REPORT OF RECOMMENDATIONS AND FINDINGS

By the EMS
Technical Review Committee

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

May 6, 2019

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Part One: Preliminary Information

Introduction

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

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

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

LIST OF MEMBERS OF THE EMS TECHNICAL REVIEW COMMITTEE, 2019

Travis Teetor, MD, Chair

Jeff Baldwin, PharmD, RP

Susan Meyerle, PhD, LIMHP

Donald Naiberk, Hospital Administrator

Lisa Pfeil

James Temme, RT

Marcy Wyrens, RRT

Part Two: Summary of Committee Recommendations

The committee members recommended approval of the EMS Community Para-medicine Proposal by a vote of four to two.

The committee members recommended approval of the EMS Critical Care Paramedic Proposal by a vote of six to zero.

Part Three: Summary of the Applicants' EMS Proposals

The Critical Care Paramedic Proposal (1)

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

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

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

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

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

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

- Critical Care Paramedic Licensure - 2 (Alaska and Connecticut)
- Critical Care Paramedic Certified - 1 (Colorado)
- Critical Care Paramedic Endorsement - 8 (Iowa, Kentucky, Massachusetts, Montana, New Hampshire, Oklahoma, Tennessee, and Wisconsin)

- Expanded Scope of Practice Designated - 3 (California, Michigan, and Pennsylvania)

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

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

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

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

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

There are no statutory limitations or restrictions on critical care transport, because it is not a recognized or regulated occupation. As a result, patients are potentially at risk due to a lack of consistent oversight and minimum education, certification, licensure, and credentialing

requirements. Nebraska Model EMS Protocols do not address the critical care aspects of the patients being cared for during these transports.

The Community Para-medicine Proposal (2)

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

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

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

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

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

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

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

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

Part Four: Discussion on issues by the Committee Members

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

Mike Miller with the Board of EMS came forward to provide an overview of the proposal for the benefit of the TRC members. He informed the committee members that the EMS Board held listening sessions to get input from the public and other members of the profession regarding what changes are needed in EMS credentialing. These sessions led to the creation of an EMS legislative proposal reviewed during the previous legislative session. Mr. Miller went on to state that because of opposition from some members of the nursing community key aspects of the bill were amended out by State Senators, including several critical care provisions and several community health and emergency transport provisions. Mr. Miller informed the TRC members that EMS leaders were advised that their ideas for change need to undergo credentialing review before the legislature can take any further action on their legislative proposal, and that this is why we are all here today beginning the process of conducting a credentialing review of ideas for making changes in EMS credentialing.

Mr. Miller went on to state that there is potential for harm to the public inherent in the current situation of EMS services in Nebraska. EMS providers are often put in situations wherein they are asked to perform procedures for which they have no formal training and very little practical experience because of new and more demanding standards for the transport of those who need emergent care. Advanced training is essential for these EMS providers to provide their services safely and effectively. Mr. Miller went on to state that the current shortfall in available nursing services has a great deal to do with these problems, especially in rural areas of our state. Ever-fewer nurses means that someone needs to take up the slack when it comes to nursing services, and, often, the only professionals who are available to do that are EMS providers, many of whom lack the necessary skills and knowledge to fill this service gap, safely and effectively.

Dr. Teetor asked the applicants to define current education and training so that the committee members can better compare and contrast what the education is now vis-à-vis what the proposed educational standard would be if the proposal passes. Mr. Miller briefly summarized the current training for the following categories:

a) EMT Responders: 50-60 hours of education, no transport, just work setting.
   EMTs: 150 to 170 hours of education, some meds, transport, foundational.

b) Advanced EMTs: 350-400 hours of education, IVs, meds, airway, limited diagnosis, transport.

c) Paramedics: 1200-1400 hours of education for basic, 12-18 months for additional education, medical director approves medications they carry, surgical airway procedures, blood transfusions, chest tubes, national examination.

d) Critical Care Paramedics: 6 credit hour course at Creighton, e.g., plus 120 additional clock hours over 15 weeks followed by an examination, transportation of high risk patients, automatic transport ventilator, central lines.

Susan Meyerle asked the applicants if issues and problems in EMS discussed by the members of the Board of EMS stem from the shortcomings of the current training situation of EMS providers. Mr. Miller responded in the affirmative.

Mr. Naiberk asked the applicants what role medical directors play in the delivery of emergency care. Mr. Miller replied that they play an oversight role and provide guidance vis-à-vis written protocols that must be followed during all EMS procedures, although there are instances when protocols can be eased to deal with a-typical situations, for example.

Dr. Teetor asked the applicants about rural-urban differences as regard the provision of EMS services. Mr. Miller responded that in most small towns and rural areas most EMS services are at the basic life-support level, and there are very few persons with Paramedic-level education or training. Some rural communities see the need to do something to upgrade the level of education and training of their EMS personnel so that they are more prepared to provide transport services.

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

James Temme asked the applicants what Iowa does vis-à-vis the issues they identified. Mr. Miller responded that Iowa has a critical care endorsement process in place that includes an educational program that allows those EMS professionals who qualify to take advanced training and if they pass the training to receive a special permit to perform certain advanced procedures.

Dr. Teetor asked the applicants if their proposal is designed to include the delivery of in-hospital care by EMS providers. Mr. Miller responded in the affirmative that this continues to be a component of their goals for Nebraska's EMS professionals. He added that EMS providers have proven that they are able to work in hospitals and clinics.

Dr. Baldwin asked the applicants about the purpose of the proposal. Is it to expand the scope to satisfy new transport standards? Mr. Miller responded in the affirmative. Dr. Baldwin asked if the proposed scope overlaps with nursing scope. Mr. Miller replied that the applicants do not seek to infringe on nursing scope or otherwise compete with nurses for service opportunities, rather, the applicants seek to work with nurses in the field and "synergize" with them to fill the gaps in service that are becoming such a problem because of the on-going nursing shortage in Nebraska. He added that EMS providers would continue to emphasize ground rescue operations while nurses would emphasize in-hospital and in-clinic care.

Marcy Wyrens asked the applicants about the reimbursement implications for the ideas being proposed. Mr. Miller responded that reimbursement is going to be a serious concern.
Tim Wilson commented that under current EMS scope of practice the ER is the only option for transporting in an emergency situation. Mr. Wilson added that there is a need for expanded

options vis-à-vis transport to other venues than the ER such as urgent care facilities, intermediate care facilities, or, even to free-standing medical professional offices, for example.

Mr. Miller commented that there are currently “pilot programs” in Nebraska that have been given permission to experiment with expanded scopes of practice for EMTs that enable them to provide services beyond the current “emergent” model of their scope of practice. One of these “pilot programs” is in McCook, Nebraska, for example. Mr. Miller commented that these programs have shown that EMTs can contribute to the overall health and welfare of small rural communities by supplementing the kinds of services provided by visiting nurses, for example. Mr. Miller went on to say that the need for this kind of supplementary care is great in rural Nebraska and that EMTs can play a role in filling this need, adding that EMTs should not be limited to transporting patients to a local ER.

Ms. Pfeil commented that the lack of adequate cell phone technology in remote rural areas weakens applicant arguments. 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, a physician speaking on behalf of the applicant group 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.

Dr. Smith stated that there is data supporting the concepts of preventive intervention 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.

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.

Would there be new harm resulting from these proposed ideas?

Lisa Pfeil asked the applicants if this part of the proposal might drive away EMT providers who like their jobs as they are without the additional complexity and liability associated with providing services that go beyond the provision of emergency services per se. Tim Wilson responded by stating that EMS providers already have a statutorily defined scope of practice. The proposal seeks to expand this scope of practice to include more advanced EMT services. Mike Miller commented that EMS providers are everywhere in Nebraska and that makes them readily available to provide the expanded scope elements defined in the community para-medicine component of the proposal more so than any other health profession in our state including nurses, for example.

Don Naiberk asked the applicants who, under the terms of the proposal, would inspect and evaluate a patient's overall health condition and determine if they can or cannot be transported, in particular, could an EMT perform such an evaluation if the proposal were to pass? Mr. Wilson responded that an EMT would play a bigger role in this given the additional education and training that would be provided under the proposal. He added that new electronic technology now enables more effective and timely triage procedures pertinent to such evaluations and that a physician hundreds of miles away can provide oversight and direction to EMTs in such matters. He went on to say that new technology has made it possible for EMTs to get medical and / or nursing input and direction on a large number of things, some of which go far beyond the traditional "emergent" model of EMT services, for example.
Lisa Pfeil asked the applicants why they want to expand EMT services in a "non-emergent" direction, and elaborated on her question by asking aren't such services already being provided by other health care providers? Continuing her questioning Ms. Pfeil asked would any of these proposed new EMT services be billable to third party payers? Tim Wilson responded that in some states Medicaid does reimburse for these kinds of services. He added that there is some grant money available for this as well. Mr. Wilson referenced the fact that there are "pilot programs" that pay for these kinds of EMT services.

Dr. Teetor asked the applicants who approves and funds these "pilot programs"? Dr. Teetor continued his questioning by asking the applicants what it is that these programs allow EMTs to do that they can't do now outside of such programs. Mr. Wilson responded that "well checks" are an example of services that cannot be provided outside of the context of the "pilot program."

Dr. Teetor asked the applicants whether or not the proposed expanded scope for EMTs would stretch EMT services too thin, specifically, would the proposal weaken their traditional mission to provide emergency care to Nebraskans? Mr. Miller responded by saying that this traditional role for EMTs has been overstated, and that there would still be plenty of EMT providers to address emergencies.

Lisa Pfeil asked the applicants if current licensure requirements cover the advanced critical care procedures requested by the applicants in their proposal. Mr. Miller responded by informing the committee members that these items are not covered by current licensure requirements but yet these items and procedures are already occurring in the field. Ms. Pfeil asked the applicants how many current EMS practitioners would be willing to undergo the cost and time away from work to acquire the advanced education and training necessary to become certified to perform the advanced procedures in question. Tim Wilson responded by stating that it isn't possible to know how many EMS providers might have these kinds of concerns but that in Iowa EMS practitioners have been doing these procedures for about a decade, and that in Iowa most of the training is done on-line, and that access to this on-line training is easy for those interested in pursuing advanced practice.

Dr. Teetor asked the applicants how education and training pertinent to the elements of advanced EMS practice would occur and what the qualifications of those providing this education and training would be. Mr. Miller responded that training would be provided by a wide variety of professionals including other paramedics who have already completed the training. Dr. Teetor then asked the applicants who else would be providing this education and training. Mr. Miller responded by stating that some training would be provided by nurses, some by respiratory therapists, and some by physicians, depending on who might be available at a particular time or place. Dr. Teetor then asked the applicants how much time would be devoted to hands-on learning for the various advanced procedures defined in the proposal. Mr. Miller replied that about a week is spent on learning these advanced procedures. Dr. Teetor responded by stating that one week is not enough time to become competent in such procedures as inserting a chest tube, adding that he spent six months learning these kinds of procedures in medical school, working "day-in-and-day-out" until he achieved competency in these procedures. Dr. Teetor added that even with this amount of training he has only done a small handful of such procedures in his entire medical career, and that he prefers not to perform such procedures as inserting tubes in a patient's chest, for example. A representative of the Nebraska Nurses Association commented that nurses typically do not perform such procedures as inserting a chest tube, for example, and that it is advanced practice nurses who perform such procedures, not RNs, for example.

Mr. Temme expressed concerns about the radiological component of the proposal which seems to include such things as interpreting radiographs, for example. Mr. Temme went on to state that only medical doctors or advanced practice nurses are capable of interpreting radiographs. Dr. Baldwin then expressed concerns about provisions in the proposal which would allow advanced practice paramedics to conduct pharmacological "infusions." Dr. Baldwin wanted clarification from the applicants regarding the elements of the proposed advanced EMS training in pharmacology that would qualify paramedics to perform such procedures.

Mr. Temme asked the applicants to provide more information about how competency is determined in EMS, adding that the proposal has raised a lot of questions and concerns about standards of competency regarding EMS education and training. Mr. Miller responded by commenting that the items about which concerns have been expressed represent procedures that are already being done vis-à-vis the provision of EMS services, albeit without the benefit of

necessary advanced education and training, and without necessary changes in EMS statutes and rules and regulations. Mr. Miller went on to state that Nebraska needs to update its EMS statutes and rules and regulations to include advanced EMS educational and training requirements to address this situation in the field.

Dr. Teetor asked the applicants if there are EMS practitioners who have been disciplined for exceeding their statutory scope of practice limitations. Mr. Miller responded that he was not aware of any such disciplinary action against current EMS providers.

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.

Are there better ways of addressing the concerns raised by the applicant group than the two ideas they proposed?

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, and 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 have 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.

All sources used to create Part Four of this report can be found on the credentialing review program link at
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

Part Five: Public Hearing Testimony and Committee Questions

The following persons came forward to present testimony on behalf of the two EMS proposals.

Electronic copies of their testimony can be found at the following web link under EMS
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

- **Rick Erickson representing Life Net**

To the Members of the Emergency Medical Services Technical Review Committee:

I am here today to speak to some of the public comments in regard to Critical Care Paramedicine as part of the Credentialing Review (407) Process.

The advent of critical care paramedic programs originates from the need to move critical patients to a tertiary care facility for a higher level of care. The Committee has made comments asking as to why physicians or APRNs do not provide these transports. The reality is these practitioners are frequently taxed by his/her workload and is unable to do so. Additionally, EMS is recognized as its own subspecialty. An EMS fellowship exists after completion of an emergency medicine residency. Asking physicians or APRNs to complete transports in this environment may prove difficult especially in high acuity scene calls. In the distant past, critical care transports were completed with a nurse from the referring hospital. It became increasingly obvious early on that this method was not sustainable especially for smaller rural facilities to allow staff to leave on multiple hour transports. Regular paramedics were unprepared to handle the complexity of some of these patients. Critical Care Paramedicine was born out of necessity three decades ago with input from many of the leaders of EMS education at the time. The curriculum developed addressed many of the topics at that time, which frequently remain the topics we see in critical care transport today.

These transports will have to be completed in one fashion or another. They have been done frequently in this state by aeromedical transport. But as we all know, the weather in Nebraska is not conducive to air transport every day. The number of transports to tertiary care facilities or specialty care centers will only continue to increase because of hospital specialization. Transports between these facilities will require highly trained transport teams. The option becomes, do we establish a level of training that is able to provide these transports, or do we allow these transports to be handled by inexperienced providers leading to adverse patient outcomes?

This starts with a basis of education. Currently, almost every state that has an education component to acquire state licensure or endorsement in critical care, uses a similar standard as outlined by the University of Maryland Baltimore County. The state of Tennessee requires additional training beyond that standard. States that do not use an education component rely strictly on the International Board of Specialty Certification's (IBSC) exams, either the CCP-C (certified critical care paramedic) or FP-C (certified flight paramedic) to attain endorsement. Colorado is the most recent state that has adopted this standard. These certification exams ensure the minimum knowledge required of an individual who has been practicing in the critical

care environment after 1-year of practice. Using this as the credentialing exam in the state of Colorado has reduced costs and standardized the knowledge required to practice in the critical care transport environment. I would highly support this model for our state as well. Once you have ensured a basic knowledge that is recognized as the industry standard, the skills used become the next concern.

I can understand the concerns of the Committee, but I ensure you in a well-developed critical care transport environment, they are mitigated. As part of the process of developing any medical practitioner, we go through multiple phases to achieve proficiency. The first phase is education. Education is used to develop the knowledge needed to practice in the environment. Additionally, exposure to the skills used in practice should be part of the educational component. From education, we next have to certify the knowledge is there. This is done through the IBSC exams. The next component is that an employer should verify the knowledge obtained and to ensure competency in the skills obtained. This is not a one-time check but needs to be done for most skills on an annual basis which ensures minimal degradation of skills.

As I have stated from the beginning, the skills in critical care transport have come out of the necessity to perform them, not a cavalier approach to adding skills to just add skills. Chest tube thoracostomy is a great example of this. While many physicians, APRN's and PA's have been trained to do these skills, many of them have not performed them since they were in school. This leads them to be gun shy or unsure. Critical care transport providers would arrive to find an unwilling practitioner willing to perform a much-needed procedure. This became a skill that required some training, but it is included in the practice of many critical care transport providers. It is a skill that is viewed as a necessity by critical care transport experts. The Commission on Accreditation of Medical Transport Systems (CAMTS) includes the requirement of a trauma course that contains those skills. The two primary options for continuing education are either to audit an ATLS course or to attend the Transport Provider's Advanced Trauma Course which includes an invasive skills component, including chest tube thoracostomy.

A comment was made about the interpretation of radiological exams. You are absolutely correct that a physician is the only one who can diagnose something from those exams. Many hospitals require a read from a radiologist for that definitive diagnosis. We stress the very basics of interpretation, not a full diagnosis. Differentiating a head bleed from an ischemic stroke and determining the type of head bleed you are dealing with are the main things we focus on in head CTs. Why? Because it changes how you treat the patient during transport to improve outcomes. Chest x-ray is no different in these terms. To give you an example, we were called to a small facility for transport of a patient experiencing a head bleed. The referring physician stated it was an epidural bleed. Upon review it was a subarachnoid. I don't fault him for telling us the wrong information or question his ability to recognize it. It was 3 am, and he looked like he had been up for the last 48 hours. A second set of eyes is never a bad thing.

The one thing that was stated that is absolutely true is the need for constant involved medical direction. At no level of pre-hospital provider is it truer than at the critical care paramedic level. An involved medical director ensures that all of these items of concern are much less of an issue. This should be part of the service licensure. The organization that I work for as a flight paramedic requires an initial training after hire. This training is approximately 7 days of classroom work with clinical scenarios using high fidelity simulation. After that, skills competencies are completed with the local medical director followed by multiple months of training under another skilled transport provider. Many of the existing critical care transport agencies follow the CAMTS accreditation standards for continuing education. Continuing

education is a necessity for successful critical care paramedics. This is best provided by the physician medical director overseeing their practice. The IBSC certifications require 100-hours of continuing education every 4 years to maintain certification. Quality critical care transport must also have a strong QA/QI program.

These transports are happening every day in the state of Nebraska. With a rising level of frequency, these transports are happening by providers that are ill-prepared to handle what they are encountering. Because of a lack of oversight by the state, many patients are being harmed, not out of malice, but out of providers being ill-trained. I have had the great opportunity to train paramedics from 48 of the 50 states, 11 of the 13 Canadian provinces and territories, and students from 10 separate countries from as far away as Australia and the United Kingdom. The critical care transport standards put before you are those that are seen as the standards across the country and most of the world.

Let me leave you with a story from one of our former critical care paramedic students. She took our class 4 years ago from the state of Tennessee. After the completion of our critical care paramedic program, she was hired by Vanderbilt LifeFlight. A year into her employment, she was dispatch to a small rural hospital for 17-year-old female who was involved in a motor vehicle collision. The small rural hospital was staffed by a family practice physician who had been practicing for more than 20 years. On review of the chest x-ray, the patient was found to have a large hemothorax with significant hypoxia. Because of her training in a critical care program and practice with her physician medical director, she placed a chest tube with no difficulty. The referring physician was concerned about placing a chest tube because he had not done the skill nor attended continuing education to place one since residency. Our former student's last chest tube was one week ago before in a cadaver lab and part to the services continuing education program. She placed the chest tube without difficulty. The hypoxia resolved with both lungs now being inflated. The patient received blood products during transport and was transported 40 minutes to a tertiary care facility. The patient was discharged from the hospital 3 weeks later and went on to graduate from high school later that year. That same patient in the state of Nebraska may not have had a chest tube placed, may not have been able to correct the hypoxia from the collapsed lung, and may have had a much worse outcome with that duration of transport. This is a scenario that plays out frequently in the state of Nebraska. We need a critical care paramedic level in the state of Nebraska to be able to do what is best for our patients.

I thank you for your time and would be willing to answer any questions you have.

Respectfully submitted,

Rick Erickson

- **Dr. Mike Miller with the EMS Education Program at Creighton University and representing the State Board of EMS Services**

Members of the Nebraska Credentialing Review, EMS proposal Technical Review Committee, thank you for the opportunity to provide testimony this afternoon regarding the two proposals before you - Critical Care Paramedic and Mobile Integrated Healthcare-Community Paramedicine, proposals that are important to the future of emergency medical services in Nebraska.

My name is Mike Miller. I am a paramedic, EMS Instructor, and registered nurse, working in emergency medicine for 35 years. The last 16 years I have worked at Creighton University, where I currently serve as Assistant Professor and EMS Education Program Director. It is my honor to serve on the Nebraska Board of EMS, and the testimony I provide today is on their behalf.

Comments:

It is important to share a brief history of how the Mobile Integrated Healthcare-Community Paramedicine and Critical Care Paramedic proposals have engaged this process to be before you today. In April 2016, the Nebraska Board of EMS, with several other Nebraska EMS stakeholders, participated in a facilitated strategic planning process, followed by 2 years of listening sessions throughout the state. Several strategic initiatives have developed from this work, including a new EMS Practice Act, approved by the Nebraska Legislature in 2018, and subsequently signed by the governor. Rules and Regulations are currently being drafted. Two aspects of the original legislation, LB924, subsequently LB1034, were removed and recommended for the Credentialing Review program - community paramedicine and critical care paramedic. The Nebraska Board of EMS unanimously supports both initiatives. This board is an all-volunteer group committed to protecting the well-being of all Nebraskans through safe and evidence-based EMS practice. Comprised of EMS personnel, three board certified emergency physicians, a physician assistant, RNs, and educators; representing paid, volunteer, urban, rural, BLS and ALS agencies; collectively the Board has 400 years of medical experience.

EMS practice has and continues to evolve rapidly, and Nebraska statutes and regulations are not keeping pace with many other areas of the country. Approval of the proposals before you allow for the recognition of innovative and collaborative healthcare delivery services, and validation of the critical care transports that have been happening for decades without accountability safeguards or standards. The need for critical care transport services is going to increase as medicine becomes increasingly complex, with services located at tertiary care facilities. Furthermore, there are gaps in services, and EMS has long been recognized as many as the nation's healthcare safety net. The recently released *EMS Agenda of the Future* (2019), a national project, has identified a framework for addressing the most critical aspects of

developing a people-centered EMS system, including adaptable and innovative, inherently safe and effective, and integrated and seamless.

There are a few important points to make regarding the proposals that have surfaced during the review meetings:

1. Safe and accountable clinical practice, with minimum standards, is the motivation for both proposals.
2. Safe clinical practice is comprised of a framework to determine competency that includes:
    a. Education - what a provider is trained to do
    b. Certification - what a provider is certified as competent against minimum standards through a valid high-stakes examination
    c. Licensed - what a provider has been granted legal authority to practice; in this case we are asking for certification as Nebraska statutes do not allow for an endorsement process
    d. Credentialed - what a provider has been authorized by physician medical director to perform, with ongoing quality controls and CME
3. EMS personnel, especially at the paramedic level, are not being recognized for the clinical capabilities they possess, including the ability to obtain a history and perform a physical examination, analyzing this information and drawing conclusions, and implementing a plan of care.
4. In the Critical Care Paramedic proposal, there has been an emphasis on the list of skills that may encompass a scope of practice for critical care paramedics. These lists were provided as a reference for what other states include, and that research has demonstrated to be part of the scope of practice for critical care paramedics, not a definitive scope of practice to be implemented in Nebraska. EMS physicians provide oversight regarding EMS practice, and they will be integral to final practice standards.
5. Mobile Integrated Healthcare-Community Paramedicine, is not new - programs began in many areas of the country in 2004. 93% of states have community paramedics or plans for implementation. The majority of community paramedic programs focuses on admission/readmission avoidance (81%), manage frequent EMS/ED users (72%), and chronic disease management (72%). Collaborative partners in a community paramedic program sees hospitals, physician groups/clinics, and Home Health agencies making the majority of referrals to community paramedics, while community paramedic programs regularly make referrals to Home Health, Social service agencies, mental health facilities, and addiction treatment centers. In short it is a collaborative care model that we need more of.

6. Community paramedic programs report high or some success in change in improved patient overall health status, cost savings, reduction in 911 utilization, reduction in reliance on the emergency department for care, reduction in 30 day readmissions, and improved patient satisfaction.

The proposals before you were developed as a beginning, not an end to the collaborative process to develop recognition and oversight of critical care paramedic and community paramedic certification credentials in Nebraska. We have an opportunity to proactively develop programs that will make a difference in the lives of Nebraskans. You have posed many excellent questions throughout the review process, and I hope you will support the progressive development of healthcare delivery by EMS. On behalf of the Nebraska Board of EMS, a group of passionate EMS subject matter experts, I ask you to support both proposals. Thank you for the privilege to be able to share my views with you today. I am happy to answer any questions you may have.

- **Michael Wanke, CCP, with Norfolk Ambulance Service**

I have practiced as a Critical Care Paramedic since 2004. I have noticed a significant increase in the need for knowledge and skills above the Paramedic scope of practice over the past 15 years. These include, but are not limited to, diagnostic equipment, mechanical ventilator therapy, arterial line monitoring, radiology interpretation, lab value interpretation, blood product infusions, complex medication infusions, monitoring intra-aortic balloon pumps, Impella devices, ECMO, etc.

Vast knowledge of the equipment needed for any given situation is paramount. You need to know how to make the correct adjustments to equipment if an unforeseen complication should arise. For instance, if the waveform on the balloon pump changes or distal pulses become weak, what does this mean and what do you need to do? Did you even pay attention to these or monitor vital signs only?

Lab values provide important information in the diagnosis, treatment, and evaluation if treatment is effective or ineffective. Understanding what labs reveal is essential. ABGs are included in this and help guide treatment for acid-base-balance as well as oxygenation. These help in selecting correct antibiotic therapy, fluid resuscitation, mechanical ventilator settings, etc.

It is important to be able to interpret diagnostic readings such as EKGs, radiology images, etc. It is unwise to accept the EKG rhythm interpretation for face value. On numerous occasions I have seen the computer interpretations that were not close to the actual electrical activity seen. If you understand what you are looking for when viewing radiology images, acute events are more easily identified.

Insulin drips, pressor agents, blood product transfusions, etc. can be safely administered and regulated to the patient needs by the Critical Care Paramedic. Truly understanding the desired effects, adverse reactions, administration parameters, and possible ineffectiveness need to be understood. If you continually administer a given medication and do not get the desired effect, what did you achieve?

Critical Care Paramedics are trained to diagnose and treat situations that may arise, or are present, with advanced diagnostic equipment including hemodynamic monitoring, lab interpretation, radiology interpretation, etc. We are capable of delivering complex medication administration safely. We can mechanically ventilate patients with numerous issues using the most advantageous settings for the patient. With advanced monitoring techniques, Critical Care

Paramedics can see if patient trending is better, unchanged, or worse, and intervein rapidly if need be. I believe the need for Critical Care Paramedics in Nebraska is of great importance. Due to our geographic vast rural areas and time frames between hospitals, we can make a significant difference in patient outcomes.

Sincerely,
Mike Wanke, CCP

The following persons came forward to present testimony in opposition to the two EMS proposals.

Electronic copies of their testimony can be found at the following web link under EMS
http://dhhs.ne.gov/Licensure/Pages/Credentialing-Review.aspx

- **Douglas Haas, APRN, NP, President of the Nebraska Nurses Association**

I am here representing the Nebraska Nurses Association. Thank you to the members of the committee for committing your time and expertise to participate in this important policy-making process.
We are opposed to the creation of a new credential titled 'Critical Care Paramedic' as presented in the applicant's letter of intent.
Title 172, the Professional and Occupational Licensure, Chapter 4 Credentialing Review Program, subsection 006 Criteria and Standards for a New Credential presents four criteria that must be met to issue the credential. The petitioners are requesting a new credential of Critical Care Paramedic along with the scope of practice accompanied by a credential holder. Chapter 4 requires the Committee to issue a recommendation related to whether the four criteria for a new credential have been met. As you deliberate these recommendations, please consider the concerns of the Nebraska Nurses Association in them –
Criterion One: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

- Per the Statues Relating to Emergency Medical Services Practice Act, paramedicine is currently not an unregulated practice, it operates under the supervision of a Physician medical director who implements protocols defined as, policies, procedures, and directions…concerning the medical procedures to be performed in specific situations. The Physician medical director is responsible for supervision of out-of-hospital emergency care providers and verification of skill proficiency. Creation of a new credential, Critical Care Paramedic, does not remove the supervision or skill proficiency verification requirement. Additionally, the proposal of this new credential does not waive the need for Physician medical director protocols to be in place at all times.

Criterion Two: Regulation of the health profession does not impose significant new economic hardship on the public, significantly diminish the supply of qualified practitioners, or otherwise create barriers to service that are not consistent with the public welfare and interest.

- Certification could be seen as a limitation to the current supply of qualified paramedics. The certification requires 100 continuing education hours as well as completion of a

renewal course every 4 years in order to maintain the certification. The applicant groups paperwork also speaks to a cost of the renewal class ranging from $1,000 to $1,500 as well as the cost of certification application costing $225 to $385. Per the applicant's testimony, many rural Nebraska ambulance crews are working largely with volunteer EMS providers.

- Another concern includes the increased requirements of the Physician medical director if obligated to create and maintain additional protocols and competencies on critical care procedures. An already overloaded system, as stated by the applicants, shows there are medical directors already underperforming in their current supervision and proficiency verification duties.

Criterion Three: The public needs assurance from the state of initial and continuing professional ability.

- Public assurance of initial professional ability is limited due to the certification requiring nothing other than an active paramedic license to apply and sit for the initial certification exam. There are recommendations for completing an accredited foundational critical care course, but once again no requirement of completing mandatory education before becoming certified. The applicants provided testimony that this credential would streamline the educational requirements, but currently the certification examination body does not require proof of baseline competence.

Criterion Four: The public cannot be protected by a more effective alternative.

- Currently there are no limitations on Physician medical directors from increasing the scope of practice to include critical care type procedures and patient management. There is already a modality in place with protocols and competency assurance that would allow the public to be able to receive these types of services from our current EMS system without the implementation of this credential. One suggestion would be to encourage the Physician medical directors to explore the available critical care paramedic courses currently available including the certification examination rather than create a new credential. It would then be the purview and responsibility of the Physician medical director to add their own protocols and crew requirements. There are programs in the state currently utilizing flight Registered Nurses and paramedics to this expanded critical care scope. To my knowledge, these individuals, including the paramedics, can perform critical care procedures related to their underlying core training and ongoing proficiency requirements as determined by the Physician medical director.

From our evaluation, the criteria set forth to evaluate the need for a new credential have not be satisfied by the applicant's application or testimony. The application itself even defines the term Credentialed as "has been authorized by physician medical director to perform role". There is lack of evidence to show why the current Physician medical director credentialing and protocol system is not being utilized to its full extent. It is due to this lack of evidence around why our current system is not being employed that the Nebraska Nurses Association opposes the creation of a new Critical Care Paramedic credential intended to increase scope of practice. Please do not recommend the creation of the Critical Care Paramedic credential.
Respectfully –
Douglass Haas, MSN, APRN-NP, FNP-BC, AGACNP-BC, CCRN-CMC
Nebraska Nurses Association President

- **Dr. Teresa L. Anderson, Ed D, RN, Past-President of the Nebraska Nurses Association**

I am here representing the Nebraska Nurses Association (NNA) and we are opposed to scope of practice changes related to Community Paramedicine. The petitioners are requesting changes to two key elements of scope of practice (SOP) as defined in Title 172, Chapter 4, Section 4-002 – the expansion of activities, functions, and responsibilities of the EMS role as well as the change and expansion of the location of the work.
Chapter 4, section 4-008, requires compliance related to each of six criteria. As you vote, please consider the concerns of the NNA –

1. "The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice":
   Our concern is that the "activities, functions, procedures, and responsibilities" of in-home or in-hospital healthcare challenges are not included in EMS provider basic education nor in location experiences to provide safe care. No evidence has been presented to indicate that harm or danger to public health and safety are now occurring because this expanded role is not available.

   NNA urges you to vote "no" on this criterion.

2. "Enactment of the proposed change in SOP would benefit the health, safety, or welfare of the public."
   There is no evidence of an added benefit of Community Paramedic services in urban areas where shortages of APRNs, RNs, LPNs, and others to care for individuals with non-emergent needs in the home do not exist. High-level evidence has not been provided to the Committee to prove that the status quo represents clear harm or danger to the public if these changes are not made. Nor is there proof that any current harm or danger is directly attributable to the absence of these expansions. General information from small-scale pilot programs is not high-level evidence.

   NNA urges you to vote "no" on this criterion.

3. "The proposed change in SOP does not create a significant new danger to the health, safety, or welfare of the public."
   These changes could easily present new danger to the health, safety, or welfare of the public if Community Paramedics do not receive the expanded training and ongoing competence validation that are required to practice in environments that involve assessment, evaluation, and critical thinking situations that are beyond basic "emergency care" training, experience, and protocols. Triage and transport protocols follow clear steps that are consistent and short-term in scope.
   In rural areas, the additional burden to small or volunteer emergency services by adding these tasks, might create a significant risk to response times and outcomes during actual emergencies.

   NNA urges you to vote "no" on this criterion.

   4. "The current education and training for the health profession adequately prepares practitioners to perform the new skill or service."

Current EMS training does not prepare practitioners to perform the new service. Community Paramedics would be required to complete between 80 – 300 additional hours of initial training, as well as ongoing education for validation of competence. Evidence of accredited programs was not provided, and none exist in Nebraska, leaving the quality of training in question.
NNA urges you to vote "no" on this criterion.

5. "There are appropriate post-professional programs and competence assessment measures available to ensure that the practitioner is competent to perform the new skill or service in a safe manner.

No plan for ongoing competence assessment measures was presented, beyond those provided by EMS Medical Directors, and the engagement and oversight of medical directors is admittedly inconsistent across Nebraska. Programs based on assessments that are "unique to the needs of the community" and designed by area emergency service providers offer flexibility, but also challenge the standardization needed to assure that EMS providers maintain competency and do not exceed the scope of their knowledge and practice. Chronic diseases often occur with multiple co-morbidities and inconsistencies, making assessment, planning, education, and coordination of care for these citizens more complex than can be addressed by the limited education of Community Paramedics, without direct supervision. Public RN scope of practice limits delegation to only those tasks that are non-complex with stable patients in an environment where validation of all delegated tasks is possible. The proposed Community Paramedic assessments, such as vital signs or weight, if unstable, immediately become a complex task, which cannot be delegated from the RN role. Why would it be trusted to a provider with a fraction of the training? Technology oversight would be limited by geography. Without a required prescription, citizens are at risk for episodic care by practitioners who do not know their medical history or cognitive functioning. Costs of the additional training, competency validation, and ongoing monitoring have not been presented, so it is not possible to determine if the costs will be prohibitive. Enough detail for a fiscal note has not been provided.
NNA urges you to vote "no" on this criterion.

6. "There are adequate measures to assess whether practitioners are completely performing the new skill or service and to take appropriate action if they are not performing competently."

Transitioning emergency services providers into an environment of ongoing care and management of chronic diseases, where they are expected to practice "collaboratively" with Registered Nurse supervision and guidance, raises the question of whether oversight of these individuals should be transferred from medical directors to within the framework of nursing care? Should the processes of complaint, investigations, and discipline provisions of the Uniform Credentialing Act, remain within the oversight of the EMS Board going forward, a practice that will lack the checks and balances of a monitoring body outside the industry that stands to gain financially from the expansion of this role? Is this an alternative caregiver, not a better one that would be managed by the EMS Board creating further fractioning of the ongoing care environment? The petitioners have mentioned the ability to charge for services and the "creation of a revenue stream" for EMS provider companies on numerous occasions during these meetings. Is this about a needed service or a new business opportunity?

The petitioners see the 407 process as "the beginning" rather than the intended final step toward introducing legislative changes that have been collaboratively examined and designed. The national expert brought to the area on March 22, 2019 was the first attempt at any

collaboration or discussion with relevant stakeholders by the petitioners. A quantitative assessment to confirm the assumptions of need and benefit is needed. An evaluation of existing roles to determine if one might be easily leveraged to meet any "gaps" would then follow. While Nebraska may have a need for an expanded EMS role in the future, there is no evidence to support expansion now. Further investigation into the longevity and legality of "pilot" programs that are exceeding the current scope should be requested.
Due to significant concern about initial and continuing competency and oversight of Community Paramedic practice; the failure of the petitioners to provide evidence that the status quo significantly threatens the health, safety, and welfare of the public in Nebraska; and implied financial gain by those proposing these changes, the Nebraska Nurses Association opposes expansion or change in the locations of care or the recognition of the scope of practice of Community Paramedicine.
Please do not recommend the removal of "out of hospital" practice requirements or the expansion of Community Paramedicine scope of practice in Nebraska.

- **Geri Johnson, RN, BSN, Director of Brown County Hospital Home Health, representing the Nebraska Home Care Association**

EMS Technical Review Committee Members:
My name is Geri Johnson, RN, BSN. I'm the Director of Brown County Hospital Home Health in Ainsworth, Nebraska. I'm also the President of the Nebraska Home Care Association and am testifying on behalf of the membership.
Our top priority is to ensure appropriate care, safety and well-being for Nebraskans to remain independent in their homes and communities. We would like to provide clarification on the scope of practice of home care providers and the existing availability of home care in the state of Nebraska. You've received a handout with a list of home health agencies in Nebraska and the counties where they are licensed to provide skilled healthcare services. You've also received a handout specifying the types of services that home health agencies provide. Additionally, I'd encourage you to review the Home Health Conditions of Participation, which is available on the Centers for Medicare and Medicaid (CMS) website and specifies the requirements for anyone wishing to provide home health services must follow.
Home health agencies commonly hire registered nurses with a minimum of three years of nursing experience. This is because nursing services in a home or community setting require a high level of skills and competencies to care for patients with complex long-term care needs. This includes caring for patients with tracheostomies, wounds, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The care and expertise that home health nurses provide helps constituents prevent emergency room stays and re-hospitalization, reducing costs in the long-term for the state.
In our review of the EMS-Community Paramedicine proposal, and of the 407 credentialing review criteria and standards for a change in scope of practice of a regulated profession, we express concerns that the proposed changes do not meet the six established criteria.

1. **The proposal indicates that this scope of practice should be allowed "without having to obtain a Home Health Agency License." Any provider that is allowed into the homes of vulnerable Nebraskans should be expected to meet state licensing requirements.**
   Licensure assures standards of operation, care and treatment by regulating governing authority, services provided, personnel qualifications, policies and job

descriptions, criteria for admission, discharge and transfer, patient care policies and procedures, documentation protocols, background checks, orientation and training requirements, competencies as well as patient rights and the reporting requirements for abuse, neglect and exploitation.

Allowing this scope of practice without proper licensure does not provide a benefit to the health, safety or welfare of the public (Criterion Two), presents a potential danger to the public's health, safety and welfare (Criterion Three), and does not provide the oversight necessary to adequately measure whether practitioners are competently performing the skills necessary to provide safe home care nor the oversight necessary for corrective action (Criterion Six).

2. **In the description of the proposed credential and proposed scope of practice, the application references a "gap" in healthcare specific to the community and that "programs are not meant to compete with existing services being provided." However, each service listed is in fact in the role and scope of home healthcare and a well-covered provider market already exists in Nebraska. There are greater benefits to coordinating/collaborating with existing resources, rather than duplicating services. NHCA is open to a collaborative work structure with EMS if clear boundaries of responsibility, licensure and interaction are established.**

The proposal lists the following MIH-CP services that may be provided:

- Providing help to patients with chronic disease management and education, including post hospital discharge follow up to prevent readmissions.
    - **i.** Chronic disease management is at the core of Home Health. It requires a skilled professional to assess the patient's condition, integrating a variety of signs and symptoms for patients with several comorbid conditions, perform typically complex medication reconciliation with review of interactions, duplications and side effects as well as coordinate a plan of care that keeps the patient safe at home. Adding an additional layer of care that is managed primarily under protocols and on-line medical direction from someone with no knowledge or background on the individual patient serves only to further fragment the patient's care and the healthcare system.
    - **ii.** Rigorous, credentialed educational programs for nurses and therapists prepare them to function independently. This application states that for Community Paramedicine "education may be handled in a variety of different ways." Allowing another level of care with no degree requirement or standard educational curriculum is not a substitute for shortages in skilled professional roles and does not close gaps in healthcare. It is

hard to see how the addition of this service in an already complex system will “increase continuity of care.”

iii. Preventing re-hospitalization is a core measure for Home Health Compare and Value Based Purchasing programs. Home Health interventions are geared toward transitioning the patient from the acute level of care and to prevent unnecessary readmissions.

- Navigate patients to alternate destinations such as primary care, urgent care, mental health or substance abuse treatment centers rather than the emergency room.
  i. Coordinating community resources is also under the purview of home health. Medical Social Workers who specialize in resource referral are an integral part of the home health team.

- Provide telephone triage, advice or other assistance to non-urgent 911 callers rather than sending scarce resources such as an ambulance.
  i. Home Health services are available 24 hours a day, 7 days a week to triage patient calls and attend to their needs. When patients call 911, they expect resources to be sent immediately for urgent situations. Having paramedics take time to differentiate urgent versus non-urgent situations could delay response and put patients in danger.

- Use telemetry technology facilitating patient in-home interaction with healthcare providers at another location.
  i. Telemonitoring, with availability of face-to-face interactions via video, are currently available in the home health setting. It is expected that this service will expand as reimbursement is becoming available to home health agencies through Medicare, Medicaid and other payers.

With 75 home care provider members of the Nebraska Home Care Association, there is currently an adequate availability of home care services in the state. With a well-covered provider market, to include non-profit providers who serve all regardless of ability to pay, there is not an inadequacy in access to cost-effective, high-quality home care services in our state (Criterion One).

3. **The proposal states that “community paramedicine education may be handled in a variety of different ways.” No standard in education or degree requirements is established by the proposal; furthermore, a range of five different levels of personnel – each with unique educational levels and skill sets – is proposed to be included in this scope of practice. Licensed home healthcare practitioners have attained certain educational and degree**

requirements and through annual required skills testing demonstrate their ability to provide this scope of service to patients.

The proposal does not specify a clear standard in education or degree requirements that will adequately prepare EMS providers to perform the full range of home care skills and services, including case management, long-term chronic disease management, wound care, physical and occupational therapy and other specialized services. Current EMS licensure requirements do not cover this scope of practice (Criterion Four). Their proposal does not establish appropriate post-professional programs and competence assessment measures to ensure EMS providers are able to perform the full range of home care skills and services (Criterion Five).

4. **The scope of services provided by home care agencies is inclusive of more than what is proposed to be provided by EMS providers; there is an existing continuum of care that ensures comprehensive, multidisciplinary, 24/7 in-home services appropriate to individual patient need.**

Any provider of home care should be educated, skilled and licensed to provide the full scope of services under that practice; the absence of some services within this scope poses a risk to public health and safety and could lead to a higher overall cost of care for the patient and a loss of comprehensive quality care (Criterion One).

We ask what the goals for *the patient* are in this proposal, and for the committee to consider what improvements can be made within the current continuum, to include EMS providers, to reach these goals – without permitting an unlicensed scope of practice that competes with current resources and is not comprehensive of what home care in Nebraska currently provides. We would respectfully request that the applicant group specify the next course of action, addresses the need for more data demonstrating the community need/gaps in services, provides an expressed plan to closely collaborate with stakeholders to develop clearly-defined boundaries and specific roles, and propose a plan to develop clear educational and continuing education standards.
I would be glad to answer questions that you may have regarding the scope of services that home health professionals deliver to Nebraskans.

Nebraska Home Care Association members represent Nebraska home health agencies and home care companies whose professional staff provides medical care and support at home to recovering, disabled, chronically or terminally ill adults and children in need of medical, nursing, social or therapeutic treatment and/or assistance.
Types of services provided by Nebraska home health agencies include highly skilled care for constituents with a variety of healthcare needs including those with complex, long-term care needs. The care and expertise they provide helps constituents prevent emergency room stays and re-hospitalization, reducing costs in the long-term for the state. Because of home care services, constituents have improved quality of life and increased independence.
Services include:

- Cardiac care (working with pacemakers and defibrillators)
- Wound care
- Infusion therapy
- Respiratory care (working with patients on ventilators and tracheotomies)

- Physical, occupational and speech therapy
- Pain management and assessment
- Administering medication and medication reconciliation

Home care companies provide bathing and hands-on personal cares including laundry and light housekeeping.
Nebraska home care providers include hospital-affiliated, for-profit, nonprofit and private duty. We encourage you to utilize our Nebraska Home Care Association office and lobbyist, and connect with the Nebraska home health agencies and home care companies in your district and throughout the state when you have questions about legislation that affects the home care industry. Contact us directly and locate provider members at www.nebraskahomecare.org.

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www.nebraskahomecare.org

Nebraska Home Care Industry

- 3,051 = Number of Home Health Employees
- 4,551 = Number of Jobs Created by Home Health
- $100M = Home Health Total Wages
- $150M = Total Impact on State Labor Income
- Nebraska has more than 70 Medicare/Medicaid certified and licensed home health agencies.
- On average, home health services are 1/10th the cost of institutional care.

Questions from TRC Members

James Temme asked Teresa Anderson whether she is currently a member of the Board of Nursing. Dr. Anderson responded that she is not currently a member of that board. Mr. Temme responded by asking Dr. Anderson how she can claim to represent this board when she isn't a member of it. Dr. Anderson replied that this board asked her to come forward and make comments on their behalf. Dr. Temme then asked Dr. Anderson if she really thinks that these two EMS proposals are motivated by a desire to make more money. Dr. Anderson responded in the affirmative and added that the applicants' two proposals include a significant amount of discussion on the implications these proposals would have for "revenue streams" and income for EMS services.

Marcy Wyrens asked Daniel Duncan why is there such a difference between what our ground based paramedics can do compared to what air rescue paramedics can do? Mr. Duncan responded by stating that air rescue paramedic services are not subject to regulation whereas ground based paramedics are regulated and these regulations do not allow them to train for, or engage in, the utilization of advanced paramedic functions or procedures. Air rescue

paramedics utilize advanced practices and procedures even though they are neither trained nor credentialed to do so. However, there is no process or regulatory mechanism in place that says they can't utilize advanced practices. So, they use them.

Lisa Pfeil asked Mr. Duncan isn't it the responsibility of the employer to see to it that all paramedic professionals under their charge are trained to do their job, whatever that might entail. Mr. Duncan responded that ideally this should be the case but the current legal situation of EMS ground services is such that they are not allowed to provide the necessary training to their ground units to use such advanced practices as critical care pumps or chest tubes, for example. He added that there is a corporate critical care standard for training to use such devices but Nebraska does not currently recognize this standard.

Part Six: Discussion and Recommendations

Discussion on the critical care component of the EMS Proposal

Prior to Committee discussion applicant representative Mike Miller came forward to present additional information on the critical care component of the proposal. Mr. Miller described the proposed additional education and training that critical care EMS providers would receive under the terms of the proposal. He related the reasons why this part of the EMS proposal is necessary, including that medical advancements are making transport services more complex and sophisticated. Critical care transport providers are now capable of providing procedures not currently identified as part of EMS scope of practice. This scope needs to be updated to include these procedures and their concomitant technologies.

Mr. Miller went on to state that EMS critical care is in great need of an update vis-à-vis the regulatory oversight of new specialized transport services and technologies not currently addressed by the current EMS scope of practice. Mr. Miller stated that there is a need for additional education and training for EMS providers vis-à-vis new procedures and technologies, and that such education is available from a variety of educational providers in a variety of different formats. An example of such an educational program is that developed by the University of Maryland Baltimore County which is offered in multiple sites across the United States. Additionally, Creighton University offers both campus-based and on-line courses for such training.

The following conversation pertained to the critical care component of the proposal occurred following a brief presentation by the applicant group:

Following the presentation described above Committee member Lisa Pfeil asked the applicants if physician medical directors are going to be willing to put in the extra time to help the applicant group implement these EMS proposals. Dr. Smith responded on behalf of the applicant group by stating that the physician medical directors he knows are “highly engaged” and that he had no doubts regarding their commitment to getting the proposed changes accomplished.

Dr. Teetor asked the applicants if the elements of the critical care proposal are already occurring “out there” in the field. The applicants responded that in some cases this is true, in others, not, but that there can be little doubt that our credentialing processes and systems need to get on top of this situation because new technology is driving EMS services forward whether we like it or not.

Mr. Naiberk asked the applicants if they were only talking about “paid services.” The applicants responded in the affirmative.

Dr. Teetor asked the applicants if RNs are involved or would likely be involved in the new EMS critical care services. An applicant representative responded in the negative vis-à-vis this question.

Discussion on the community para-medicine component of the EMS Proposal

Prior to Committee discussion applicant representative Tim Wilson came forward to present additional information on the community para-medicine component of the proposal. Mr. Wilson described the proposed additional education and training that community para-medicine EMS providers would receive. He also described the nature of the services they would be providing in local communities and how these services would come to fit the unique characteristics of each community by focusing on the following:

- Connecting patients to primary care providers
- Performing post-hospital follow-up care
- Integrating services such as public health, home health systems, and primary care providers
- Providing education and health promotion programs

Mr. Wilson continued his remarks by stating that this approach to the delivery of services would reduce 9-1-1 requests for non-urgent, non-transport services that are not reimbursable, and by decreasing down-time between calls, keeping medical skills exercised and improve access to a community's primary care professionals.

The following conversation pertained to the community para-medicine component of the proposal:

Ms. Wyrens asked the applicants if there are any formal educational opportunities in community para-medicine in Nebraska. The applicants responded that there are no such opportunities but that there are on-line courses available.

Ms.Pfeil asked the applicants how oversight would work given that the services in question would have to be adapted to the unique circumstances of each community. The applicants responded that such uniqueness occurs in EMS all the time, and that the statute and rules and regulations would offer guidance in this regard.

Dr. Meyerle asked the applicants how a community health para-medicine practitioner would be able to judge whether a person with chronic mental health issues should be transported to an ER or to another type of facility or not transported at all. The applicants responded that a para-medicine practitioner would be trained to network with mental health providers in such a situation.

Dr. Teetor asked the applicants at what level--county, town, or region, for example--these services would be directed from. The applicants responded that current service regions would be the appropriate level for such purposes.

Ms. Wyrens commented that the proposal makes a lot of assumptions about admission and readmission issues, and went on to ask the applicants who, under the terms of their proposal, would decide which patient gets admitted--or readmitted--and which would not. The applicants responded that for this aspect of the proposed new services collaboration

with other health professionals would play a big part in how these decisions would be made.

Dr. Meyerle commented that we all have become familiar with the intended consequences of such a concept, but then hastened to add that it's the unintended consequences of implementing such a concept that concerns her.

Committee Actions Taken on the Six Statutory Criteria:

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Critical Care Proposal (1): Voting yes were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no nay votes.

Community Para-Medicine Proposal (2): Voting yes were Naiberk, Baldwin, Temme, and Wyrens. Voting no were Pfeil and Meyerle.

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Critical Care Proposal (1): Voting yes were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no nay votes.

Community Para-Medicine Proposal (2): Voting yes were Naiberk, Baldwin, Meyerle, and Temme. Voting no were Pfeil and Wyrens.

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Critical Care Proposal (1): Voting yes were Naiberk, Baldwin, Meyerle, Temme, and Wyrens. Voting no was Pfeil.

Community Para-Medicine Proposal (2): Voting yes were Naiberk, Baldwin, Pfeil, and Temme. Voting no were Meyerle and Wyrens.

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Critical Care Proposal (1): Voting yes were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no nay votes.

Community Para-Medicine Proposal (2): Voting yes were Naiberk, Baldwin, Meyerle, and Temme. Voting no were Pfeil and Wyrens.

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill of service in a safe manner.

Critical Care Proposal (1): Voting no were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no yes votes.

Community Para-Medicine Proposal (2): Voting no were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no yes votes.

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Critical Care Proposal (1): Voting no were Naiberk, Pfeil, Temme, and Wyrens. Voting yes were Baldwin and Meyerle.

Community Para-Medicine Proposal (2): Voting no were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no yes votes.

Action taken on the entirety of the two components of the EMS proposal occurred as follows:

The committee members took action on the entirety of each proposal vis-à-vis two "up-or-down" votes to determine whether or not to recommend approval of these two ideas for making changes in EMS services.

Critical Care Proposal (1): Voting to recommend approval of this component of the proposal were Naiberk, Baldwin, Pfeil, Meyerle, Temme, and Wyrens. There were no nay votes. By this vote this component of the proposal was recommended for approval.

Comments by the Committee Members:

Naiberk: Education and training of EMS transport personnel will improve as a result.
Baldwin: Transport services will benefit and expertise of EMS providers will improve.
Pfeil: The need was clearly shown as was the plan for education and training.
Meyerle: The need was clearly shown as was the plan for education and training.
Temme: The need was clearly shown.
Wyrens: The need was clearly shown.

Community Para-Medicine Proposal (2): Voting to recommend approval of this component of the proposal were Naiberk, Baldwin, Meyerle, and Temme. Voting not to recommend approval were Pfeil and Wyrens. By this vote this component of the proposal was recommended for approval.

Comments by the Committee Members:

Naiberk: Sees no risk to this concept; Sees opportunity for better utilization of EMS resources.
Baldwin: Sees opportunity for better utilization of EMS resources and development of new skills.
Pfeil: Sees no need for this concept. Sees potential for invasion of privacy.
Meyerle: Collaboration among variety of professionals holds promise of better use of resources.
Temme: Public need was clearly stated and documented.
Wyrens: It's not clear how collaboration would work, also costs were not clearly demonstrated.