REPORT OF RECOMMENDATIONS AND FINDINGS ON THE PROPOSAL TO EXPAND THE SCOPE OF PRACTICE OF SOME EMS PROVIDERS

By the Nebraska
State Board of Health

To the Director of the Division of Public Health of the Department of Health and Human Services, and the Members of the Health and Human Services Committee of the Legislature

September 16, 2019

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature which is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether or not the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division along with any other materials requested by these review bodies. These two review bodies formulate their own independent written reports on the same credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

The Members of the Nebraska State Board of Health, 2019

Kevin Borcher, PharmD, RP

Shane Fleming, BSN, MSN, RN

Michael Hansen, (Hospital Administrator)

Russell Hopp, DO

Diane Jackson, APRN

Kevin Low, DDS

Joel Bessmer, MD

Debra Parsow (Public Member)

Wayne Stuberg, PhD, PT (Vice Chair)

Travis Teetor, MD (Chair)

Joshua Vest, DPM

Douglas Vander Broek, DC

Jeromy Warner, PsyD, LP

BOH Meetings held to discuss the EMS proposal

Meetings of the Credentialing Review Committee of the Board, June 5, June 17, and September 16, 2019

The Meeting of the Full Board of Health, September 16, 2019

Part Two: Summary of Board of Health Recommendations on the EMS Proposal

Summary of the Board's Credentialing Review Committee Recommendations

EMS Proposal: Critical Care: The Board Committee members approved this component of the EMS proposal.

EMS Proposal: Community Paramedicine: The Board Committee members approved this component of the EMS proposal.

Summary of the Recommendations of the full Board of Health

The members of the full Board of Health approved both components of the EMS proposal.

Part Three: Summary of the EMS Proposal

The Critical Care Paramedic Proposal (1)

Critical care transportation has developed over the past three decades to involve an expanded scope of practice for paramedics. Educational programs have been designed recognizing that paramedics need additional preparation and ongoing education to prepare and maintain advanced critical care during inter-facility transports, including performing advanced clinical patient assessments and providing invasive care beyond the standard scope of advanced prehospital care. Specialists trained with demonstrated competency is essential to the quality delivery of critical care transport. Current paramedic education, based upon national educational standards and guidelines, does not include necessary knowledge and skills to manage critical patients during a high-risk transfer.

There are many critical care education courses available, consisting of 80 or more additional education hours beyond a paramedic program, based on national education standards and guidelines. A framework used as a model for other levels of EMS providers, includes four inter-related aspects leading to safe clinical practice:

- Education - trained to do
- Certified - certified as competent
- Licensed - has been granted legal authority to practice
- Credentialed - has been authorized by physician medical director to perform role

The International Board of Specialty Certification (IBSC) does not believe paramedics should work in a critical care environment without being certified. The legal risk is exponentially increased without validation of clinical competency. Critical care paramedic certification targets competency at the mastery level of paramedic practice coupled with entry-level competency over the knowledge, skills and abilities contained within the critical care transport specialty. (Appendix F)

Raynovich, et al., (Air Medical Journal, 2013), convey the following from surveyed paramedics: “My employer removed mechanical vents due to bad outcomes secondary to 20 minutes of in-service training.” Another paramedic reports: “Most paramedics are pressured into transporting patients that they are not comfortable with.” Research has demonstrated that paramedics currently deliver medical care using equipment and medications at a level above their education and for which they are not certified, licensed, or credentialed to function (Appendix A). Critically ill or injured patients requiring transportation to or between specialty tertiary care centers will continue to grow, and the development of guidelines and standards are necessary for public protection.

The historical evolution of paramedicine has created a situation in which specialized practice is not well defined or accepted, yet as tertiary care centers provide highly sophisticated care to patients, specialists capable of transporting these patients is essential. The International Association of Flight and Critical Care Paramedics reports various policy approaches to EMS personnel involved in critical care transport:

- Critical Care Paramedic Licensure - 2 (Alaska and Connecticut)
- Critical Care Paramedic Certified - 1 (Colorado)
- Critical Care Paramedic Endorsement - 8 (Iowa, Kentucky, Massachusetts, Montana, New Hampshire, Oklahoma, Tennessee, and Wisconsin)
- Expanded Scope of Practice Designated - 3 (California, Michigan, and Pennsylvania)

Current education programs do not prepare paramedics for roles in critical care transport. Additional education and credentialing is necessary for safe practice in a critical care environment. Other health professions, including nursing and medicine have additional education, certification, and credentialing processes to function in critical care. While the scope of practice may vary slightly, the typical practice of a critical care paramedic includes the following:

- Advanced clinical patient assessment (analysis and synthesis of clinical information)
- Chest Tube Thoracostomy - acute insertion
- Transvenous or Epicardial Pacing (management of)
- Hemodynamic monitoring (pulmonary artery catheter, central venous pressure)
- Intra-aortic Balloon Pump monitoring
- Invasive Cardiac Assist Device monitoring
- Extracorporeal Membrane Oxygenation monitoring
- Venous Central Line - obtaining
- Arterial Line monitoring
- Intracranial Pressure monitoring
- Ventilators - multimodal, with blender, that are used on patients requiring pressure control, pressure support, or other advanced settings
- Radiology films
- Point of Care Ultrasound - FAST exams
- Obstetric Fetal Monitoring
- Polypharmacy - complex infusions

Nebraska is a geographically large, rural state that relies upon critical care specialists to care for critically ill and traumatized patients. Currently there is no framework in Nebraska to verify education, certification, licensure, or credentialing for personnel functioning in critical care. Ensuring public protection and safe, quality medical care is paramount. The Nebraska Board of EMS supports the development of statutes and regulations to formally recognize and provide oversight for EMS personnel engaged in critical care transport. This entails the following process:

- Successful completion of a Nebraska Board of EMS approved certification application
- Make application to Nebraska Licensure Unit

Critical care transport paramedics are not currently recognized in Nebraska. Paramedics are involved in providing these necessary transportation functions, often during inter-facility transports when specialized services are not available at the patients current location. This may involve ground or aeromedical transportation services. Patients may be initially transported to a critical access or community hospital that does not have the capability to definitively treat a patient, or specialized transportation services may be requested directly to the scene of a medical or trauma event by EMS, usually when located in rural Nebraska with extended transport times.

There are no statutory limitations or restrictions on critical care transport, because it is not a recognized or regulated occupation. As a result, patients are potentially at risk due to a lack of consistent oversight and minimum education, certification, licensure, and credentialing requirements. Nebraska Model EMS Protocols do not address the critical care aspects of the patients being cared for during these transports.

The Community Para-medicine Proposal (2)

Mobile Integrated Health – Community Para-medicine (MIH-CP) programs have been on the rise for the past decade. According to the Mobile Integrated Healthcare and Community Para-medicine (MIH-CP): 2nd National Survey (Appendix A), forward thinking EMS agencies designed the programs to meet individual community healthcare needs following the Institute for Healthcare Improvement's Triple Aim of improved patient experience of care, improved population health and reduced per capita cost of healthcare. This is accomplished by identifying gaps in healthcare specific to a community. Programs are not meant to compete with existing services being provided. MIH-CP services that may be provided include but are not limited to:

- Providing help to patients with chronic disease management and education, including post-hospital discharge follow-up to prevent admissions or re-admissions;
- Navigate patients to alternate destinations such as primary care, urgent care, mental health or substance abuse treatment centers rather than the emergency room;
- Provide telephone triage, advice or other assistance to non-urgent 911 callers rather than sending scarce resources such as an ambulance; and
- Use telemedicine technology facilitating patient in home interaction with healthcare providers at another location.

This proposal seeks to establish Community Para-medicine within the State of Nebraska. This will require changes to terminology currently used to describe EMS within Nebraska Statute and Rules and Regulations. First is the removal of the reference "out-of-hospital." "Out-of-hospital" is a location of service and should not be interpreted as part of the scope of practice as it is now in statutes and regulation. The National EMS Scope of Practice Model (Appendix B) states EMS professionals are increasingly practicing in areas other than "out of hospital," typically referencing ambulances. For more than two decades and currently, Nebraska EMS personnel practice in out of hospital, in hospital and other health clinic settings demonstrating that "out of hospital" is no longer a relevant term.

Community Para-medicine providers and personnel work in locations other than hospitals or health care clinics. The providers will be providing non-emergent care to patients within their homes and other locations. Currently the Emergency Medical Services Practice Act restricts EMS providers to "include the identification of and intervention in actual or potential health problems of individuals and are directed toward addressing such problems based on actual or perceived traumatic or medical circumstances prior to or during transportation to a hospital or for routine transportation between health care facilities or services." The EMS Act further restricts EMS Services to the "perceived individual need for medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury." Healthcare continues to evolve rapidly, and more and more care is transitioning to the in-home environment, or settings outside of hospitals. Community Para-medicine and EMS providers may work in a variety of health care settings and provide care in homes for non-emergent situations. The necessary changes to the EMS Practice Act will allow EMS Services and personnel (license level of EMT, AEMT, EMT-I or Paramedic) to work in a variety of health care settings (i.e. nursing home, hospital, etc.) and to provide care in non-emergent situations, is essential for the benefit of patients and the healthcare system.

EMS services will be required to obtain approval from the Nebraska EMS Board and Nebraska Department of Health and Human Services (DHHS) prior to any EMS Service or provider beginning MIH-CP services. The EMS Service shall submit to the EMS Board and

DHHS an application that will consist of the community healthcare needs assessments. A rural health assessment performed by local hospitals or public health districts may be utilized to satisfy the community needs assessment. Additionally, the application will need to outline the details of what services will be provided, including copies of any protocols that may be needed, policies that are created, how EMS personnel and other healthcare professionals will receive and maintain the education on patient care for the services provided, and how medical oversight of the program will be provided by the physician medical director. The physician medical director will need to sign and approve all aspects of the application. Applications will be submitted, reviewed and inspected by subject matter experts before launching an MIH-CP program, and upon EMS services regularly scheduled inspection. The EMS Practice Act and Rules and Regulations must be changed to allow EMS services to provide these MIH-CP without having to obtain a Home Health Agency License. EMS services will be required to document all patient encounters with the minimum standards required by 172 NAC 12.004.09C and all subsections. The regulation should be updated to require the Nebraska Emergency Medical Services Data Software System to provide for a Community Para-medicine component.

Community Para-medicine (CP) programs are not currently recognized in statutes or regulations. CP programs with formal associations with hospitals have been piloted in Nebraska. Because CP is not recognized, no services have been officially recognized.

No statutory limitations exist because the practice is not recognized in statutes. Not advancing the Community Para-medicine proposal may result in continued gaps in healthcare, potential return visits to the emergency room and/or admissions or readmissions to hospitals, resulting in less effective care and increased costs for the patient and the entire healthcare system.

The full text of the applicants' proposal can be found under the EMS subject area on the credentialing review program link at
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Four: Discussion on issues by the Board Committee Members

The following discussions occurred during the meetings of the Credentialing Review Committee of the Board of Health prior to the meeting wherein the members of the full Board formulated their recommendations on the EMS proposal.

What are the shortcomings of the current EMS practice situation, if any? If there are shortcomings what needs to be done to rectify the situation?

Shane Fleming, R.N., asked Dr. Miller how he envisions EMS community paramedic services being supported financially. Dr. Miller replied that such EMS services would help reduce overall health care costs by addressing the needs of clients in situ without the high costs of transport to a hospital "ER." He added that compensation of some kind is necessary to make these services viable and that to get this done requires that we first make changes in current Nebraska law and rules and regulations so as to allow EMS paramedics to provide these kinds of services in the first place.

How would the ideas proposal by the applicant group be helpful in addressing the shortcomings of the current practice situation of EMS providers? Overall, would the public benefit from these proposed ideas?

Mr. Miller informed the committee that over the past four years EMS Board members traveled throughout Nebraska and engaged communities in listening sessions involving their proposals. He further stated both proposals strive to protect Nebraska citizens and are motivated by evidence based practices. Additionally, Mr. Miller discussed that the applicant group are advocates for education, exams, certification and local medical oversight for both proposals. He finally asked for the support of the Board of Health and to re-affirm the work of the technical review committee. He further stated that the EMS Board was unanimous in supporting both the Critical Care Paramedic and Community Para-medicine proposals.

Would any harm come from approving the ideas proposal by the applicant group?

Jamie Summerfelt, CEO and President of the Visiting Nurse Association in Omaha/ Nebraska, came forward to present testimony. Jamie is also the President-Elect of the Nebraska Home Care Association and presented testimony on behalf of the membership.

A copy of Geri Johnson's testimony from the April 1, 2019 EMS Technical Review Committee Public hearing was submitted. Geri is the Nebraska Home Care Association President and wasn't able to attend today s hearing. My comments today are responses to additional points the applicant group presented on April 1st and one additional consideration. Our top priority is to ensure appropriate care, safety and well-being for Nebraskans to remain independent in their homes and communities. Your handouts include a list of home health agencies in Nebraska and the counties where they are licensed to provide skilled healthcare services; and a handout with the types of services that home health agencies provide. You're also encouraged to review the Home Health Conditions of Participation, which is available on the Centers for Medicare and

Medicaid (CMS) website and specifies the requirements for anyone wishing to provide home health services must follow.

When a community paramedic is responding to a call in the home or community and determines that a client s needs are different than stabilizing and transporting to a hospital, urgent care or facility, then the role of that paramedic ought to be to help connect the client with the professional or other resource licensed, trained and operating under the respective scope of practice to meet the patient's needs. Based on the applicant group's comments at the April 1st public hearing it sounds like that's the intent to integrate services such as public health home health systems and primary care providers. Referring the client to those appropriate resources is the recommended course of action.

The applicant group referenced wanting to provide education and health promotion programs. We support working in collaboration with the appropriate stakeholders to directly educate Nebraskans and their family members or other caregivers on maintenance and preventative care.

The proposal does not specify a clear standard in education or degree requirements that will adequately prepare EMS providers to perform the full range of home care skills and services/including case management long-term chronic disease management wound care, physical and occupational therapy and other specialized services. Current EMS licensure requirements do not cover this scope of practice.

At the EMS Technical Review Committee public hearing the applicant group also stated that they intend to perform post-hospital follow-up care. Our members would ask for clarification on what that care would entail. We would also like to better understand how this care will be designed and communicated if home care is in place to avoid duplication and assure ail plans of care are clear, collaborative, and avoid unnecessary expense. If post-hospital follow-up care is intended to include chronic disease management and education including post hospital discharge follow up to prevent readmissions, we wanted to reiterate that chronic disease management is at the core of home health. It requires a skilled professional to assess the patient's condition, integrating a variety of signs and symptoms for patients with several comorbid conditions, perform typically complex medication reconciliation with review of interactions, duplications, and side effects as well as coordinate a plan of care that keeps the patient safe at home. Adding an additional layer of care that is managed primarily under protocols and on-line medical direction from someone with no knowledge or background on the individual patient serves only to further fragment the patient s care and the healthcare system. Home health agencies commonly hire registered nurses and licensed therapists with a minimum of three years of nursing experience. This is because clinical services in a home or community setting require a high level of skills and competencies to care for patients with complex long-term care needs. This includes caring for patients with tracheostomies, wounds/chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The care and expertise that home health professionals provide in the home and community helps
constituents prevent emergency room stays and re-hospitalization/ reducing costs in the long-term for the state.

Rigorous, credentialed educational programs for nurses and therapists prepare them to function independently. The application states that for Community Para-medicine education may be handled in a variety of different ways. Allowing another level of care with no degree requirement or standard educational curriculum is not a substitute for shortages in skilled

professional roles and does not close gaps in healthcare. It is hard to see how the addition of this service in an already complex system will "increase continuity of care.

Preventing re-hospitalization is a core measure for CMS Home Health Compare and Value Based Purchasing programs. Home Health interventions are geared toward transitioning the patient from the acute level of care and to prevent unnecessary readmissions. We ask what the goals for the patient are in this proposal, and for the Board of Health to consider what improvements can be made within the current continuum, to include EMS providers, to reach these goals - without permitting an unlicensed scope of practice that competes with current resources and is not comprehensive of what home care in Nebraska currently provides. We would respectfully request that if the Board of Health determines that community paramedicine may be a viable program in Nebraska/ then establish pilots with community assessments in several regions across the state/ with the stipulation that a home health agency in each of the pilot communities are required to be involved with every patient. The Nebraska Home Care Association would offer to have one or more members be part of a work group with the applicant group and other stakeholders to develop a list of guidelines and/or desired outcomes for the pilot. If evidence shows that a community para-medicine program meets the objectives and criteria outlined in the proposal that it doesn't impact public safety and it doesn't overlap with home health services, then the case could made to move forward with implementation of the program with any interested communities once the assessments are completed and evaluated.

Thank you for your thoughtful consideration and work to ensure Nebraskans receive the care/services and support they need to remain safe and comfortable at home and in their communities.

The Board Committee members heard from Jerry Johnson, R.N., with the Brown County Hospital Home Health Care Program. Ms. Johnson stated that she is opposed to the EMS Community Health Paramedic proposal because in effect it would allow this kind of care to be provided without adherence to strict licensure standards to which other home health providers are expected to adhere. She added that EMS would need to see to it that their community paramedic proposal meets these same strict licensure standards before her organization could consider supporting it.

Mike Miller came forward to respond to Ms. Johnson's comments. He stated that EMS community paramedic services would be credentialed via a specialty certification concept to which all who want to provide such services would be required to adhere. Dr. Miller went on to state that community paramedics would not be attempting to provide all of the services that home health care practitioners provide. Their services would be for the purpose of filling in gaps in current services and would not be for the purpose of attempting to compete with extant home health care services.

Is there a better way to address these concerns?

Ms. Parsow asked whether the applicant group has met with their opposition. Mr. Miller stated they have reached out to the nursing community prior to the 407 review and have met with their colleagues at home health. He further indicated that the applicant group does not view this as competition and are happy to work with and engage any group that has an interest. Ms. Parsow reinforced that collaboration is the best route to take during this process.

Part Five: Recommendations of the Credentialing Review Committee of the Board during its September 16, 2019 Bimonthly Meeting

Comments by Travis Travis Teetor, MD

During their September 16, 2019 morning meeting the committee members received comments from Travis Teetor, MD, Chairperson of the EMS TRC, on the issues raised by the EMS proposal. Pertinent to the critical care component of the proposal Dr. Teetor stated that for the most part the members of the TRC he chaired were accepting of both components of the proposal. Dr. Teetor went on to comment on some concerns be continues to have about the critical care component of the proposal. He went on to state that some of the procedures to be added to EMS scope of practice raise safety concerns. These procedures included such new, proposed scope elements such as central lines, the use of balloon pumps, ventilators, and the use of chest tubes. Dr. Teetor stated that even medical doctors are reluctant to utilize chest tube procedures and do so only when there is no alternative, for example. This is a highly risky procedure even in the controlled environment of a medical facility let alone "out in the field," so to speak. He went on to state that the proposed education and training for these new, proposed scope elements was very minimal compared to what a medical student receives. He also raised the concern that EMS services in remote rural areas of the state are going to have a harder time incorporating the new scope elements than those in more urban areas of Nebraska.

Dr. Stuberg asked Dr. Teetor to comment regarding whether or not he would recommend approval of the critical care element of the EMS proposal given his concerns about some of the new, proposed scope elements. Dr. Teetor indicated that despite these concerns he would support this component of the proposal for the following reasons: 1) these scope elements are already being used "in the field" by EMS personnel and that's unlikely to change or be reversed, 2) the proposal would at least provide some kind of educational and training foundation for the use of these modalities by EMS personnel, whereas right now there is no base-line education or training for EMS vis-à-vis these modalities. Some education and training is better than no education and training, 3) the proposal defines an oversight system for those who would be utilizing the new modalities with a medical director overseeing procedures wherein these modalities are applied.

Regarding the community paramedicine component of the EMS proposal Dr. Teetor stated that, for him, this component was less controversial than the critical care component. He stated that financial concerns, including financially-related access to care concerns, predominated the discussions on this component of the EMS proposal rather than safety concerns. He went on to state that some TRC members were concerned that this component of the proposal might adversely impact the ability of some, smaller EMS units to maintain their focus on providing emergency medical services in the field. Some TRC members were concerned that this component of the EMS proposal would create unnecessary duplication of community health services given that there are already nurses and home health professionals who have already been providing these services for many years. Dr. Teetor went on to say that most TRC members concluded that this part of the proposal would not create unnecessary duplication because it would be more narrowly focused on filling gaps in home health services rather than competing with services already being provided. He went on to state that the applicants made it clear that emergency care is and always will be the principal focus of EMS, and that any community health services provided by EMS personnel would be provided if and only if there was sufficient money and personnel available to do so without detracting from their principal mission of providing emergency care.

Comments by interested parties

Testimony was received from Janet Seelhoff representing home health services and Tim Wilson representing the applicant group. Ms. Seelhoff state that her group would be willing to work with EMS providers in the context of home health services if the proposal were to pass even though her group continues to oppose the current community health component of the EMS proposal. Mr. Wilson Commented on the need for greater communication and collaboration among all of those who provide or seek to provide home health services in our state, adding that EMS in Nebraska wants to be part of a team effort with home health providers to provide these kinds of services to the public in our state.

The Formulation of Recommendations by the Board Committee members

Following their discussion on the proposal the CR Committee members took action on the proposal via 'up-down' votes on both of the component parts of the EMS proposal in order to advise the members of the full Board of Health.

Action on the critical care component of the proposal went as follows:

Voting to approve this component of the proposal were Parsow, Stuberg, and Vest. There were no nay votes or abstentions.

Action on the community paramedicine component of the proposal went as follows:

Voting to approve this component of the proposal were Parsow, Stuberg, and Vest. There were no nay votes or abstentions.

There was no further action of discussion by the Board Committee members.

Part Six: Recommendations of the Full Board of Health on the Proposal

Actions taken by the members of the full Board of Health:

The members of the full Board of Health took action on the EMS proposal via a single roll call vote. Voting to approve this proposal were the following Board members:

Borcher
Hansen
Hopp
Jackson
Low
Parsow
Stuberg
VanderBroek
Vest
Warner

There were no nay votes or absentions. By this action the Board of Health members recommended approval of the EMS proposal.

There was no further action of discussion by the Board members.