient's presentation. <sup>210</sup><br><br><u>Adult:</u><br>- Pain Management: 0.4 mg SQ/IV/IM/IN/ETT as needed (Paramedic only).<br>- Overdose: 2 mg IN (EMRs and EMTs); 0.4 mg IV/IM or 2mg IN. If no response, may repeat initial dose every 5 minutes to a total of 10mg (AEMT and Paramedic)<br><u>Pediatric:</u><br>- Pain Management: 0.4 mg SQ/IV/IM/IN/ETT as needed (Paramedic only).<br>- Overdose: 0.1 mg/kg up to 2 mg, IV/IM/SQ/IN or ETT. Repeat every 2 minutes as needed (Paramedic only) |
| <b>NJ</b> | N/A <sup>211</sup>                                   | [EMT-B] Within scope of practice. (IN only) <sup>212</sup> | N/A <sup>213</sup>                                    | N/A                                      | Within scope of practice. <sup>214</sup> | <u>Adult:</u><br>- EMTs: Administer up to a maximum dose of 2mg (1mg per nostril), via IN only. <sup>215</sup><br>- Paramedics: Administer up to 2 mg via IV or IM. Start with 1 mg and titrate the dose to reversal of any respiratory depression. <sup>216</sup><br><u>Pediatric:</u><br>- EMTs: Contact medical director for guidance or online medical direction. <sup>217</sup><br>- Paramedics: Administer 0.1 mg, with a maximum dose of 2 mg, via IV/IO/ET. <sup>218</sup>  |

|           | EMR  | EMT  | AEMT  | EMT-I   | Paramedic   | Protocol*  |
|-----------|--|--|---|---|---|--|
| <b>NM</b> | [EMS First responder] <sup>219</sup><br><br>Within scope of practice. (with medical director approval, IN only) <sup>220</sup> | [EMT-Basic] Within scope of practice (with medical director approval, SQ, IM, or IN route). <sup>221</sup> | N/A   | Within scope of practice (with medical director approval). <sup>222</sup>   | Within scope of practice (with medical director approval). <sup>223</sup>   | <u>Adult:</u> <sup>224</sup><br>0.4 mg – 2.0 mg IV/IO (2.0 mg total dose); 0.4 – 2.0 mg IM, SQ, ET; 2mg (1mg per naris) IN. Titrate to respiratory effort/rate. May be repeated at 2 - 3 minutes, if needed.<br><u>Pediatric:</u><br>0.1 mg/kg < 5 yrs or ≤ 20 kg, 2 mg ≥ 5 yr or > 20kg IV, ET, IM, SQ, IO. May be repeated at 0.1 mg/kg if no response.<br><u>Neonate:</u><br>0.1 mg/kg slow IVP, ET, IM, SQ, IO; repeat in 2-3 minutes, if needed (mix 1 ml of naloxone, 0.4 mg in 9 ml of D5W, which gives 0.04 mg/ml).<br><br>Note: Much higher doses should be given to patients with suspected propoxyphene (Darvon®), pentazocine (Talwin®), and fentanyl overdoses. |
| <b>NV</b> | [First responder] <sup>225</sup><br><br>Not within scope of practice. <sup>226</sup>   | Not within scope of practice. <sup>227</sup>   | N/A   | Within scope of practice if authorized to administer naloxone pursuant to a written protocol approved by the Division. <sup>228</sup> | Within scope of practice if authorized to administer naloxone pursuant to a written protocol that is approved by the Division. <sup>229</sup> | Varies depending on the patient's presentation. <sup>230</sup> Current protocol will change with this year's updates to the Nevada Administrative Code, which will follow national standards. <sup>231</sup><br><u>Adult:</u><br>- Altered mental status: 2.0 mg IV push and observe for response.<br>- Unconscious patient: 1.0 mg IV push and observe for response.<br><u>Pediatric:</u><br>Unconscious patient: 0.1 mg/kg up to 2 mg IV or ET.  |
| <b>NY</b> | [Certified First Responder] <sup>232</sup><br>Within scope of practice (IN only). <sup>233</sup>                               | Within scope of practice (IN only). <sup>234</sup>   | [EMT-CC] Within scope of practice. <sup>235</sup> | [EMT-I] Within scope of practice. <sup>236</sup>  | [EMT-P] Within scope of practice. <sup>237</sup>  | The State Emergency Medical Advisory Committee (SEMAC) is charged with developing statewide protocols. A statewide basic life support (BLS) protocol has been released, but an advanced life support (ALS) protocol has not yet been released. ALS protocols are currently   |

|           | EMR  | EMT   | AEMT   | EMT-I  | Paramedic                                | Protocol*   |
|-----------|--|---|--|--|--|---|
|           |  |   |  |  |  | <p>developed on a regional level.<sup>238</sup></p> <p>Statewide BLS Protocol:<sup>239</sup><br/>           Adult: 2 mg via IN only (1mg/1ml per nostril)<br/>           Pediatric: 1 mg via IN only (0.5mg/0.5ml per nostril)</p> <p>After 5 minutes, if a patient's respiratory rate is not greater than 10 breaths/minute, administer a second dose of naloxone following the same procedure as above and contact medical control.</p>   |
| <b>OH</b> | Within scope of practice (IN or auto-injector only) <sup>240</sup> | Within scope of practice (IN or auto-injector only). <sup>241</sup> | Within scope of practice. <sup>242</sup>               | Within scope of practice. <sup>243</sup>           | Within scope of practice. <sup>244</sup> | Protocol for administration is set by the medical director of each EMS agency. <sup>245</sup>   |
| <b>OK</b> | Within scope of practice. <sup>246</sup>                           | Within scope of practice. <sup>247</sup>                            | [EMT-I/85]<br>Within scope of practice. <sup>248</sup> | [AEMT]<br>Within scope of practice. <sup>249</sup> | Within scope of practice. <sup>250</sup> | <p>Protocols must be adopted by the Physician Director of an EMS Provider or Regional EMS System and must be approved by the Department of Health.<sup>251</sup> The State Department of Health has approved a model of EMS protocols from which local physician directors may deviate with approval by the Department.<sup>252</sup></p> <p>Model protocols vary depending on symptoms presented:</p> <p>Cardiac Arrest<sup>253</sup>:<br/> <u>Adults</u>: 2 mg IVP/IOP. May repeat once.<br/> <u>Pediatric</u>: .5 mg IVP/IOP. May repeat once.</p> <p>Apnea/Agonal Breathing<sup>254</sup> due to Poisoning,<sup>255</sup><br/>           Syncope,<sup>256</sup> Altered Mental Status,<sup>257</sup> or Respiratory Arrest<sup>258</sup>:<br/> <u>Adults</u>: 2 mg IVP/IOP/IN. May repeat up to 4 mg.<br/> <u>Pediatric</u>: .5 mg IVP/IOP/IN. May repeat up to 2 mg.</p> |



|           | EMR  | EMT   | AEMT                                     | EMT-I   | Paramedic                                | Protocol*   |
|-----------|--|---|--|---|--|---|
|           |  |   |  |   |  | <p>Ineffective breathing activity<sup>259</sup> due to Altered Mental Status,<sup>260</sup> Poisoning,<sup>261</sup> or Syncope<sup>262</sup>;<br/>           Adults &amp; Pediatric: .5 mg IVP/IOP/IN. May repeat up to 2 mg.</p> <p>In non-respiratory or non-cardiac arrest situations, titrate administration slowly.<sup>263</sup></p>   |
| <b>OR</b> | Not within scope of practice. <sup>264</sup> | Not within scope of practice. <sup>265</sup>  | Within scope of practice. <sup>266</sup> | Within scope of practice. <sup>267</sup>            | Within scope of practice. <sup>268</sup> | Authority to develop protocols/standing orders is delegated to the supervising physician. <sup>269</sup>  |
| <b>PA</b> | Not within scope of practice. <sup>270</sup> | Not within scope of practice. <sup>271</sup>  | Within scope of practice. <sup>272</sup> | N/A   | Within scope of practice. <sup>273</sup> | <p>Dosage and route vary depending on patient's presentation.<sup>274</sup></p> <p><u>Adult:</u></p> <ul style="list-style-type: none"> <li>- Possible narcotic response: If significant respiratory depression, administer naloxone 0.4 mg IV, titrate additional doses until adequate ventilation or total of 2 mg.</li> <li>- Evidence of opiate overdose and respiratory depression: 0.4 mg IV/IO (or 2 mg IM/IN); may repeat in titrated doses up to 2 mg total.</li> </ul> <p><u>Pediatric:</u></p> <ul style="list-style-type: none"> <li>- Infant care: Consider naloxone 0.1 mg/kg IV/IN</li> <li>- Evidence of opiate overdose and respiratory depression: 0.1 mg/kg IV/IO/IM/IN (maximum dose 0.4 mg); may repeat in titrated doses up to 2 mg total.</li> </ul> |
| <b>RI</b> | N/A <sup>275</sup>                           | [EMT-B and EMT-I]<br>Within scope of practice (initial IN only; additional IN / any IM require Medical Control order.) <sup>276</sup> | N/A                                      | [EMT-C]<br>Within scope of practice. <sup>277</sup> | Within scope of practice. <sup>278</sup> | <p>Protocol varies by patient's presentation and training level of EMS provider.<sup>279</sup></p> <p>BLS: 0.4 mg IN or contact Medical Control for permission to administer Naloxone 0.4 mg IM. If narcotic overdose is suspected repeat Naloxone in 2.0mg doses to a total of 10mg or as directed by medical control. If narcotic overdose is not suspected, repeat naloxone in 0.4 mg doses at 1-minute intervals until improvement in mental</p>  |

|           | EMR  | EMT  | AEMT   | EMT-I   | Paramedic                                | Protocol*   |
|-----------|--|--|--|---|--|---|
|           |  |  |  |   |  | <p>status or a total dose of 2 mg.</p> <p>ALS: 0.4mg via IV push, IM, IN or diluted in 10 mL normal saline by endotracheal tube. If narcotic overdose is suspected repeat Naloxone in 2.0mg doses to a total of 10mg or as directed by medical control.</p>   |
| <b>SC</b> | Not within scope of practice. <sup>280</sup> | Not within scope of practice. <sup>281</sup> | Within scope of practice—<br>IN only. <sup>282</sup> |   | Within scope of practice. <sup>283</sup> | <p>Authority to develop protocols is delegated to the local EMS provider's medical control physician.<sup>284</sup> The Department of Health published approved protocols in 2010 but noted that medical control physicians are not obligated to adopt the protocols.<sup>285</sup></p> <p>State-approved protocol (ALS):<sup>286</sup></p> <p>Routes:</p> <p><u>Adults:</u><br/>0.4-2 mg slow administration (IV, IO, IM, SC, ET) titrated to respirations.</p> <p><u>Pediatric:</u><br/>.1 mg/kg for children &lt;5 years old or &lt;20 kg.<br/>2 mg for children &gt;5 years old or &gt;20 kg.<br/>May repeat every 2-3 minutes as needed.</p> |
| <b>SD</b> | N/A <sup>287</sup>                           | Not within scope of practice. <sup>288</sup> | Within scope of practice. <sup>289</sup>             | [EMT-99 & EMT-85] Not within scope of practice. <sup>290, 291</sup> | Within scope of practice. <sup>292</sup> | <p>Advanced Emergency Medical Technicians and Paramedics are licensed by the South Dakota Board of Medical and Osteopathic Examiners; the Board is also granted the authority to approve educational programs for instruction of advanced life support personnel.<sup>293</sup></p> <p>South Dakota does have a BLS suggested protocol; agency protocols are set by their Medical Director.<sup>294</sup></p>   |
| <b>TN</b> | Not within scope of practice. <sup>295</sup> | Not within scope of practice. <sup>296</sup> | Within scope of practice. <sup>297</sup>             | [EMT-IV] Not within scope of practice. <sup>298</sup>               | Within scope of practice. <sup>299</sup> | <p>Authority to develop protocols delegated to Emergency Medical Directors of licensed EMS providers.<sup>300</sup> State protocols developed by the Division of EMS may be adopted as written or used as guidelines by EMS</p>   |

|           | EMR  | EMT  | AEMT                                     | EMT-I                                    | Paramedic                                | Protocol*  |
|-----------|--|--|--|--|--|--|
|           |  |  |  |  |  | <p>Directors.<sup>301</sup></p> <p>State-approved protocol:<sup>302</sup></p> <p>Drug Ingestion:<sup>303</sup> AEMTs and Paramedics<br/> <u>Adult:</u> 0.4 mg IV/IO/IM/IN titrated to adequate ventilation if narcotic use is suspected.<br/> <u>Pediatric:</u> 0.1 mg/kg IVP/IN if narcotic use is suspected.</p> <p>Unconscious / Unresponsive / Altered Mental Status:<sup>304</sup><br/> AEMTs and Paramedics<br/> <u>Adult:</u> 0.4 mg IV/IM/IN/IO titrated to adequate ventilation.<br/> May repeat up to 2 mg.<br/> <u>Pediatric:</u> &lt; 5 y.o. 0.1 mg/kg IV, &gt; 5 y.o. 0.4 mg IV. May repeat up to 2 mg.</p> |
| <b>TX</b> | <p>[ECA – Emergency Care Attendant]<sup>305</sup></p> <p>Not within scope of practice.<sup>306</sup></p> | Not within scope of practice. <sup>307</sup>       | N/A                                      | Within scope of practice. <sup>308</sup> | Within scope of practice. <sup>309</sup> | No statewide protocols; responsibility for protocols is devolved to each EMS system. <sup>310</sup>  |
| <b>UT</b> | Not within scope of practice. <sup>311</sup>   | Within scope of practice. (IN Only) <sup>312</sup> | Within scope of practice. <sup>313</sup> | N/A <sup>314</sup>                       | Within scope of practice. <sup>315</sup> | <p>Utah provides EMS Protocol Guidelines, but the use of these guidelines by individual EMS agencies is voluntary. Agencies may adopt them fully as written or may utilize them as a reference to develop their own protocols and standing orders.<sup>316</sup></p> <p>Altered Mental Status<sup>317</sup> or Overdose<sup>318</sup>:<br/> <u>Adult:</u><br/> EMT: 0.4-2mg IN. May repeat once.<br/> AEMT/Paramedic: 0.4-2mg IV/IM/IO/IN. May repeat once.</p>  |

|           | EMR  | EMT  | AEMT                                     | EMT-I                                    | Paramedic                                | Protocol*  |
|-----------|--|--|--|--|--|--|
|           |  |  |  |  |  | <u>Pediatric:</u><br>EMT: 0.1 mg/kg (max 2mg per dose) IN. May repeat once.<br>AEMT/Paramedic: 0.1 mg/kg (max 2mg per dose) IV/IM/IO/IN. May repeat once.<br><u>Newborn Resuscitation:</u> <sup>319</sup><br>0.1 mg/kg repeated every 2-3 minutes as needed for babies of suspected narcotic addicted mothers.   |
| <b>VA</b> | Not within scope of practice. <sup>320</sup>   | Within scope of practice. <sup>321</sup>           | Within scope of practice. <sup>322</sup> | Within scope of practice. <sup>323</sup> | Within scope of practice. <sup>324</sup> | Protocols are developed by collaboration between the Operational Medical Directors of licensed EMS agencies and state, regional, and local EMS authorities. <sup>325</sup> However, in practice, at least ten of the eleven Regional EMS Councils do not permit EMT-Bs to administer naloxone. <sup>326</sup>  |
| <b>VT</b> | Within scope of practice (IN Only). <sup>327</sup>   | Within scope of practice (IN Only). <sup>328</sup> | Within scope of practice. <sup>329</sup> | N/A                                      | Within scope of practice. <sup>330</sup> | <u>Adult:</u> <sup>331</sup><br>EMT: 1 mg IN per nostril (for a total of 2mg)<br>AEMT: 0.4-2mg IV/IO/IM/SQ/IN; If no response, may repeat every 5 minutes to a total of 10 mg.<br><u>Pediatric:</u> <sup>332</sup><br>EMT: Infant or toddler – .05mg per nostril (for a total of 1 mg); Small child – 1mg per nostril (for a total of 2 mg)<br>AEMT: 0.1mg/kg IV/IO/IM/SQ/IN to a max of 2mg. Unless severe respiratory depression due to overdose, then .01-2mg/kg IV/IO/IM/SQ/IN; If no response, may repeat every 5 minutes to a total of 10mg. |
| <b>WA</b> | [First Responder]<br><br>Not within scope of practice. <sup>333334</sup><br><sup>335</sup> | Not within scope of practice. <sup>336,</sup>      | Within scope of practice. <sup>337</sup> | N/A                                      | Within scope of practice. <sup>338</sup> | <u>Adult:</u> <sup>339</sup><br>Initial dose of 2 mg IV/IM; if necessary, dose may be repeated in 2 to 3 minute intervals to a maximum of 10 mg. For ET administration, dilute medication with normal saline to a volume of 3-5 ml and follow with several positive-pressure ventilations.<br><u>Pediatric:</u><br>If less than or equal to 5 years of age or less than or equal   |

|           | EMR  | EMT   | AEMT  | EMT-I                                    | Paramedic                                | Protocol*   |
|-----------|--|---|---|--|--|---|
|           |  |   |   |  |  | to 20 kg: 0.1 mg/kg. If greater than 5 years of age or greater than 20 kg: 2.0 mg.<br>Route of administration:<br>IV, IM, ET (ET dose should be increased to 2.5 times the IV dose).  |
| <b>WI</b> | Not within scope of practice. <sup>340</sup> | Not within scope of practice, unless practicing under an approved pilot program. <sup>341</sup> | Within scope of practice. <sup>342</sup>  | Within scope of practice. <sup>343</sup> | Within scope of practice. <sup>344</sup> | <p>The Department of Health Services has developed sample protocols, but local services are permitted to amend these protocols using the Medical Director approval form.<sup>345</sup><br/>Protocol also varies by patient's presentation and provider training level.</p> <p><u>Adult:</u><br/>ALOC: If narcotic overdose expected, administer 0.4 mg to 2 mg.<br/>Toxic Exposure and Overdose: If the patient has an altered level of consciousness and a narcotic overdose is suspected, consider Narcan 0.4 – 2 mg IV/IM/Sub-Q and repeat every 5 minutes X 3 total doses. If there is no response to Narcan, consider an alternative explanation or contact medical</p> <p><u>Pediatric:</u><br/>Toxic Exposure and Overdose: &lt; 20 kg 0.1. mg/kg/dose. Greater than or equal to 20 kg or &gt; 5 years old give 0.4 – 2 mg/dose IV/IM/Sub-Q and repeat every 5 minutes X 3 total doses. If there is no response to Narcan, consider an alternative explanation or contact medical control.</p> |
| <b>WV</b> | Not within scope of practice. <sup>346</sup> | Not within scope of practice. <sup>347</sup>  | Within scope of practice, if ordered by Medical Command Physician. <sup>348</sup> | N/A                                      | Within scope of practice. <sup>349</sup> | <p><u>Adult:</u><sup>350</sup><br/>If blood glucose level is &gt;80, administer naloxone 2 mg IV. If IV cannot be established, may administer intranasal (IN) via atomizer, or intramuscular (IM).</p> <p><u>Pediatric:</u><br/>Not specified.</p>  |

|           | EMR   | EMT  | AEMT   | EMT-I                                    | Paramedic                                | Protocol*  |
|-----------|---|--|--|--|--|--|
| <b>WY</b> | [First Responder]<br><br>Not within scope of practice. <sup>351</sup> | Not within scope of practice. <sup>352</sup>       | N/A  | Within scope of practice. <sup>353</sup> | Within scope of practice. <sup>354</sup> | Authority to develop protocols delegated to the health care facilities. <sup>355</sup>   |
| <b>DC</b> | Not within scope of practice. <sup>356</sup>                          | Within scope of practice (IN only). <sup>357</sup> | Within scope of practice. <sup>358</sup>           | Within scope of practice. <sup>359</sup> | Within scope of practice. <sup>360</sup> | <u>Adult:</u> <sup>361</sup><br>BLS: 2mg IN only, may repeat twice.<br>ALS: 2mg IV/IM/IN. If no response from the initial dose within 5 minutes, repeat 4mg IV/IN and titrate to effect thereafter if indicated.<br><u>Pediatric:</u> ALS personnel only<br>0.1mg/kg IV/IM/IN, up to a maximum single dose of 2mg.                                 |
| <b>PR</b> | N/A <sup>362</sup>  | Not within scope of practice. <sup>363</sup>       | N/A <sup>364</sup>                                 | N/A                                      | Within scope of practice. <sup>365</sup> | 2 mg IM, repeat every 5 minutes until ventilation improved<br><i>or</i><br>0.4 mg IV, repeat every 2 minutes until respiratory failure improved. <sup>366</sup>  |
| <b>GU</b> | Not within scope of practice. <sup>367</sup>                          | Not within scope of practice. <sup>368</sup>       | EMT-I:<br>Within scope of practice. <sup>369</sup> | N/A                                      | Within scope of practice. <sup>370</sup> | It is unclear whether Guam has adopted statewide protocols. The Code is clear that protocols must be approved by the EMS Medical Director. <sup>371</sup> However, the Code also indicates that the Office of EMS has authority to develop treatment protocols. <sup>372</sup> It does not appear that protocols have been adopted. <sup>373</sup> |

\*Medical guidance subject to modification — check current policies and protocols.

## Supporters



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- <sup>12</sup> Rawlinson C, Crews P. Access to Quality Health Services in Rural Areas Emergency Medical Services: A Literature Review. College Station, TX: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center; 2003.
- <sup>13</sup> Davis CS, Southwell JK, Niehaus VR, Walley AY, Dailey MW. Emergency Medical Services Naloxone Access: A National Systematic Legal Review. Acad Emerg Med 2014;21(10):1173-177.
- <sup>14</sup> The "U.S." row is based on U.S. DEP'T TRANSP., NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., DOT HS 810 657, NATIONAL EMS SCOPE OF PRACTICE MODEL 24 (2007) [hereinafter U.S. DEP'T TRANSP., NATIONAL EMS SCOPE OF PRACTICE MODEL], available at <http://www.ems.gov/education/EMSScope.pdf>. Administration of pharmaceuticals by EMRs is limited to use of unit-of-dose auto-injectors for the administration of life saving medications intended for self or peer rescue in hazardous materials situations. It does not seem likely that this definition was intended to apply to naloxone.

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- <sup>15</sup> U.S. DEP'T TRANSP., NATIONAL EMS SCOPE OF PRACTICE MODEL at 30. Administration of pharmaceuticals by EMTs is limited to oral glucose and aspirin and assisting the patient in taking their own prescribed medications. It is possible that this definition would encompass administration of naloxone that was prescribed to the patient, although it is not clear.
- <sup>16</sup> *Id.* See Psychomotor Skills, p.26. AEMTs may administer a narcotic antagonist to a patient suspected of a narcotic overdose.
- <sup>17</sup> See EMERGENCY MEDICAL TECHNICIAN – INTERMEDIATE: NATIONAL STANDARD CURRICULUM (1998), MODULE V, POISONING/OVERDOSE EMERGENCIES, 4(c)(3)(A) *available at* <http://www.nhtsa.gov/people/injury/ems/EMT-I/index.html>
- <sup>18</sup> U.S. DEP'T TRANSP., NATIONAL EMS SCOPE OF PRACTICE MODEL at 27.
- <sup>19</sup> *Id.* at 15.
- <sup>20</sup> Although there is no national dosing protocol, the FDA has approved dosage indications for naloxone hydrochloride, *available at* <http://www.accessdata.fda.gov/spl/data/29058a27-d2de-464a-94bb-328e039b8595/29058a27-d2de-464a-94bb-328e039b8595.xml>.
- <sup>21</sup> *Id.*
- <sup>22</sup> *Id.*
- <sup>23</sup> STATE OF ALASKA. MODEL STANDING ORDER AND TREATMENT PROTOCOLS FOR ETT/EMT-1, *available at* <http://dhss.alaska.gov/dph/Emergency/Documents/ems/assets/Downloads/2003AKEMTprotoEMT1.pdf>.
- <sup>24</sup> *Id.* Basic life support includes administration of oxygen, patient's prescribed nitroglycerin, bronchodilator inhaler, or epinephrine autoinjector and OTC medicines, including activated charcoal. ALASKA ADMIN. CODE TIT. 7, § 26.999.
- <sup>25</sup> ALASKA ADMIN. CODE TIT. 7, § 26.040(E). Note that An EMT-II and EMT-III who is not under the supervision of a medical director may only perform those procedures defined as basic life support in ALASKA ADMIN. CODE TIT. 7, § 26.999.
- <sup>26</sup> Mobile Intensive Care Paramedic (MICP) scope of practice is governed by State Medical Board regulations (compared to Alaska Department of Health and Social Services for EMT-I, EMT-II and EMT-III). ALASKA ADMIN. CODE TIT. 12 § 40.370.
- <sup>27</sup> These protocols were designed to serve as a model for those services wanting to adopt written protocols or those that need revised protocols. They are model guidelines and not intended to be interpreted as strict orders. STATE OF ALASKA. MODEL STANDING ORDER AND TREATMENT PROTOCOLS FOR EMT-I, EMT-2, EMT-3 AND MICP. (SECOND EDITION, NOVEMBER 2003, *available at* <http://dhss.alaska.gov/dph/Emergency/Documents/ems/assets/Downloads/2003AKEMTprotoalllevels.pdf>.
- <sup>28</sup> Although the Alabama EMS Final Rules define "Emergency Medical Responder," there is no defined scope of practice for EMRs. See ALA. ADMIN. CODE r. 420-2-1-.02(24) (2013) (defining "Emergency Medical Responder"); See ALABAMA EMS PATIENT CARE PROTOCOLS, *infra* note 29.
- <sup>29</sup> ALA. DEP'T OF PUB. HEALTH, OFFICE OF EMS & TRAUMA, ALABAMA EMS PATIENT CARE PROTOCOLS §1.01 (7<sup>th</sup> ed., 2013), *available at* <http://www.adph.org/ems/assets/7thEditionProtocols120513.pdf>.
- <sup>30</sup> *Id.*
- <sup>31</sup> *Id.*
- <sup>32</sup> *Id.*
- <sup>33</sup> *Id.* at § 5.22.
- <sup>34</sup> Emergency Medical Responders do not appear to be defined in Arkansas law. See ARK. CODE ANN. § 20-13-202; 007-28-001; ARK. CODE R. § I.
- <sup>35</sup> ARK. DEP'T OF HEALTH, SECTION OF EMERGENCY MEDICAL SERVICES, SCOPE OF PRACTICE FOR ALL LICENSED EMSP LEVELS, *available at* <http://www.healthy.arkansas.gov/programsServices/hsLicensingRegulation/EmsandTraumaSystems/Documents/Rules/SkillsAllLevels.pdf>; ARK. STATE BOARD OF HEALTH, SECTION OF EMERGENCY MEDICAL SERVICES, RULES AND REGULATIONS FOR EMERGENCY MEDICAL SERVICES § VIII(1) (hereafter ARK. RULES).



<sup>36</sup> *Id.* May only administer medications if they have been trained in the pharmacology of the medication and credentialed to administer the medication by the EMS agency medical director.

<sup>37</sup> *Id.*

<sup>38</sup> See ARK. RULES § VI(B)(3).

<sup>39</sup> ARK. DEP'T OF HEALTH, SECTION OF EMS, BASIC LIFE SUPPORT PROTOCOLS, *available at* <http://www.healthy.arkansas.gov/programsServices/hsLicensingRegulation/EmsandTraumaSystems/FormsManualsMemos/Documents/Manuals/BasicLifeSupportProtocols.pdf>.

<sup>40</sup> Although the Arizona EMS statute defines “Emergency Medical Responder,” neither the statute nor regulations otherwise refer to EMRs, and no EMR scope of practice appears to exist. See ARIZ. REV. STAT. § 36-2201(16) (defining “Emergency Medical Responder”); See ARIZ. ADMIN. CODE ARTICLE 5, § R9-25-101 (“Emergency Medical Responder” is not defined).

<sup>41</sup> ARIZ. ADMIN. CODE ART. 5, § R9-25-503, *available at* [http://www.azsos.gov/public\\_services/title\\_09/9-25.htm](http://www.azsos.gov/public_services/title_09/9-25.htm).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> May use Nalmeferene HCl (2 mg/2mL) if Naloxone HCl is not available. ARIZ. DEP'T OF HEALTH SERVS. BUREAU OF EMERGENCY MEDICAL SERVICES AND TRAUMA SYSTEM. DRUG PROFILES, *available at* <http://www.azdhs.gov/bems/documents/DrugProfiles.pdf>

<sup>45</sup> Although some local EMS agencies in California continue to reference a basic “First Responder” certification, it appears likely these local EMS agencies' websites have not been updated and that such references are no longer applicable.

<sup>46</sup> Naloxone administration is an optional skill for EMTs, and requires training to consist of no less than two hours and a written and skills examination. CAL.CODE REGS. tit. 22, §§ 100064(a), 100064(c), *available at* <http://www.emsa.ca.gov/Media/Default/Word/2014%20Regulations%20Book.docx>. Administration is limited to “means other than intravenous injection.” CAL. HEALTH & SAFETY CODE § 1797.8(b), *available at* [http://www.emsa.ca.gov/Media/Default/PDF/EMSA\\_Statutes2013.pdf](http://www.emsa.ca.gov/Media/Default/PDF/EMSA_Statutes2013.pdf). See also CAL. EMERGENCY MED. SERVS. AUTH., NALOXONE ADMINISTRATION (April 2013), *available at* [http://www.emsa.ca.gov/Media/Default/PDF/Naloxone\\_20Administration\\_20%28April\\_202013%29.pdf](http://www.emsa.ca.gov/Media/Default/PDF/Naloxone_20Administration_20%28April_202013%29.pdf).

<sup>47</sup> CAL.CODE REGS. tit. 22, §§ 100106(b)(4)(C), (b)(8)(F), *available at* [http://www.emsa.ca.gov/Media/Default/PDF/ch3\\_aemt.pdf](http://www.emsa.ca.gov/Media/Default/PDF/ch3_aemt.pdf).

<sup>48</sup> CAL.CODE REGS. tit. 22, § 100146(c)(1)(R)(22).

<sup>49</sup> See CAL. HEALTH & SAFETY CODE §§ 1798(a), 1797.220; CAL.CODE REGS. tit. 22, §§ 100064(a), 100107(f), 100148(d).

<sup>50</sup> Colorado has no EMR or equivalent. EMS PROVIDER CERTIFICATION FREQUENTLY ASKED QUESTIONS, *available at* <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline%3B+filename%3D%22Certification+ Frequently+Asked+Questions.pdf%22&blobheadvalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251808764370&ssbinary=true>.

<sup>51</sup> 6 CODE COLO. REGS § 1015-3:2 app. B, tbl. B.2, *available at* <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadvalue1=inline%3B+filename%3D%22Chapter+2+-+Rules+Pertaining+to+EMS+Practice+and+Medical+Director+Oversight.pdf%22&blobheadvalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251861886727&ssbinary=true>.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.* § 1015-3:2.4.2.6.

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<sup>56</sup> Permitted via intramuscular auto-injector or intranasal spray only. STATE OF CONN., DEP'T OF PUBLIC HEALTH, CHANGE TO EMR, EMT, AEMT SCOPE OF PRACTICE – ADMINISTRATION OF NALOXONE, available at [http://www.ct.gov/dph/lib/dph/ems/pdf/communication\\_statements/2014\\_06\\_change\\_to\\_emr\\_emt\\_aemt\\_scope\\_of\\_practice\\_-\\_administration\\_of\\_naloxone.pdf](http://www.ct.gov/dph/lib/dph/ems/pdf/communication_statements/2014_06_change_to_emr_emt_aemt_scope_of_practice_-_administration_of_naloxone.pdf).

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* In Connecticut, protocols and scope of practice are defined either by the sponsor hospital (31 total) in which EMT practice as mobile intensive care units. In some cases, protocols and scope of practice may be defined by the EMS region (5 total). Each sponsor hospital or region may have its own protocols or standards of care.

<sup>61</sup> CONN. AGENCIES REGS. § 19A.-179a, available at <http://www.cga.ct.gov/2011/pub/chap368d.htm> .

<sup>62</sup> CONN. PUBLIC HEALTH CODE §19a-179-12, available at [http://www.ct.gov/dph/lib/dph/public\\_health\\_code/sections/19a-179-1\\_to\\_19a-179-21\\_office\\_of\\_ems.pdf](http://www.ct.gov/dph/lib/dph/public_health_code/sections/19a-179-1_to_19a-179-21_office_of_ems.pdf)

<sup>63</sup> No EMR or similar level defined in statute. See DEL. CODE. ANN. tit. 16, § 9702.

<sup>64</sup> EMTs in Delaware are generally not permitted to administer Naloxone. DELAWARE BASIC LIFE SUPPORT PROTOCOLS, GUIDELINES AND STANDING ORDERS FOR PREHOSPITAL AND INTERFACILITY PATIENTS, available at <http://statefireschool.delaware.gov/pdfs/BLSStandingOrders2013.pdf>. However, as of October 2013, EMTs are permitted to administer intranasal naloxone with the written approval of the State EMS Director or BLS Medical Director under a pilot protocol. DEL. OFFICE EMS, DELAWARE BASIC LIFE SUPPORT PROTOCOLS, GUIDELINES AND STANDING ORDERS MID-CYCLE UPDATE FOR PREHOSPITAL AND INTERFACILITY PATIENTS 2-3 (effective Oct. 16, 2013), available at <http://www.dhss.delaware.gov/dph/ems/files/blsprotocolsmidcycle2013.pdf> .

<sup>65</sup> Delaware law provides for 3 levels of emergency services personnel: EMTs, AEMTs, and paramedics. DEL. CODE. ANN. tit. 16, § 9702(1),(12),(17). However, training programs and protocols have only been developed for EMTs and paramedics.

<sup>66</sup> DEL. OFFICE OF EMS. STATEWIDE STANDARD TREATMENT PROTOCOLS. PARAMEDIC STANDING ORDERS, GUIDELINES AND POLICIES 2012. ALTERED MENTAL STATUS. available at: <http://www.dhss.delaware.gov/dph/ems/files/paramedicstandingorders2012.pdf>

<sup>67</sup> DELAWARE BASIC LIFE SUPPORT PROTOCOLS, GUIDELINES AND STANDING ORDERS MID-CYCLE UPDATE FOR PREHOSPITAL AND INTERFACILITY PATIENTS, at 2.

<sup>68</sup> DEL. OFFICE OF EMS. STATEWIDE STANDARD TREATMENT PROTOCOLS. PARAMEDIC STANDING ORDERS, GUIDELINES AND POLICIES 2012, at 15.

<sup>69</sup> *Id.* at 41.

<sup>70</sup> EMRs do not appear in the Florida statutes. See FLA. STAT. § 401.23.

<sup>71</sup> EMTs in Florida may provide only basic life support services, which do not include administration of medication other than epinephrine via autoinjector. FLA. STAT. §§ 401.23(7), (11).

<sup>72</sup> Florida only has two levels of prehospital providers: EMT and paramedic. *Licensing EMS Provider*, FLA. DEP'T HEALTH, <http://www.floridahealth.gov/licensing-and-regulation/licensing-ems-education/index.html> (last visited Sept. 8, 2014). See also FLA. STAT. § 401.23.

<sup>73</sup> Paramedic is defined to provide both basic and advanced life support services. Advanced life support services include administration of medication. FLA. STAT. §§ 401.23(1), (17).

<sup>74</sup> FLA. ADMIN. CODE r. 64J-1.004(4)(a).

<sup>75</sup> The Georgia statute does not define EMR or any like qualification level. GA. CODE ANN. § 31-11-2. However, Georgia's regulatory code defines a "First Responder" as "an individual who has successfully completed an appropriate first responder course approved by the department and otherwise meets the eligibility requirement set forth in this chapter. GA. COMP. R. & REGS. 511-9-2-.02(II) (2014). There is no clearly defined scope of practice for a "first responder." See GA. SCOPE OF PRACTICE, *supra* note 76. The Clinical Operating Guidelines mention "first responders," but it is unclear whether this use is intended to convey the regulatory or lay definition of a first responder. See EMERGENCY MEDICAL SERVICES PREHOSPITAL CLINICAL OPERATING GUIDELINES, *supra* note 80.

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- <sup>76</sup> Ga. OFFICE OF EMERGENCY MED. SERVS. & TRAUMA, R-P11A, SCOPE OF PRACTICE FOR EMS PERSONNEL 5 (2014) [hereinafter GA. SCOPE OF PRACTICE], *available at* [http://dph.georgia.gov/sites/dph.georgia.gov/files/Scope\\_of\\_Practice\\_7-2014.pdf](http://dph.georgia.gov/sites/dph.georgia.gov/files/Scope_of_Practice_7-2014.pdf). The Clinical Operating Guidelines do not appear to permit IN administration of naloxone; this is likely because the EMT scope of practice has been updated (as directed by HB 965, 2014) since the Guidelines were promulgated.
- <sup>77</sup> *Id.* at 5.
- <sup>78</sup> *Id.*
- <sup>79</sup> *Id.*; *see also* GA. CODE ANN. § 31-11-54(a)(1).
- <sup>80</sup> GA DEP'T OF PUB. HEALTH, EMERGENCY MEDICAL SERVICES PREHOSPITAL CLINICAL OPERATING GUIDELINES 152 (2013), *available at* [http://dph.georgia.gov/sites/dph.georgia.gov/files/EMS%202013%20clinical%20guideliness\\_0.pdf](http://dph.georgia.gov/sites/dph.georgia.gov/files/EMS%202013%20clinical%20guideliness_0.pdf).
- <sup>81</sup> HAW. REV. STAT. § 321-222 (Defining "First responder personnel" as "a person who has successfully completed a United States Department of Transportation approved First Responder Course of training in emergency basic life support."). The revised First Responder: National Standard Curriculum, which outlines the requirements of approved first responder courses, is available at <http://www.nhtsa.gov/people/injury/ems/pub/frnsc.pdf>.
- <sup>82</sup> Implied by the exclusion of naloxone administration from the scope of practice for EMT-Bs. *See* HAW. CODE R. § 16-85-59(a).
- <sup>83</sup> HAW. CODE R. §§ 16-85-56(a); 16-85-59(a).
- <sup>84</sup> The administrative code only describes two levels of EMS personnel: EMT-Bs and paramedics. *Id.* § 16-85.53.5.
- <sup>85</sup> *Id.* §§ 16-85-56(a); 16-85-59(b).
- <sup>86</sup> STANDING ORDERS POLICY FOR MOBILE INTENSIVE CARE TECHNICIANS, ADULT AND PEDIATRIC PATIENTS, § A-9 (2010) *available at* <http://health.hawaii.gov/ems/files/2013/10/SO2013.pdf>.
- <sup>87</sup> *Id.*, § A-14
- <sup>88</sup> IOWA DEP'T OF PUB. HEALTH, BUREAU OF EMERGENCY MED. SERVS., IOWA EMERGENCY MEDICAL CARE PROVIDER SCOPE OF PRACTICE (2014) [HEREINAFTER IOWA SCOPE OF PRACTICE], *available at* [http://www.idph.state.ia.us/ems/common/pdf/proposed\\_042013.pdf](http://www.idph.state.ia.us/ems/common/pdf/proposed_042013.pdf). Scope of Practice for Iowa EMS Providers is "defined and approved in accordance with the rules of the [Iowa Department of Public Health]." IOWA CODE § 147A.8(1). The scope of practice rules are incorporated by reference into the Iowa administrative code. IOWA ADMIN. CODE. r. 641-131.3(3).
- <sup>89</sup> IOWA SCOPE OF PRACTICE, *supra* note 88, at 6.
- <sup>90</sup> IOWA SCOPE OF PRACTICE, *supra* note 88, at 12.
- <sup>91</sup> IOWA SCOPE OF PRACTICE, *supra* note 88, at 12. EMT-Intermediates must transition to EMTs or AEMTs by March 31, 2016. Letter from Iowa Bureau of Emergency Medical Servs. to Iowa EMS Providers (January 2011), *available at* [http://www.idph.state.ia.us/ems/common/pdf/transition/transition\\_2011.pdf](http://www.idph.state.ia.us/ems/common/pdf/transition/transition_2011.pdf).
- <sup>92</sup> IOWA SCOPE OF PRACTICE, *supra* note 88, at 12.
- <sup>93</sup> IOWA DEP'T OF PUB. HEALTH, BUREAU OF EMERGENCY MED. SERVS., STATEWIDE EMS TREATMENT PROTOCOLS ADULT & PEDIATRIC 14, 30 (2014), *available at* [http://www.idph.state.ia.us/ems/common/pdf/ems\\_protocols.pdf](http://www.idph.state.ia.us/ems/common/pdf/ems_protocols.pdf).
- <sup>94</sup> *Id.* at 51.
- <sup>95</sup> IDAHO EMSPC SCOPE OF PRACTICE, STATEWIDE PROTOCOLS AND PROCEDURES *available at* [http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/EMSPC\\_protocols.pdf](http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/EMSPC_protocols.pdf).
- <sup>96</sup> *Id.*
- <sup>97</sup> *Id.*

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<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* Scope of practice document notes that naloxone “should be carefully titrated to reverse respiratory depression without inducing agitation or withdrawal.”

<sup>101</sup> The Illinois legislature recently revised the statute defining the licensure levels of “Emergency Medical Services personnel” to include Emergency Medical Responders (EMR or First Responder). 210 ILL. COMP. STAT. ANN. 50/3.50(C-5) (WEST 2014). See also 210 ILL. COMP. STAT. ANN. 50/3.5 (WEST 2014) (Defining “Emergency Medical Responder”). EMRs “may perform emergency and non-emergency medical services as defined in this Act, in accordance with his or her level of education, training, and licensure, the standards of performance and conduct prescribed by the Department in rules adopted pursuant to this Act, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System.” 210 ILL. COMP. STAT. ANN. 50/3.55(a) (WEST 2014). Thus, administration of naloxone may fall within an EMR’s scope of practice if the EMR is sufficiently educated, trained, and licensed, there are no other regulatory rules otherwise barring the EMR from administering Naloxone, and the administration of Naloxone by EMRs is contained within an approved Program Plan.

<sup>102</sup> Illinois’ curriculum for EMS providers follows the national model. 210 ILL. COMP. STAT. 50/3.10(a)-(c). However, the regulations state that “[a]ny person licensed as an EMT-B, EMT-I or EMT-P shall perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in this Part, and the requirements of the EMS System in which he or she practices, as contained in the approved Program Plan for that System.” ILL. ADMIN CODE. tit. 77, § 515.550(a) (emphasis added). This has led to intra-state variation in scope of practice. For example, the Peoria Area Emergency Medical System permits basic life support providers to administer naloxone via IN. PEORIA AREA EMS SYSTEM, PREHOSPITAL CARE MANUAL 107, 109, 111, 144, 172, 285 (Oct. 24, 2013), available at <http://www.paems.org/pdfs/protocols/adult-protocol-manual.pdf> (revised Sept. 2014).

<sup>103</sup> 210 ILL. COMP. STAT. ANN. 50/3.55(a) (WEST 2014).

<sup>104</sup> *Id.*

<sup>105</sup> 210 ILL. COMP. STAT. 50/3.20(a).

<sup>106</sup> Indiana passed legislation in 2012 defining an “Emergency medical responder.” IND. CODE § 16-18-2-109.8. Although Indiana regulations continue to define a “First responder,” the definition of both “First responder” and “Emergency medical responder” appear identical. See 836 IND. ADMIN. CODE 1-1-1(32). Thus, it seems likely the Indiana legislature intended to replace the use of “First responder” with “Emergency medical responder,” but this intent is not explicitly stated.

<sup>107</sup> Effective Mar. 26, 2014, state law permits EMRs, EMTs, AEMTs, and Paramedics to administer naloxone. IND. CODE § 16-31-3-23.5.

<sup>108</sup> *Id.* Indiana’s administrative code states that each level of EMS providers are only permitted to perform procedures for which they are trained and that have been approved by the Indiana EMS Commission as within the scope of practice for that provider level. 836 IND. ADMIN. CODE 4-4-1(e)(1), 4-7.1-3(e)(1), 4-9-3(e)(1), available at <http://www.state.in.us/legislative/jac/title836.html>. A document outlining the scope of practice for each level of provider can be found on Indiana’s EMS website. IND. EMERGENCY MED. SERVS. COMMISSION, LEVELS OF EMS PERSONNEL CERTIFICATION, available at [http://www.in.gov/dhs/files/IN\\_EMS\\_lvls\\_EMS\\_Personnel\\_Cert061713.pdf](http://www.in.gov/dhs/files/IN_EMS_lvls_EMS_Personnel_Cert061713.pdf).

<sup>109</sup> See *supra* note 107 (AEMTs permitted to administer naloxone); see also 836 IND. ADMIN. CODE 2-7.2-3-(d).

<sup>110</sup> See *supra* note 107 (Paramedics permitted to administer naloxone).

<sup>111</sup> IND. CODE §§ 16-31-2-7, 16-31-3-20.

<sup>112</sup> 836 IND. ADMIN. CODE 1-2-1(e)(9).

<sup>113</sup> KAN. STAT. ANN. § 65-6144.

<sup>114</sup> KAN. STAT. ANN. § 65-6121.

<sup>115</sup> KANSAS EMERGENCY MEDICAL SERVICES EDUCATION STANDARDS: ADVANCED EMERGENCY MEDICAL TECHNICIAN (2010) available from [http://www.ksbems.org/html%20pages/KS\\_AEMT.pdf](http://www.ksbems.org/html%20pages/KS_AEMT.pdf) at 38, 109.

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<sup>116</sup> KAN. BOARD OF EMS: ADVANCED EMT MEDICATION LIST (2012) available at <http://www.ksbems.org/html%20pages/AEMT%20medication%20list%20%2805-01-2012%29.pdf>

<sup>117</sup> KAN. STAT. ANN. § 65-6119.

<sup>118</sup> KAN. STAT. ANN. § 65-6112(r).

<sup>119</sup> While the Kentucky EMS website makes clear that the state has adopted the national nomenclature of EMR, the relevant statute has not been updated and continues to refer to “first responders.” See Ky. Board of Emergency Med. Servs., Certification & Licensure, available at [http://kbems.kctcs.edu/Certification\\_and\\_Licensure.aspx](http://kbems.kctcs.edu/Certification_and_Licensure.aspx). As with EMTs and Paramedics, this statute refers to the national curriculum. KY. REV. STAT. ANN. §§ 311A.165.

<sup>120</sup> Kentucky outlines the scope of practice for EMTs and Paramedics as procedures “(a) [s]pecified in the most recent curriculum of the United States Department of Transportation training course [for emergency medical technicians or paramedics]; and (b) [a]ny additional procedure specified by the board by administrative regulation.” KY. REV. STAT. ANN. §§ 311A.165(1); 311A.170(1). Neither the curriculum nor the additional regulations permit EMTs to administer naloxone. 202 KY. ADMIN. REGS. 7:701 § 2.

<sup>121</sup> AEMTs are not specifically addressed in the statutes or regulations, but are included in the commonwealth’s EMS patient care protocols. Presumably AEMTs are also permitted to perform procedures specified in the national curriculum.

<sup>122</sup> Kentucky authorizes paramedics to perform “any procedure specified in the most recent curriculum of the United States Department of Transportation training course for paramedics.” KY. REV. STAT. ANN. § 311A.170.

<sup>123</sup> “[P]rotocols, standing orders, and similar medical control documents” are developed by “[e]ach emergency medical services medical director for an ambulance service” and submitted to the Kentucky Board of Emergency Medical Services for approval. KY. REV. STAT. ANN. §§ 311A.180(1). State protocols were developed for potential adoption by individual ambulance services. COMMONWEALTH OF KY., PATIENT CARE PROTOCOLS 307, available at [http://kbems.kctcs.edu/en/Medical\\_Direction/Protocols.aspx](http://kbems.kctcs.edu/en/Medical_Direction/Protocols.aspx).

<sup>124</sup> “Licensed emergency medical responder” is defined as “any individual who has successfully completed an emergency medical responder education program based on National EMS Education Standards approved by the bureau and who is licensed by the bureau.” LA. REV. STAT. § 40:1231(15).

<sup>125</sup> Pursuant to LA. REV. STAT. § 40:978.1(B), an “EMS practitioner” as defined in state law may “receive a prescription for naloxone or another opioid antagonist, maintain the naloxone or other opioid antagonist in the first responder’s possession, and administer the naloxone or other opioid antagonist to any individual who is undergoing or who is believed to be undergoing an opioid-related drug overdose.” “EMS practitioner” is defined as “an individual who is a licensed emergency medical responder, licensed emergency medical technician, licensed advanced emergency medical technician, or a licensed paramedic.” LA. REV. STAT. § 40:1231(12).

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> LA. REV. STAT. § 40:1232.4.

<sup>130</sup> LA. ADMIN. CODE tit. 48, § 6037.

<sup>131</sup> For further information, see Optional First Responder Naloxone Program for First Responders – Frequently Asked Questions, available at <http://www.mass.gov/eohhs/docs/dph/emergency-services/first-responder-naloxone-faqs.pdf>. The EMS Pre-Hospital Treatment Protocols state that EMTs and EMT-Intermediates may administer nasal or auto-injector naloxone “if trained and authorized.” MASS. DEPT OF PUB. HEALTH, OFFICE OF EMERGENCY MED. SERVS., EMERGENCY MEDICAL SERVICES PRE-HOSPITAL TREATMENT PROTOCOLS 2.14 (Effective September 6, 2014) [hereinafter MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS], available at <http://www.mass.gov/eohhs/docs/dph/emergency-services/treatment-protocols-12-03.pdf>.

<sup>132</sup> MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS AT 2.14. The regulations refer to this level at “Emergency Medical Technician-Basic” but the Protocols use the federal “EMT” designation. 105 MASS. CODE REGS. 170.810. *Id.*

<sup>133</sup> The scope of practice with relation to naloxone administration for AEMTs is identical to that of paramedics. *Id.* at 2.14.

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- <sup>134</sup> Massachusetts is transitioning EMT-Intermediates to AEMTs. See Commonwealth of Massachusetts, Office of Emergency Medical Services, “Dear Massachusetts certified EMT-Intermediate,” available at <http://www.mass.gov/eohhs/docs/dph/emergency-services/scope-of-practice/emt-intermediates.pdf>. As with EMTs, EMT-Intermediates are only permitted to administer nasal or auto-injector naloxone “if trained and authorized.” MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS, *supra* note 131, at 2.14.
- <sup>135</sup> The regulations state that a Paramedic may perform the functions of an Advanced EMT as well as “advanced life support related to treatment of cardiac or respiratory arrest, poisoning, overdose, or other major trauma or illness, in accordance with the Statewide Treatment Protocols.” 105 MASS. CODE REGS. 170.840(A). State Protocols permit paramedics to administer naloxone via IV, IM, SC, or IN. MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS, *supra* note 131, at 72, 249.
- <sup>136</sup> MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS, *supra* note 131, at 2.14.
- <sup>137</sup> Route of administration is unclear; elsewhere the protocols specify 0.4-2mg IV/IM/SQ/IN/ETT, to be repeated as needed if no response. MASS. EMS PRE-HOSPITAL TREATMENT PROTOCOLS, *supra* note 131, at Appendix A1.
- <sup>138</sup> Maryland regulations state that an “EMS provider shall provide emergency medical services in accordance with the ‘Maryland Medical Protocols for EMS Providers’.” CODE OF MARYLAND REGULATION (COMAR) 30.02.03.01 available at <http://www.dsd.state.md.us/comar/getfile.aspx?file=30.02.03.01.htm>. Per the July 2014 protocol, EMRs are permitted to administer naloxone under an optional protocol. MD. INST. EMERGENCY MED. SERVS., THE MARYLAND MEDICAL PROTOCOLS FOR EMERGENCY MEDICAL SERVICES PROVIDERS 146 (effective July 1, 2014) [hereinafter MARYLAND MEDICAL PROTOCOLS FOR EMS PROVIDERS], available at <http://www.miemss.org/home/LinkClick.aspx?fileticket=RbnabALtvXg%3d&tabid=106&mid=907>.
- <sup>139</sup> MARYLAND MEDICAL PROTOCOLS FOR EMS PROVIDERS, *supra* note 138, at 207-1.
- <sup>140</sup> MARYLAND MEDICAL PROTOCOLS FOR EMS PROVIDERS, *supra* note 138, at 242.
- <sup>141</sup> *Id.*
- <sup>142</sup> MARYLAND MEDICAL PROTOCOLS FOR EMS PROVIDERS, *supra* note 138, at 39.
- <sup>143</sup> *Id.* at 40.
- <sup>144</sup> 16-163-5 ME. CODE R. § 2(1)(A); ME. EMERGENCY MED. SERVS., PREHOSPITAL TREATMENT PROTOCOLS [hereinafter Maine Protocols] Gold 3-4, Yellow 5, Pink 5-6, Gray 20 (effective Dec. 1, 2013), available at [http://www.maine.gov/ems/documents/2013\\_Maine\\_EMS\\_Protocols.pdf](http://www.maine.gov/ems/documents/2013_Maine_EMS_Protocols.pdf).
- <sup>145</sup> 16-163-5 ME. CODE R. § 2(1)(B)(4) (EMTs may administer medication “as approved by the Board and as allowed by Maine EMS protocol.”), available at [http://www.maine.gov/ems/documents/Rules\\_Effective\\_May\\_1\\_2013.pdf](http://www.maine.gov/ems/documents/Rules_Effective_May_1_2013.pdf).
- <sup>146</sup> *Id.* § 2(2)(A) (AEMTs may administer medication “as approved by the Board and as allowed by Maine EMS protocol.”).
- <sup>147</sup> *Id.* § 2(2)(C) (Paramedics may administer medication “as approved by the Board and as allowed by Maine EMS protocol.”).
- <sup>148</sup> MAINE PROTOCOLS, *supra* note 144.
- <sup>149</sup> “Medical first responder” is defined as “an individual who has met the educational requirements of a department approved medical first responder course and who is licensed to provide medical first response life support as part of a medical first response service or as a driver of an ambulance that provides basic life support services only. Medical first responder does not include a police officer solely because his or her police vehicle is equipped with an automated external defibrillator.” MICHIGAN PUBLIC HEALTH CODE § 333.20906 (8).
- <sup>150</sup> Under Michigan’s EMS treatment protocols, only AEMTs (formerly EMT-Specialist) and paramedics may administer naloxone. MICH. DEP’T OF CMTY. HEALTH, MICHIGAN PROTOCOLS (updated Apr. 14, 2014), available at [http://www.michigan.gov/mdch/0,4612,7-132-2946\\_5093\\_28508-132260--,00.html#mca\\_protocols](http://www.michigan.gov/mdch/0,4612,7-132-2946_5093_28508-132260--,00.html#mca_protocols).
- <sup>151</sup> *Id.* MICHIGAN PUBLIC HEALTH CODE § 333.20912 (1)(a) authorizes the Department of Community Health to review and approve the curricula for emergency medical services personnel; a requirements document for EMT education references the National Standard Curriculum (See [http://www.michigan.gov/documents/EMT\\_Objectives\\_9-02\\_156011\\_7.pdf](http://www.michigan.gov/documents/EMT_Objectives_9-02_156011_7.pdf) page TA-2, last paragraph), however, this is not implicitly expressed in code or statute.
- <sup>152</sup> MICHIGAN PROTOCOLS, *supra* note 150

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- <sup>153</sup> *Id.*
- <sup>154</sup> MICHIGAN ADULT TREATMENT PROTOCOLS: ALTERED MENTAL STATUS, SECTIONS 1-3, available at [http://www.michigan.gov/mdch/0,4612,7-132-2946\\_5093\\_28508-132260--00.html#mca\\_protocols](http://www.michigan.gov/mdch/0,4612,7-132-2946_5093_28508-132260--00.html#mca_protocols).
- <sup>155</sup> *Id.* See PEDIATRIC ALTERED MENTAL STATUS, SECTIONS 3-1
- <sup>156</sup> Implied by the exclusion of EMRs from the statute authorizing EMTs and above to administer naloxone. Under the statute, only “ambulance service personnel” may administer Naloxone. EMRs are not included in the statutory definition of “ambulance service personnel.” MINN. STAT. § 144E.001, SUBD. 3a. Available at <https://www.revisor.mn.gov/statutes/?id=144E.001>. See MINN. STAT. § 144E.101, SUBD. 6(d) (excluding EMRs from ambulance service personnel authorized to administer an opiate antagonist).
- <sup>157</sup> MINN. STAT. § 144E.101, SUBD. 6(d). Available at <https://www.revisor.mn.gov/laws/?id=232&doctype=Chapter&year=2014&type=0>. Minnesota statute provides that “[a] basic life-support service licensee’s medical director may authorize ambulance service personnel to perform intravenous infusion and use equipment that is within the licensure level of the ambulance service, **including administration of an opiate antagonist**. Ambulance service personnel must be properly trained. Documentation of authorization for use, guidelines for use, continuing education, and skill verification must be maintained in the licensee’s files.” (emphasis added). “Ambulance service personnel” is defined as “individuals who are authorized by a licensed ambulance service to provide emergency care for the ambulance service and are: (1) EMT’s, AEMT’s, or paramedics . . . .” MINN. STAT. § 144E.001, SUBD. 3a, available at <https://www.revisor.mn.gov/statutes/?id=144E.001>.
- <sup>158</sup> *Id.*
- <sup>159</sup> *Id.*
- <sup>160</sup> MINN. STAT. § 144E.265 SUBD. 2 (6), available at <https://www.revisor.leg.state.mn.us/statutes/?id=144E.26>. The state does maintain Pre-Hospital Guidelines for BLS providers, but they have not yet been updated to reflect the recent change to permit EMTs to administer naloxone. Minn. Emergency Medical Services Regulatory Board, Sample BLS *Guidelines*, available at <http://mn.gov/health-licensing-boards/emr/ambulanceservices/patientcareguidelines.jsp>.
- <sup>161</sup> “First responder” is defined as “a person who has successfully completed an emergency first response course meeting or exceeding the national curriculum of the United States Department of Transportation and any modifications to such curricula specified by the department through rules adopted pursuant to sections 190.001 to 190.245 and who provides emergency medical care through employment by or in association with an emergency medical response agency.” MO. REV. STAT. § 190.100(21).
- <sup>162</sup> Mo. Rev. Stat. § 190.255 (2014).
- <sup>163</sup> Effective August 28, 2014, EMTs may administer naloxone if they are “acting under the directives and establish protocols of a medical director of a local licensed ground ambulance service . . . .” and have “received training in recognizing and responding to a narcotic or opiate overdose and the administration of naloxone to a person suffering from an apparent narcotic or opiate-related overdose. See Mo. Rev. Stat. § 190.255 (2014).
- <sup>164</sup> Mo. Rev. Stat. § 190.255 (2014).
- <sup>165</sup> For EMT-Ps, Missouri refers to the national scope of practice with regard to training, but does not adopt the national scope of practice. See 19 CSR 30-40.331(2)(L)(4). Per the National Scope of Practice Model, EMT-Ps are permitted to administer narcotic antagonists. See <http://health.mo.gov/safety/ems/pdf/SoPFinal.pdf>.
- <sup>166</sup> See 19 CSR 30-40.303(2)(C) MISSOURI CODE OF STATE REGULATIONS (2012), available at <http://www.sos.mo.gov/adrules/csr/current/19csr/19c30-40.pdf>.
- <sup>167</sup> “Medical first responder” is defined as “a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved “First Responder: National Standard Curriculum” training program, as developed and promulgated by the United States Department of Transportation; (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services.” MISS. CODE ANN. § 41-59-3.
- <sup>168</sup> See 15-12-31 MISS. CODE R. §§ 4.15, 4.16; MISSISSIPPI EMS APPROVED MEDICATION AND FLUID LIST, *infra* note 156.

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- <sup>169</sup> See 15-12-31 Miss. CODE R. §§ 6.19, 6.20; see also MISSISSIPPI EMS APPROVED MEDICATION AND FLUID LIST (Feb. 2013), available at [http://msdh.ms.gov/msdhsite/\\_static/resources/2597.pdf](http://msdh.ms.gov/msdhsite/_static/resources/2597.pdf).
- <sup>170</sup> See 15-12-31 Miss. CODE R. § 7.22; MISSISSIPPI EMS APPROVED MEDICATION AND FLUID LIST, *supra* note 169. Typically mid-level EMS personnel are permitted to administer naloxone, especially when a state has transitioned to national standards and scope of practice. MS is transitioning to national scope of practice, but appears to only be transitioning for EMT-Bs and paramedics. Letter from Alisa Habeeb Williams, Dir., Bureau Emergency Med. Servs., to All Mississippi EMS Prehospital Providers, All Mississippi EMS Educators, and All Mississippi Licensed Ambulance Providers (May 17, 2012), available at [http://msdh.ms.gov/msdhsite/\\_static/resources/4870.pdf](http://msdh.ms.gov/msdhsite/_static/resources/4870.pdf).
- <sup>171</sup> 15-12-31 Miss. CODE R. § 7.26.2(18) (effective Mar. 31, 2014); MISSISSIPPI EMS APPROVED MEDICATION AND FLUID LIST, *supra* note 169.
- <sup>172</sup> 15-12-31 Miss. CODE R. § 1.1.6, app. 1, app. 2. The off-line Medical Director must be approved by the State EMS Medical Director, but the protocols need not be specifically reviewed. *Id.*
- <sup>173</sup> Prior to January 1, 2014, Montana used the term “Emergency medical technician – first responder” or “EMT-F” for this class of responder. See MONT. ADMIN. RULES § 24.156.2701(I); see also MONT. ADMIN. RULES § 37.104.101(17).
- <sup>174</sup> MONT. BOARD OF MED. EXAMINERS: EMERGENCY MEDICAL TECHNICIANS MONTANA PREHOSPITAL PROTOCOLS (2014) [hereinafter MONTANA PREHOSPITAL PROTOCOLS], available at [http://bsd.dli.mt.gov/license/bsd\\_boards/med\\_board/pdf/emt\\_protocols.pdf](http://bsd.dli.mt.gov/license/bsd_boards/med_board/pdf/emt_protocols.pdf).
- <sup>175</sup> MONT. ADMIN. RULES § 24.156.2771 at (1)(a) available at <http://www.mtrules.org/gateway/RuleNo.asp?RN=24.156.2771>; MONTANA PREHOSPITAL PROTOCOLS, *supra* note 174, at 18.
- <sup>176</sup> MONT. ADMIN RULES § 24.156.2771 at (2)(a). See MONTANA PREHOSPITAL PROTOCOLS, *supra* note 174, at 19.
- <sup>177</sup> After January 1, 2014, Montana has only four licensee levels: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced EMT (AEMT), and Paramedic. See MONT. ADMIN. RULES § 24.156.2751 at (3) available at <http://www.mtrules.org/gateway/RuleNo.asp?RN=24.156.2751>.
- <sup>178</sup> MONTANA PREHOSPITAL PROTOCOLS, *supra* note 174, at 19.
- <sup>179</sup> MONT. CODE ANN. § 50-6-203 at (1)(b).
- <sup>180</sup> MONTANA PREHOSPITAL PROTOCOLS, *supra* note 174.
- <sup>181</sup> N.C. MED. BD., APPROVED MEDICATIONS FOR CREDENTIALLED EMS PERSONNEL 2 (2014), available at <http://www.ncems.org/nccpstandards/NCMBApprovedMedSkillsforEMSPersonnel.pdf>.
- <sup>182</sup> *Id.* See also N.C. Gen. Stat. § 143-514 (delegating authority to the North Carolina Medical Board to determine scope of practice for EMS personnel).
- <sup>183</sup> N.C. MED. BD., APPROVED MEDICATIONS FOR CREDENTIALLED EMS PERSONNEL, *supra* note 181, at 2.
- <sup>184</sup> *Id.*
- <sup>185</sup> 10A N.C. ADMIN. CODE 13P .0405(a).
- <sup>186</sup> *Id.* at 13P .0405(b).
- <sup>187</sup> N.C. COLLEGE OF EMERGENCY PHYSICIANS, DRUG LIST 11 (2012), available at <http://www.ncems.org/nccpstandards/druglists/druglistsAandB.pdf>. The protocols have not yet been updated to encompass BLS administration (IN only).
- <sup>188</sup> N.D. STATE HEALTH DEP’T. (2011). ACCEPTED SKILLS FOR EMS PROVIDERS. Available at [http://www.ndhealth.gov/ems/pdfs/Skill\\_Guidelines\\_Summary2014.pdf](http://www.ndhealth.gov/ems/pdfs/Skill_Guidelines_Summary2014.pdf).
- <sup>189</sup> N. D. ADMIN. CODE § 33-36-04-02 (“The emergency medical technician’s core scope of practice includes basic, noninvasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies.”).
- <sup>190</sup> *Id.* See also ACCEPTED SKILLS FOR EMS PROVIDERS, *supra* note 188.



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- <sup>191</sup> *Id.* According to Kelli Sears, State EMS Training Coordinator, North Dakota Department of Health, Emergency Medical Services and Trauma, there are currently two licensed I-99 and neither are practicing in the state (personal communication November 4, 2014).
- <sup>192</sup> *Id.*
- <sup>193</sup> NORTH DAKOTA ADVANCED LIFE SUPPORT EMS PROTOCOL INSTRUCTIONS 2.1.5. Available at <http://www.ndhealth.gov/ems/ALS.htm>
- <sup>194</sup> *Id.* See 2.1.5 POISONING OR OVERDOSE.
- <sup>195</sup> *Id.* See PEDIATRIC 2.2.5 ALTERED MENTAL STATUS.
- <sup>196</sup> *Id.* See PEDIATRIC 2.2.5 POISONING OR OVERDOSE.
- <sup>197</sup> 172 NEB. ADMIN CODE § 11-009.02 (EMRs not permitted to administer Naloxone.). Prior to September 1, 2010, Nebraska used the licensure classification of “First responder” rather than “Emergency medical responder.” NEB. REV. STAT. § 38-1217(1).
- <sup>198</sup> 172 NEB. ADMIN CODE § 11-009.02 (EMTs not permitted to administer naloxone.).
- <sup>199</sup> *Id.* § 11-009.03A(11)(g) (AEMTs permitted to administer naloxone.).
- <sup>200</sup> *Id.* § 11-009.04A(21)(g) (EMT-Is permitted to administer naloxone.).
- <sup>201</sup> *Id.* § 11-009.05A (Paramedics “may perform all the practices and procedures of an Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician, and Emergency Medical Technician-Intermediate.”).
- <sup>202</sup> NEB. BOARD OF EMERGENCY MED. SERVS., APPROVED EMS MODEL PROTOCOLS: BASIC AND ADVANCED LIFE SUPPORT ALL PROVIDER LEVELS (2012) (Individual medical directors “may choose to enhance or omit portions of these protocols in accordance with current medical practice and standards”), available at <http://dhhs.ne.gov/publichealth/Licensure/Documents/EMSmodelProtocols2012.pdf>.
- <sup>203</sup> *Id.* at 37, 56, 96, 111, 141.
- <sup>204</sup> Under New Hampshire’s revised EMS Patient Care Protocols (updated 5/14/2014), EMRs may administer Naloxone IN. See 2013 NH Patient Care Protocols – Version 1.7, at 2.15, available at <http://www.nh.gov/safety/divisions/fstems/ems/advlifsup/documents/ptprotocols.pdf>. See also Notice from Bureau Chief, Nick Mercuri regarding Intranasal Narcan, available at <http://www.nh.gov/safety/divisions/fstems/ems/documents/narcannotice.pdf>.
- <sup>205</sup> Although the scope of practice protocols explicitly authorize only EMRs and above to administer naloxone, the New Hampshire Administrative Code also includes a definition for “First Responder.” “First responder (FR)” is defined as “a person who has successfully completed a course which meets the objectives set forth in USDOT, NHTSA, first responder national standard curriculum, dated 1995, and the division approved first responder testing process.” NEW HAMPSHIRE ADMIN. RULES, CHAPTER SAF-C 5901.62. It is not clear whether “First Responders” still exist in practice and, if so, whether they are authorized to administer naloxone.
- <sup>206</sup> Under the revised New Hampshire EMS Patient Care Protocols, EMT-Bs and EMTs may administer naloxone IN. See 2013 NH Patient Care Protocols – Version 1.7, *infra* note 197.
- <sup>207</sup> See 2013 NH Patient Care Protocols – Version 1.7, *infra* note 197.
- <sup>208</sup> Although the scope of practice protocols explicitly authorize only EMRs and above to administer Naloxone and do not contain any reference to EMT-Is, the New Hampshire Administrative Code continues to include a definition for “EMT-intermediate (EMT-I).” NEW HAMPSHIRE ADMIN. RULES, CHAPTER SAF-C 5901.55. It is not clear whether EMT-Is still exist in practice and, if so, whether they are authorized to administer Naloxone. However, given that EMT-Is exceed the training requirements for EMRs and EMRs may administer naloxone via IN route, it is implied that an EMT-I may do the same.
- <sup>209</sup> See 2013 NH Patient Care Protocols – Version 1.7, *infra* note 197.
- <sup>210</sup> NEW HAMPSHIRE PATIENT CARE PROTOCOLS (2013, UPDATED 5/14/2014), available at <http://www.nh.gov/safety/divisions/fstems/ems/advlifsup/documents/ptprotocols.pdf>
- <sup>211</sup> The New Jersey Administrative Code does not define any level below EMT-B. See N.J. ADMIN.CODE §§ 8:40-1.3, 8:41-1.3.

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- <sup>212</sup> Although the EMT-B scope of practice statute does not include administration of naloxone, the New Jersey Department of Health, Office of Emergency Medical Services issued a waiver allowing all New Jersey EMTs and Paramedics to administer Naloxone IN . See N.J. ADMIN.CODE § 8:40A-10.1(b) (not listed as within scope of practice for EMT-Basics). *But See* CERTIFICATE OF WAIVER EMERGENCY MEDICAL TECHNICIANS, available at [http://www.nj.gov/health/ems/documents/narcan/narcan\\_waiver.pdf](http://www.nj.gov/health/ems/documents/narcan/narcan_waiver.pdf).
- <sup>213</sup> New Jersey only has two classifications of EMTs, EMT-B and EMT-Paramedic. *Id.* § 8:41-1.3.
- <sup>214</sup> Paramedics are authorized to perform advanced life support (ALS). EMT-Basics are permitted to perform basic life support (BLS). *Id.* As ALS crewmembers, Paramedics are approved to administer naloxone. *Id.* § 8:41-6.1(a)(16).
- <sup>215</sup> New Jersey Naloxone Clinical Protocol, available at [http://www.nj.gov/health/ems/documents/narcan/narcan\\_protocol.pdf](http://www.nj.gov/health/ems/documents/narcan/narcan_protocol.pdf)
- <sup>216</sup> Administration of naloxone is indicated when “an adult patient is unconscious or presents with altered mental status.” *Id.* § 8:41-7.18(a). The code instructs ALS crewmembers to administer naloxone (starting with 1 mg and up to 2 mg) via IV or IM. *Id.* § 8:41-7.18(a)(5)(iii)-(iv).
- <sup>217</sup> See New Jersey Naloxone Clinical Protocol, *supra* note 215.
- <sup>218</sup> Administration of Naloxone is indicated when “a pediatric patient presents with altered mental status.” *Id.* § 8:41-8.11(a). The code instructs ALS crewmembers to “administer Naloxone 0.1 mg/kg, with a maximum dose of 2 mg via IV/IO/ET.” *Id.* § 8:41-8.11(a)(7).
- <sup>219</sup> An EMS-First Responder is defined as “a person who is licensed by the department and who functions within the emergency medical services system to provide initial emergency aid.” N.M. STAT. ANN. § 24-10B-3(L).
- <sup>220</sup> N.M. ADMIN. CODE § 7.27.11.8(K)(2)(c)(v) (Naloxone added as an allowable drug for EMS-FR to administer with medical director approval. An EMS-FR may not administer any medication, except oxygen, without the medical director’s approval.)
- <sup>221</sup> N.M. ADMIN. CODE § 7.27.11.8(L)(1)(2)(c)(viii), available at <http://www.nmems.org/documents/ScopeofPracticeRule72711-Dec312012.pdf>.
- <sup>222</sup> *Id.* § 7.27.11.8(M)(2)(c)(viii).
- <sup>223</sup> *Id.* § 7.27.11.8(N)(2)(c)(xxi).
- <sup>224</sup> NEW MEXICO EMERGENCY MEDICAL SERVICES GUIDELINES: DRUGS 55 (2012), available at [http://www.nmems.org/documents/DrugGuidelinesFinal-Dec2012\\_000.pdf](http://www.nmems.org/documents/DrugGuidelinesFinal-Dec2012_000.pdf).
- <sup>225</sup> “First responder” is defined as “a person who has successfully completed the national standard course for first responders.” NEV. ADMIN. CODE § 450B.115. As of January 1, 2016 Nevada will transition to the national levels, and FR will become EMR. Until that time, the state will recognize 8 levels of licensure. See Nev. Div. of Public and Behavior Health, Transition to the New Emergency Medical System Education Standards, available at [http://health.nv.gov/EMS/Transition\\_NewEMSStandards.pdf](http://health.nv.gov/EMS/Transition_NewEMSStandards.pdf).
- <sup>226</sup> Implied by regulations prohibiting an EMT-B from administering or assisting in administering any “dangerous drug.” See NEV. ADMIN. CODE § 450B.461(3). See *infra* note 214.
- <sup>227</sup> “A basic emergency medical technician shall not administer or assist in administering any dangerous drug.” NEV. ADMIN. CODE § 450B.461(3). A “dangerous drug” includes “[a]ny drug which has been approved by the Food and Drug Administration for general distribution and bears the legend: ‘Caution: Federal law prohibits dispensing without prescription.’” NEV. ADMIN. CODE § 454.201(1). Thus, because Naloxone requires a prescription and bears said legend, it is considered a “dangerous drug” that EMT-Bs are not permitted to administer or assist in administering.
- <sup>228</sup> An advanced emergency medical technician or paramedic may administer a dangerous drug only if the dangerous drug is named on the inventory of medication issued by the medical director of the service and either: (1) “An order is given to the advanced emergency medical technician or paramedic by a physician or a registered nurse supervised by a physician;” or (2) “The advanced emergency medical technician or paramedic is authorized to administer the drug pursuant to a written protocol that is approved by the Division.” See NEV. ADMIN. CODE § 450B.461(2).
- <sup>229</sup> *Id.*
- <sup>230</sup> NEVADA STATE HEALTH DIVISION PROTOCOLS (2003), PDF obtained from Patrick Irwin, State of Nevada, 24 June 2013.

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- <sup>231</sup> Personal correspondence with Patrick Irwin, Program Manager, Nevada Office of EMS, 24 June 2013.
- <sup>232</sup> N.Y. STATE DEP'T HEALTH, CERTIFIED FIRST RESPONDER, available at <https://www.health.ny.gov/professionals/ems/policy/00-09.htm> (last accessed September 24, 2014).
- <sup>233</sup> "The SEMAC has approved an amendment to the Altered Mental Status protocol in the New York State CFR and EMT/AEMT BLS Protocols which will enable EMS agencies and certified Basic Life Support EMS providers to administer intranasal naloxone to patients experiencing an acute opioid overdose." N.Y. STATE DEP'T HEALTH, INTRANASAL NALOXONE (NARCAN) FOR BASIC LIFE SUPPORT EMS AGENCIES (Dec. 10, 2013), available at <http://www.health.ny.gov/professionals/ems/policy/13-10.htm>.
- <sup>234</sup> The regulations state that EMS personnel must "treat patients in accordance with the applicable State approved protocols, unless authorized to do otherwise for an individual patient by a medical control physician." N.Y. COMP. CODES R. & REGS. tit. 10, § 800.15(b). The State Emergency Medical Advisory Committee (SEMAC) is charged with developing statewide standards and protocols for treatment. N.Y. PUB. HEALTH LAW § 3002-a(2)(a). As of December 10, 2013, BLS personnel are permitted to administer naloxone using a mucosal atomizer device (MAD). N.Y. STATE DEP'T HEALTH, INTRANASAL NALOXONE (NARCAN) FOR BASIC LIFE SUPPORT EMS AGENCIES (Dec. 10, 2013), available at <http://www.health.ny.gov/professionals/ems/policy/13-10.htm>; see also N.Y. STATE DEP'T HEALTH, UPDATED PROTOCOLS FOR EMT BLS (July 25, 2011), available at [http://www.health.ny.gov/professionals/ems/pdf/emt\\_protocol\\_updates\\_2011.pdf](http://www.health.ny.gov/professionals/ems/pdf/emt_protocol_updates_2011.pdf). Note that the Department of Health's website also states that the scope of practice of EMS personnel "is defined by curriculum, protocol, and physician medical direction at the EMS agency, region, and State levels." This means that scope of practice, particularly for ALS, could potentially vary throughout the state. *EMS Certification and Reciprocity Frequently Asked Questions*, N.Y. STATE DEP'T HEALTH, <http://www.health.ny.gov/professionals/ems/certification/certification.htm> (last visited Nov. 12, 2013).
- <sup>235</sup> Under the applicable regulations, "Advanced emergency medical technician means a person certified pursuant to these regulations as an emergency medical technician-intermediate, an emergency medical technician-critical care, or an emergency medical technician-paramedic." N.Y. COMP. CODES R. & REGS. tit. 10, § 800.3(p). New York is currently transitioning to the National Educational Standards. Under the national curriculum, AEMTs are ALS providers and are permitted to administer naloxone. N.Y. STATE DEP'T HEALTH, ADVANCED LIFE SUPPORT PRACTICAL SKILLS EXAMINATION MANUAL (Nov. 2012) [hereinafter N.Y. ADVANCED LIFE SUPPORT PRACTICAL SKILLS EXAMINATION MANUAL], available at [http://www.health.ny.gov/professionals/ems/national\\_education\\_standards\\_transition/docs/als\\_pse\\_manual.pdf](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/docs/als_pse_manual.pdf); see also NATIONAL EMERGENCY MEDICAL SERVICES EDUCATION STANDARDS: ADVANCED EMERGENCY MEDICAL TECHNICIAN INSTRUCTIONAL GUIDELINES: NEW YORK BUREAU OF EMS VERSION, available at [http://www.health.ny.gov/professionals/ems/national\\_education\\_standards\\_transition/docs/nys\\_aemt\\_education\\_standards.pdf](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/docs/nys_aemt_education_standards.pdf). The training curriculum for Emergency Medical Technician – Critical Care includes the administration of naloxone for the treatment of overdose. *Advanced Emergency Medical Technician – Critical Care Original Course Curriculum, Module 5, Lesson 5: Poisoning/Overdose Emergencies*, N.Y. STATE DEP'T HEALTH, <http://www.health.ny.gov/professionals/ems/pdf/emtccomod5lesson5.pdf> (last visited Nov. 24, 2013).
- <sup>236</sup> The EMT – Intermediate training curriculum does not include the administration of naloxone. *Advanced Emergency Medical Technician – Intermediate Original Course Curriculum, Module 1, Lesson 3: General Pharmacology*, N.Y. STATE DEP'T HEALTH, <http://www.health.ny.gov/professionals/ems/pdf/emtio13.pdf> (last visited Sept. 24, 2014). However, during NY's transition to national standards, the EMT-I level will be replaced by the national AEMT level. The EMT-CC level will remain unchanged. *Transitioning to the National Education Standards*, N.Y. DEP'T HEALTH, [http://www.health.ny.gov/professionals/ems/national\\_education\\_standards\\_transition/](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/) (last visited Nov. 26, 2013). AEMTs are permitted to administer naloxone. N.Y. ADVANCED LIFE SUPPORT PRACTICAL SKILLS EXAMINATION MANUAL, *supra* note 235. EMT-Is are permitted to administer naloxone pursuant to the policy described in , INTRANASAL NALOXONE (NARCAN) FOR BASIC LIFE SUPPORT EMS AGENCIES, *supra* note 234.
- <sup>237</sup> NATIONAL EMERGENCY MEDICAL SERVICES EDUCATION STANDARDS: PARAMEDIC INSTRUCTIONAL GUIDELINES, available at [http://www.health.ny.gov/professionals/ems/national\\_education\\_standards\\_transition/docs/paramedic\\_education\\_standards.pdf](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/docs/paramedic_education_standards.pdf).
- <sup>238</sup> N.Y. PUB. HEALTH LAW § 3002-a(2)(a); *What is the Bureau of Emergency Medical Services*, N.Y. STATE DEP'T OF HEALTH, <http://www.health.ny.gov/professionals/ems/about.htm> (last visited Sep. 24, 2014).
- <sup>239</sup> N.Y. STATE DEP'T OF HEALTH, NEW YORK STATE EMT/AEMT BLS PROTOCOLS: ALTERED MENTAL STATUS (HYPOGLYCEMIA AND OPIOID OVERDOSE) (June 10, 2014), available at [http://www.health.ny.gov/professionals/ems/pdf/altered\\_mental\\_status\\_protocol.pdf](http://www.health.ny.gov/professionals/ems/pdf/altered_mental_status_protocol.pdf).
- <sup>240</sup> Effective August 1, 2014, EMRs may administer naloxone via IN route with written protocol. See OHIO ADMIN. CODE § 4765-12-04(B)(4). Ohio's EMS Scope of Practice authorizes EMRs to administer Naloxone via auto-injector or intranasal route. See OHIO SCOPE OF PRACTICE, *infra* note 245.. Before an EMR may administer Naloxone, they must complete training and receive the approval of the medical director. See CAROL A. CUNNINGHAM, ST. MED. DIR., OHIO DEP'T PUB. SAFETY, DIV. EMERGENCY MED. SERVS., OHIO EMS SCOPE OF PRACTICE: UPDATE 1 (Nov. 21, 2013), available at [http://publicsafety.ohio.gov/links/MR2013/Ohio%20EMS%20Scope%20of%20PracticeNaloxoneDR\\_C1113.pdf](http://publicsafety.ohio.gov/links/MR2013/Ohio%20EMS%20Scope%20of%20PracticeNaloxoneDR_C1113.pdf).

<sup>241</sup> Ohio's EMS Scope of Practice authorizes EMTs to administer Naloxone via auto-injector or intranasal route. See Ohio EMS Scope of Practice, *supra* note XX. EMTs must complete training and receive the approval of the medical director before the EMT may administer Naloxone. See OHIO EMS SCOPE OF PRACTICE: UPDATE 1 (Nov. 21, 2013), *supra* note 240.

<sup>242</sup> OHIO ADMIN. CODE § 4765-16-04(B)(1)(g) (AEMTs are permitted to administer naloxone if they have appropriate training and if the administration is authorized by a physician or other certain medical authorities or if it is in accordance with written protocols), *available at* <http://www.publicsafety.ohio.gov/links/4765-16-04.pdf>; see also OHIO SCOPE OF PRACTICE, *infra* note 245, at 3.

<sup>243</sup> Ohio is transitioning from EMT-Is to AEMTs. Ohio Rev. Code Ann. § 4765.011 states that:

(A) With respect to the following individuals who receive certificates to practice issued under this chapter, all of the following apply: . . . (3) An emergency medical technician-intermediate or EMT-I shall be also known as an advanced emergency medical technician or AEMT, respectively. . . . (B) With respect to the provisions of this chapter and all other provisions of the Revised Code that refer to the individuals specified in division (A) of this section, all of the following apply: . . . (3) A reference to an emergency medical technician-intermediate or EMT-I is deemed to be a reference to an advanced emergency medical technician or AEMT, respectively.

Ohio Admin. Code. 4765-1-02 further states that:

(A) In accordance with [sections 4765.01](#) and [4765.011 of the Revised Code](#), with respect to individuals who receive certificates to practice issued under [section 4765.30 of the Revised Code](#), all of the following shall apply: . . . (3) An emergency medical technician-intermediate or EMT-intermediate shall be also known as an advanced emergency medical technician or AEMT, respectively; . . . (B) With respect to the provisions set forth in Chapters 4765-1 to 4765-19 of the Administrative Code that refer to the individuals specified in paragraph (A) of this rule, all of the following shall apply: . . . (3) A reference to an emergency medical technician intermediate or EMT-intermediate is deemed to be a reference to an advanced emergency medical technician or AEMT.

Finally, Ohio Admin. Code 4765-16-02 states that "(A) An EMT-intermediate who is not certified as having completed training in emergency pharmacology . . . must complete the 2002 transitional EMT-intermediate update curriculum, as outlined in this rule, prior to July 1, 2005, in order to renew a certificate to practice after that date." The curriculum includes understanding the basics of pharmacology, including the administration of naloxone. OHIO ADMIN. CODE 4765-16-02(B)(1); *see also* OHIO SCOPE OF PRACTICE, *infra* note 245, at 3 (noting that AEMTs are permitted to administer naloxone).

<sup>244</sup> *Id.* at § 4765-17-03(A) (stating that paramedics are permitted to perform services within the scope of practice for AEMTs); *see also* OHIO SCOPE OF PRACTICE, *infra* note 245, at 3.

<sup>245</sup> "In accordance with rule 4765-10-06 of the Administrative Code, the individual medical director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. Each community may need to tailor and revise the protocol to fit their region and individual practice, but must ensure that they remain within the approved scope of practice. EMS medical directors are reminded that they are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted."

STATE BOARD OF EMERGENCY MED., FIRE, & TRANSPORTATION SERVS., SCOPE OF PRACTICE (Apr. 16, 2014) [hereinafter OHIO SCOPE OF PRACTICE], *available at* [http://www.publicsafety.ohio.gov/links/ems\\_scope\\_practice.pdf](http://www.publicsafety.ohio.gov/links/ems_scope_practice.pdf).

<sup>246</sup> The Oklahoma protocols have not been updated to reflect that OKLA STAT. tit. 63, § 1-2506.1 authorizes EMRs and EMTs to administer naloxone via IN or auto-injector routes. However, the protocols contain a "Special Comment" noting that EMRs and EMTs may administer naloxone IM and AI for opioid overdose. See OKLA. STATE DEP'T OF HEALTH, STATE OF OKLAHOMA 2014 EMERGENCY MEDICAL SERVICES PROTOCOLS 3A.3, 4I.2, 6B.3, 6E.3, 8A.3 (Effective Jan. 1, 2013) [Hereinafter OKLAHOMA PROTOCOLS 2014], *available at* <http://www.ok.gov/health2/documents/2014%20State%20of%20Oklahoma%20Protocols.pdf>.

<sup>247</sup> Effective November 1, 2013, all EMTs (and police and firefighters) are authorized to administer naloxone to an individual exhibiting signs of an opiate overdose. OKLA STAT. tit. 63, § 1-2506.1. Although Oklahoma's administrative code only provides for 3 levels of EMTs (EMT-B, EMT-I, EMT-P), OKLA. ADMIN. CODE § 310:641-5-12, the Oklahoma Emergency Response Systems Development Act includes AEMTs within the definition of "Licensed emergency medical personnel." OKLA STAT. tit. 63, § 1-2503(17). However, the state is encouraging EMT-Is to transition to AEMTs. INTERMEDIATE TO ADVANCED EMERGENCY MEDICAL TECHNICIAN TRANSITION COURSE (May 5, 2011), *available at* <http://www.ok.gov/health2/documents/04022012185%20to%20AEMT%20document.pdf>.

<sup>248</sup> See OKLAHOMA PROTOCOLS 2014, *supra* note 246.

<sup>249</sup> See OKLAHOMA PROTOCOLS 2014, *supra* note 246.

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<sup>250</sup> See OKLAHOMA PROTOCOLS 2014, *supra* note 246.

<sup>251</sup> OKLA. STAT. tit. 63, § 1-2506; OKLA. ADMIN. CODE § 310:641-3-50(c)(7).

<sup>252</sup> OKLAHOMA PROTOCOLS 2014, *supra* note 246, at Preface.

<sup>253</sup> *Id.* at 4I.1.

<sup>254</sup> *Id.* at 16GG.1

<sup>255</sup> *Id.* at 8A.1.

<sup>256</sup> *Id.* at 6E.1.

<sup>257</sup> *Id.* at 6B.1.

<sup>258</sup> *Id.* at 3A.1.

<sup>259</sup> *Id.* at 16GG.2. The general formulary provided for naloxone indicates that the maximum dosage for adults for ineffective breathing activity is 4 mg. However, every specific protocol for ineffective breathing activity indicates a maximum dosage of 2 mg. It is unclear from the protocols when a maximum dosage of 4 mg would be appropriate for treating ineffective breathing activity.

<sup>260</sup> *Id.* at 6B.1.

<sup>261</sup> *Id.* at 8A.1.

<sup>262</sup> *Id.* at 6E.1.

<sup>263</sup> *Id.* at 16GG.2.

<sup>264</sup> Under the current Oregon Administrative Code, EMRs are not permitted to administer naloxone. See OR. ADMIN. R. 847-035-0030(8). However, on August 1, 2014, the Oregon Medical Board submitted a proposed rules change to expand the EMR scope of practice “to allow the preparation and administration of naloxone via intranasal device or auto-injector for suspected opioid overdose...” See 53 Or. Bull. 17 (August 1, 2014), available at [http://arcweb.sos.state.or.us/pages/rules/bulletin/0814\\_bulletin/0814\\_toc\\_bulletin.html](http://arcweb.sos.state.or.us/pages/rules/bulletin/0814_bulletin/0814_toc_bulletin.html).

<sup>265</sup> Currently, EMTs are not permitted to administer Naloxone. See OR. ADMIN. R. 847-035-0030(9). However, EMTs may “[p]erform all procedures that an Emergency Medical Responder may perform.” OR. ADMIN. R. 847-035-0030(9)(a). Thus, once the proposed rule permitting EMRs to administer Naloxone becomes final, EMTs will be authorized to administer naloxone via IN or auto-injector routes. See *supra* note XX.

<sup>266</sup> *Id.* at 847-035-0030(10)(g)(c).

<sup>267</sup> *Id.* at 847-035-0030(11)(a).

<sup>268</sup> *Id.* at 847-035-0030(12)(a).

<sup>269</sup> *Id.* at 847-035-0025(1)(a), available at [http://arcweb.sos.state.or.us/pages/rules/oars\\_800/oar\\_847/847\\_035.html](http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_847/847_035.html).

<sup>270</sup> EMRs are only authorized to perform “[Basic Life Support] skills involving basic interventions with minimum EMS equipment...” 35 PA. C.S. § 8114. Pennsylvania’s Statewide BLS Protocol – 2013 does not authorize the administration of naloxone for BLS providers. See Statewide BLS Protocol – 2013, available at [http://www.portal.state.pa.us/portal/server.pt/document/1324791/statewide\\_bls\\_protocols-2013.pdf](http://www.portal.state.pa.us/portal/server.pt/document/1324791/statewide_bls_protocols-2013.pdf). A complete list of skills is required to be posted in the Pennsylvania Bulletin, See § 8113 (g), available at <http://www.pabulletin.com/secure/data/vol43/43-23/1050.html>. However, a law passed in October 2014 requires that naloxone be added to the scope of practice of EMRs and EMTs by December 31, 2014. See S.B. 1164, available at <http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2013&sessInd=0&billBody=S&billTyp=B&billNbr=1164&pn=2328>.

<sup>271</sup> 35 PA. C.S. § 8115. See also Statewide BLS Protocol – 2013 and the complete list of skills, *supra* note 270.

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<sup>272</sup> *Id.* See § 8116. See also Statewide ALS Protocol – 2013, available at [http://www.portal.state.pa.us/portal/server.pt/document/1324790/statewide\\_als\\_protocols-2013.pdf](http://www.portal.state.pa.us/portal/server.pt/document/1324790/statewide_als_protocols-2013.pdf); the complete list of skills, *supra* note 270.

<sup>273</sup> *Id.* See § 8117.

<sup>274</sup> PA. DEP'T OF HEALTH. (2013). PENNSYLVANIA STATEWIDE ADVANCED LIFE SUPPORT PROTOCOLS. Available at [http://www.portal.state.pa.us/portal/server.pt/community/emergency\\_medical\\_services/14138/ems\\_statewide\\_protocols/625966](http://www.portal.state.pa.us/portal/server.pt/community/emergency_medical_services/14138/ems_statewide_protocols/625966)

<sup>275</sup> Rhode Island law does not appear to recognize a level below EMT. See 31-5-40 R.I. CODE.

<sup>276</sup> Rhode Island's regulations state that "[e]ach Emergency Medical Technician in discharging his or her functions and responsibilities . . . shall be subject to the current standards of practice as set forth in the *State of Rhode Island Prehospital Care Protocols and Standing Orders* approved by the Department." 31-5-40 R.I. CODE R. § 8.1. In February 2014, the Rhode Island Department of Health issued a revision to the STATE OF R.I. AND PROVIDENCE PLANTATIONS DEP'T OF HEALTH, PREHOSPITAL CARE PROTOCOLS AND STANDING ORDERS to permit EMTs to administer Naloxone 0.4mg intranasally (IN) by standing order; administration of Naloxone intramuscularly (IM) or additional doses via either the IM or IN route require authorization from Medical Control. See STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS DEPARTMENT OF HEALTH, PREHOSPITAL CARE PROTOCOLS AND STANDING ORDERS, *infra* note 279.

<sup>277</sup> "Functions which a licensed EMT-C is authorized to perform include advanced emergency medical care as defined in the *State of Rhode Island Prehospital Care Protocols and Standing Orders*." *Id.* § 8.6. Rhode Island's regulations also define EMT-I, but state that the EMT-I "licensure designation shall be synonymous with that of 'Emergency Medical Technician-Basic (EMT-B).'" *Id.* § 1.10.2.

<sup>278</sup> "Functions which a licensed EMT-P is authorized to perform based on his/her training include advanced emergency medical care as defined in the *State of Rhode Island Prehospital Care Protocols and Standing Orders*" *Id.* § 8.8.

<sup>279</sup> STATE OF R.I. AND PROVIDENCE PLANTATIONS DEP'T OF HEALTH, PREHOSPITAL CARE PROTOCOLS AND STANDING ORDERS 4.7, 4.10, 8.4 (2014) (last updated February 2014), available at <http://www.health.ri.gov/publications/protocols/PreHospitalCareAndStandingOrders.pdf>.

<sup>280</sup> Administration of naloxone is not included in the approved skills for EMRs. See SOUTH CAROLINA APPROVED SKILLS BY CERTIFICATION LEVEL 3, *infra* note 281.

<sup>281</sup> S.C. DEPT. OF HEALTH & ENVIRONMENTAL CONTROL, SOUTH CAROLINA APPROVED SKILLS BY CERTIFICATION LEVEL 3 (2012), available at <http://www.scdhec.gov/health/ems/cskills.pdf>. Each level of EMT (basic, intermediate, paramedic) is generally permitted to perform the functions taught in the approved curriculum. S.C. Code Ann. Regs. 61-7-902 (2006). The curriculum for training programs is either the Department of Transportation curriculum or another curriculum approved by the Department. S.C. Code Ann. Regs. 61-7-901. Therefore, scope of practice seems to be generally defined according to National Standards.

<sup>282</sup> S.C. DEPT. OF HEALTH & ENVIRONMENTAL CONTROL, SOUTH CAROLINA APPROVED SKILLS BY CERTIFICATION LEVEL, *supra* note 281, at 3. Though AEMTs are permitted to administer intranasal naloxone according to the 2012 list of approved skills, the State protocols published in 2010 allow only paramedics to administer naloxone. See S.C. DEPT. OF HEALTH & ENVIRONMENTAL CONTROL, DIVISION OF EMS & TRAUMA, SOUTH CAROLINA EMS PRE-HOSPITAL PROTOCOLS 27, 30, 42, 43, 55, 57 (2010), available at <http://www.scdhec.gov/health/ems/EMS-Protocols-Sections-1-4.pdf>. Therefore, if a local medical control physician adopts the 2010 State Protocols as written (i.e. he/she does not revise the protocols to authorize AEMTs to administer naloxone), AEMTs in that locality will not be authorized to administer naloxone.

<sup>283</sup> *Id.*

<sup>284</sup> S.C. CODE ANN. REGS. 61-7-402 (2006). General provisions found at Code of Laws of SC, Title 44, Chapter 61, Article 1.

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- <sup>285</sup> Memorandum from Jennifer L. Paddock, Director of Division of EMS & Trauma, to All EMS Agencies, Medical Control Physicians and EMTs (Nov. 1, 2010), *available at* <http://www.scdhec.gov/health/ems/EMS-Pre-Hospital-Protocol-Release-Memo.pdf>. Eventually the Department of Health plans to use mandatory statewide protocols. *Id.*
- <sup>286</sup> S.C. DEPT. OF HEALTH & ENVIRONMENTAL CONTROL, DIVISION OF EMS & TRAUMA, SOUTH CAROLINA EMS FORMULARY 60 (2010), *available at* <http://www.scdhec.gov/health/ems/emsformulary.pdf>. *See also* S.C. DEPT. OF HEALTH & ENVIRONMENTAL CONTROL, DIVISION OF EMS & TRAUMA, SOUTH CAROLINA EMS PRE-HOSPITAL PROTOCOLS 27, 30, 42, 43, 55, 57 (2010), *available at* <http://www.scdhec.gov/health/ems/EMS-Protocols-Sections-1-4.pdf>.
- <sup>287</sup> According to the SD Department of Public Safety's website, SD recognizes five levels: EMT, EMT-Intermediate/85, AEMT, EMT-Intermediate/99, and Paramedic. *See* [https://dps.sd.gov/emergency\\_services/emergency\\_medical\\_services/](https://dps.sd.gov/emergency_services/emergency_medical_services/).
- <sup>288</sup> SOUTH DAKOTA EMT-BASIC PREHOSPITAL TREATMENT GUIDELINES, 3<sup>RD</sup> ED., *available at* [https://dps.sd.gov/emergency\\_services/emergency\\_medical\\_services/documents/20143-20-14EMT-BasicSouthDakotaGuidelines.pdf](https://dps.sd.gov/emergency_services/emergency_medical_services/documents/20143-20-14EMT-BasicSouthDakotaGuidelines.pdf).
- <sup>289</sup> S.D. CODIFIED LAWS § 36-4B-16.2.
- <sup>290</sup> *Id.* § 36-4B-16.
- <sup>291</sup> *Id.* § 36-4B-16.1. It is unclear whether EMT-I/85s and EMT-I/99s in South Dakota are permitted to administer naloxone. These two levels are being phased out as part of the transition to national standards.
- <sup>292</sup> *Id.* § 36-4B-17.
- <sup>293</sup> *Id.* § 36-4B-10.
- <sup>294</sup> Correspondence from Brad Janecke (30 July 2013). BLS suggested protocol *available at* [http://dps.sd.gov/emergency\\_services/emergency\\_medical\\_services/documents/2013updatedguidelines.pdf](http://dps.sd.gov/emergency_services/emergency_medical_services/documents/2013updatedguidelines.pdf).
- <sup>295</sup> *See* TENN. COMP. R. & REGS. 1200-12-01-.04(1)(b); TENN. DIVISION OF EMERGENCY MED. SERVS., TENNESSEE EMERGENCY MEDICAL SERVICES PROTOCOL GUIDELINES (2014), *available at* <http://health.state.tn.us/ems/PDF/Protocols.pdf> [hereinafter [TENNESSEE PROTOCOLS](#)].
- <sup>296</sup> *See* TENN. COMP. R. & REGS. 1200-12-01-.04(1)(c); [TENNESSEE PROTOCOLS](#).
- <sup>297</sup> TENN. COMP. R. & REGS. 1200-12-01-.04(1)(d). Tennessee is currently transitioning to national EMS personnel levels. Tennessee has created an AEMT level, and the EMT-IV level will be phased out by 2016. AEMTs are permitted to administer IV or IN naloxone. DONNA G. TIDWELL, T.N. OFFICE OF EMS, EMERGENCY MEDICAL SERVICES UPDATE 9 (2013) [hereinafter TENN. EMERGENCY MEDICAL SERVICES UPDATE], *available at* [http://health.state.tn.us/ems/PDF/EMS\\_Update\\_2013.pdf](http://health.state.tn.us/ems/PDF/EMS_Update_2013.pdf).
- <sup>298</sup> EMT-IVs will continue to function at their current scope of practice until their license is upgraded to AEMT by the Office of EMS. [TENNESSEE PROTOCOLS](#), *supra* note 295. As discussed above, Tennessee is transitioning to national personnel levels. The last day to complete licensure for EMT-IV is May 31, 2013. All EMT-IVs must transition to AEMTs by Dec. 31, 2016. TENN. EMERGENCY MEDICAL SERVICES UPDATE, *supra* note 297, at 23, 35.
- <sup>299</sup> TENN. COMP. R. & REGS. 1200-12-01-.04(1)(e); [TENNESSEE PROTOCOLS](#), *supra* note 295.
- <sup>300</sup> TENN. COMP. R. & REGS. 1200-12-01-.14(4)(a).
- <sup>301</sup> [TENNESSEE PROTOCOLS](#), *supra* note 295, at Introduction.
- <sup>302</sup> *Id.* at 106, 202, 205, 304, 313, 316, Procedure—Intranasal Medication, Reference—Medication Dosage.

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<sup>303</sup> *Id.* at 202.

<sup>304</sup> *Id.* at 316.

<sup>305</sup> The Texas Administrative Code defines an “Emergency care attendant (ECA)” as an “individual who is certified by the department as minimally proficient to provide emergency prehospital care by providing initial aid that promotes comfort and avoids aggravation of an injury or illness.” 25 TEX. ADMIN. CODE § 157.2 (24)

<sup>306</sup> 25 TEX. ADMIN. CODE § 157.32 (c)(1)(A)

<sup>307</sup> *Id.* See (c)(2)

<sup>308</sup> *Id.* See (c)(3)(A)

<sup>309</sup> *Id.* See (c)(4)(A)

<sup>310</sup> See TEX. HEALTH & SAF. CODE § 773.114(2).

<sup>311</sup> Utah has adopted the EMS National Education and Scope of Practice. Thus, “[a]n EMR, EMT, AEMT, or Paramedic may perform the skills as described in the EMS National Education Standards, to their level of certification, as adopted in this section.” UTAH CODE § R426-5-200 (3). Although the state does vary from the national standards in some respects (as in permitting EMTs to administer naloxone) the Utah State EMS Protocol Guidelines only permit EMTs, AEMTs, and Paramedics administer Naloxone. See Utah State EMS Protocol Guidelines, *infra* note 316-319.

<sup>312</sup> *Id.* The Utah State EMS Protocol Guidelines permit EMTs to administer Naloxone via IN route.

<sup>313</sup> *Id.*

<sup>314</sup> As of September 30, 2013, Utah completed their transition from EMT-Is to AEMTs and thus, unlike during the transition period, EMT-Is and EMT-IAs are no longer recognized nor deemed equivalent to AEMT certification. See §§ R426-5-1000 (1)(b), (5)(a).

<sup>315</sup> See *supra* note 311.

<sup>316</sup> See The Bureau of Emergency Medical Services Utah State EMS Protocol Guidelines, available at <https://health.utah.gov/ems/stateprotocolguidelines/>.

<sup>317</sup> 2013 Utah EMS General Protocol Guidelines, available at [https://health.utah.gov/ems/stateprotocolguidelines/2013\\_utah\\_ems\\_general.pdf](https://health.utah.gov/ems/stateprotocolguidelines/2013_utah_ems_general.pdf).

<sup>318</sup> 2013 Utah EMS Medical Protocol Guidelines, available at [https://health.utah.gov/ems/stateprotocolguidelines/2013\\_utah\\_ems\\_medical.pdf](https://health.utah.gov/ems/stateprotocolguidelines/2013_utah_ems_medical.pdf).

<sup>319</sup> 2013 Utah EMS Cardiac Protocol Guidelines, available at [https://health.utah.gov/ems/stateprotocolguidelines/2013\\_utah\\_ems\\_cardiac.pdf](https://health.utah.gov/ems/stateprotocolguidelines/2013_utah_ems_cardiac.pdf).

<sup>320</sup> VA. OFFICE OF EMERGENCY MED. SERVS., SCOPE OF PRACTICE – FORMULARY FOR EMS PERSONNEL 1 (2013) [*hereinafter* VIRGINIA FORMULARY], available at [http://www.vdh.virginia.gov/OEMS/Files\\_page/Training/ScopeOfPractice-Formulary.pdf](http://www.vdh.virginia.gov/OEMS/Files_page/Training/ScopeOfPractice-Formulary.pdf). See also 12 VA. ADMIN. CODE § 5-31-1050 (defining scope of practice for EMS personnel as “those procedures, skills, or techniques for which he is currently licensed or certified, provided that he is acting in accordance with local medical treatment protocols and medical direction provided by the OMD of the licensed EMS agency with which he is affiliated and within the scope of the EMS agency licenses as authorized in the Emergency Medical Services Procedures and Medications Schedule as approved by the board.”), available at <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC5-31-1050>.

<sup>321</sup> IV therapy does not appear to be within the scope of practice for EMT-Bs. VA. OFFICE OF EMERGENCY MED. SERVS., SCOPE OF PRACTICE – PROCEDURES FOR EMS PERSONNEL 4 (2013), available at [http://www.vdh.state.va.us/OEMS/Files\\_page/Training/ScopeOfPractice-Procedures.pdf](http://www.vdh.state.va.us/OEMS/Files_page/Training/ScopeOfPractice-Procedures.pdf).

<sup>322</sup> VIRGINIA FORMULARY, *supra* note 320, at 1.

<sup>323</sup> *Id.*



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- <sup>324</sup> *Id.*
- <sup>325</sup> 12 VA. ADMIN. CODE § 5-31-1890(B)(7). However, recent legislation requires that, “the Board of Health shall direct the State Emergency Medical Services Advisory Board to, by July 1, 2014, develop and facilitate the implementation of ... (ii) a standard operating procedure template to be used in the development of local protocols for emergency medical services personnel for basic life support services provided by emergency medical services personnel.” H.B. 1856 (Effective July 1, 2013), *available at* <http://lis.virginia.gov/cgi-bin/legp604.exe?131+ful+CHAP0429+pdf>.
- <sup>326</sup> VA’S REGIONAL EMS COUNCILS, <http://www.vaems.org/> (last visited Oct. 10, 2014). The eleventh region, the Northern Virginia EMS Council, further delegates authority to determine protocol to individual agencies within the region. N. VA. EMS COUNCIL, N. VA. REGIONAL PROTOCOL GUIDELINES (Effective February 5, 2009), *available at* [http://northern.vaems.org/index.php?option=com\\_content&view=article&id=483&Itemid=16](http://northern.vaems.org/index.php?option=com_content&view=article&id=483&Itemid=16).
- <sup>327</sup> As of June 26, 2014, with appropriate training and credentialing, EMRs may now administer naloxone via IN route. See MEMORANDUM FROM DANIEL WOLFSON, MD, VT STATE EMS MEDICAL DIRECTOR, TO VERMONT EMRS AND VT DISTRICT MEDICAL ADVISORS, ENHANCEMENT OF EMR SCOPE OF PRACTICE TO INCLUDE USE OF INTRANASAL NALOXONE FOR SUSPECTED OPIOID OVERDOSE WITH SEVERE RESPIRATORY DEPRESSION (June 26, 2014), *available at* [http://healthvermont.gov/adap/treatment/naloxone/documents/EMR\\_naloxone\\_use\\_memo.pdf](http://healthvermont.gov/adap/treatment/naloxone/documents/EMR_naloxone_use_memo.pdf).
- <sup>328</sup> National Education and Scope of Practice standards are incorporated by reference at 12-5-17 VT CODE R. § 6.3.1, with the exception of the Intermediate-level. See also VT. DEP’T HEALTH, VERMONT STATEWIDE EMERGENCY MEDICAL SERVICES PROTOCOLS (Mar. 2014) [hereinafter VERMONT STATEWIDE EMERGENCY MEDICAL SERVICES PROTOCOLS], *available at* <http://healthvermont.gov/hc/ems/documents/FinalProtocols2014Mar17REVISED140326draftHYPERLINKEDVERSION2COMPLETEREVIEWED.pdf>
- <sup>329</sup> VERMONT STATEWIDE EMERGENCY MEDICAL SERVICES PROTOCOLS, *supra* note 328.
- <sup>330</sup> *Id.*
- <sup>331</sup> The authority to develop protocols is delegated to district medical advisors. 12-5-17 VT CODE R. § 1.12. The Statewide protocols were “reviewed, edited, and approved of by all Vermont’s District Medical Advisors and other stakeholders.” VERMONT STATEWIDE EMERGENCY MEDICAL SERVICES PROTOCOLS, *supra* note 328. The protocols include guidelines for administering naloxone. *Id.* at 2.3A, 2.16A, 2.17A, app. 1.
- <sup>332</sup> *Id.* at 2.3P, 2.16P, 2.17P, app. 1.
- <sup>333</sup> WAC 246-976-182 outlines authorized care for all EMS personnel, in general terms. It appears Washington is following the National Education and Scope of Practice standards due to the level of EMS providers the state has elected, although this does not appear to be explicitly expressed.
- <sup>334</sup> See WASH. STATE DEP’T OF HEALTH. (2005). FIRST RESPONDER FIELD PROTOCOLS. *Available at* <http://www.doh.wa.gov/Documents/Pubs/530053.pdf>.
- <sup>335</sup> RCW 18.73.081, Authority to develop minimum standards for first responder and EMT training is delegated to the Secretary.
- <sup>336</sup> *Id.* See WASH. STATE DEP’T OF HEALTH. (2005). EMT-BASIC FIELD PROTOCOLS. *Available at* <http://www.doh.wa.gov/Documents/Pubs/530006.pdf>. See also See WASH. STATE DEP’T OF HEALTH. (2005). INTRAVENOUS THERAPY TECHNICIAN FIELD PROTOCOLS. *Available at* <http://www.doh.wa.gov/portals/1/Documents/2900/ivprt.pdf>.
- <sup>337</sup> *Id.* See WASH. STATE DEP’T OF HEALTH. (2005). INTERMEDIATE LIFE SUPPORT TECHNICIAN FIELD PROTOCOLS. *Available at* <http://www.doh.wa.gov/portals/1/Documents/Pubs/530141.pdf>.
- <sup>338</sup> *Id.*
- <sup>339</sup> WASH. STATE DEP’T OF HEALTH. (2005). INTERMEDIATE LIFE SUPPORT TECHNICIAN FIELD PROTOCOLS, *supra* note 337. Note: it may be assumed the protocols in place for AEMTs applies also to those licensed at the Paramedic level. In addition, regional patient care procedures may also be in place, See WAC 246-976-182 (2) *available at* <http://apps.leg.wa.gov/wac/default.aspx?cite=246-976-182>.
- <sup>340</sup> Wisconsin’s regulations state that emergency medical services personnel “may only perform the skills, use the equipment, and administer the medications that are specified by the department in the Wisconsin scope of practice for the level to which the individual is licensed, certified, or credentialed.” Wis. ADMIN. CODE DHS § 110.12. See also WISCONSIN EMS FIRST RESPONDER (EMR) SCOPE OF PRACTICE P-00451a, *available at* <http://www.dhs.wisconsin.gov/publications/p0/p00451a.pdf>.
- <sup>341</sup> Under 2013 protocols, EMT-Bs are only permitted to administer naloxone (listed as Narcan) under an approved pilot program. Wis. DEP’T HEALTH SERVS., WISCONSIN EMS SCOPE OF PRACTICE: EMERGENCY MEDICAL Technician 2 (Nov. 2012), *available at* <http://www.dhs.wisconsin.gov/publications/p0/p00451.pdf>.

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- <sup>342</sup> WIS. DEP'T HEALTH SERVS., WISCONSIN EMS SCOPE OF PRACTICE: INTERMEDIATE TECHNICIAN / ADVANCED EMT 1 (Nov. 2012), *available at* <http://www.dhs.wisconsin.gov/publications/p0/p00451c.pdf>.
- <sup>343</sup> WIS. DEP'T HEALTH SERVS., WISCONSIN EMS SCOPE OF PRACTICE: INTERMEDIATE 2 (Nov. 2012), *available at* <http://www.dhs.wisconsin.gov/publications/p0/p00451b.pdf>.
- <sup>344</sup> See WIS. DEP'T HEALTH SERVS., WISCONSIN EMS SCOPE OF PRACTICE: PARAMEDIC (Nov. 2012), *available at* <http://www.dhs.wisconsin.gov/publications/p0/p00451e.pdf>. See also WIS. DEP'T HEALTH SERVS., WISCONSIN EMS SCOPE OF PRACTICE: WISCONSIN PARAMEDIC CURRICULUM BASED MEDICATION LIST (June 2011), *available at* [http://www.dhs.wisconsin.gov/ems/License\\_certification/Paramedic\\_Curriculum\\_Meds0611.pdf](http://www.dhs.wisconsin.gov/ems/License_certification/Paramedic_Curriculum_Meds0611.pdf).
- <sup>345</sup> The regulations state that the medical directors of individual service providers are responsible for patient care protocols as part of the service provider's operational plan. WIS. ADMIN. CODE DHS § 110.35(2). However, the Department of Health Services has developed model guidelines for adoption. If individual service providers want to implement different protocols than those found in the model guidelines, the protocols must be submitted to the department using the Medical Director Approval Form. *Wisconsin Sample EMS Patient Care Guidelines*, WIS. DEP'T HEALTH SERVS., [http://www.dhs.wisconsin.gov/ems/EMSUnit/Protocols/Treatment\\_protocols.htm](http://www.dhs.wisconsin.gov/ems/EMSUnit/Protocols/Treatment_protocols.htm) (last visited Oct. 22, 2014).
- <sup>346</sup> EMRs are not permitted to administer naloxone. See W. VA. OFFICE EMERGENCY MED. SERVS., EMERGENCY MEDICAL RESPONDER SCOPE OF PRACTICE (2013), *available at* <http://wvoems.org/medical-direction/scope-of-practice/emergency-medical-responder-scope-of-practice>. See also W. VA. OFFICE EMERGENCY MED. SERVS., 6000 SERIES BASIC LIFE SUPPORT PROTOCOLS (2013), *infra* note 347.
- <sup>347</sup> EMTs are not permitted to administer naloxone. See W. VA. OFFICE EMERGENCY MED. SERVS., 6000 SERIES BASIC LIFE SUPPORT PROTOCOLS (2013), *available at* <http://www.wvoems.org/media/241029/6000%20combined.pdf>. However, effective January 1, 2015, updated BLS and ALS protocols will permit EMTs to administer naloxone via IN route with the approval of the EMS Medical Command Physician. See 2015 BLS and ALS protocols, *available at* <http://wvoems.org/medical-direction/protocols/revised-protocols>.
- <sup>348</sup> AEMTs are permitted to administer naloxone (IV, IN, or IM) if ordered by Medical Command Physician. W. VA. OFFICE EMERGENCY MED. SERVS., 5000 SERIES ADVANCED CARE PROTOCOLS 5213, 5605 (2013) [hereinafter 5000 SERIES ADVANCED CARE PROTOCOLS], *available at* <http://www.wvoems.org/media/241077/5000%20combined.pdf>.
- <sup>349</sup> W. VA. OFFICE EMERGENCY MED. SERVS., 4000 SERIES PARAMEDIC PROTOCOLS 4605 (2013) [hereinafter 4000 SERIES PARAMEDIC PROTOCOLS], *available at* <http://www.wvoems.org/medical-direction/protocols/4000-series-protocols>.
- <sup>350</sup> 5000 SERIES ADVANCED CARE PROTOCOLS, *supra* note 348 at 5605; 4000 SERIES PARAMEDIC PROTOCOLS, *supra* note 349, at 4605. The Medical Policy and Care Committee is responsible for creating, reviewing, and approving treatment, triage and transportation protocols. W. Va. Code R. § 64-48-9.1.b.
- <sup>351</sup> A First Responder is defined as "an individual who has successfully completed a training program that is current with the Department of Transportation's First Responder program or an approved First Responder training program sponsored by the Division. A First Responder shall not practice alone as an ambulance attendant in Wyoming." W.S. 33-36-101, CHAPTER 1 § 4(k).
- <sup>352</sup> W.S. 33-36-101, CHAPTER 6 § 11(d).
- <sup>353</sup> *Id.* See § 11(e).
- <sup>354</sup> *Id.* See § 11(f).
- <sup>355</sup> See STATE OF WYOMING RULES AND REGULATIONS FOR WYOMING TRAUMA PROGRAM, CHAPTER 2, SECTION (3)(c). Protocol for EMT Intermediate and Paramedic systems should be filed by the physician medical director. These are then approved by the Division and the Task Force, See also W.S. 33-36-101, CHAPTER 6 § 4(a).
- <sup>356</sup> See D.C. TREATMENT PROTOCOLS, *infra* note 357. Further, D.C. EMS regulations state that "[t]he Director shall develop a scope of practice policy in accordance with the Department of Transportation and the National Highway Traffic Safety Administration's current national standard guidelines." 29 D.C. CODE MUN. REGS. § 526.1 Under the NHTSA national guidelines, EMRs are not permitted to administer naloxone.
- <sup>357</sup> The D.C. Emergency Services Act grants broad authority to the Mayor to establish licensing and certification requirements, issue regulations, conduct inspections and investigations, and ensure compliance with the Act and promulgated regulations. D.C. CODE §§ 7-2341.01–7-2341.17. The Mayor delegated this authority to the Director of the Department of Health.

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Mayoral Order 2009-89 (June 1, 2009), available at <http://www.dcregs.dc.gov/Gateway/NoticeHome.aspx?NoticeID=388599>. This included the authority to define scope of practice. 29 D.C. CODE MUN. REGS. § 504.12(c). Under the most recent D.C. EMS Protocols, (effective May 21, 2014), all licensure levels at EMT and above are permitted to administer naloxone to adults. BLS personnel may only administer naloxone via IN route to adults; BLS personnel are not permitted to administer naloxone to pediatric patients. AEMTs or other ALS personnel may administer naloxone to both adult and pediatric patients via IV/IN/IM routes. DEP'T OF HEALTH, EMERGENCY MED. SERVS., EMERGENCY MEDICAL SERVICES EMS PROTOCOLS [hereinafter D.C. TREATMENT PROTOCOLS] (Effective May 21, 2014), available at [http://fems.dc.gov/sites/default/files/dc/sites/fems/publication/attachments/0.%20%20%20Complete%20DCFEMS%20EMS%20Protocols%202014%20Version%201.0%20Final%204\\_29\\_2014.pdf](http://fems.dc.gov/sites/default/files/dc/sites/fems/publication/attachments/0.%20%20%20Complete%20DCFEMS%20EMS%20Protocols%202014%20Version%201.0%20Final%204_29_2014.pdf).

<sup>358</sup> See *supra* note 357.

<sup>359</sup> *Id.*

<sup>360</sup> *Id.*

<sup>361</sup> D.C. TREATMENT PROTOCOLS, *supra* note 357, at 266.

<sup>362</sup> Puerto Rico does not recognize an EMR or EMR-like licensure level. See *infra* note 364.

<sup>363</sup> P.R. LAWS ANN. tit. 20, § 3464(1).

<sup>364</sup> Puerto Rico's statutes only describe two levels of EMS personnel: EMT-Bs and EMT-Ps. *Id.* §§ 3454(d),(e), 3462, 3463.

<sup>365</sup> *Id.* § 3464(2).

<sup>366</sup> GOBIERNO DE PUERTO RICO, CUERPO DE EMERGENCIAS MÉDICAS DE PUERTO RICO, PROTOCOLO MEDICO DE TRANSPORTE PRE-HOSPITALARIO 5.5 (2011), available at [http://www2.pr.gov/agencias/cempr/Documents/PROTOCOLO\\_MEDICO\\_DE\\_TRANSPORTE\\_PRE-HOSPITALARIO.pdf](http://www2.pr.gov/agencias/cempr/Documents/PROTOCOLO_MEDICO_DE_TRANSPORTE_PRE-HOSPITALARIO.pdf).

<sup>367</sup> An "Emergency Medical Responder" or EMR is defined as "the first trained individual, such as police officer, firefighter, lifeguard, or other rescuer, to arrive at the scene of an emergency to provide initial medical assistance." 10 GUAM CODE § 84102(t).

<sup>368</sup> See 10 GUAM CODE § 84102 (defining an EMT-B as someone that provides basic life support and defining basic life support to exclude administration of medication). See also 10 GUAM CODE § 84110 (requiring training programs to utilize curricula that is consistent with the Department of Transportation, National Highway Traffic Safety Administration, and the National Emergency Medical Services Advisory Council); U.S. DEP'T TRANSP., NATIONAL EMS SCOPE OF PRACTICE MODEL, *supra* note 14, at 24.

<sup>369</sup> See 10 GUAM CODE § 84102 (defining an EMT-I as someone who's scope of practice includes provision of advanced life support and defining advanced life support to include administration of drugs).

<sup>370</sup> *Id.* (defining an EMT-P as someone who's scope of practice includes provision of advanced life support and defining advanced life support to include administration of medication).

<sup>371</sup> 10 GUAM CODE § 84102(cc) and (aa).

<sup>372</sup> 10 GUAM CODE § 84122.

<sup>373</sup> The Code creates both the Office of EMS at § 84103 and the Guam EMS Commission at § 84106, which are instructed to collaborate to implement the EMS System § 84105(l). The Office of EMS is given authority to develop treatment protocols at § 84122, while the EMS Commission is given authority to adopt rules and regulations at § 84118. I was unable to find protocols or regulations. My impression is that regulations have not been enacted because the "Public Health and Services Act" is listed in the Regulations but states "No rules filed." 26 GUAM ADMIN. R. & REGS. § 1, available at <http://www.justice.gov.gu/CompilerofLaws/GAR/26GAR/26GAR001-6A.pdf>.