DRAFT MINUTES
of the Third Meeting of the
EMS Technical Review Committee

March 4, 2019
1:00 p.m. to 4:00 p.m.
Lower Level "A"
The Nebraska State Office Building, Lincoln, NE

Members Present	Members Absent	Staff Present
Travis Teetor, MD (Chair)	James Temme, RT	Matt Gelvin
Jeff Baldwin, PharmD, RP		Ron Briel
Lisa Pfeil		Marla Scheer
Donald Naiberk, Hospital Administrator		
Susan Meyerle, LIMHP		
Marcy Wyrens, RRT		

I. Call to Order, Roll Call, Approval of the Agenda

Dr. Teetor called the meeting to order at 1:05 p.m. The roll was called; a quorum was present. Dr. Teetor welcomed all attendees. The agenda and Open Meetings Law were posted and the meeting was advertised online at http://dhhs.ne.gov/licensure/Pages/credentialing-review.aspx . The committee members approved the agenda for the third meeting and the minutes of the second meeting by acclamation.

II. Scheduling an Additional Meetings

During a brief discussion the Committee members agreed that the following meeting scheduled for April 1, 2019 would be the public hearing for this review.

III. Discussion on the Proposal

The committee members first took up the community para-medicine component of the proposal.

At the beginning of this discussion the applicants introduced two physicians for the purpose of presenting their information and insights about the ideas being proposed by the applicant group. These two physicians were Dr. Eric Ernest and Dr. Jim Smith, the current Chairperson of the EMS Board in Nebraska.

Dr. Smith stated that there is data supporting the concepts of preventive interv ention found in the current 407 proposal for community paramedicine. Data shows that such interventions reduce the incidences of readmissions to hospitals on the part of patients with chronic conditions. This is especially true in rural areas wherein these kinds of programs make it possible for patients with chronic health issues to receive care at home rather than having to travel great distances to receive care in a hospital, for example. Dr. Smith cited COPD as an example of a chronic condition that can be dealt with at home with the aid and assistance of a community paramedic program. He added that the coming of telehealth technology has greatly facilitated the delivery of this kind of care. Telehealth makes it possible for an EMS provider who is on-site to communicate at a very high level with a physician who might be hundreds of miles away so as to get the benefit

of their knowledge and insight into the best way to address the needs of the patent in question. Herein, the on-site paramedic can--consistent with paramedic scope of practice--follow instructions from the on-line physician vis-à-vis the needs of the patient. In this way the on-site paramedic becomes a physician extender unlike the current situation wherein the paramedic's options are limited to transporting the patient to a hospital ER that might be a great distance from the patient's home rather than providing care for that patient in-situ in their home.

Ms. Pfeil commented that the lack of adequate cell phone technology in remote rural areas weakens Dr. Smith's argument. Dr. Teetor commented that the decline in population in remote rural areas in our state raises questions regarding how a community paramedic service could find enough employees to maintain a viable service of the kind envisioned by the applicant group. Dr. Smith responded by stating that he is sure that there will be enough volunteers to operate the paramedic component of such a service. He went on to state that the concern he has about such a service is that in some remote rural areas there aren't enough physicians or advanced practice nurses available to provide expert medical advice to the paramedics on-site who need such input.

Ms. Pfeil asked how members of the public would be informed about the availability of community paramedic services in their area. Dr. Smith responded by stating that hospitals and clinics would inform patients about such services as part of their discharge plans.

Ms. Wyrens asked how community paramedic services would be funded. Dr. Smith responded by stating that there are revenue streams and reimbursement systems available for these kinds of services that are already operating in some other states. He added that third party payers also play a role in reimbursement of these kinds of services because of the promise they hold vis-à-vis preventive care, for example. Dr. Ernest added that he is confident that the passage of the applicants' proposal would greatly facilitate the willingness of third party payers to reimburse for community paramedic services.

Mr. Naiberk asked the applicants who would be doing patient assessments in a typical community paramedic program, and went on to ask what would their qualifications be to do such assessments? Dr. Ernest responded by stating that on-site personnel would be functioning under physician approved protocols for such procedures, and would be supervised and advised by qualified medical directors via a telemedicine communications link.

Ms. Meyerle asked what potential for new harm might arise from community paramedic services. Dr. Smith responded by stating that additional educational requirements and requirements pertinent to medical oversight would adequately address concerns about the potential for new harm.

Ms. Pfeil asked how a community paramedic program would determine who was eligible for their services and who would not. Dr. Ernest responded that physician supervisors would make these kinds of determinations based on objective criteria.

The committee members then took up the critical care component of the proposal.

Dr. Smith commented that the critical care component of the EMS proposal pertains to the provision of care in situations wherein special procedures and technologies are utilized to keep a patient alive until they can be transported to a facility wherein medical professionals--physicians and / or advanced practice nurses--provide them life-saving therapies and / or procedures. Dr. Smith went on to state that the purpose of the current critical care component of the proposal is to provide Nebraska EMS providers with the most up-to-date education and training available. This would provide the public with the assurance that all EMS providers are competent to use all technologies available to them to save lives. Under the current situation such assurance is not possible because many paramedics lack adequate education and training to utilize such things as chest tubes, safely and effectively, for example. He added that peer review, medical oversight, and telemedicine would play key roles in maintaining the quality and safety of the services that would comprise community para-medicine.

Dr. Teetor asked the applicants why not utilize the services of physicians and / or APRNs on EMS transport services instead to devoting so much time and money to providing additional education and training to paramedics? APRNs and physicians already know what they need to know to "get the job done." Dr. Smith responded by stating that there aren't enough physicians or APRNs in remote rural areas to make this alternative work, and even if there were it is highly unlikely that very many of them would make medical transport their life-long career. An additional complication is that APRNs and physicians would likely demand salaries that are beyond what EMS programs could afford.

Ms. Wyrens commented that medical oversight is often problematical and flawed throughout the health care world, then asked the applicants how can you place so much trust in this dimension of health care? Dr. Ernest and Dr. Smith both responded, asserting that their experiences with medical oversight in the provision of EMS services has been very positive and very encouraging vis-à-vis its prospects in being able to assure quality of care under the terms of the two proposals.

Dr. Teetor asked the applicants who would be making money off of the services you are proposing if these proposals were to pass? Mike Miller responded on behalf of the applicant group by clarifying that no new revenues would be generated by either of these two proposals. Instead of new revenues there would be significant cost savings. For example, these cost savings would include cost savings to hospital ERs because there would be a reduction in the utilization of these kinds of resources once the new EMS services are in place. Mr. Miller added that no one is going to be making a windfall off of either of these proposals.

A member of the Nebraska Nurses Association commented that it would not be in the interests of the State of Nebraska to create EMS outreach programs that might become obsolete once the full implications of telehealth takes hold in our state. It may get to the point where these kinds of outreach services are no longer necessary. Patients might one day be able to use these technologies to take care of their own access to care needs.

Another member of the Nebraska Nurses Association asked the applicants what implications the proposal would have pertinent to HIPAA. Mike Miller responded that he did not have an answer to that question at this time.

IV. Next Steps

The next step in the review process on this proposal is the public hearing.

V. Other Business and Adjournment

There being no further business, the committee members unanimously agreed to adjourn the meeting at 3:50 p.m.