

5 YEAR REPORT TO THE LEGISLATURE 2016



**NEBRASKA BOARD
OF
EMERGENCY MEDICAL SERVICES**

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

INTRODUCTION

In this current climate of fiscal responsibility to the citizens of Nebraska, the Board of Emergency Medical Services has continued to look at ways to provide effective and responsible patient-centered care while simultaneously upholding Emergency Medical Services as an essential service in the State of Nebraska. The personnel that make up Emergency Medical Services are affected by the decisions that are formulated by government and national organizations. These decisions include determining the amount of education and training that is required to obtain licenses and certificates to practice, and development of new protocols and standards to ensure the level of care in the time of an emergency is done so in a professional and safe manner. The people who serve as Nebraska Emergency Medical Services personnel strive to ensure the Good Life.

Purpose

This report is a five-year review, required of the Nebraska State Board of Emergency Medical Services under Neb. Rev. Stat. § 38-1216. The intent of this report is to inform the legislature on the implementation of the Emergency Medical Services Act, to provide an evaluation of the out-of-hospital emergency care needs of the citizens of the State of Nebraska and to show the essential need of Emergency Medical Services, along with the recommendations of the Board of Emergency Medical Services.

Legislative Intent

It is the intent of the Legislature in enacting the Emergency Medical Services Practice Act to (1) effectuate the delivery of quality out-of-hospital emergency medical care in the state, (2) eliminate duplication of statutory requirements, (3) merge the former boards responsible for regulating ambulance services and emergency medical care, (4) replace the former law regulating providers of and services delivering emergency medical care, (5) provide for the appropriate licensure of persons providing out-of-hospital medical care and licensure of organizations providing emergency medical services, (6) provide for the establishment of educational requirements and permitted practices for persons providing out-of-hospital emergency medical care, (7) provide a system for regulation of out-of-hospital emergency medical care which encourages out-of-hospital emergency care providers and emergency medical services to provide the highest degree of care which they are capable of providing, and (8) provide a flexible system for the regulation of out-of-hospital emergency care providers and emergency medical services that protects public health and safety.

The act shall be liberally construed to affect the purposes of, carry out the intent of, and discharge the responsibilities prescribed in the act.

Source: Laws 1997, LB 138, § 2; R.S.1943, (2003), § 71-5173; Laws 2007, LB463, § 486. Operative date December 1, 2008

The Board of Emergency Medical Services

1) The board shall have seventeen members appointed by the Governor with the approval of a majority of the Legislature. The appointees may begin to serve immediately following appointment and prior to approval by the Legislature.

(2)(a) Seven members of the board shall be active out-of-hospital emergency care providers at the time of and for the duration of their appointment, and each shall have at least five years of experience in his or her level of licensure at the time of his or her appointment or reappointment. Of the seven members who are out-of-hospital emergency care providers, two shall be emergency medical responders, two shall be emergency medical technicians, one shall be an advanced emergency medical technician, and two shall be paramedics.

(b) Three of the members shall be qualified physicians actively involved in emergency medical care. At least one of the physician members shall be a board-certified emergency physician.

(c) Five members shall be appointed to include one member who is a representative of an approved training agency, one member who is a physician assistant with at least five years of experience and active in out-of-hospital emergency medical care education, one member who is a registered nurse with at least five years of experience and active in out-of-hospital emergency medical care education, and two public members who meet the requirements of section 38-165 and who have an expressed interest in the provision of out-of-hospital emergency medical care.

(d) The remaining two members shall have any of the qualifications listed in subdivision (a), (b), or (c) of this subsection.

(e) In addition to any other criteria for appointment, among the members of the board appointed after January 1, 2017, there shall be at least three members who are volunteer emergency medical care providers, at least one member who is a paid emergency medical care provider, at least one member who is a firefighter, at least one member who is a law enforcement officer, and at least one member who is active in the Critical Incident Stress Management Program. If a person appointed to the board is qualified to serve as a member in more than one capacity, all qualifications of such person shall be taken into consideration to determine whether or not the diversity in qualifications required in this subsection has been met.

(f) At least five members of the board shall be appointed from each congressional district, and at least one of such members shall be a physician member described in subdivision (b) of this subsection.

(3) Members shall serve five-year terms beginning on December 1 and may serve for any number of such terms. The terms of the members of the board appointed prior to December 1, 2008, shall be extended by two years and until December 1 of such year. Each member shall hold office until the expiration of his or her term. Any vacancy in membership, other than by expiration of a term, shall be filled within ninety days by the Governor by appointment as provided in subsection (2) of this section.

(4) Special meetings of the board may be called by the department or upon the written request of any six members of the board explaining the reason for such meeting. The place of the meetings shall be set by the department.

(5) The Governor upon recommendation of the department shall have power to remove from office at any time any member of the board for physical or mental incapacity to carry out the duties of a board member, for continued neglect of duty, for incompetency, for acting beyond the individual member's scope of authority, for malfeasance in office, for any cause for which a professional credential may be suspended or revoked pursuant to the Uniform Credentialing Act, or for a lack of license required by the Emergency Medical Services Practice Act.

(6) Except as provided in subsection (5) of this section and notwithstanding subsection (2) of this section, a member of the board who changes his or her licensure classification after appointment or has a licensure classification which is terminated under section 38-1217 when such licensure classification was a qualification for appointment shall be permitted to continue to serve as a member of the board until the expiration of his or her term.

Source Laws 1997, LB 138, § 5; Laws 1998, LB 1073, § 146; Laws 2004, LB 821, § 18; R.S.Supp.,2006, § 71-5176; Laws 2007, LB463, § 499; Laws 2009, LB195, § 12; Laws 2016, LB952, § 1. Effective Date: July 21, 2016

The Purpose and Duties of the Board of Emergency Medical Services

In addition to any other responsibilities prescribed by the Emergency Medical Services Practice Act, the board shall:

(1) Promote the dissemination of public information and education programs to inform the public about out-of-hospital emergency medical care and other out-of-hospital medical information, including appropriate methods of medical self-help, first aid, and the availability of out-of-hospital emergency medical services training programs in the state;

(2) Provide for the collection of information for evaluation of the availability and quality of out-of-hospital emergency medical care, evaluate the availability and quality of out-of-hospital emergency medical care, and serve as a focal point for discussion of the provision of out-of-hospital emergency medical care;

- (3) Review and comment on all state agency proposals and applications that seek funding for out-of-hospital emergency medical care;
- (4) Establish model procedures for patient management in out-of-hospital medical emergencies that do not limit the authority of law enforcement and fire protection personnel to manage the scene during an out-of-hospital medical emergency;
- (5) Not less than once each five years, undertake a review and evaluation of the act and its implementation together with a review of the out-of-hospital emergency medical care needs of the citizens of the State of Nebraska and submit electronically a report to the Legislature with any recommendations which it may have; and
- (6) Identify communication needs of emergency medical services and make recommendations for development of a communications plan for a communications network for out-of-hospital emergency care providers and emergency medical services.

Source: Laws 1997, LB 138, § 6; R.S.1943, (2003), § 71-5177; Laws 2007, LB463, § 500; Laws 2012, LB782, § 38. Operative Date: July 19, 2012.

The Board of Emergency Medical Services meets an average of four times a year. Most meetings are held in Lincoln, but meetings have been held in other areas of the state to coincide with gatherings of interested Emergency Medical Services providers. In order to be fiscally responsible, some Board business is done by conference call or e-mail ballot. Regular items on the Board's agenda include reports from Department of Health and Human Services Emergency Medical Services/Trauma Programs, EMS Training Coordinator, and Trauma Board Chairperson. Additional agenda items include issues relating to regulations, applications for licensure, and disciplinary matters. Board subcommittees report on Emergency Medical Services and Out-of-Hospital providers, Education, Legislation, Scope of Practice, and the ENARSIS data system. Since January 2012, the Emergency Medical Services Board has reviewed 73 out-of-hospital emergency medical care provider license applications and 22 emergency medical service or training agency license applications.

Support

Support for the Board of Emergency Medical Services, Emergency Medical Services, and Out-of Hospital Personnel is provided by the Department of Health and Human Services (DHHS) Division of Public Health, Licensure Unit – Office of Rehabilitation and Community Services and Emergency Medical Services and Trauma Program areas. The Emergency Medical Services and Trauma Program is funded primarily through the Fifty Cents for Life cash fund. The program is supplemented by several smaller sources, including federal grants such as the Preventative Health & Health Services Block Grant, Rural Health FLEX Grant, and general funds to support the Stroke System of Care Act implementation and aid for Emergency Medical Services Training and Education tuition assistance. The Licensure Unit - Office of Rehabilitation and community services is funded through the Fifty Cents for Life cash fund, the Health Care Cash fund, the Professional and Occupational Licensure Cash fund and general funds.

Licensure

The Licensure Unit, Office of Rehabilitation and Community Services is responsible for the administration of the Board of Emergency Medical Services and licensing of all Out-of-hospital Emergency Care Providers, Emergency Medical Services, EMS Training Agencies, and EMS Instructors for the entire State of Nebraska; a total of 8,039 licenses.

Emergency Medical Services and Trauma Program Overview

The Emergency Medical Services and Trauma Program currently oversees the following programs: Emergency Medical Services (EMS) Program, Trauma System, Critical Incident Stress Management Program (CISM), Emergency Medical Services for Children (EMSC), EMS Training, Education, and Training Agency Compliance, eNARSIS, LUCAS grant administration, Duracell Battery grant administration, 12-Lead Distribution and STEMI program, Stroke System of Care Act Implementation (2016), and the FirstNet implementation committee.

Rules and Regulations

Regulations pertaining to the practice of emergency medical care in the State of Nebraska, 172 NAC 11, 12, and 13 for Out of Hospital Emergency Care Providers, Emergency Medical Services, and Emergency Medical Services Training Agencies, were promulgated in 2012. The 2012 regulation changes and additions included mandatory electronic reporting in E-NARSIS within 72 hours for all service runs; changes to the continuing competency requirements for all professions; and, the addition of a self-report biennial Quality Assurance Report for all services. In 2016, approval was granted to open all three chapters of regulations for additional revision with the goal of promulgation of new regulations in 2017.

Training Agencies

Regulations also require that all training for certification be provided through an approved training agency or Distributive Learning Organization. Training Agencies must meet standards set by the Board, and are subject to approval, inspection, review, and termination of approval as set forth in the 172 NAC 13. In 2012, regulations were developed to authorize Distributive Learning that allows instructor, students, and content to be located in different non-centralized locations so that instruction and content are delivered independent of time and place and may be offered in one or more of the following methods: print, internet, videotape, CD-ROM/DVD, satellite and television. There are currently 22 Training Agencies and 1 Distributive Learning Organization licensed in the State of Nebraska. A Training Agency must utilize a licensed Emergency Medical Service Instructor to provide instruction. An Instructor must be dually licensed as an out-of-hospital emergency care provider and may only instruct at or below the level which they are licensed. There are currently 294 licensed Instructors in Nebraska.

Out-of-Hospital Providers

Current out-of-hospital emergency care provider classifications include Emergency Medical Responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians and Paramedics. The numbers of out-of-hospital emergency care providers has changed since 2011 (See **Table 1**). These classifications are established by statute and regulations were last promulgated in 2012 to address authorized practices and procedures, training and testing requirements, recertification requirements, and other criteria and qualifications for each classification. To ensure public safety, monitoring and physician medical director standards are also included in the regulations. It should be noted that a majority (82%) of providers consider themselves volunteers. During the strategic planning session held in April 2016, the estimated value of services provided by volunteer out-of-hospital emergency care providers is \$113,797,530.⁰⁰ annually. This was derived, in part, by the Department of Labor, Bureau of Statistics' value of a volunteer hour and coupled with the average costs incurred to run an emergency medical service; including equipment, facilities and supplies.

Table 1: Out-of-Hospital Emergency Care Providers

Breakdown of personnel numbers as reported in *License2000*.

Classification	2016 Numbers (%)	2011 Numbers (%)
Emergency Medical Responder/First Responder ¹	482 (6.6%)	704 (9%)
Emergency Medical Technician	5253 (72%)	5913 (75.6%)
Advanced Emergency Medical Technician	19 (0.2%)	1 (0.01%)
Emergency Medical Technician – Intermediate ²	77 (1%)	108 (1.4%)
Paramedic	1463 (20.1%)	1095 (14%)
Total Numbers	7294	7821

¹ First Responder classification was removed from licensure due to a legislative change in 2009. Licensees were given the opportunity to transition their license to Emergency Medical Responder status in 2012.

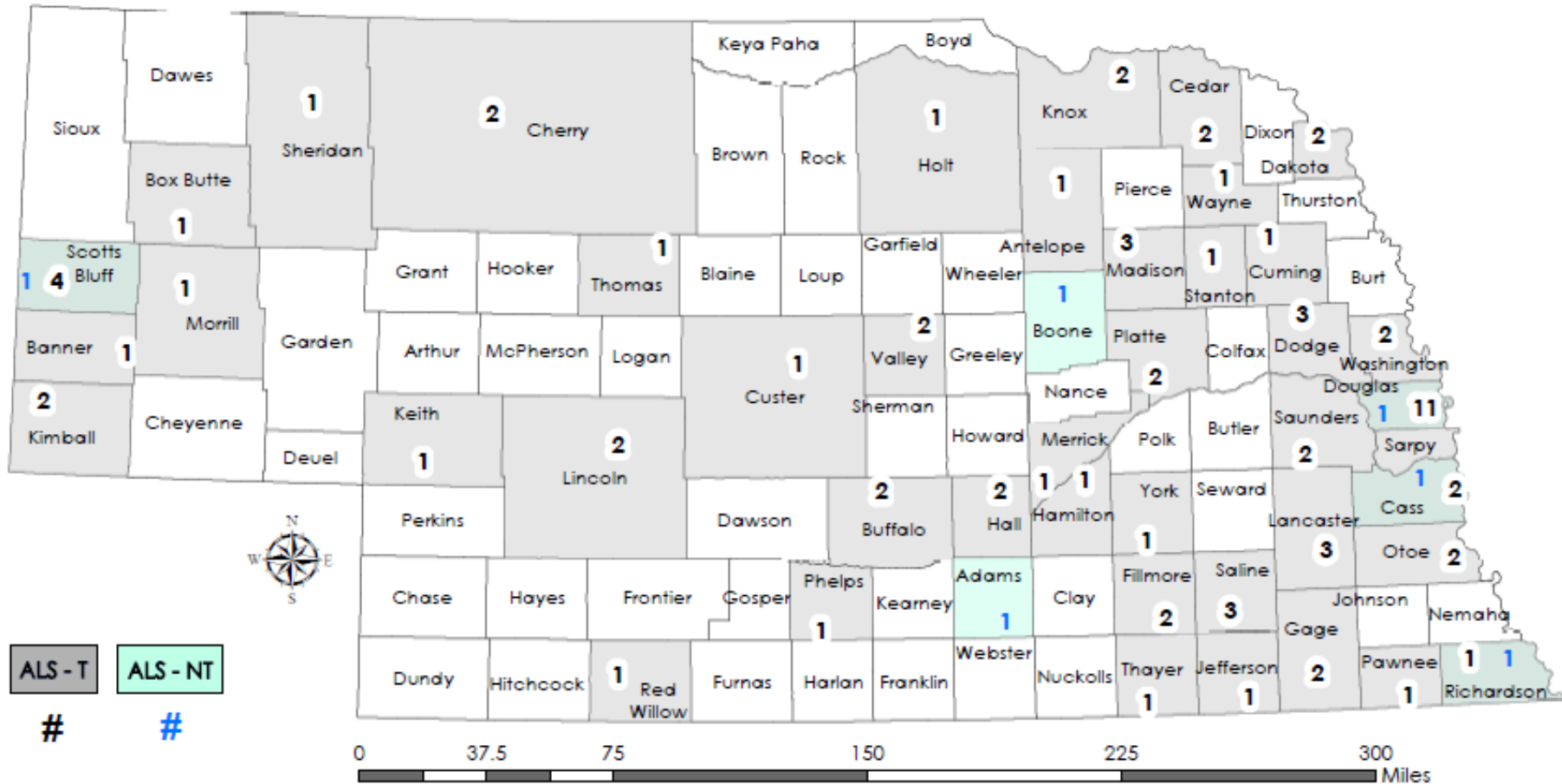
² Emergency Medical Technician – Intermediate is no longer issued as an initial license type. Those individuals who hold this type of license may continue to do so.

Emergency Medical Services

Reports from August 2016 show 421 Emergency Medical Services licensed in the State of Nebraska. All services provide emergency medical care through one of two levels. These license levels are Basic Life Support (BLS) and Advanced Life Support (ALS). Within these levels, a service may be either a transporting or non-transporting service. (See **Table 2** and **Maps 1,2,3**) The regulations, last promulgated in 2012, address the standards and requirements for vehicles, equipment, maintenance, sanitation, inspections, personnel, training, Physician Medical Direction, records maintenance, and practices and procedures to be provided by employees or members of each classification of service. Unlike the laws in place to ensure that fire protection is provided to the community, there are no laws that mandate the availability of emergency medical services across the State of Nebraska.

Table 2: Emergency Medical Services	
Breakdown of emergency medical services as reported in <i>License2000</i> and <i>E-NARSIS</i>	
Classification	2016 Numbers (%)
EMS Level	
Basic Life Support	324 (77%)
Advanced Life Support	97 (23%)
Total	421
Paid/Volunteer Status	
Volunteer	347 (82%)
Non-Volunteer/Paid	53 (13%)
Mixed Volunteer and Non-Volunteer	21 (5%)
Organizational Type	
Fire Department	275 (65%)
Governmental, Non-Fire	81 (19%)
Private, Non-Hospital	46 (11%)
Hospital	16 (4%)
Tribal	3 (1%)

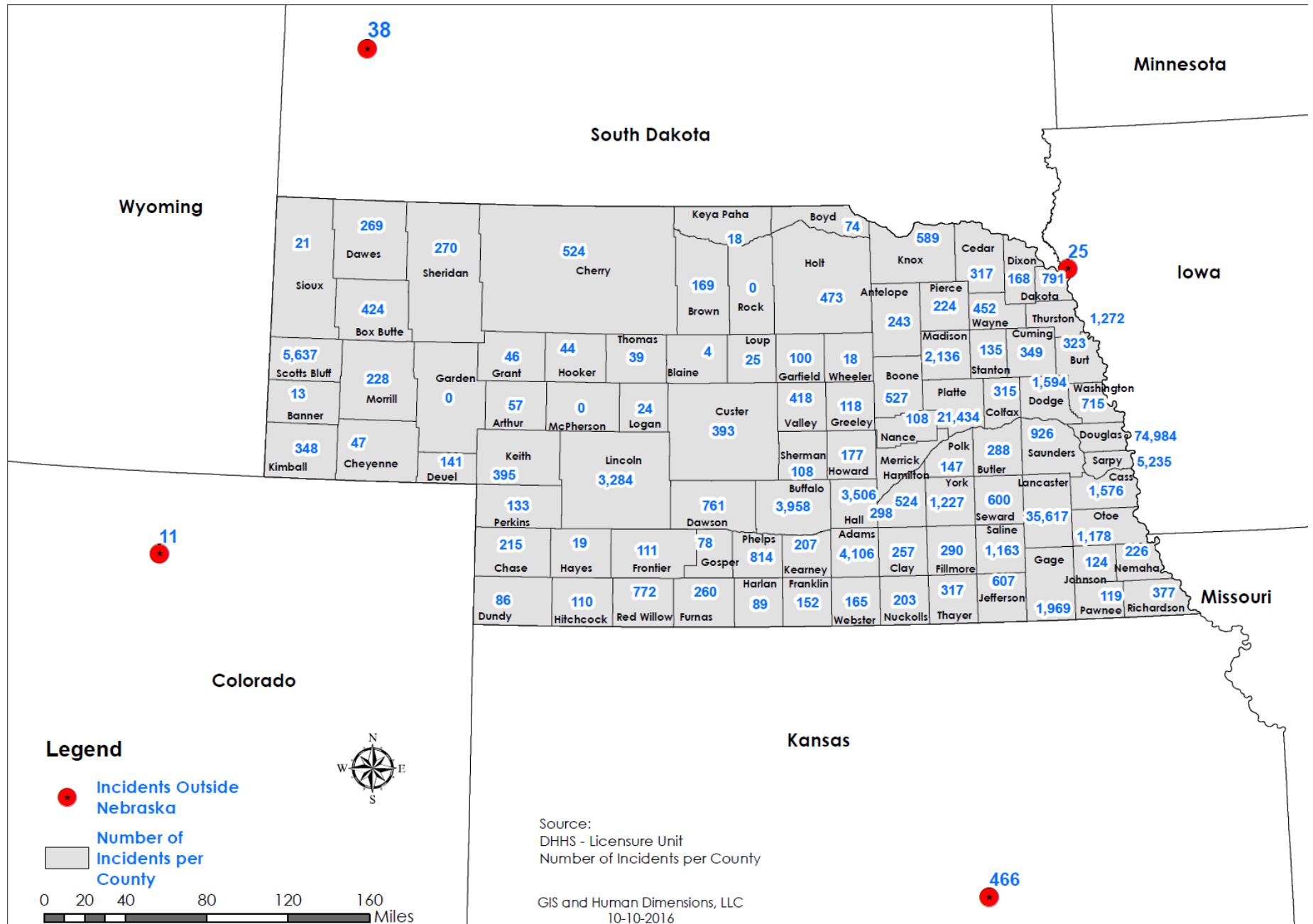
Map 2: Number of ADVANCED Life Support (ALS) Emergency Medical Services by County (T=Transport,NT=Non-Transport)



Source:
DHHS - Licensure Unit
ALS and BLS data

GIS and Human Dimensions, LLC
10-07-2016

Map 3: Number of Emergency Incidents per County, as reported in ENARSIS



Emergency Medical Services Program

The Emergency Medical Services Program offers technical assistance and support to all emergency medical services, out-of-hospital emergency care providers, EMS physician medical directors, healthcare facilities, and EMS training agencies. The Program is active in providing support to: Trauma, Emergency Medical Services for Children (EMSC), Critical Incident Stress Management (CISM), and Education and Training. Technical assistance is offered regarding a variety of issues (i.e. system development, rules and regulations, statutes, strategic planning, protocol and policy development, documentation, quality improvement, mandatory reporting regulations, education, significant exposure procedures, and systems of care). When needed, they provide technical assistance and/or participate in training exercises, disaster, biohazard, and terrorism preparedness planning and education.

During the past five years, the EMS Regional Specialists trained 421 licensed Emergency Medical Services to complete electronic patient care reports in eNARSIS within 72 hours of an incident per rules and regulations promulgated in 2012. Beginning in 2014, Regional Specialists assisted Emergency Medical Services in complying with the Quality Assurance Report requirement for service license renewal. Staff worked collaboratively with Physio-Control to distribute and conduct training on LUCAS II CPR Compression Devices made available by a three-year, 5.9 million dollar grant from the Leona M. and Harry B. Helmsley Charitable Trust awarded to the Nebraska Department of Health and Human Services, Emergency Medical Services/Trauma Program.

Emergency Medical Services for Children

The goal of the EMS for Children Program is to ensure that child will receive high quality care if treated and transported by ambulance to a hospital anywhere across the State of Nebraska. The education provided by the program ensures that both the hospital and ambulance service are prepared for any situation that may arise with a pediatric patient.

Over the past five years, the EMS for Children grant has accomplished the following:

- Developed a Pediatric Emergency Training Simulation (PETS) course for rural hospitals in 2014. This is a hands-on, scenario-based course for both out-of-hospital emergency care providers and hospital providers to practice the skills needed when caring for pediatric patients in emergencies. This course is still taught in communities and has trained over 1680 participants to date. Of those 1680 participants, 898 were RNs, 111 were LPNs, 618 were out-of-hospital emergency care providers, 14 were physicians and 39 were respiratory care providers and other hospital personnel.
- Provide a quarterly pediatric tele-health series available to any hospital in Nebraska through the Nebraska Tele-health System. This series has provided nine pediatric topics and provided education to 1280 EMS providers and nurses at over 45 hospitals across the state.
- Provided Emergency Guidelines for the schools across Nebraska. Many schools no longer employ a school nurse on staff. The EMSC program collaborated with the Department of Education to provide this resource.
- Developed a pediatric reference card for ambulance services to have at their fingertips. All services were given a reference card for each of their ambulances.

Critical Incident Stress Management

Nebraska Critical Incident Stress Management Program was started in 1987 and trains volunteers to provide crisis support to reduce the harmful effects of critical incident stress for: law enforcement officers, firefighters, emergency medical services, corrections personnel, hospitals, emergency management personnel and dispatchers.

The **core functions** of the Nebraska Statewide Critical Incident Stress Management Program are:

1. Recruitment and retention of volunteers (training, continuing education);
2. Intervention services (defusing, debriefings, referral);
3. Prevention (education, consult agencies).

The Nebraska CISM program responds when providers have been called to major incidents that have happened across the state. This includes the death of an Omaha Police Officer, the Von Maur shooting, the Alliance hostage situation, the tornados in Pilger and Beaver Crossing. This is in addition to responding to any other incidents where services or hospitals have called for an intervention.

The program provides education to current peer-to-peer volunteers, provides an annual conference and maintains a database on less than \$7,000 a year. In 2016 alone, the program has provided over 75 interventions. The program's volunteers are available and respond twenty-four hours a day, seven days a week.

Education, Training and Compliance Program

The Education and Training program works with licensed emergency medical service training agencies and instructors to help them create and present educational activities that meet both Emergency Medical Services (EMS) professional standards as well as State and Federal compliance standards. The program oversees the State EMS educational and professional requirements in Rules and Regulations through providing individual site inspections of training agencies. Additionally, the Education and Training program manages over \$380,000.00 in State Legislative appropriated funds that are designated to enhance EMS initial and continuing education for providers in Nebraska through tuition reimbursement, add-on skills training, on-site training, continuing education, conferences, and leadership training. The funding also supports a distributive education system for EMS providers implemented in 2016. The program serves as the state representative for the National Registry of EMTs and oversees National Registry testing for paramedic and Advanced EMT students. The Education and Training program strives to ensure quality and consistency in statewide EMS education by continuous improvement for the ultimate goal of high quality pre-hospital patient care.

Trauma System of Care

The Nebraska EMS and Trauma Program, under advisement of the Nebraska Trauma Advisory Board and Regional Trauma Advisory Boards, has developed trauma educational courses and trainings for both out-of-hospital emergency care providers and hospital providers to improve patient care. The program reviewed reports and applications for the designation of 20 trauma centers and the re-designation of 28 hospitals for a total of 48 designated trauma centers.

In 2012, *LB46* was introduced to redefine terms and change the provisions relating to rehabilitation centers and trauma centers and to appeal the original sections the *NE Trauma System Act*. The legislation became law in August 2015. Trauma injury prevention strategies, including advisement on the Department's prevention plan of which trauma is a component was developed, to include education of providers and the public. Regional trauma plans were revised and goals were identified. On July 28 and 29, 2016, the American College of Surgeons conducted a *Benchmark Indicator and Scoring Assessment (BIS)* of the NE Trauma System and provided a written report to the program (Sanddal et. al 2016). This was conducted to provide an assessment of the Nebraska trauma system's current resources and needs and to identify goals for future system development. The challenges and barriers of the Nebraska Statewide Trauma system are described in this report.

The "*2015 Annual State Trauma Registry Report*" was written (NE DHHS, 2015). The Nebraska Trauma Registry provided information for several state public reports and injury prevention activities such as Injury in Nebraska, substance abuse prevention, motorcycle helmet usage and ATV injury studies, agricultural injury studies, violence related injury studies including pediatric traumas etc. Data from the Nebraska Trauma Registry was used to study associations between socioeconomic status and motor vehicle traffic crash injury severity and treatment outcomes. In September 2016, a *NE Trauma Registry, Trauma in Nebraska* fact sheet was created (NE DHHS, 2016). This fact sheet shows a trend of the decrease in the trauma mortality rate from 2012 to 2016 and also describes accomplishments of trauma system.

eNARSIS

The Nebraska Ambulance Rescue Service Information System (NARSIS) is the means for reporting care of the patient by the out-of-hospital emergency care provider. During the last 5 years, the Nebraska Ambulance Rescue Service Information System (NARSIS) has transitioned from a written paper reporting system with some electronic records being submitted, to exclusively electronic patient care reporting system. The electronic system allows out-of-hospital emergency care providers to submit electronic patient care data. The database can then analyze data entered allowing reports to be created throughout the year. Physician Medical Directors (PMD's) can review patient care records for quality improvement from any computer that is connected to the internet. Because all data is now electronic, the department is starting to see an increase in data requests for pre-hospital form data.

On December 15, 2012 regulations passed giving Ambulance services 2 years to become compliant with electronic reporting at the highest NEMSIS standard. From 2011 through December 15, 2014, the EMS/Trauma Program was in the process of transitioning all Ambulance Service personnel to report electronically to the State. By December 15, 2014 all Ambulance Services licensed in Nebraska were reporting electronically to the State. In January 2016 the transition to most current version of NEMSIS was completed as well as services becoming compliant with a regulatory 72 hour reporting rule. This time frame ensures that all runs are entered in a timely matter and that the pre-hospital patient data is made available for hospital use.

The EMS and Trauma Program continually offers education and technical assistance. Continuous communications and system management is necessary with the vendor, pre-hospital provider, hospital personnel, to sustain an excellent electronic patient care documentation system. With the department's collaboration with the vendor, Nebraska has been a leader in the nation in the implementation of an electronic pre-hospital care record.

FirstNET

FirstNet is required by national law, PL 112-96. The vision is to provide out-of-hospital emergency care providers with the first high-speed wireless nationwide public safety broadband network (NPSBN). The EMS and Trauma program sits on the Nebraska Consultation Task Team (CTT). The CTT gathers state specific input and information on varying topics. The initial focus of the CTT will be on Quality of Service, Priority and Preemption (QPP) for the network. This initiative will bring huge opportunities for Emergency Medical Services throughout the state.

STEMI, Stroke System of Care, and LUCAS

The EMS and Trauma Program has been in the process of increasing patient survival rates related to cardiovascular care. The first step was obtaining 12 lead equipment with the ability to transmit information to Critical Access Hospitals and Hospitals with Catheter Lab capabilities. The American Heart Association and the EMS and Trauma Program distributed 12 lead devices to services across the state. The department partnered with the American Heart Association to provide education to hospitals, services and all providers to quickly identify someone having a myocardial infarction, often identified in the field, to start treatment as quickly as possible and transport the patient to definitive care. This has resulted in a significant decrease in the amount of time patients sit in rural hospitals waiting for transport to a catheter lab ready facility.

In efforts to support cardiac care, the department accepted a grant to distribute CPR compression devices. The LUCAS II CPR Compression Devices were made available by a three-year, 5.9 million dollar grant from the Leona M. and Harry B. Helmsley Charitable Trust awarded to the Nebraska Department of Health and Human Services, Emergency Medical Services/Trauma Program. Hospitals and Emergency Medical Services across the state are being awarded these devices to deliver a consistent, accurate, and better quality CPR to patients. The first two years of this grant have been very successful with lives saved that would not have been saved before. 2017 will be the final disbursement year for these devices.

In 2016, LB 722 was passed creating the Stroke System of Care Act. The purpose of this bill will be to designate hospitals as stroke centers, develop triage, treatment, and transport protocols for EMS and hospitals as needed, and a posting of non-designated hospitals plans on a website. Work on this project is underway and will continue indefinitely, similar to the trauma system of care.

CARES Registry

In 2015 the EMS and Trauma Programs office supported an initiative to have the State of Nebraska join the Cardiac Arrest Registry to Enhance Survival (CARES). The CARES program originated through a collaboration in 2004 between the Centers for Disease Control & Prevention and Emory University School of Medicine’s Department of Emergency Medicine. It is a national data base to record cardiac arrest incident and outcome information. The CARES program seeks to:

- Save more lives form Out of Hospital Cardiac Arrest (OOHCA).
- Strengthen collaboration between 911 centers, first responders, emergency medical service agencies and hospitals.
- Provide a simple, confidential process for assessing patient outcomes in compliance with HIPAA.
- Offer technical assistance to help community leaders identify and prioritize opportunities to improve EMS performance.
- Generate national and statewide reports annually for benchmarking capability.

Nearly 50% of Nebraska’s population is under the surveillance of the CARES Registry. Table 3 shows Nebraska EMS agency data as compared to national numbers.

TABLE 3: Nebraska CARES EMS Agencies Survival Rates

Non-Traumatic Etiology Survival Rates	
Overall:	15.2% (355)
Bystander Wit'd:	20.0%(150)
Unwitnessed:	7.9% (164)
Utstein ¹ :	39.0% (59)
Utstein Bystander ² :	48.6% (35)

National CARES EMS Agencies Survival Rates

Non-Traumatic Etiology Survival Rates	
Overall:	10.6% (55381)
Bystander Wit'd:	16.1%(20481)
Unwitnessed:	4.6% (28245)
Utstein ¹ :	33.1% (6596)
Utstein Bystander ² :	36.8% (4013)

Emergency Medical Services BOARD'S CONCERNS and RESPONSES

In 2015, the Board held eleven public forums across the State to hear the concerns of stakeholders and the general public regarding Emergency Medical Services in the State of Nebraska. The following areas were identified as areas of public/stakeholder concern:

Community Paramedics	Quality Assurance Reporting/Squad Inspections
Communications	Recruitment and Retention
Education and Training	Regulations and Licensure Division and Disciplinary Proceedings
EMS Board	Response
EMS Instructors	Rules and Regulations
EMS Training Agencies	Safety
EMT Classes	Special Projects
E-NARSIS/ELITE/Documentation	Skills
Equipment and Supplies	Scope of Practice
Funding	State EMS Leadership and State Regional EMS Specialists
Leadership in EMS	Transport/Tiered Intercept Issues
Licensure	Working Relationships
LR298	
Physician Medical Directors	
Medications/Procedures	
National Registry	
Ownership of EMS in Nebraska	
Model Protocols	

Source: Appendix F *EMS Open Forums 2015*

Based upon the comments gathered during the public forums, the Board of Emergency Medical Services, the EMS/Trauma Systems Program, and the Licensure Unit, with funding support from and the Office of Rural Health, contracted with nationally recognized SafeTech, LLC to facilitate an all-day strategic planning session. Members of the public were invited to attend. A plan was created that listed the following eight areas as priorities:

Rules and Regulations

Update EMS rules and regulations to ensure regulatory structure supports current vision of patient-centric system and current opportunities, challenges and needs.

- *Open regulations to update licensure requirements.*
- *Identify leadership and group to oversee process ensuring appropriate hearings, stakeholder input and statutory requirements are followed.*
- *Steward the process to ensure goal is met.*
- *Explore changes needed around scope of practice to accommodate exploration of concepts like community paramedic and mobile integrated health.*

EMS as an Essential Service

EMS is broadly recognized as an essential public service in Nebraska with clear designation in statute or rule for who or whom is responsible for the provision of EMS.

- *Identify a group to research this issue.*
- *Gain understanding of barriers to the designation of responsibility.*
- *Form recommendations and a strategy for accomplishing this goal.*

Physician Medical Directors

Strengthen and improve local EMS Medical Direction engagement and effectiveness across Nebraska.

- *Evaluate the current system of medical direction.*
- *Explore medical director development, education, support, regional approaches, best practices in other states.*

- *Make recommendations to the Board for strengthening and improving the local EMS Medical Direction.*

EMS Data Collection

A comprehensive vision for EMS data collection and use in Nebraska linked to practical and clear clinical performance indicators.

- *Assemble a team of appropriate stakeholders and develop a data vision/planning process.*

Recruitment and Retention

A five-year plan with specific practical actions that addresses EMS workforce including the decline in volunteerism and current and future needs across Nebraska.

- *Form working group to include the Nebraska State Volunteer Firefighter Association (NSVFA) and Nebraska Emergency Medical Service Association (NEMSA)*
- *Assess available data and get clear handle on scope of challenges and needs.*
- *Create a process for educating local officials/communities about workforce issues/needs.*
- *Apply principles of workforce planning to create a plan and identify specific practical actions to develop appropriate workforce.*
- *Continue the promotion of EMS leadership development.*

EMS Education/Examination

A thorough evaluation of the EMS education and testing process to ensure Nebraska has a best practice process (an educational assessment.)

- *Plan and conduct an educational assessment.*
- *Explore issues related to testing concerns expressed in open forums.*
- *Seek to understand what needs improvement or change.*
- *Make recommendations to the Board.*

Communication/Collaboration

Acknowledged improvement in communication and collaboration between:

1. *Nebraska Board of Emergency Medical Services*
 2. *DHHS – Licensure Unit*
 3. *DHHS – EMS/Trauma Program*
 4. *Stakeholders across Nebraska*
 5. *Systems of Care*
- *Encourage EMS related DHHS staff to attend and participate in Board meetings.*
 - *Host regular joint staff meeting between Licensure Unit and EMS/Trauma Program.*
 - *Continue to use and develop communication links with key stakeholders such as open forums.*
 - *Explore open meeting limits and possibilities with using technology.*
 - *Experiment with using technology to expand communication.*

EMS Regional Specialists

Strengthen capacity of EMS Regional Specialists to identify local agency sustainability and assist local agencies and communities in navigating change process.

THE BOARD'S RECOMMENDATIONS TO THE LEGISLATURE

EMS as an Essential Service

Pre-hospital emergency care is a vital service that must be guaranteed for the citizens of the State. It should be the responsibility of the government to declare the continuing availability of those services. A statute requiring local governments to ensure the provision of Emergency Medical Services is needed. The Board recommends reintroducing language making governing entities responsible for ensuring emergency medical services are available to all residents in the county. Language similar to this was stricken from LB 952 prior to passage of the bill. Those governing entities could continue to support the volunteer system, contract Emergency Medical Services out to private agencies, or form their own Emergency Medical Services.

Funding

Support to maintain the EMS/Trauma Programs and EMS Board should be increased to support the magnitude of work and programming being accomplished. Current projections show the 50 Cents for Life cash fund as insolvent by 2018. No fees are charged for the issuance of any initial emergency medical service license, so a cash fund from licensure fees does not exist for this profession type. The 50 Cents for Life cash fund supports tuition reimbursement, continuing education, additional skills training, and offsets the need to charge licensure fees for license classifications of emergency medical personnel. Many out-of-hospital emergency care providers and services would not be able to obtain and/or maintain licensure without this funding support. The 50 Cents for Life cash fund will no longer be able to support the programs it currently supports, which will result in either the loss of programs or staff. This, in turn, will result in losing EMS personnel, both volunteer and professional, and services. The EMS Board encourages an evaluation of the current 50 Cents for Life tax that is assessed when licensing vehicles and would recommend an increase to a minimum of \$2.00 for life. This would help support all current programs relating to Emergency Medical Services.

EMS Education/Examination

Having an emergency medical care system that is consistent and proficient is paramount to patient-centered care. It is recommended that the education and examination requirements for out-of-hospital emergency care providers remain commensurate with the requirements currently outlined in 172 NAC 11,12,13 which are based upon national recommendations.

Development of a Community Paramedic/Mobile Integrated Healthcare Provider

The concept for the community paramedic/mobile integrated healthcare provider is one of prevention rather than reaction. A licensed out-of-hospital emergency care provider could go out into the community, apart from an emergency situation, to perform patient care that is within their scope of practice. For example, if a patient is released from the hospital and has a chronic condition, the community paramedic/mobile integrated healthcare provider would be able to check-in with the patient, perform duties within their scope of practice (blood pressure, blood glucose monitoring, etc) and report to the primary care physician. The goals would be to prevent excessive hospital readmissions, provide preventative care, and reduce morbidity. The community paramedic/mobile integrated healthcare provider program would aid in the shortage of healthcare providers in rural areas. Currently there is no funding available to proceed with a pilot community paramedic/mobile integrated healthcare provider program in Nebraska. Additionally, a statutory change would need to occur to amend language requiring that out-of-hospital emergency care provider may not assume the duties incident to the title or practice the skills of an out-of-hospital emergency care provider unless he or she is employed by or serving as a volunteer member of an emergency medical service licensed by the Department. (§38-1224)

Recruitment and Retention

With over half of the licensed Emergency Medical Services confirming the need for additional volunteers, efforts need to be renewed to recruit and retain more volunteers, especially for the rural areas where populations are dwindling and aging-out. As mentioned earlier on page 5, during the strategic planning session held in April 2016, the estimated value of services provided by volunteer out-of-hospital emergency care providers is \$113,797,530.⁰⁰ annually. The Board recognizes and applauds recent legislative efforts to provide incentive and relief for volunteer out-of-hospital emergency medical care providers through the passage and approval of LB 886, to “Adopt the Volunteer Emergency Responders Incentive Act and provide income tax credits.” However, it is the opinion of the Board of Emergency Medical Services that more must be done to support the Emergency Medical Care System in the State of Nebraska.

Communications

Being able to communicate at the scene of an accident is vital to the provision of proper medical care. Communication with Medical Dispatch, receiving hospitals, and with other Emergency Medical Services is vital. The State needs to properly fund an adequate Wireless Communications System, invest in user-friendly universal applications to aid in patient care, and require dispatch protocols to ensure prompt and concise relay of information.

APPENDIX

- Appendix A Board of Emergency Medical Services Members
- Appendix B Board Administration and Licensure Staff
- Appendix C Emergency Medical Services/Trauma Programs Staff
- Appendix D Emergency Medical Services Program Regions
- Appendix E Urban/Rural Designation by County Map of Nebraska
- Appendix F Public Forums Comment Summary
- Appendix G Nebraska Board of Emergency Medical Services Strategic Plan

Appendix A
Board of Emergency Medical Services Members

**BOARD OF EMERGENCY MEDICAL SERVICES
CURRENT BOARD MEMBERS**

Three Emergency Medical Physicians

John S. Bonta, MD, FACEP – Lincoln
Thomas J. Deegan, MD, FAAP – Omaha
James Smith, MD – North Platte (Chair)

Two Paramedics

Michael D. Bailey - Ansley
Scott Wiebe – Lincoln (Secretary)

One Intermediate/Advanced Emergency Medical Technician

Carl L. Rennerfeldt – Blair

Training Agency Representative

Karen Kae Bowlin, NREMT- Ogallala

Physician Assistant

Donald Harmon - Beatrice

Two Emergency Medical Technicians

Troy Hiemer - Columbus
Ann Fiala – Ainsworth (Vice-Chair)

Emergency Medical Responder

Joel Cerny – Linwood (NSVFA Liaison)
Gary (Randy) Boldt - Omaha

Two Members at Large

Charles LaFollette – Lincoln
Michael G. Miller, EdD, MS, RN, NRP - Omaha

Two Public Members

VACANT
VACANT

Registered Nurse –

Linda Jensen – Herman

Appendix B
Board Administration and Licensure Unit Staff

**Nebraska Department of Health and Human Services
Division of Public Health
Emergency Medical Services Licensing Staff**

**Claire Covert-ByBee
Program Manager II
Office of Rehabilitation and Community Services, Licensure Unit
Division of Public Health
402-471-0547
Fax 402-742-1152
Website: <http://dhhs.ne.gov/publichealth/Pages/crIEMSHome.aspx>
Claire.covertbybee@nebraska.gov**

**Jacye LaFayette-Dymacek
Health Licensing Coordinator
Office of Rehabilitation and Community Services, Licensure Unit
Division of Public Health
402-471-0371
Fax 402-742-1152
Website: <http://dhhs.ne.gov/publichealth/Pages/crIEMSHome.aspx>
Jacye.lafayette-dymacek@nebraska.gov**

**Cynthia Hendel
Health Licensing Specialist, .5 FTE
Office of Rehabilitation and Community Services, Licensure Unit
Division of Public Health
Office 402-471-2299
FAX 402-742-1152
Website: <http://dhhs.ne.gov/publichealth/Pages/crIEMSHome.aspx>**

Appendix C
Emergency Medical Services/Trauma Programs Staff

**Nebraska Department of Health and Human Services
Division of Public Health
Nebraska EMS / Trauma Program Contacts**

Tim Wilson
EMS / Trauma Program Manager II
tim.wilson@nebraska.gov
Phone: (office) 402-471-0124 or (cell) 402-480-1072

Dr. Joseph Stothert - Trauma Physician Medical Director
The Nebraska Medical Center e-mail:
jstother@unmc.edu Phone: (office) 402-559-8884

Sherri Wren - Trauma Program Manager
e-mail: sherri.wren@nebraska.gov Phone: (office)
402-471-0539 or (cell) 402-429-3311

Doug Fuller - EMS IT Business System Analyst
e-mail: doug.fuller@nebraska.gov Phone: (office)
402-471-3578 or (cell) 402-326-1279

Wendy Snodgrass - EMS Education Compliance Manager
e-mail: wendy.snodgrass@nebraska.gov
Phone: (office) 402-873-5082 or
(cell) 402-314-9184

Carol Jorgensen - Central Region EMS Specialist
e-mail: carol.jorgensen@nebraska.gov Phone:
(office) 308-856-4967 or (cell) 308-440-4346

Sharon Steele - EMS IT System Analyst
e-mail: sharon.steele@nebraska.gov Phone: (office)
308-535-8095 or (cell) 308-530-2419

Brenda Jackson - Support Staff
e-mail: brenda.jackson@nebraska.gov Phone: 402-
471-0790

Dr. Eric Ernest - EMS Physician Medical Director UNMC / Dept. of Emergency Medicine e-mail:
eric.ernest@unmc.edu
Phone: (Office) 402-559-3586 or
(assistant) 402-559-6705 (cell): 402-201-6138

Dr. Thomas Deegan - EMSC Physician Medical Director
Children's Hospital of Omaha e-mail:
tdeegan@childrensomaha.org
Phone: (office) 402-955-5147

Crystal Dailey, RN - Trauma RN Specialist
e-mail: crystal.dailey@nebraska.gov Phone: (office)
402-722-4300
Cell Phone: 402-289-7431

Debbie Kuhn - EMS for Children & CISM Program Manager
e-mail: debbie.kuhn@nebraska.gov Phone: (office)
402-471-0119 or (cell) 402-326-0173

Julie Smithson - Southeast Region EMS Specialist e-mail: julie.smithson@nebraska.gov
Phone: (office) 308-946-3409 or (cell) 308-940-
1994

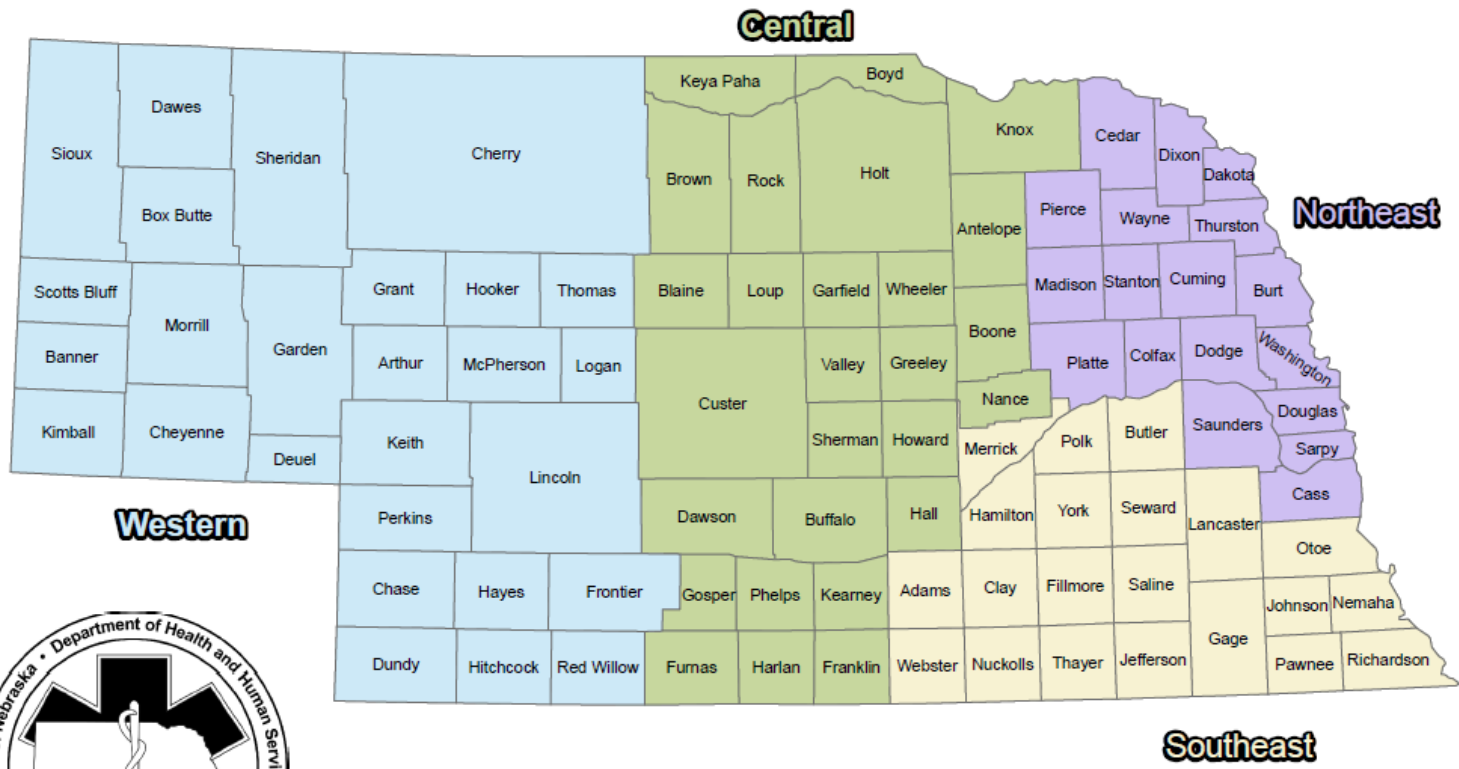
Jackie Larrington Western Region EMS Specialist
e-mail: jackie.larrington@nebraska.gov Phone:
(office) 308-436-6950 (cell) 308-765-9868

Ben Leseberg – Northeast Region EMS Specialist
e-mail: ben.leseberg@nebraska.gov
Phone: (office) 402-471-1680
(cell) 402-525-3700

Rob Rowan – Support Staff
e-mail: rob.rowan@nebraska.gov
Phone: 402-471-8129

Appendix D
Emergency Medical Services Program Regions

Nebraska Emergency Medical Services Program



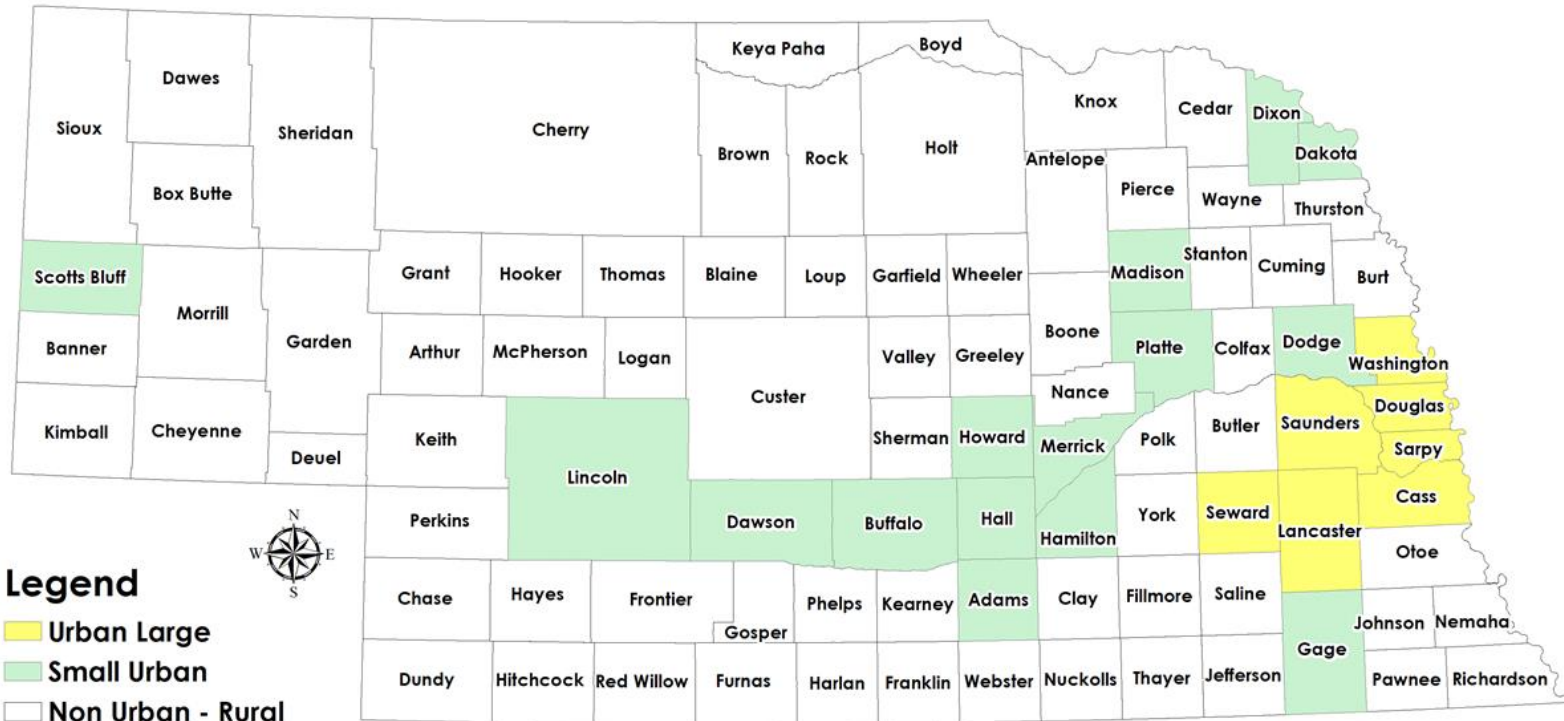
Division of Public Health

www.dhhs.ne.gov/ems

Map created by
DHHS GIS
7/7/2016

Appendix E
Map of Nebraska Urban/Rural Designation by County

County-Based Urban/Rural Designation



Legend

- Urban Large
- Small Urban
- Non Urban - Rural



Department of Health & Human Services
DHHS
 NEBRASKA
 September 2016

Appendix F

Public Forums Comment Summary

EMS Open Forums 2015
State of Nebraska
Summary

Fall 2015

State of Nebraska EMS Open Forums

August 29, 2015 **North Platte, NE**

September 29, 2015 **Blair, NE**

October 1, 2015 **Omaha, NE**

October 14, 2015 **Columbus, NE**

October 17, 2015 **Nebraska City, NE**

October 22, 2015 **Lincoln, NE**

October 26, 2015 **Kearney, NE**

October 27, 2015 **Kimball, NE**

November 2, 2015 **Edgar, NE**

November 10, 2015 **Ord, NE**

November 21, 2015 **Ainsworth, NE**

Notes are summarized within the following topics:

- **Community Paramedics**
- **Communications**
- **Education and Training**
- **EMS Board**
- **EMS Instructors**
- **EMS Training Agencies**
- **EMT Class**
- **E-Narsis/Elite/Documentation**
- **Equipment and Supplies**
- **Funding**

- **Leadership in EMS**
- **Licensure**
- **LR298**
- **Medical Directors**
- **Medications/Procedures**
- **National Registry**
- **Ownership of EMS in Nebraska**
- **Protocols**
- **QAR/Squad Inspections**
- **Recruitment and Retention**
- **Regulations and Licensure Division and Disciplinary proceedings**
- **Response**
- **Rules and Regulations**
- **Safety**
- **Scope of Practice**
- **Skills**
- **Special Projects**
- **State EMS Leadership and State Regional EMS Specialists**
- **Transport/Tiered Intercept Issues**
- **Working Relationships**

Community Paramedic:

Discussion and interest on this topic

Generally attendees seem to want more information about the program

Communications:

A general expression of desire for better ways to help all EMS personnel, Medical Directors, Physician Surrogates stay informed and updated.

Example: There was mention that some attendees felt less than informed on “Mission Lifeline efforts in the state of Nebraska.”

Attendees listed how they get their updates and communications regarding EMS in Nebraska and they included:

State EMS specialist/and grant coordinator, e-mails from county disaster coordinator, state mailing list, Julie Smithson, NSVFA Constant Contact and from Dean Cole. They stated sometimes the information is shared and sometimes it is not.

Request for looking at how we can guarantee better communications in the future and included suggestions such as using List Serves, existing newsletters such as published by NEMSA, etc.

Suggestion to have every EMS person in the State of Nebraska automatically registered on List Serve or some other form of guaranteed and regular communications.

Suggestion to encourage everyone to become member of NEMSA because they would be guaranteed 3 newsletters per year, facebook postings, agency and individual news and updates. Question was posed “Who is responsible to make sure all Medical Directors get necessary communications regarding EMS in the State?”

Expressed concern that they perceive blocks in communications which may be intentional or purely based on poor follow through on multiple levels of the organizations.

Suggestion to have the EMS Board Meeting minutes approved and published immediately after the official EMS Board meetings and to be placed on List Serves.

Concern over: very difficult to find the EMS Board Minutes in a timely fashion....no link easily accessible from the State Web site. Recommend a better way to easily access minutes and communications vital to the EMS personnel regarding discussions and decisions at the Board level.

Concern over lack of communications about Quality Assurance Reports.

Example provided to demonstrate need for improved communications: Question concerning trying to do away with backboards- as of March protocol has been changed, have Medical Directors sign off, this was news to many in attendance of this meeting. Is there a way services can be notified of protocol updates; need to send email contact changes to the state; questioned if state is sending out the update information via email

Communication – Generally thought that communication is inconsistent and poor throughout the state to all EMS stakeholders. It was thought the EMS Board used to have a newsletter and that might be helpful. Broad support and appreciation for the current EMS forums was expressed and a desire for them to continue. Others expressed a desire for electronic distribution of information, such as a list serve.

Attendees stated there is not good enough communications among the following entities: DHHS, EMS Division, and EMS Board. They stated current communications are not good enough\ for volunteer and paid services and not good enough for training agencies or PMD's.

One forum group had a couple nurses present who stated that the DHHS/Board of Nursing has the capability to email each nurse in Nebraska and they asked why can't DHHS/EMS Board do the same?

There was a strong request from one group present (including the PMD present) that EMS services be required to provide some sort of written documentation when transferring care (primarily on interfaculty transfers) from the service to the hospital regarding what was done in

the ambulance. The hospital(s) is/are needing some type of standardized written/typed form that can be left with the hospital staff so that they know what took place on each transfer.

Concern about lack of communications about QAR's

Stated the communications from HHS is not good. Need to do better

Perception that Mission Life line roll out communications were not good. Expressed feelings that communication between ALS tier and BLS crew members is in the good to excellent rating for the most part. Always important to communicate thoroughly and frequently.

Medical Director gets no information from the state.

Voiced concern because no contact from the state coordinator to their organization

Desire for a state newsletter with info if not at least most recent EMS Board minutes

Education and Training:

There was discussion of a need for education on Rules and Regulations and suggestion that this be included in formal coursework for EMR, EMT, Advanced EMT, Medic

Need for education on how to safely and effectively handle Behavioral Health patients especially due to long transport times occurring to reach facilities with open beds for Behavioral Health patients.

Suggestion to have Crisis Intervention and Prevention classes for Pre-hospital personnel.

Concerns about too many hours for initial training

Recommendations:

HAZ MAT and Nims training do not need to be part of initial training.

EMT training be an offered as a credit class in high school - credits for high school science/health class and credits for college course. It should be offered and available in every Nebraska high school - and promoted. McCook is the only known high school offering it currently.

Have a fund drive state-wide to teach CPR to high school students. It was stated that many high schools offer it currently.

There is concern that currently colleges won't accept EMT class as credit hours toward their degree programs - thus students won't take it in college. Can this be changed?

It was suggested to find more ways to fund EMT scholarships/training - one suggestion was by approaching hospitals to help with EMT scholarship programs.

There was lengthy discussion on “allowable layperson hours” with CEU’s for EMT/EMR levels. Reportedly former State EMS Education Coordinator allowed 10 hrs of “Community Emergency Response Training” which included training on basic medical education, basic 1st aid, use of fire extinguisher, etc. It is perceived that current State EMS Education Coordinator and State EMS Leaders will not allow this. They’re asking why because they said it very much pertained to EMS. This group would like to see an opening up of allowable continuing education opportunities that have been or are currently declined by Current leaders in EMS Office. It is very difficult to get EMTs/EMRs to continuing education in the smaller, remote areas when everybody’s schedules are packed and so it becomes discouraging for EMTs/EMRs to continue renewing their licenses.

Training on CPR and EMT training needs to be available to High Students

Glucometer, EPI, Albuterol all take extra training.

Some not aware of all of the training requirement (subjects)

Some student need to be able to do more ride alongs then 5 to help them develop their skills

If additional training is necessary most EMT's are willing to do this via add on modules to get there.

Stroke education has been great but still need live drills to be tested and QA/QI activities from the onset of stroke to arrival at the hospital or to air transport.

Cost of taking a class is prohibitive. There has to be assistance from somewhere.

What about a driving skills test, since often the squads need a qualified driver,

Suggestions For education: How about scene safety, cot operations, soft restraints, OD/Suicide scenarios, infection control, documentation, skin color and condition, basic cardiac rhythm identification, 12 lead and transmission classes.

Suggestion: If paid services need additional training for employees, they should be willing to have education plans and programs. But volunteers should be encouraged to work for paid services, and they can, could and should work together.

A request to have the refresher set by the state

Recommendation to have standardized training across the state insofar as keeping what people are learning very much the same from border to border. This group feels EMS training needs to be structured to include critical thinking skills - they think this will pay off with the NR exam too let alone on scenes. This particular area’s instructors are not getting any support from the

Community College as they're often jostled from location to location when doing classes, especially EMT class. They have to make their own copies quite often. Also, quite often, the instructor will have their schedule of what each class time will cover, but the college (or Private Ambulance people) will change class topics unexpectedly just hours before the class is held, thus throwing the instructor off on what they were prepared to train on at that particular session. So...again....a lot of inconsistencies with training also attributed to the private ambulance company's influence.

EMS Board:

The question was asked “why can't the State Board of EMS support such programs as the Community Paramedic Programs or other such programs that could potentially improve care across Nebraska.” “Why is it difficult to get support from EMS Board for various projects?”

Expressed need to have some EMS board meetings to be held outside of Lincoln. Attendees expressed appreciation that the EMS Board members were donating their time to have these open forum meetings around the State and that we should have more open forums every few years.

Several attendees at multiple open forum meetings misunderstand the role of the EMS board. Board members explained the EMS Board doesn't have as much power as you may think, we are an advisory board. We make recommendations and all final changes to rules and regulations are made through HHS, Legislature and Lawyers. We can make changes to protocols but have to be very careful to not conflict with the Rules and Regulations. There is a time of approximately 3 to 5 years before Rules and Reg's can be adjusted. It is felt that the current Rules and Reg's are too lengthy and it would be beneficial to have a shortened version.

Suggested a statutory change be made regarding the State EMS Board makeup to ensure better representation of rural Nebraska.

Questions regarding the Role of the EMS Board – an explanation of the how the EMS Board is constituted and the work of the board was explained to the group. It is clear that EMS providers and personnel do not completely understand the function of the board, including the constraints the board has. It was noted the board serves in an advisory capacity. A comment was made that there is not sufficient representation from rural Nebraska on the Board. It was shared that the 17 member board has 6 members residing in communities of essentially 12,000 or less. Furthermore, all members of the board seek to represent all Nebraskan's in matters related to EMS, including the challenges we know confront rural, frontier, and volunteer areas of the state. Meeting structure was also raised as a concern relating to closed session and having to wait for an unknown period of time. It was shared with the group the meetings were restructured a number of years ago to end-load the closed session portion of the meeting to allow for attendance by EMS stakeholders.

The meeting concluded with appreciation expressed to the EMS Board members present for taking the time to volunteer their service and for seeking input regarding EMS in Nebraska.

This group is very much in favor of the EMS Board holding forums across the state each year.

Thank you to the EMS Board for taking the forum to different areas in Nebraska.

Suggestion: EMS Board needs 1-2 rural, volunteer BLS service representatives if at all possible.

Would like to see the EMS forums continue.

EMS Instructors:

It was stated there are no incentives for anyone to take the instructor's class to become EMS instructors in the state, such as means of reimbursement for cost of the class or other such ideas.

One department recently sent 10 members to EMT training and only 4 passed national registry exam.

Move passage rate for the agency to the individual instructor. Currently the passage rate is 70% for the entire agency with no requirement for the individual instructor. A higher passage rate not specified would be required of each instructor.

Need more responsibility on the instructor to improve pass/fail rate;

Uncertainty about how the pass/fail requirements are determined and what is the process

Meeting participants want individual instructors to be held accountable for the 70% pass rate, not just the training agency.

The group suggested there needs to be ONE text book for NREMT training and it should be written in accordance with the NREMT test. They do not feel the student should have to be taught how to take the NREMT.

Attendees think there should be a competency test required every 2 years for instructors to keep their license.

The instructors present stated there is difficulty getting enough and appropriate equipment for teaching EMS classes.

The question was asked if we (State of Nebraska) requires the student to take the National Registry Test, then why is the student responsible for paying for it (\$75)? Others feel that it is ok that the student be responsible for it because then the student has "ownership" and tries harder to pass it. There was a suggestion that the State should "reward the passing student".

Support for developing standardized training requirements for instructors. They also believe strongly that ALL EMS instructors across the state should be required to be Nationally Registered in the level of training they're providing.

It was asked if the pass rates of both training agencies and individual instructors could be made public in order to hold agencies and instructors accountable.

There was a request for more choices of instructors

One EMR class in the area had 5 different Instructors before it was over,

There are concerns that the training agency isn't training them as to what is on the test.

Recommend National Registry to be required for all EMS instructors

The question was asked "who trains EMS Instructors and how much training are they required to have?" "Does anyone monitor the quality of EMS Instructors?"

Suggestion was made to work on statewide consistency for training and instructors so that everyone is on the "same page."

Discussion that there seems to be a wide range of competencies, knowledge, and capabilities of instructors and perhaps this is affecting the pass rates for National Registry adversely for the students in the State of Nebraska.

Discussion on how much continuing education is required for EMS instructors to stay current and licensed.

EMS Training Agencies:

How much influence does the training agency have on the required hours; can recertifications be regulated so fees don't increase

Meeting participants want individual instructors to be held accountable for the 70% pass rate, not just the training agency.

It was asked if the pass rates of both training agencies and individual instructors could be made public in order to hold agencies and instructors accountable.

Want more choices of instructors

One EMR class in the area had 5 different Instructors before it was over,

There are concerns that the training agency isn't training them as to what is on the test.

Some EMT's would take the Advanced EMT Bridge Course if it were available.

EMT Class:

Length of EMT class too long

Request to reduce the hours of the curriculum to no more than 150 hours.

One group suggested there needs to be ONE text book for NREMT training and it should be written in accordance with the NREMT test. They stated they do not feel the student should have to be taught to take the NREMT exam.

There should be a competency test required every 2 years for instructors to keep their license.

The instructors present stated there is difficulty getting enough and appropriate equipment for teaching EMS classes.

The question was asked if we (State of Nebraska) requires the student to take the National Registry Test, then why is the student responsible for paying for it (\$75)? Others feel that it is ok that the student be responsible for it because then the student has “ownership” and tries harder to pass it. There was a suggestion though that the State should “reward the passing student”.

Request that part of the instruction for EMT class be online.

It was requested to limit an EMT course to no more than 150 hours.

Leveraging technology (blended online learning) to better deliver EMT courses was also discussed, noting how much time may be saved in rural areas where there is a commute to and from the course location.

There were questions about the possibility of being able to do some of the EMS initial training on line to cut down the travel time for the students.

Felt that the State should be more involved in Funding of initial EMS Training

Recommendation that initial hours need to be shortened

Possible cutting out parts of EMT training to lessen hours but they understand credit hours are a money generating business to training agencies.

Comment was made regarding the number of hours of initial training..... 95% of the calls all the EMT needs to know is to load and go.

E-Narsis/Elite/Documentation:

No real issues with 72 hour reporting. They understand that early reports are much more accurate.

Documentation/Enarsis/Elite – Reporting data is a time consuming process. Elite system crashed. Do we really need 346 data points?

There was a strong request that EMS services be required to provide some sort of written documentation when transferring care (primarily on interfacility transfers) from the service to the hospital regarding what was done in the ambulance. The hospital(s) is/are needing some type of standardized written/typed form that can be left with the hospital staff so that they know what took place on each transfer.

Strong sentiment that the Board needs to seriously consider not requiring non-transporting EMRs to submit eNARSIS forms. Since they are not transporting and are just appearing at the scene to “stabilize” the situation as much as their scope of practice allows until a transporting unit arrives, they do not think they should have to submit a report.

The Enaris documentation requirements seem more focused on getting statistics than patient care. It should not make a difference what nationality someone is.

If done correctly, current documentation takes about one hour on many runs. We usually work on it all the way home, and then finish in 30-45 minutes after a 45 minute trip home. And then if you bill or pay to have billing done it is another hour to complete more documentation.

Suggest possibly using YouTube for education on how to work through the elite enarsis. One squad has not had any contact to train them for the change.

Equipment/Supplies:

Question was asked "if a service wants to provide 911, is there a requirement regarding the condition of current equipment being in 'good' condition?" It was stated that as long as the equipment was operational and did not pose a threat to the patient's nor crew's well-being and it functions the way it supposed to for patient care, then there are no regulations governing it otherwise.

Need regulation on outdated equipment usage

Funding:

State deemed it necessary to take revenue funds away from the departments and give to city boards...this is not going to help the current problems facing EMS in State of Ne

Lots of personal money being spent by EMS providers in the State of NE with low pass rates in general on the National registry. Is there funding available to help?

Leadership in EMS:

Leadership – Need for leadership in each agency is essential, including the EMS medical director. In many cases the EMS MD's are simply not engaged.

Some sought resources to deal with politicians who stifle the advancement of EMS delivery.

Licensure:

Need critical care licensure level

Temporary Licensure: There were questions regarding the ability to get a temporary license between time of completing coursework and successful passing of National Registry. It seemed there may be a knowledge gap for attendees here regarding this part of rules and regs.

Request for consideration of active participation at the state level for air medical response teams and specifically to actively move toward licensure of Air Medical Ambulances.

Need comprehensive data base for screening potential EMS personnel:

It was stated there are different standards utilized and different data bases used to screen for EMS personnel in the State of Nebraska.

The concern was raised that there may be potential to miss some important information about a person's background that might later adversely impact patient care.

In Nebraska there is a higher level of clearance utilized for students going into EMS course work than what is required for new EMS providers.

Different standards of background checks and clearance are followed for volunteer EMS vs Paid ambulance companies vs EMS students.

Attendees were reminded that temporary licenses were available for students and so they can keep up their skills before the passing National Registry

Accessing the NREMT exam was raised as an issue with it taking 9 steps from completing the class to submission of the application to DHHS – it needs to be streamlined.

Air Medical Regulations. An air medical transport team was present to participate in discussions. At the end of the forum they spoke up and strongly requested regulations for air medical. They also would like to have a “seat” on the EMS Board. They would like to have “standardization of Critical Care Paramedics” - a standard set for anyone agreeing to provide emergency care service. They stated there is a distinct difference between a Critical Care Paramedic and a Critical Care Nurse.

The documentation and requirements for a squad/city to become ALS prohibit most (especially volunteer) from even thinking about it.

Discussion on how hard it is to transfer into the state for licensing

LR298

Health and Human Services Committee conducted hearing on Friday, October 2nd concerning LR298 which was introduced to improve the emergency medical services system in Nebraska. The Interim Study Resolution, introduced by Senator Dan Watermeier (Syracuse) and co-sponsored by Senator Al Davis (Hyannis) and Mark Kolterman (Seward), is intended to elicit factual circumstances impacting your community's ability to supply emergency medical services to your citizens and visitors, as well as to explore possible solutions.

LR298 – the resolution was discussed in broad terms, including the main goals of the initiative. Regrets were noted that LR298 has become an adversarial process, as that was not the intent.

Medical Directors:

Discussion was held on the PMD's signing off on quarterly reports and whether or not this is a good idea.

Need better conversation between medical directors of services working together

Some services had very good Medical Directors and some very poor.

Dr. Smith offered to email anyone that wanted it a CD with Medical Director training materials.

Question was asked if the Hospital that the services transfer patients too should provide the Medical Director. This wouldn't work for service as some transport to several different Hospitals.

Concern voiced regarding medical director advising epi pens, IV's with medical director signing off but had to stop because not paramedics and now medical director says his hands are tied.

Leadership – Need for leadership in each agency essential, including the EMS medical director. In many cases the EMS MD's are simply not engaged. Some sought resources to deal with politicians who stifle the advancement of EMS delivery.

Physician Medical Directors. This group felt PMD's struggle with a lack of education regarding their own liability as a PMD. This is in regard to the PMD's possibly fearing what the State of Nebraska and more specifically, the direction of the current science of emergency medicine, is allowing and aiming at allowing EMT's to do in the field. The group feels the PMD's may be fearing that EMT's are being “encouraged” to “practice medicine” on scenes by allowing so much into their scope of practice or what it appears is being allowed. The group feels there is more structure needed for PMD's in the sense that services should require PMD's to be engaged and utilized by all services, paid and volunteer. An idea they suggested was to have “regionalized PMD's” out of each trauma centers then use local physicians as surrogate PMD's.

Most, if not all, were in agreement that a PMD course should be mandated. Questions were asked if many services contract with PMD's so that the PMD is held to certain expectations and requirements as set by the services (ensuring engagement from the PMD).

It was suggested and agreed upon that training should be available to PMD's at EMS conferences, complete with CME's for the physicians. The group members were agreeable with the following being added to the regulations: "Medications as approved by the PMD" so that there's more flexibility in the regs for addition/subtraction of medications available to (mostly) ALS services.

Opinion expressed that Medical Directors are good in some areas weak in others

Class for MD is available: Should it be mandatory for all State of Nebraska Medical Directors?

Medical Directors are getting hard to find. It is difficult to get them to be active, involved and be able to meet with the department.

Medical director would like to teach the modules and would do tests and skills if knew what was needed. However, Medical Director was afraid to teach squad anything because of comments made that he couldn't

Medications/Procedures:

Epi pen costing too much. How can we get EPI pens to be more affordable? Possibly through the use of group purchasing. There is possible "vial" available in Washington state that may be cheaper.

Discussion was held on medications/procedures to be allowed for EMT's: the use of D50 for EMT's vs oral glucose on unconscious patients, the use of Narcan for overdosed patients, the ability for BLS to do IO injections.

National Registry Concerns:

Discussion was held on how to get people to pass the National Registry EMT test. Reading comprehension was stated to be a likely possible issue for many. It was asked if there can be a State of NE test and explanation was given as to why not. It was stated there needs to be standards placed on instructors to ensure their ability to instruct/teach. It is felt the instructors need to have a standard to follow and comply with. With this discussion it was also suggested that hours required for maintaining National Registry certification be reduced. It was stated we (EMS Board) don't get to decide National Registry Certification criteria.

Fear of National Registry Exam mentioned many times by participants

Reading level of the National Registry class may be too difficult for some taking the exam

Mike Miller explained the Fiz Dap Predictive Testing which can be done for a fee of \$20 to prepare the student for success in taking the National Registry exam. Many participants were not aware of FizDap.

EMS Instruction – It was requested to limit an EMT course to no more than 150 hours. Meeting participants want individual instructors to be held accountable for the 70% pass rate, not just the training agency. Leveraging technology (blended online learning) to better deliver EMT courses was also discussed, noting how much time may be saved in rural areas where there is a commute to and from the course location. Accessing the NREMT exam was raised as an issue with it taking 9 steps from completing the class to submission of the application to DHHS – it needs to be streamlined.

One small town has paid for 10 people to take the EMT class, most pass the class, and class final test – and can't get thru the NREMT. This same group has only one active EMT to show for it. Same town had 3 Paramedic Students in town at one point. 1 passed NREMT. All three passed classes, did clinicals, passed skills tests, took most if not all of the ACLS, PEDS, PALS, and others; attempted NREMT written up to 5-6 times, One paramedic passed, and then moved. No medic students at this time. Reason: cost, and difficulty of NREMT.

People have served on NREMT testing board, admit the questions are designed to FAIL, not to make you think, make you FAIL.

Individual stated "I've taken Paramedic, passed class, passed class testing, and NREMT skills testing, took NREMT 5 times and a refresher, and still failed it, Spent > \$10k to get to here; and would spend more if I could be of use as a medic in the rural or urban community."

The group suggested there needs to be ONE text book for NREMT training and it should be written in accordance with the NREMT test. They do not feel the student should have to be taught how to take the NREMT.

They feel there should be a competency test required every two years for instructors to keep their license.

The instructors present stated there is difficulty getting enough and appropriate equipment for teaching EMS classes.

The question was asked if we (State of Nebraska) requires the student to take the National Registry Test, they why is the student responsible for paying for it (\$75)? Others voiced that it is ok that the student be responsible for it because then the student has "ownership" and tries harder to pass it. There was a suggestion that the State should "reward the passing student."

National Registry Exam: (NRE) / Training in general:
Questions on why we use the National Registry Exam.

Can we just use the test found in the book that was used in the training

One department recently sent 10 members to EMT training and only 4 passed national registry exam. It was asked if the pass rates of both training agencies and individual instructors could be made public in order to hold agencies and instructors accountable.

Comments made that just because you pass the NRE that does not make you a good EMT. Felt that the determination of pass/fail should look at 1/3 Skill, 1/3 Class room quizzes and 1/3 Final Exam.

Questions about what happens after a student has failed their three attempts at the NRE. Do they have to take the whole EMT class again?

It was discussed that it is very important for EMS students to take National Registry as soon as possible after completing coursework to support success.

There was a discussion about the use of Predictive Exams such as FizDap to predict the student's probability of passing National Registry and then the program gives a learning prescription to the student.

Questioned the possibility of being able to do some of the EMS initial training on line to cut down the travel time for the students.

Asked question: If Nurses do not have to pass a National Registry Exam why do EMTs?

Felt that the State should be more involved in Funding of initial EMS Training

Initial hours need to be shortened

Recommend reducing the time from completion of class/curriculum to the time of test to support student for success.

National Registry is never going away and some can't pass the test, can state implement something so these people can be a supplement to the service, some type of permission to use because these people just can't pass the test.

- Discussed testing for EMR
- Discussed "Helping Hands"

Are we seeing individuals earning their National Registry status but then later letting it go?

Accessing the NREMT exam was raised as an issue with it taking 9 steps from completing the class to submission of the application to DHHS – it needs to be streamlined.

The group suggested there needs to be ONE text book for NREMT training and it should be written in accordance with the NREMT test. They do not feel the student should have to be taught how to take the NREMT. They feel there should be a competency test required every 2 years for instructors to keep their license. The instructors present stated there is difficulty getting enough and appropriate equipment for teaching EMS classes. The question was asked if we (State of Nebraska) requires the student to take the National Registry Test, then why is the student responsible for paying for it (\$75)? Others feel that it is ok that the student be responsible for it because then the student has “ownership” and tries harder to pass it. There was a suggestion though that the State should “reward the passing student”.

National Registry Exam: (NRE) / Training in general:
Questions on why we use the National Registry Exam.

Have heard that NR only wants a 70% pass rate

NR seems to ask the same question over and over.

It was asked if the pass rates of both training agencies and individual instructors could be made public in order to hold agencies and instructors accountable.

Want more choices of instructors

One EMR class in the area had 5 different Instructors before it was over,

NR not a learning tool as there is little feedback as far what you didn't know, just general areas.

Cost of training is too high and little or no State reimbursement,

Questions re: are student allowed to become EMR if they fail the NR for EMTs?

There are concerns that the training agency isn't training them as to what is on the test.

People do not want to put in the time when they hear how many hours are required.

It was discussed that it is very important for EMS students to take National Registry as soon as possible after completing coursework to support success. One training agency makes them wait 2 weeks to schedule to take the pretest, then two weeks to Schedule the NR and then maybe two weeks to to get the testing done.

People said they took a written NR test???

Why do we have to use NR.

Dr. Smith described to the attendees about the use of Predictive Exams such as FizDap to predict the student's probability of passing National Registry.

Some pass the FizDap testing and still fail NR.

Suggestion that we need to go away from licensing and go toward Credentialing

Skills tests are certification exams. Get the students trained so they can pass the needed skills tests. They are also based on skills and practices that likely will soon disappear.

Most of the discussion was on passing the National Registry written exam. One attendee thought the state pass rate would be around 36%.

Frustrations because there is no immediate feedback for why the person fails the National Registry exam and therefore no way to learn from mistakes.

Attendees thought it would be very helpful if the person taking the test and failing could know what areas they were weak in so they could focus the review and be encouraged to retake the exam.

Many times if the person fails the National Registry exam at first attempt they may never try again and may even quit the department which equates to lost time and money for the service in addition to loss of membership.

One department recently sent 12 members to EMT training and only 1 passed national registry exam and that same department recently sent 4 members to another instructor and 3 passed.

It was asked if the pass rates of both training agencies and individual instructors could be made public in order to hold agencies and instructors accountable.

The question was asked “who trains EMS Instructors and how much training are they required to have?” “Does anyone monitor the quality of EMS Instructors?”

Suggestion was made to work on statewide consistency for training and instructors so that everyone is on the “same page.”

Discussion that there seems to be a wide range of competencies, knowledge, and capabilities of instructors and perhaps this is affecting the pass rates for National Registry adversely for the students in the State of Nebraska.

Discussion on how much continuing education is required for EMS instructors to stay current and licensed.

Suggestion: “Could the National Registry Exam be structured so that if the person testing failed the

EMT national registry exam but demonstrated competency in EMR could be given EMR status.” (Mike Miller gave an excellent explanation for why this is probably not possible because each level must take a specific exam which is carefully structured to measure competency)

It was discussed that it is very important for EMS students to take National Registry as soon as possible after completing coursework to support success...It was suggested that it be a

requirement to have all training agencies sit down with each student and sign them up for a National Registry exam as part of the final course completion.

(Mike Miller described to the attendees about the use of Predictive Exams such as FizDap to predict the student's probability of passing National Registry and then the program gives a learning prescription to the student. The student is then able to focus the study pathway and more accurately prepare for National Registry exam and augment their knowledge base. This approach has been used by some training agencies with good success and higher pass rate.) The question was asked if in the future “could the State perhaps fund these predictive exams in an effort to improve pass rates and success with the first time National Registry exam taking. The predictive exams cost approx \$20 per person which allows two attempts at the predictive exam. This was discussed and considered to be a reasonable option from all aspects of the economic standpoint.

Asked questions related to accommodations for ADA at National Registry exam.
(Mike Miller was able to address these questions.)

Ownership of EMS in Nebraska:

This question was asked by one attendee: “ Who owns EMS in the State of Nebraska?” and further stated “EMS Needs Ownership” and “EMS needs a person at the State Level.”

Discussion of EMS not deemed as essential service and no provision to require EMS services be provided.

This question was asked by one attendee: “ Who owns EMS in the State of Nebraska?” and further stated “EMS Needs Ownership”

Expressed need for the State to pay a greater percentage of the Initial EMS training

Opinion voiced that DHHS is a financial mess.

Suggested that EMS needs to break away from DHHS

Request that jurisdiction be placed with the county with the ability that the county can pass the responsibility of jurisdiction to another entity (possibly fire districts) if both agree.

EMS as an Essential Service – Who is responsible for EMS?

EMS Districts. All present at this particular forum were mostly in favor of districting EMS much like has been done for fire service.

This question was asked by one attendee: “ Who owns EMS in the State of Nebraska?” and further stated “EMS Needs Ownership” and “EMS needs a person at the State Level.”

Rural Fire Boards are doing a good job in this area.

DHHS doesn't understand EMS in Rural Nebraska.

Protocols:

Question: Could we add IV Tylenol for pain control.

What about adding auto-injectors of Glucagon and Narcan for EMT's

What about adding Ketamine to the protocol

To assure safety for patients and EMS personnel do we need a more prescriptive protocol for handling Behavioral Health patients who might be out of control or who might lose control.

What about adding auto-injectors of Glucagon and Narcan for EMT's
Dr. Smith reminded attendees that changing Protocols is much easier than changing Rules and regs as long as the changes to Protocols do not conflict with the rules and regs.

Question concerning trying to do away with backboards- as of March this protocol has been changed, Have Medical Directors signed off? This change was news to many in attendance of this meeting.

Is there a more effective way services can be notified of protocol updates and changes so that they are not left out of the loop?

There is a need for all services to send email contact updates and changes to the state.

There were questions if state is sending out the update information via email

QAR/Squad Inspections:

Concern over the way the current Squad Inspection/Audits are being handled.

Perception of an individual Squad Captain during the on-site audit was that the individual department had passed the inspection with no problems at all. The inspector gave impression that everything was fine.

Then the Squad Captain received a letter saying they had failed by "missing 5 minor points."

Request to look at how it is worded when the QAR/audit letter is sent....Could this letter be worded in a more positive light instead of focusing on "YOU FAILED."

Suggestion for future that perhaps it might serve everyone much better to foster better working relationships if the EMS Board and the Licensure Division would adopt an approach that was based on wanting to help the rescue departments to improve and succeed rather than focusing so much on failures.

Suggestion: for QAR audits: could it be called Deficiencies instead of FAILURE. Perhaps stating it as deficiencies and then providing assistance in addressing the deficiencies would foster

a much better working relationship and more trust between the Department of Regulations and Licensure and the Squads.

For future strategic planning asked for a more helpful approach in the whole QAR/Audit process Suggest the State of Nebraska hire resource personnel who are trained and educated to assist in addressing the deficiencies found with the squads.

Why isn't there a provisional status for the QAR...currently it is only Pass or Fail and it takes only one item to fail. The question was asked if this is really a fair approach.

There is a perceived lack of communications about Quality Assurance Reports.

Real fear of being audited and having services shut down for not having proper paperwork completed. **Recruitment and Retention:**

Attendees voiced low pass rate for National Registry exam as one of the top deterrents for recruitment and retention.

They suggested being able to use individual modules to move up into new roles might help retention.

They asked for more creative solutions for Education and better access to education to shorten the actual time spent in formal classroom: Example would be to have the student independently view some portions of the class content on You Tube or on internet prior to classroom time.

Suggestion to leverage technology and utilize long-distance learning and Live/Interactive Learning with on-line courses maximized.

Some type of incentive to volunteers if earned. (no specifics suggested at this time.)

Lack of getting personnel to respond, many times a second page is required- can we get nurse's that may be available to assist? Bridge class for nurse's to EMT; by-law change requirements and a sign off from medical director

Incentives for Volunteers – Recruitment and retention is a significant concern for many. Various options were offered as incentives for volunteers including tax credit, retirement program, insurance program, etc.

There is a slim pool of recruits in small towns most service don't require them to be both EMT and Firefighters.

Opinion that responders in smaller towns don't need to take as many hours of training; they just need to be there.

Training on CPR and EMT training needs to be available to High Students

EMT's in this area are really aging with poor outlook for replacement EMTs.

Have one RN on the department and 2 former medic students and these resources are not being used to their potential.

Surrounding communities are all struggling with having recruitment and retention.

Regulations and Licensure Division and Disciplinary proceedings:

It was suggested there should be a way for the person/department under investigation to be able to directly address the Regulations/Licensure Division and EMS Board and to be able to tell their side of the story and be able to defend and explain their actions/etc. Asked for a process to be able to represent self or their own department.

Concerns raised about inconsistent information given to rescue departments regarding the impact of Censures and other types of discipline. Example: one squad was instructed by Licensure Division that Censure for their department would disappear from the record in a certain number of years and then found out from a different person at Licensure Division that Censure will always be a part of their record.

Concerns about following protocol exactly and then still being disciplined based on an interpretation of "expert source."

Expressed a feeling that the Regulations and Licensure Division personnel do not want to help. Suggest a better approach would be if DHHS staff members could ask "How can I help you and then follow-up with actively assisting the squads to do their best work."

Expressed a reluctance or a "fear" of calling for help to the Regulations and Licensure Division.

For future strategic planning asked for a more helpful approach when they reach out to Regulations and Licensure Division

For future to have the Regulations and Licensure Division and the EMS Board keep in mind the huge impact on each squad who gets a failure to pass or a Censure or any other discipline.

Relationship with DHHS – Many in the group expressed concern over the perceived punitive and adversarial relationship with DHHS and those working in EMS and the Licensure Unit. Most interactions were described as unhelpful, lacking support and encouragement, with little explanation as to why things are the way they are. There is a perceived lack of respect for volunteers from DHHS staff. Some offered that this is a two-way process and volunteer agencies and others do not always work well with DHHS to solve problems collaboratively. Generally, the group articulated a need to work together and the relationship is in need of repair. Rumors spread and there is a great deal of fear that all volunteer agencies are going to be disbanded and replaced with hospital or county led EMS services.

Response:

EMS Response Agencies that Don't Show-up – Concern was expressed too many volunteer agencies will respond with many more than needed volunteers for structure fires or crashes, but other medical calls often go unanswered.

Tiering. One area has an excellent tiering system with superior connectedness between mutual aiding BLS departments and Hospital/ALS crews! We were very impressed with their tiering system and how well they all get along not only with calls but with education and PMD support. They stated they started this tiering system off good with “baby steps” by introducing ALS tiering on cardiac calls only, then moved “gently” to other areas where ALS should be utilized, thus never “pouncing” on the BLS volunteer services by stating WE ARE HERE AND WE WILL DICTATE. By having the hospital and ALS system approach the local area like this, they stated, it diminished “territorial” issues, which obviously has been a very good thing, allowing area services to be very open-minded about working together and training together. Excellent system. This community may be a potential model for the future in Nebraska. This group suggested that QA/QI be set up in all mutual aid districts/areas so that EMS in the state can move forward with providing the best possible quality of care.

Lack of getting personnel to respond, many times a second page is required- can we get nurse's that may be available to assist? Bridge class for nurse's to EMT; by-law change requirements and a sign off from medical director

Lack of membership and response times are lagging during critical times of the day.

There is a definite need for ALS on the scene quickly with the first page.

Small communities need the ability to know exact responders availability both for local and county on a daily basis to guarantee coverage for the community. How could this be accomplished? How could this information be coordinated and how could dispatch use the calendar data. Could this be placed on Google or some other type of electronic site? This would allow the appropriate persons to be able to know at any time of the day how many responders are available in the community, their names and the exact hour of availability. How would this information get coordinated?

Are all current 911 and mutual aid agreements really being followed and enforced?

Mutual aid has worked well in the past for Mass casualty or MVA's but often does not work well for illness and or medical types of calls or other protocols.

Rules and Regulations:

Air Medical Regulations: Two forums had attendees who strongly requested regulations for air medical. They also would like to have a “seat” on the EMS Board for Air Medical Representative.

Discussion was held on development of regulations for Critical Care Paramedic, Air Ambulances, Community Paramedicine and non-911 transport.

KKK Specs and new regulations are creating a huge financial burden to many Squads.

Discussion on the potential need to open Rules and Regulations to re-write in a shorter and more general format to fit our current rapidly changing healthcare situation

Request to open the Rules and Regulations and make them more fluid and more easily adaptable to changing times in EMS.

Dr. Smith reminded attendees that changing Protocols is much easier than changing Rules and Regulations as long as the changes to Protocols do not conflict with the rules and regs. Discussion briefly regarding the potential need to open Rules and Regulations to re-write in a shorter and more general format to fit our current rapidly changing healthcare situation.

Rules and Regs can only be opened when the EMS board is granted permission to do so.

Opinion is it takes too long to get Rules and regs changed.

Concerns that the EMS board does not have as much power as they need to have to change rules and regs.

The group was all in agreement that science is moving much faster than what the NE Regulations can keep up with. Our current system of regulations (for EMS) binds us too tightly, they feel.

Dr. Smith briefly discussed the potential need to open Rules and Regulations to re-write in a shorter and more general format to fit our current rapidly changing healthcare situation.

General opinion that rules and regs need to be in a shorter format.

Safety:

Discussion of safety measures for patients and Pre-Hospital personnel when transporting Behavioral Health Patients

Scope of Practice:

Clarification was made with end tidal CO2: all levels can use the # but can't interpret the wave form.

Could Aerosol Narcan be added to scope of practice for all levels of providers

Could Injectable EPI be added to scope of practice for EMT due to the cost of the injectable pen

Could IO's be added for basic level

Could D50 administration be added for EMT level

Why can't EMT's use a laryngoscope and perform Endotracheal Intubations

Why can't EMT's use the IV pump?

Clearer orders on what RN can do in pre-hospital area

What can EMT, advanced level do in hospital

Skills:

Question was asked: "Why is the glucometer an additional skill and not just included in the allowable procedures?"

Could glucometer usage for EMT be added without the module class part of curriculum

Special Projects:

Discussion was held on the progress of Mission: LifeLine and the Lucas devices.

Many attendees described feeling left out of the loop of communications regarding Special projects.

State EMS and State Regional EMS Specialists:

Attendees reported having difficulty reaching new EMS contact person for Northeast Nebraska and suggested it may be because he is new to his position. They knew his name and seemed to understand he may need time to acclimate to his new duties but they did seem interested in contact and assistance soon.

Felt that the State should be more involved in Funding of initial EMS Training

Some providers do not know who their EMS Specialist is.

Felt there were issues between some EMS Specialists and the Licensure department.

There is a perceived disconnect between EMS and the Licensure division.

Felt that EMS Specialist should visit every service in their area every two years

Thought that some State Regional EMS Specialists were doing a good job.

Transport/Tiered Intercept Issues:

Discussion was held on the stipulations surrounding the allowance of EMR's to transport without an EMT or higher level provider present.

Direction from EMS Board was requested regarding ALS intercepts/tiered responses in regards to mandating ALS intercepts/tiered responses with basic services when there's potential need for ALS services.

Want Protocols and mandated tiering with ALS

Could there be mandated mutual dispatch so tiering will work better

Believe the goal should be IV access, transmission of 12 lead EKG, advanced airway, prior to ALS tiered response and they would communicate with medical direction to continue.

Suggest something like an EMT-A class or Advanced First Responder (can apply oxygen and transport) and then call ALS intercept or even tier with another local BLS if available.

There has to be a better way to get ALS procedures started in advance of some communities currently when needed.. We must think outside the box.

We are seeing a minimal amount of procedures during ALS tiered response and most of the times little more is needed and the tiered departments don't get paid. I think goal is to reduce time sitting on the side of the road trying to get IV, etc and reduce transport times.....suggest Tier and go responses.

Working Relationships:

Perceived inconsistent information given out by the DHHS Regulations and Licensure Division and EMS Division:

Example

Definition of Extraction Training.....Some at State level say it is the same as extrication and some say it is not the same as extrication. This is very confusing to the EMS personnel and their squad leadership when planning for education and training. It depends who you talk to at the State level what definition you obtain.

Concern that there seems to be a disconnect between State EMS Department Personnel and the DHHS Regulations and Licensure Division creating the appearance that there is an area for needed improvement to bring the state together. Suggestion to work on this for the future to bring cohesiveness to EMS in Nebraska.

Voiced concern about a perceived disconnect on various issues related to EMS in the State of Nebraska. Example: Need active participation at the state level for air medical transport and specifically to actively move toward licensure of same.

Relationship with DHHS – Many in the group expressed concern over the perceived punitive and adversarial relationship with DHHS and those working in EMS and the DHHS Licensure Unit. Most interactions were described as unhelpful, lacking support and encouragement, with little explanation as to why things are the way they are. There is a perceived lack of respect for volunteers from DHHS staff. Some offered that this is a two-way process and volunteer agencies and others do not always work well with DHHS to solve problems collaboratively. Generally, the group articulated a need to work together and the relationship is in need of repair. Rumors have spread and there is a great deal of fear that all volunteer agencies are going to be disbanded and replaced with hospital or county led EMS services.

Expression of Fire Based EMS services perception of adversarial relationships and disrespect shown when dealing with DHHS and Members of Leadership Team for State EMS Office.

Concern expressed about particular areas of the state where private ambulance entities and owners are perceived to have complete control over everything that happens in that area of the state to include paid ALS and all the volunteer services. There is a perception that anything that happens in this particular area must first go through the owners of the private ambulance company to include the Community College for that area of the State of Nebraska and the courses they are able to offer. This same area expressed concern about being required to utilize only one PMD dictated by the private ambulance entity and the owner. This particular area's instructors express concern about not getting any support from the Nebraska Community College for that area as the instructors are often jostled from location to location when doing classes, especially EMT class. They have to make their own copies quite often. Also, quite often, the instructor will have their schedule of what each class time will cover, but the college (or private ambulance company leadership) will change class topics unexpectedly just hours before the class is held, thus throwing the instructor off on what they were prepared to train on at that particular session. Verbalizations of a lot of inconsistencies with training and attributed to outside influence of private ambulance company influence. This group strongly feels the college curriculum in this location is not training/teaching to the level of the NREMT.

One individual was adamant that NE EMS needs to be educating the public via radio/newspaper, etc. about what 911 is to be used for....they are tired of being called to the John Q Public residence to help John back into bed, and things like that.

Expressions of perceptions that State EMS leaders and staff are not listening and being rude or noncaring with tone of voice on phone calls and the tone of letters written to services.

Concern about lack of contact and working relationship with the particular regional EMS coordinator/specialist assigned to that area.

Public Forum Meeting Dates and EMS Board Members in Attendance

8/29/15 – North Platte

Mike Bailey
Karen Bowlin
Ann Fiala
Jim Smith

10/17/15 – Nebraska City

Don Harmon

10/22/15 – Lincoln

Mike Miller

9/29/15 – Blair

Joel Cerny
Linda Jensen
Mike Miller
Carl Rennerfeldt
Jim Smith

10/26/15 – Kearney

Ann Fiala
Don Harmon

10/27/15 – Kimball

Karen Bowlin

Ann Fiala

10/1/15 – Omaha

Randy Boldt
Linda Jensen
Mike Miller

Jim Smith

11/2/15 – Edgar

Joel Cerny
Don Harmon
Jim Smith

10/14/15 – Columbus

John Bonta
Joel Cerny
Troy Hiemer
Jim Smith

11/10/15 – Ord

Karen Bowlin

11/21/15 –

Ainsworth

Karen Bowlin

Appendix G
Nebraska Board of Emergency Medical Services
Strategic Plan 2016

Nebraska Board of Emergency Medical Services

Strategic Plan

2016

This planning document is a work in progress and the result of an ongoing strategic planning process begun in 2015. The process includes:

- listening to stakeholders across Nebraska;
- in depth evaluations of data, concerns and challenges;
- meetings between the Nebraska Board of Emergency Medical Services, the Department of Health and Human Services' Licensure Unit and the EMS/Trauma Program and key EMS and healthcare stakeholders; and
- leadership focused on proactively investing time and other resources in preparing for the future.

The vision and goals below reflect the important opportunities, challenges and needs of EMS in Nebraska today and in the coming five years. The planning process will be ongoing. This document will continue to evolve and change as work is accomplished and more is learned.

Vision:

The following reflects the Board and staff's vision of EMS in Nebraska in five years.

In 2021 Nebraska residents and visitors will be served by emergency medical services that are:

- *Above all, patient centered*
- *Part of a planned system with an appropriate distribution of resources*
- *Appropriately led and regulated at the state level by various parts working collaboratively and communicating internally and externally*
- *Seen, valued and funded as an essential public service*
- *Providing the appropriate level of clinical care with engaged medical direction*
- *Fully staffed with workers who are valued and reasonably educated, staffed, supported and held accountable*
- *Locally sustainable and reliable*
- *Integrated into the larger healthcare system*

This vision will be supported by, but not limited to, the following strategic priorities/goals:

Strategic Priority/Goal

Update EMS rules and regulations to ensure regulatory structure supports reflect current vision of patient centric system and current opportunities, challenges and needs.

- **Current actions:**

- Open rules and regulations update process (completed)
- Identify leadership and group to oversee process ensuring appropriate hearings, stakeholder input and statutory requirements are followed. ○ Steward this process to ensure goal is met. ○ Explore changes needed around scope of practice to accommodate exploration of concepts like community paramedic and mobile integrated health.
- **Ownership:** Ann Fiala and Linda Jensen
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goal

EMS is broadly recognized as an essential public service in Nebraska with clear designation in statute or rule for who or whom is responsible for the provision of EMS.

- **Current action:**
 - For a group to research this issue; ○ Gain understanding of barriers to the designation of responsibility; and ○ Form recommendations and a strategy for accomplishing this goal.
- **Ownership:** Randy Boldt, Carl Rennerfeldt and Troy Hiemer
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goal

Strengthen and improve local EMS Medical Direction engagement and effectiveness across Nebraska.

- **Current actions:**
 - Evaluate the current system of medical direction
 - Explore medical director development, education, support, regional approaches, best practices in other states
 - Make recommendations for strengthening and improving the local EMS Medical Direction to the Board
- **Ownership:** Dr. Eric Ernest, Dr. John Bonta, Don Harmon, PA, Dr. Thomas Deegan
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goal

A comprehensive vision for EMS data collection and use in Nebraska linked to practical and clear clinical performance indicators.

- **Current action:** Assemble a team of appropriate stakeholders and develop a data visioning/planning process.
- **Ownership:** Scott Wiebe and Doug Fuller
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goal

A five-year plan with specific practical actions that addresses EMS workforce including the decline in volunteerism and current and future needs across Nebraska.

- **Current actions:**
 - Form working group (include involvement of NSVFA & NEMSA)
 - Assess available data and get clear handle on scope of challenges and needs
 - Create a process for educating local officials/communities about workforce issues/needs
 - Apply principles of workforce planning to create a plan and identify specific practical actions to develop appropriate workforce
 - Continue the promotion of EMS leadership develop
- **Ownership:** Mike Bailey, Joel Cerny, Charles LaFollette
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goal

A thorough evaluation of the EMS education and testing process to ensure Nebraska has a best practice process (an educational assessment).

- **Current actions:**
 - Plan and conduct an educational assessment
 - Explore issues related to testing concerns expressed in open forums
 - Seek to understand what needs improvement or change
 - Make recommendations to Board
- **Ownership:** Dr. Mike Miller, Brian Monaghan, Karen Bowlin
- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goals

Acknowledged improvement in communication and collaboration between:

- Nebraska Board of Emergency Medical Services
- DHHS – Licensure Unit

- DHHS - EMS/Trauma Program
- Stakeholders across Nebraska
- Systems of care

Better access to Board meetings.

- **Current actions:**

- Encourage EMS related DHHS staff to attend and participate in Board meetings
- Host regular joint staff meeting between Licensure Unit and EMS/Trauma Program
- Continue to use and develop communication links with key stake holders such as open forums
- Explore open meeting limits and possibilities with using technology
- Experiment with using technology expand communication

- **Ownership:** Dr. James Smith, Tim Wilson, Claire Covert-ByBee

- **Timeline:** To be determined by owners and reported at next Board meeting

Strategic Priority/Goals

Strengthen capacity of EMS Regional Specialists to identify local agency sustainability and assist local agencies and communities in navigating change process.

Deferred for future discussion