

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 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.

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 then 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 You tube 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 FizDap 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 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 followup 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 then 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 non-caring 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.