NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Board of Emergency Medical Services Meeting Agenda

Date: December 8, 2023

Time:
08:30 a.m. - 10:30 a.m.
Committee Meetings

10:30 a.m. – Open Session
10:40 a.m. – Closed Session
11:30 a.m. – Open Session

Location:
Nebraska State Office Building
Meadowlark Room – Lower Level
301 Centennial Mall South
Lincoln, NE 68509

For Information Contact:
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Tonja.Bohling@nebraska.gov

The Board will be working through the lunch break.

All items known at the time of distribution of this agenda are listed. A current agenda is available at the Department of Health and Human Services, Division of Public Health Office of Emergency Health Systems. If auxiliary aids or reasonable accommodations are needed for attendance at a meeting, please call Tonja Bohling at (402) 471-8129 (voice), or for persons who are deaf or hard of hearing, please call the Nebraska Relay System at 711 (TDD), prior to the meeting date. Advance notice of seven days is needed when requesting an interpreter.

2024 Board Meeting Dates:

Friday, February 9, 2024
Monday, May 13, 2024
Friday July 12, 2024
Monday, September 9, 2024
Friday, December 6, 2024

NOTE: Dates are subject to change

1) Call to Order, Roll Call, and Declaration of a Quorum
   Announcement: "This is a public meeting, and the open meetings law is posted."
2) Adoption of Agenda
3) Approval of September 11, 2023, and October 12, 2023, Minutes
4) Closed Session (approximately 10:40 a.m.)
   Announcement: The board will go into closed session for the review and discussion of investigative reports, licensure applications and other confidential information and for the protection of the reputation of individuals.
   a) Investigation Reports
   b) Applications
   c) Other Confidential Information
   Open session will start approximately 11:30 a.m.
5) Board Recommendations from closed session
6) Concussion Presentation (Dr. Katie Higgins, Dr. Todd Caze)
7) Office of Emergency Health Systems
   a) Licensing (Wilson)
   b) EMS Program (Jorgensen)
   c) Education & Training Agency Compliance (Snodgrass)
   d) Emergency Medical Services for Children (Kuhn)
   e) Critical Incident Stress Management (Kuhn)
   f) Trauma System (Bailey / Wren)
   g) Stroke/STEMI System (Neumiller / Wilson)
   h) EHS Data Systems (Steele / Wilson)
      i) RFP for EHS Data Systems
   i) Statewide Physician Medical Director Update (Ernest)
8) EMS Board Committee Reports
   a) Legislation and Rules and Regulations (Smith)
      i) Meeting with Governor
   b) Scope of Practice (Fiala)
      i) Model Protocol Revision (Fiala / Ernest)
      ii) Proposed changes/additions/deletions (Fiala)
      iii) Law Enforcement K9 Transport
   c) EMS Education (Bowlin/Hovey)
   d) EMS Workforce (Cerny)
9) NSVFA Update (Cerny)
10) NEMSA (Bowlin)
11) EMS Training Agencies (Fuehring)
12) EMR Discussion (Smith/Wilson)
   a) NHTSA National Emergency Medical Service Scope of Practice Model
   b) National Emergency Medical Services Education Standards
   c) State Data
   d) Discuss the Idaho Information
   e) Discuss CMS Regulations and third-party payor.
   f) Liability – Public Health and Safety
13) Executive Committee Elections (Smith)
14) 2024 Board Meeting Dates (Smith)
   a) Proposed 2024 dates: Friday, February 9; Monday, May 13; Friday July 12; Monday, September 9; Friday, December 6.
15) Meeting Postings Locations (Smith)
   a) NOTE: Current Postings are on the OEHS website, sent through OEHS contacts, and through the newsletter.

16) Public Comment
17) Adjourn

EMS Board agenda packet for public use:
https://dhhs.ne.gov/OEHS%20EMS%20Board%20Documents/EMS-Board-Agenda.pdf

JOIN MEETING LINK:
https://sonvideo.webex.com/sonvideo/j.php?MTID=m47a644bec2f5b05035024538fa32189e
Meeting number: 2493 697 3121
Meeting password: jUMvE2yG9d6

NOTE: If you join the meeting and get a message stating, **"Meeting is Locked"** or **"Meeting has not Started",** this means that the Board is still in closed session, please try joining in a few minutes.

MINUTES OF THE MEETING
of the NEBRASKA
BOARD OF Emergency
Medical Services

Monday, September 11, 2023

CALL TO ORDER

The meeting of the Nebraska Board of Emergency Medical Services was called to order by Dr. James Smith, Board Chairperson, at 10:37, Monday, September 11, 2023 at the Nebraska State Office Building Lower Level Meadowlark Conference Room, Lincoln NE 68508. Copies of the agenda were emailed in advance to the Board members, emailed to interested parties, and posted on the Department of Health and Human Services website on Tuesday, September 5, 2023. Smith announced the location of an available copy of the Open Meetings Act within the room.

ROLL CALL

The following board members were present to answer roll call:

- Michael Bailey
- Ryan Batenhorst
- Noah Bernhardson
- Randy Boldt
- Karen Bowlin
- Joel Cerny
- Todd Hovey
- Linda Jensen
- Jonathan Kilstrom
- Brent Lottman
- Dion Neumiller
- Dr. James Smith
- Leslie Vaughn Jr.

The following Board members were absent:

- Ann Fiala
- Prince Harrison
- Carolyn Petersen
- Michael Sheridan

The following staff members from the Department and the Attorney General's Office were also present during all or part of the meeting:

- Tonja Bohling
- Christy Duryea
- Carol Jorgensen
- Anna Harrison, *Compliance Monitor*
- Trevor Klaassen, *Licensing Investigator*
- Mark Meyerson, *Licensing Investigator*
- Mindy Lester, *Assistant Attorney General*
- Wendy Snodgrass
- Sharon Steele
- Edith Titamoh
- Tim Wilson
- Sherri Wren

A quorum was present, and the meeting convened.

ADOPTION OF THE AGENDA

MOTION: Bernhardson made the motion, seconded by Bowlin, to adopt the agenda for the September 11, 2023, Board of Emergency Medical Services meeting with the change of moving the closed session toward the end of the meeting due to Investigations having another board meeting at the same time.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Fiala, Harrison, Petersen, Sheridan. Motion carried.

APPROVAL OF THE MINUTES

Dr. Smith mentioned 9/11/2001 and those who EMS workers and families who sacrificed. A moment of silence was had in remembrance of those who gave their lives.

MOTION: Boldt made the motion, seconded by Jensen, to approve the minutes of the July 7, 2023 meeting.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Fiala, Harrison, Petersen, Sheridan. Motion carried.

AGENDA ITEM: Office of Emergency Health Systems

Program reports were submitted for Board review prior to the meeting and were in the portal.

Licensing: Tim added to the written report submitted. The Department wants to put together a couple of educational classes to cover the the new rules and regulations that took effect this year. Beginning in October there will be a change of expiration dates. For EMTs renewal will be changed to March 31, 2024. Postcards go out in January. All other levels will have an expiration date of March 31, 2025. Licensing has been busy with new applications. Several services are switching ownership or upgrading their licensing level. Additional duties have been transferred over to Christy to help distribute workload. Grants highlights: An EMS assessment is in process and the Department is scheduling two in-person meetings in each region for the stakeholders. Participation is encouraged for those interested. This will supplement the surveys sent out to get a feel for the pulse of EMS in Nebraska.

Another project being worked on by Tim Wilson and Carol Jorgensen is targeting services across the state for telehealth. The Department is currently waiting for signature on the contract. The Department currently has a vendor that will install telehealth equipment and provide telehealth services. This will help supplement staffing within EMS moving forward. This will be a lifeline for EMS in the field to get ahold of paramedics, RNs, or physicians for medical advice, documentation, coordination with flight or receiving facilities. This is a pilot project funded for one year. The Department's hope is to show proof of concept and find future funding so it can be extended beyond the one year. South Dakota has shared their data on how it all works. The Department will send out information and be contacting people. There will be a quick turnaround. Currently the contract is in legal review and Tim should have it in 2-4 weeks.

Wilson addressed the funding issues in the Office of Emergency Health Systems. Fifty Cents For Life is a cash fund providing funding to the OEHS. This fund supports EMS, Trauma, CISM, and EMSC. EMSC is primarily funded by grants. The Department has been able to secure some additional funding for operation for the next two years. Due to the funding issues, the Department was not able to obtain money for all OEHS staffing. The OEHS will be loosing a Trauma Registrar. The remaining staff will have to pick up the slack managing the trauma registry and the data collection points.

a. EMS Program: No updates beyond the written report.

b. Education and Training Agency Compliance: Snodgrass gave an update in addition to written report. There were 13 participants at the leadership class. It will be hard to justify holding future leadership classes with such low attendance. It was moved to a five-day session, but it did not really make a difference. The class coincided with Flatrock, which may have affected attendance

some. The class ended yesterday and feedback has not been returned as of yet . Wendy will share feedback from evaluations at the next Board meeting. She also put in for funds for another leadership class in hopes of getting more attendees. Karen Bowlin added it is a great class. It is a shame attendance is as low as it is. Dr. Smith commented everyone has great things to say about the class so he doesn't know if it is a time commitment issue, a seasonal issue, or a time format issue ie. 3 days versus 5 days versus week-long. Paid services are also utilizing the class.

Snodgrass also added a simulation rooms update: Four rooms are currently being installed: one each in Scottsbluff, Norfolk, North Platte, and Mid Plains – a total of six are designated to be installed across the state. One agreement was signed and one is pending signatures. These are tied to community colleges and one at Creighton. Ryan Batenhorst added these rooms are 14'X14' in size and very interactive. Snodgrass also commented these rooms are funded by the CDC Health Disparity Grant. The project was a little over $1 million of awarded funds. Funding also covers additional maniquines, I-simulate/cardiac monitors, or other additional equipment as needed. Dr. Smith asked how tracking will be done regarding whether this helps with pass rates or how it will be utilized. Snodgrass answered usage data will start being collected and types of users, ie. initial, Continuing Education, EMS, nursing, etc. and once they get going, draw a line and see where the cognitive pass rates go from there and see if there is any correlation. Also, collection of retention data will be done to see if there is any change there.

Dr. Smith stated the challenge as medical directors is annual competencies. Smith asked the status of the SIM-NE trucks. Wendy responded the trucks have been hitting 5-6 stops per month across the state. Dr. Smith suggested maybe these rooms could be leveraged by medical directors and utilized to help with annual competencies. Bailey commented any time the simulator trucks and rooms can be used is great. The biggest thing is getting the interaction between hospitals and the EMS squads. The more we continue to grow that team, the better results we have in the field, especially communication back and forth and information coming back to EMS. Dr. Smith asked who pays for the trucks to go somewhere or how is it reimbursed? Volunteer services are free, but some paid services are charged for the use of the trucks. There is an online request form that is filled out to reserve the trucks. Tim commented that for the simulation rooms, OEHS helped with the initial purchase and the incorporation of the rooms is just into their normal business model. The simulation rooms are for all health care professionals they would teach.

Dr. Smith brought up the need to find a solution to have classes for EMS education similar to the Fire Service education. Challenges include lack of instructors, location, and time. He proposed the possibility of having a statewide EMT class that moves around to different regions to share travel and has virtual option as well. Wendy posed questions of what training agency would it be through? What about the community college boundaries? Dr. Smith suggested boundaries are inhibitory to being successful here. If training agencies want their boundaries, maybe use agencies that do not have boundaries and let the market drive the process and let the buyer beware. Discussion was had. Points highlighted were: Nebraska does not have a high count of EMS instructors across the state; for EMS Instructor recruitment, a primary instructor has to be identified in a facility; college boundaries are not set by the community colleges, but are set by the Governor; ¼ of the licensed EMS instructors will teach certification classes, the rest teach continuing education (the education committee was going to look into how to bring up the certification number); Dr. Smith suggested the schools collaborate and teach a class together to get around the boundary issue – possibly putting together a memorandum of understanding and sharing a pool of instructors in the region and using the new simulation lab resources, etc. Bowlin added some questions colleges will have are regarding registration and who will get the money, and whose curriculum will be used. Dr. Smith also suggested this issue be explored more in-depth by the education committee. Batenhorst suggested offering an online class and having the simulation trucks come from their areas to create that lab opportunity. Snodgrass commented the Training Agency Director's Group is being restarted for better collaboration between training agencies. Todd Hovey

and Karen Bowlin are going to ask to be included in on the Training Agency Director's Group meetings.

c. Emergency Medical Services for Children (EMSC) Program: Wilson reported there are no additions to what Debbie Kuhn submitted in her written report. He did note the Carter Kits need to be picked up and removed from OEHS office; if servics did not complete training for them yet and have a PECC designated, please get this done. The EMSC grant was renewed and there is some carry over funding the Department will be doing additional projects with this upcoming year.

d. Critical Incident Stress Management (CISM) Program: Wilson reported there is nothing different than what Debbie put in her report. CISM has been swamped with requests this last month and have had a record number of activations again, as they have for the last four years or so. Dr. Smith commented it would be nice to have data presented at the next meeting to compare and see how number of activations has gone up. Wilson also commented a lot of peers are poised to retire soon from CISM teams; those retiring are also some of our most active members and this will be potentially a big issue.

   Wilson spoke on the Code Red System. Code-Red sends messages to all peers in the region about debriefings and they respond back if they can make it or not. This is very beneficial for scheduling of the debriefings. Requests are up significantly. There were, during a one-week period, eight activations. Nebraska is one of the few states in which CISM is codified into our Statutes. Recently, a survey has been implemented post-debriefing to get feedback. Data is starting to come in from that. A typical CISM debrief is about one hour long, but depends on how many people or what is going on. This is all volunteer with mileage reimbursed. This volunteer basis is a barrier, especially with mental health. The funding source to reimburse CISM volunteers is through grant money for CISM. The Nebraska State Patrol also helps reimburse for the mileage. There is continuing education for the peers. The instructor count needs to be increased so there can be better peer-to-peer education.

e. Helmsley AED Project: Becka reported 105 uses and 15 known saves this year. The officers are overwhelmingly thankful they have the AEDs. This project is strictly involving law enforcement.

11:27 a.m. *Jensen left.*

11:30 a.m. *Jensen returned.*

f. Trauma Program: Sherri added to her written report. Winnebago and Cozad are showing great interest in designation again.

   The challenge next year will be spending $60,000 for training from the PHHS Block Grant. Class attendance is a struggle. You try to encourage people to take classes and they don't atttend or don't submit all the paperwork in time.

   The Trauma Nurse Coordinator Conference in June in Lincoln went well, with 85 participants and around 60 of them in-person. The 2024 TNC Conference will be held at Great Plains Regional in North Platte.

   The loss of the registrar position due to lack of funding has been a hard loss for the Trauma Program. The Department wants the program to do performance improvement and planning which will be hard to do without a registrar. There is a transition meeting scheduled for next week to see what the former registrar, Andrew Ngochoch, did and see what current staff can carry as far as his workload.

11:36 a.m. *Bernhardson left.*

11:38 a.m. *Bernhardson returned.*

g. Stroke/STEMI Program: Becka Neumiller reported nothing new other than what was submitted on her written report.

11:42 p.m. *Harrison joined.*

h. EHS Data Systems: Tim updated the Board on the Request For Proposal for the Data System. It is at Department of Administrative Services for review and he hopes to have it back this week. He added although there is staffing turnover in administration, we still have to get administrative authorization to post. This shouldn't be an issue as there are Statutory requirements in both EMS and Trauma to keep and maintain the data system.

Sharon Steele presented a Power Point presentation on National Roadway Safety Strategies. There were 5 objectives: safer people, safer vehicles, safer roads, safer speeds, and post-crash care. Post-crash care is what Steele focused on, with the main focus on enhancing survivability of individuals involved in crashes. The outreach campaigns were: To develop and implement a plan for EMS personnel for on-scene safety, advance Traffic Incident Management (TIM) Training and Technology, expand the use and support of NEMSIS by funding applied to research and data quality improvement, improve the delivery of EMS rapid nation, and focus on shortening ambulance on-scene response times. Performance measures looked at for the State of Nebraska are as follows: use of ICD ten-codes specifically related to motor vehicle crashes, use patient incident disposition, the incident had to be a 911 call.

Bernhardson asked what the data was looking at for scene-time, if they were looking at ambulance arrival or first arriving unit? This was derived from what is indicated on the patient care record. Wilson commented that particular correlation was not looked at. Bernhardson commented another thing learned from QA is scene-time varies based on the interventions used and maybe what interventions are delaying scene-time needs to be looked at in the future. Tim commented Traffic Safety Funding is being used this year. EMS and Trauma Registry are two different components and were not correlated. He also mentioned Department staff is busy, but there may be a possibility next year to hire an intern or temporary staff member to work on collecting this data. Dion Neumiller asked how many crashes was the report referencing? Sharon said she didn't have that information right off as this data set just pulls 911 calls for all of 2022 and it will take her a while to pull all that data. Discussion arose regarding documentation of intervention. Wilson said there are training issues on documentation; these are issues that need to be addressed globally. This is an initial step of data collection – the biggest thing learned is the Department has a need for a full-time data analyst.
This is an overall starting point. We now have the data, so now we need to look at how are we going to use this to improve care.

11:51 a.m. *Kilstrom left.*

11:54 a.m. *Kilstrom returned.*

i. Statewide Physician Medical Director Update: Dr. Ernest reported protocol revision is 90% done and would circle back to the Scope of Practice Committee. Education content for the EMSC medical directors course will be looked at once the protocol revisions are done.

Break to grab lunch then working through lunch 12:05 p.m.-12:15 p.m.

AGENDA ITEM: EMS Committee Reports

Dr. Smith gave a brief update on the Governor's Volunteer First Responder Summit in Broken Bow. Jerry is going to send a summation to Dr. Smith. Tim Wilson wants to maintain the momentum with the partners around the table. He has some Rural Health Flex Grant funding he can apply to keep the EMS conversation going.

a. Legislative/Rules and Regulation Committee Update: Dr. Smith gave a report. Relative to community paramedicine, one of the goals is to enable community paramedicine processes. Hospitals may drive this process in general. We can engage with Medicaid to take the first step with reimbursement with paramedicine followed by insurance companies. Wilson is going to start this dialogue with that department. The PHHS Grant has $30,000 for education for community paramedicine instructors.

   Dr. Smith advised there is an open window to make some changes in the rules and regulations. Wilson commented these will be opened up due to changing from version 3.4 to 3.5 of the data standards which affects the Data Dictionary. In order for those to be enforceable, the regulations have to be opened to update with the most recent version of the Data Dictionary. He encouraged Board members to start looking at the rules and regulations for any needed changes.

   Dr. Smith broached the biggest talking point in the Legislative Committee and at the Summit in Broken Bow was funding for EMS as an essential service. The only way this will happen is if the Board engages with the following to educate them on what the issues/problems/solutions are: the Governor's Office, Legislators, and Lobbyists of the Governor's Office/Legislators. In order to allow Board members to do this, Board permission is needed.

12:25 p.m. Boldt left.

MOTION: Mike Bailey made the motion, seconded by Linda Jensen to authorize members of the Legislative Subcommittee of the EMS Board to engage with Legislators, the Governor's Office and Lobbyists relative to educating them of potential upcoming legislation for the duration of the next legislative session.

Discussion was had. It was brought up there will be designated people and talking points and these people will report their findings back to the Board.

Voting Yes: Bailey, Batenhorst, Bernhardson, Bowlin, Cerny, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Boldt, Fiala, Harrison, Petersen, Sheridan. Motion carried.

b. Scope of Practice Committee Update: Linda Jensen reported, the topic of Glucagon came up in committee discussion. Dr. Smith summarized, as a point of clarification, it is the Board's opinion based on previous discussion, it is allowable for EMTs who have the proper training to draw up and administer Glucagon.

   Mike Bailey discussed concussion training. He would like to invite Dr. Kate Higgins, Neurologist with UNMC and Nebraska Athletic Department at the NCAA level, to speak at the next Board meeting on December 8, 2023 on collegiate athlete concussions. No motion is needed for this so Bailey will contact and ask.

12:35 p.m. Boldt returned.

   i. Model Protocol Revision - The use of mechanical CPR devices by EMRs was discussed during this subcommittee meeting. Statutes state they cannot be used, but verbiage is very grey.

MOTION: Noah Bernhardson made the motion, seconded by Mike Bailey, it is the position of the Board EMR use of Mechanical CPR devices is within their skills of practice based off of our understanding of national scope and educational guidelines.

Discussion was held. Bowlin asked how it will fit into the National Education Guidelines? How is this going to be passed on to the training agencies? Tim Wilson will ask Department Legal to review this in light of scope before sending it out.

The motion was amended to "Pending Department approval, it is the position of the Board EMR use of Mechanical CPR devices is within their skills of practice based off of our understanding of national scope and educational guidelines."

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Fiala, Harrison, Petersen, Sheridan. Motion carried.

The following questions were brought up - Is it going to cause issues if you have traumatic damage to the chest? Will this do more harm than good? Boldt added the Lucas device is the most dangerous. Clarification was made by Dr. Smith the motion is specifically for a mechanical CPR device. Mike Bailey will bring up at the next Trauma Board meeting in November.

ii. Protocol Changes/Additions/Deletions & Protocol Discussion (PMD Changes, etc.) - No report due to Ann Fiala's absence.

c. EMS Education Committee: Karen Bowlin gave an update. The Education Committee reviewed the points of a study and came up with two main points: 1) Evidence-based EMS teaching methods 2) Instructor Competencies

The Committee is going to look into current instructor courses and see how these are done in other states. There are not a lot of current instructor courses so they are going to do more research on that. They will also look at bring up continuing education courses for instructors. Another issue they are going to look at is why many instructors do not teach credentialling classes, they only teach continuing education.

d. EMS Workforce Committee Update: Joel Cerny updated the Board. The Workforce Committee is anxious to look at the results of the survey that went out. There is a need to get out to the public what the EMS workforce needs are. They discussed how to get more EMT training into the highschools. Broken Bow, McCook, and Imperial have some good programs and the Committee should reach out to them. The Committee also talked about leadership issues. He also spoke on retention and having the Department possibly sending out award certificates for 5 years/10 years/20 years, etc. Wilson talked to the Committee about Rural Health Grant funding.

12:55 p.m. Klaussen joined.

AGENDA ITEM: POLST Discussion

Jacob Dahlke, Director of the Office of Healthcare Ethics at Nebraska Medicine and State Representative for the National POLST Collaborative for the State of Nebraska presented a discussion on POLST: Portable Medical Orders. The two things he is looking for from the EMS Board are to 1) gain some clarification and validate POLST is a valid, durable, transportable medical order that can exist outside of a hospital setting; and 2) be able to provide some support for how to get this information out to appropriate bodies.

He gave a brief background.

In 2021 NHPCA (Nebraska Hospice and Palliative Care Association) took over POLST. Its key strength is it is part of a national template/form, making POLST reciprocal with any program that interacts with it in many states. Nebraska uses the national POLST template. There are three parties that interact with the POLST form: the patient, their physician, and EMS providers. It is ideally a tool that provides a better way

for EMS providers to obtain information before arriving on scene. There are gaps between current state and ideal state. These gaps can be bridged primarily through education provided by POLST. They offer educational webinars. Ideally there would be an opt-in web-based registry of POLST forms that would be accessible to physicians, patients, and EMS providers, etc. Currently there is a paper version. The process starts with conversation between physician and patient, complete the form/medical order set, there is a distribution (scanning med records, put into Care Everywhere, or a webased registry, patient would have a copy to take home), and then orders on POLST form would be carried out.

The goal is to have the Board recognize POLST as an option and have conversations to integrate in Nebraska.

The Nebraska Hospice and Palliative Care Association has a calendar of webinars.

Dr. Smith recommended to have the report sent to him and he will send copies the Board and to the Protocol Committee for review.

1:10 p.m. *Batenhorst left.*

CLOSED SESSION

MOTION: Kilstrom made the motion, seconded by Bowlin, for the Board to go into closed session for the purpose of reviewing and discussing investigative reports, licensure applications, and other confidential information, and for the prevention of needless injury to the reputation of the individuals.

Voting Yes: Bailey, Bernhardson, Boldt, Bowlin, Cerny, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Batenhorst, Fiala, Harrison, Petersen, Sheridan. Motion carried.

1:11 p.m. *Meeting went into closed session.*

1:13 p.m. *Batenhorst returned.*

1:17 p.m. *Neumiller left.*

1:19 p.m. *Neumiller returned.*

1:37 p.m. *Hovey and Snodgrass left.*

2:03 p.m. *Hovey and Snodgrass returned.*

2:20 p.m. *Vaughn left.*

2:23 p.m. *Vaughn returned.*

2:25 p.m. *Lester, Klaussen, Meyerson, A. Harrison, Bernhardson, and Kilstrom left.*

2:26 p.m. *Meeting returned to Open Session.*

OPEN SESSION

MOTION: Lottman made the motion, seconded by Bailey, for the Board to go into open session.

Voting Yes: Bailey, Batenhorst, Boldt, Bowlin, Cerny, Hovey, Jensen, Lottman, Neumiller, Smith, Vaughn. Voting No: None. Abstain: None. Absent: Bernhardson, Fiala, Harrison, Kilstrom, Petersen, Sheridan. Motion carried.

2:30 p.m. *Kilstrom returned.*

AGNEDA ITEM: Board Recommendations from Closed Session

– None

AGENDA ITEM: Nebraska State Volunteer Fire Association (NSVFA)

Cerny gave a report on NSVFA happenings. NSVFA will be sending firefighters to Symposium in the Sun in Clearwater Florida on November 9-12, 2023. The annual meeting will be held in South Sioux City on October 19-21, 2023. On Thursday, Oct. 19 there will be leadership training by Douglas Klien. Tim Wilson will also be speaking on Friday. Expenses, for those eligible, will be paid by the Safer Grant. Interested people can register at NSVFA.org. The State Association is helping Nebraska Public Media with a program called "Working Fires" to air publically at the end of October, 2023. This is about volunteer firefighter and EMS departments in Nebraska. A preview of the show will be shown at the Annual Conference

AGENDA ITEM: Nebraska Emergency Medical Services Association (NEMSA)

Amy Santos gave an update. Marlene Bomar went to Broken Bow to meet with the Governor. A mini-conference will be held in Murray, NE on October 14, 2023. Also, a mini-conference is scheduled in Broken Bow in January, 2024. Dr. Shayla Coffey, who is part of the NEMSA Board now, and Dr. Compost are working on a three-hour Physician Medical Director (PMD) training course to be piloted at the January, 2024 conference in Broken Bow. This will touch on the duties of an EMS Service PMD. Another topic will be on scopes of EMTs, EMRs and Paramedics. They will also talk through and develop a QA plan for those services they will be directing.

March Super Conference will have a "Tool-Day" Medical Director Training. Medical Director Day will be on a Saturday.

Dr. Shayla Coffey added the intent is to better educate the PMDs on EMS. The January meeting will be in-person only with the goal of eventually having a virtual option. Dr. Smith suggested contacting American College of Emergency Physicians (ACEP) for a list of Medical Directors.

AGENDA ITEM: PUBLIC COMMENT

Michael Dwyer, with the Arlington Fire & Rescue and Nebraska State Volunteer Fire Association – Legislative Committee commented CISM is really critical from both the mental health and a retention perspective.

Dwyer commented Sharon's presentation was a good conversation about data. He commented call to scene and response times were not included in the data from the PowerPoint presentation. This data is a good guage of the success of an EMS system/area and should be included in data.

A Legislative reminder: LR203 (Senator Dorn's bill) will be heard on October 25, 2023. This bill specifically speaks to EMS. Although it has not been made public, approval to share this information with the Board was given by Senator Hansen, Chairman of the HHS Committee.

The State Fire Marshal's Office solicited Dwyer to do a research on EMS in Nebraska and a few surrounding states. He shared his findings report on this research. He conducted 29 interviews of 50 people over 3 months of work. South Dakota is doing really innovative things, Kansas EMS is rough. He said through all the research, he did not find any model in the country that is doing EMS well, so Nebraska has an opportunity to lead in this realm. From the interviews, he came up with a list of 20 ideas. The top two issues are Leadership and National Registry. He will send the report to Tim Wilson and Wilson will get it out to all the board members.

Smith commented leadership issues keeps rising and National Registry is not going away. Concerns Smith brought up were the sample-size/end value and selection bias. We need to keep in mind this is a

small group of people that are very passion about it. Dwyer stressed Fire and EMS need to work together and be unified with regard to going to the Legislature.

Discussion of National Registry was held.

2:48 p.m. *Boldt left.*

CONCLUSION AND ADJOURNMENT

There being no further business, the meeting adjourned at 3:04 P.M. by Dr. Smith.

Respectfully submitted,

Tonja Bohling
OEHS Administrative Technician

MINUTES OF THE MEETING
of the NEBRASKA
BOARD OF Emergency
Medical Services

Thursday, October 12, 2023

CALL TO ORDER

The meeting of the Nebraska Board of Emergency Medical Services was called to order by Dr. James Smith, Board Chairperson, at 10:04 a.m., Thursday, October 12, 2023, This meeting was held via Zoom. Copies of the agenda were emailed in advance to the Board members, emailed to interested parties, and posted on the Department of Health and Human Services website on 10/3/2023.

ROLL CALL

The following board members were present to answer roll call:

- Michael Bailey
- Ryan Batenhorst
- Dr. Noah Bernhardson
- Randy Boldt
- Karen Bowlin
- Joel Cerny
- Ann Fiala
- Todd Hovey
- Linda Jensen
- Jonathan Kilstrom
- Brent Lottman
- Dion Neumiller
- Carolyn Petersen-Moore
- Dr. James Smith
- Leslie Vaughn

The following Board members were absent: Dr. Prince Harrison and Michael Sheridan.

The following staff members from the Department were also present during all or part of the meeting:

- Tonja Bohling
- Christy Duryea
- Shanerika Flemings, *DHHS Attorney*
- Wendy Snodgrass

A quorum was present, and the meeting convened.

ADOPTION OF THE AGENDA

MOTION: Bailey made the motion, seconded by Fiala, to adopt the agenda for the 10/12/2023, Board of Emergency Medical Services meeting.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Petersen-Moore, Smith, and Vaughn. Voting No: None. Abstain: None. Absent: Harrison and Sheridan. Motion carried.

CLOSED SESSION

MOTION: Bernhardson made the motion, seconded by Boldt, for the Board to go into closed session for the purpose of reviewing and discussing investigative reports, licensure applications, and other confidential information, and for the prevention of needless injury to the reputation of the individuals.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Petersen-Moore, Smith, and Vaughn. Voting No: None. Abstain: None. Absent: Harrison and Sheridan. Motion carried.

10:10 a.m. *Meeting went into closed session Fiala presiding.*

10:11 a.m. *Dr. Smith left.*

10:15 a.m. *Vaughn left.*
10:18 a.m. *Vaughn returned.*
10:40 a.m. *Bowlin left.*
10:55 a.m. *Bowlin returned.*
11:03 a.m. *Dr. Smith returned.*

11:03 a.m. *Meeting returned to Open Session.*

OPEN SESSION

MOTION: Bernhardson made the motion, seconded by Bailey, for the Board to go into open session.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Hovey, Jensen, Kilstrom, Lottman, Neumiller, Petersen-Moore, and Vaughn. Voting No: None. Abstain: None. Absent: Harrison, Sheridan and Smith. Motion carried.

LICENSURE RECOMMENDATIONS

PIONEER AMBULANCE SERVICE DBA MEDICS AT HOME – ADVANCED LIFE SUPPORT LICENSURE INITIAL APPLICATION

MOTION: Bernhardson made the motion, seconded by Hovey, to deny the application for Initial Advanced Life Support Licensure of Pioneer Ambulance Service DBA Medics At Home.

Voting Yes: Bailey, Batenhorst, Bernhardson, Bowlin, Cerny, Fiala, Hovey, Kilstrom, Lottman, Neumiller, Petersen-Moore, and Vaughn. Voting No: None. Abstain: Boldt, Jensen, Smith. Absent: Harrison and Sheridan. Motion carried.

PUBLIC COMMENT

Dr. Smith reminded everyone the next meeting is December 8, 2023 and also reminded of subcommittee meetings beforehand the meeting.

Dr. Smith commented he was invited to speak with the Governor on October 19, 2023 about the status of rural EMS.

CONCLUSION AND ADJOURNMENT

There being no further business, the meeting adjourned at 11:07 a.m..

Respectfully submitted,

Tonja Bohling

Tonja Bohling
OEHS Administrative Technician

Concussion Awareness & Recognition

Kate Higgins, PsyD, ABPP
Board Certified Clinical Neuropsychologist
Husker Athletics
Nebraska Medicine Concussion Clinic

IN OUR GRIT, OUR GLORY™

Caze Concussion Institute

Todd Caze, PhD
Sport Neuropsychologist
Caze Concussion Institute

CONCUSSION IS A RELATIVLEY COMMON INJURY

- 33 million children worldwide annually sustain a concussion (Davis et al. 2017)
- Almost 30% of US adults report experiencing at least 1 concussion in their lifetime (Daugherty et al., 2020)

- Estimated yearly impact of $17 billion in health care costs (CDC, 2017)

EARLY IDENTIFICATION IMPERATIVE FOR RECOVERY

- Receiving specialty concussion care ≤7 days improves recovery (Eagle et al., 2020; Kontos et al.,2020)
- Patients receiving delayed clinical care were 6x more likely to experience a prolonged recovery (Kontos et al., 2020).

EMERGENCY MED PROVIDERS ARE UNIQUELY POSITIONED

- Initiate early recognition and education
  - *touchpoints with rural communities and populations that might otherwise go undiagnosed, such as victims of domestic violence*
  - *even without diagnosing, EMT/first responders can orient downstream providers to concerns for a concussion*

THE VESTIBULAR AND OCULAR MOTOR SCREENING

An accessible, objective and evidence-based screening tool

Vestibular/Ocular Motor Test:	Not Tested	Headache 0-10	Dizziness 0-10	Nausea 0-10	Fogginess 0-10	Comments
BASELINE SYMPTOMS:	N/A					
Smooth Pursuits						
Saccades – Horizontal						
Saccades – Vertical						
Convergence (Near Point)						(Near Point in cm): Measure 1: _____ Measure 2: _____ Measure 3:
VOR – Horizontal						
VOR – Vertical						
Visual Motion Sensitivity Test						

SUPPORT FOR THE VOMS

(Eagle et al., 2021)

- MDC for visual tasks ≥1

(Eagle et al., 2021)

- MDC for vestib tasks ≥ 2

Ferris et al., 2022

- Greatest diagnostic utility of any current tool
- AUC= .85; Sensitivity= 77%; Specificity= 83%

Kate Higgins, PsyD ABPP
402-239-0932
khiggins@huskers.com

Todd Caze, PhD
402-235-8086
cazeinstitute.com

Office of Emergency Health Systems Reports

a) EMS Licensing Report (Wilson)

- Licenses Issued:

Licensure Level	YTD Licenses Issued	YTD Average Days to Issue	Sept to November Licenses Issued	Sept to November Average Days to Issue
AEMT	14	20	0	0
EMS Advanced Service	4	84	2	31
EMS Basic Service	4	41	0	0
EMS Instructor	29	11	4	4
EMT	453	24	89	25
Emergency Medical Responder	22	4	2	10
Paramedic	114	23	48	20
Total:	640	23	145	23

- Other Activities:
  - Working on scheduling informational session on regulatory changes
  - Reminder that all EMTs renew March 31, 2024

b) EMS Program (Jorgensen)

- The EMS Program has made 504 individual EMS contacts in January, 491 in February, 566 in March, 373 in April, 356 in May, 351 in June, 388 in July, and 519 in August, 301 in September, 435 in October for a total of 4,284 individual contacts in 2023. (Count does not include others assisted such as hospitals, EMS training agencies, etc.) These individual contacts are largely due to their need for technical assistance.
- The number of licensed EMS services are below:

Western	67
Central	103
Northeast	119
Southeast	130
Total	419

- EMS service periodic inspections are continuing across the state. We have also done some initial inspections of a few services that are changing license levels or changing ownership.
- We have hired Bruce Meier as the new Western Region EMS Specialist. He has an office in the DHHS office building in Scottsbluff. We are excited to have Bruce part of the EMS Program.

- As part of the Nebraska EMS statewide assessment, EMS listening sessions were held in October by SafeTech Solutions. Two in-person listening sessions were held in each of the four EMS regions. SafeTech Solutions is hopeful to have a report to the Office of Emergency Health Systems some time in December 2023. Thank you to all that completed the surveys or attended a listening session.
- A Telehealth in EMS Demonstration Project is going to begin in Nebraska. A few services will be participating in a one-year project. AVEL e-Care is the company that will be installing equipment in the back of ambulances and conducting training for those services. We look forward to getting this started and to collect data to quantify the benefits of an EMS telehealth system in Nebraska.
- PHHS Block Grant: Funding cycle began on 10-1-2023 and goes through 9-30-2024: Approved for $30,000 to fund a community paramedicine instructor course and community paramedicine provider level courses.

c) Education and Training Agency Compliance (Snodgrass)

- All agreements are in place for the six sites for the simulation project. Five sites have started and/or have finished installation.
- The four training agency inspections scheduled for this year have been completed.
- Working with the EMSC program to host pediatric education for EMS providers. Training will be provided online and in person covering safe transport of children with the Pedi-Mate, obtaining basic vital signs/assessment, and the Handtevy provider course.
- Starting work on the EMS pre-course video. This will be an informational video outlining the commitment needed for an initial EMS course.
- Assisting training agencies and providers on the new regulation changes.
- Starting work on the 2024 monthly Zoom continuing education class schedule. I'm always looking for topics and presenters.

d) Emergency Medical Services for Children Program (Kuhn)

- The EMSC Program is moving forward with the Pediatric Readiness hospital recognition project. EMSC was asked to host a booth at the ENA conference in October. Diane, Becka and Sharron Lubbers provided information on the National Peds Readiness Project (NPRP), Trauma, Stroke & STEMI and CISM. Diane and Becka have agreed to leave Peds Readiness application packets with hospitals when they do their visits.
- The Midwest EMSC Committee is offering an EMS symposium on November 2, 2023 and November 9, 2023 for nursing staff with various speakers for both. CEU's for nurses will be provided through Minnesota Children's Hospital.
- EMSC is sending out a letter to services that indicated they had a Pediatric Champion on the ambulance assessment. The letter will provide directions for a 1-hour training on Spectrum Disorders-Autism. A Carter Kit will be provided to those services that complete the training.

e) Critical Incident Stress Management Program (Kuhn)

- CISM requests are up again his year. We are offering a Zoom class Group Intervention course as an alternative for the training. The training will be conducted over four days and 3.5 hours each day.
- The CISM Program continues to partner with UNMC – College of Nursing to develop, enhance and promote continuing education to nursing staff. Their grant aims are to enhance the support

of hospital nurses and personnel who deal with crisis incidents that may have lasting psychological impact. UNMC – College of Nursing is providing continuing education credit for nurses, nurse practitioners, psychologists, and all social workers. The goal of this partnership is to increase hospital personnel as CISM members that would be willing to be available to respond to a request in hospitals to conduct an intervention session for those involved in crisis situations.

- The emergency response notification system has been active for a couple of months and seems to be working well. New badges have made and distributed to team members.
- The 2023 Statewide CISM Conference was held in September with about 45 people in attendance. Discussion was held about moving the conference around the state instead of holding in Grand Island or Kearney.
- Nebraska CISM offered a program on PTSD vs Moral Injury on Zoom to all ambulance services and fire departments. About 100 people participated in the training.
- We are in the process of setting up the 2024 CISM training and are always in need of new members.

f) Trauma System Program (Wren)

- *Trauma Center Designations:*
  - 52 Trauma Centers Designated

    Designations:

    Great Plains Regional, North Platte (General) – Region 3

    Cherry County Hospital – Valentine (Basic) – Region 3

    Pending**:**

    Providence Medical Center, Wayne (Basic) – Region 1

    Grand Island Regional, Grand Island (Basic) – Region 3

- *2023 Upcoming Trauma Center Designation Visits:*
  - Memorial Hospital, Pender (Basic) – Region 1
  - Phelps Memorial Health Center, Holdrege (Basic) – Region 3
  - Annie Jeffrey Memorial Medical Center, Osceola (Basic) – Region 2
  - Genoa Community Hospital, Genoa (Basic) – Region 1
- *Grants***:**
  - Nebraska Preventive Health and Health Services Block Grant (PHHSBG) – New 2023-2024 Grant Award = $60,000. The funds will be used for the trauma registry, prevention, and leadership training.
- *Trauma Advisory Board Vacancies:*
  - EMS Agency Professional (Urban) – One vacancy
  - Physician practicing in emergency medicine in rural level 3 or 4 – One vacancy
- *Request for Proposal:*
  - Trauma Registry Request for Proposals are pending.
- *Next Trauma Advisory Board Meeting:*
  - November 17, 2023 – CHI Good Samaritan, Kearney

g) Stroke/STEMI System Program (Neumiller)

- *Stroke:*

- Having finished up the 2023 grant year, my program sent a total of 6 RN's and one Dr. to advanced level stroke training, created public education materials in English and Spanish, and ended with a very successful Telemundo campaign thanks to Dr. Marco Gonzalez.
- For the 2024 grant year the State Stroke Taskforce will be working on 2–3-day stroke bootcamps around the state as well as concentrating on women's unique stroke presentations that can cause them to have delayed and missed diagnosis. The taskforce's goal is to equip women with the education they need to advocate for themselves and their loved ones.
- The taskforce is still looking for individuals who would like to participate on their EMS, clinical and rehab committees if you are interested, please let me know.

- *STEMI:*
  - Actively working on recruiting additional agencies to CARES (Cardiac Arrest Registry to Enhance Survival). CARES has seen a recent surge in states participating since receiving grants this year from the CDC ($23 million) and the Helmsley Charitable Trust ($899,215). Nebraska is one of 33 states that currently participate, the goal is to expand to all 50.
- *Leona M. and Harry B. Helmsley Charitable Trust Law Enforcement AED grant:*
  - DHHS is entering into the final phase of the Helmsley Charitable Trust law enforcement (LE) AED grant. AS of 11/1 LE has used their AEDs 126 times prior to EMS arrival on scene with 14 known saves. (54 medical calls, 16 trauma, 2 drownings, 4 OD, 50 calls with no information).
  - Nebraska, South Dakota, Montana along with The Helmsley Charitable Trust will be presenting the challenges and successes of this initiative at the Citizen CPR Cardiac Arrest Survival Summit at the end of November.

h) EHS Data Systems Program (Steele)

- Sharon Steele, Tim Wilson, and Mason Holmes completed the review of the validation rules for NEMSIS Version 3.5.0. Next steps will be to update the validation rules in the Nebraska Elite software and to continue moving forward with additional 3.5.0 updates for the Nebraska Elite software.
- The RFP is in the process of moving through approval steps within NE DHHS.
- Mason Holmes and Sharon Steele attended the National Association of State EMS Officials (NASEMSO) Meeting in Reno, Nevada. While at the NASEMSO Meeting, attendance at the Data Managers Council (DMC) occurred. Mason Holmes attended the NEMSIS Annual Meeting in Park City, Utah while Sharon Steele attended the NEMSIS Annual Meeting virtually.
- Sharon Steele, Mason Holmes, Tim Wilson, and Diane Schoch attended a training for Trauma Registry.
- Nebraska Motor Vehicle Crash (MVC) Performance Measure work has begun (see slide presentation).

NE EMS Board Report
Nebraska Emergency Health Systems

Nebraska Post Crash Care Performance Measures

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January 27, 2022 Secretary Buttigieg released the **National Roadway Safety Strategy (NRSS).** At the core of this strategy is a Department-wide adoption of the Safe System Approach, which focuses on five key objectives: safer people, safer roads, safer vehicles, safer speeds, and post-crash care.

Post-Crash Care: Enhance the survivability of crashes through expedient access to emergency medical care, while creating a safe working environment for vital first responders and preventing secondary crashes through robust traffic incident management practices.

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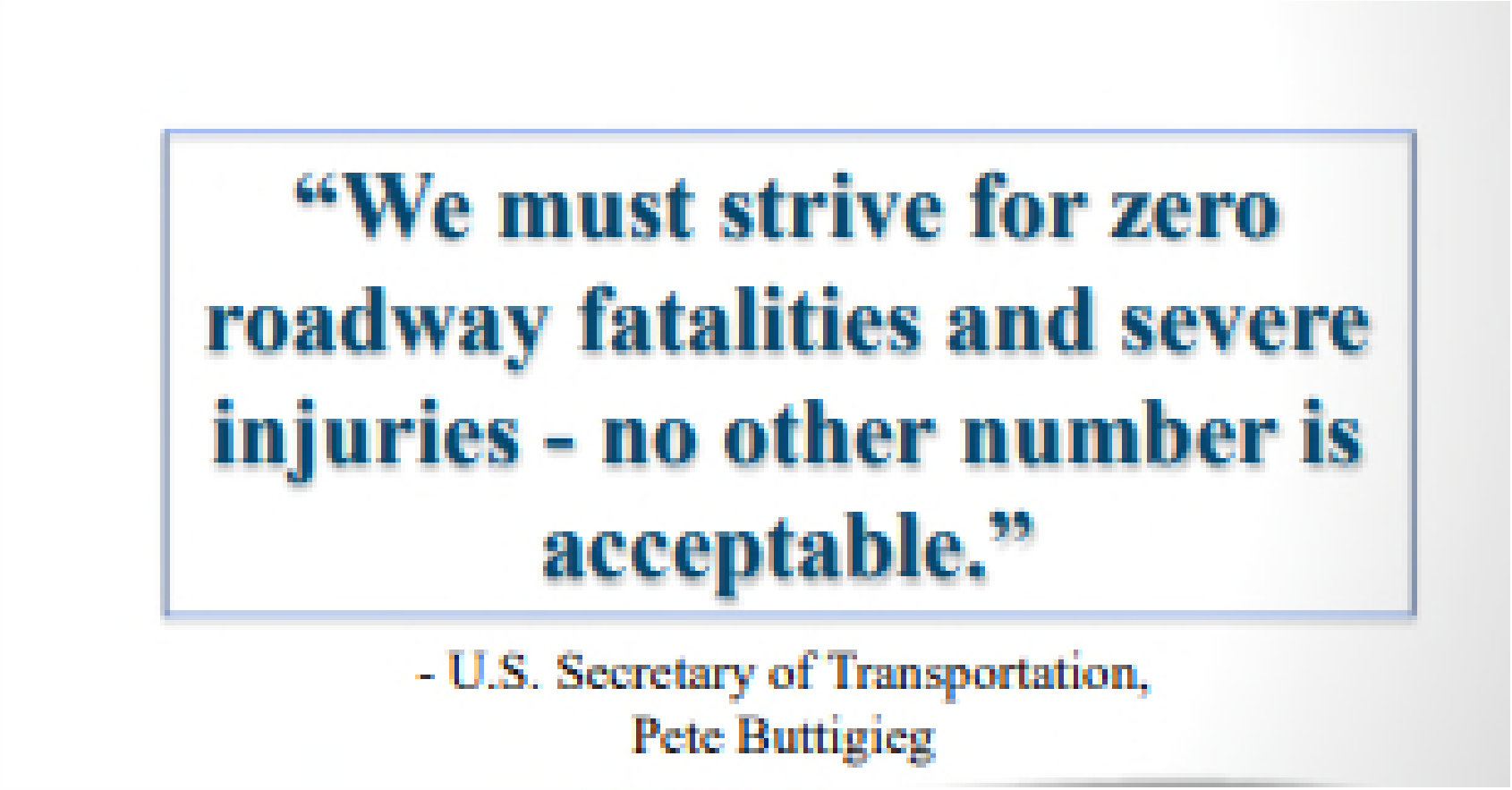
National Roadway Safety Strategy (NRSS)



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National Roadway Safety Strategy (NRSS)

Targeted the National EMS Information System (NEMSIS) education and outreach campaigns, and enforcement.

1. Develop and implement an outreach plan for EMS personnel for on-scene safety and traffic incident training.
2. Advance Traffic Incident Management training and technologies targeted at improved responder and motorist safety.
3. Expand the use of and support for NEMSIS by funding applied research and data quality improvements.
4. Improve the delivery of EMS throughout the nation in collaboration with FICEMS and NEMSAC by focusing on shortening ambulance on-scene response times.

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Criteria Used to pull records Identifying Motor Vehicle Crash for Emergency Medical Services in Nebraska

- Used ICD 10 codes that reference a Motor Vehicle Crash (MVC) occurred for the Type of Injury recorded (eInjury.01)
- Used Values that indicated there was a patient recorded in the data element of Patient/Incident Disposition (eDisposition.12)
- Used values that indicated the response was a 911 call for Response Mode to Scene (eResponse.05)

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NE MVC/Patient Contact/911 Performance Measure –

MVC related injuries (eInjury.01=MVC) & 911 EMS Responses (eResponse.05=911 Response (Scene) & Patient Contact (Patient/Incident Disposition, eDisposition.12=indicates a patient was present)
all 911 EMS Responses (eResponse.05=911 Response (Scene)) with Patient Contact (Patient/Incident Disposition, eDisposition.12=indicates a patient was present)

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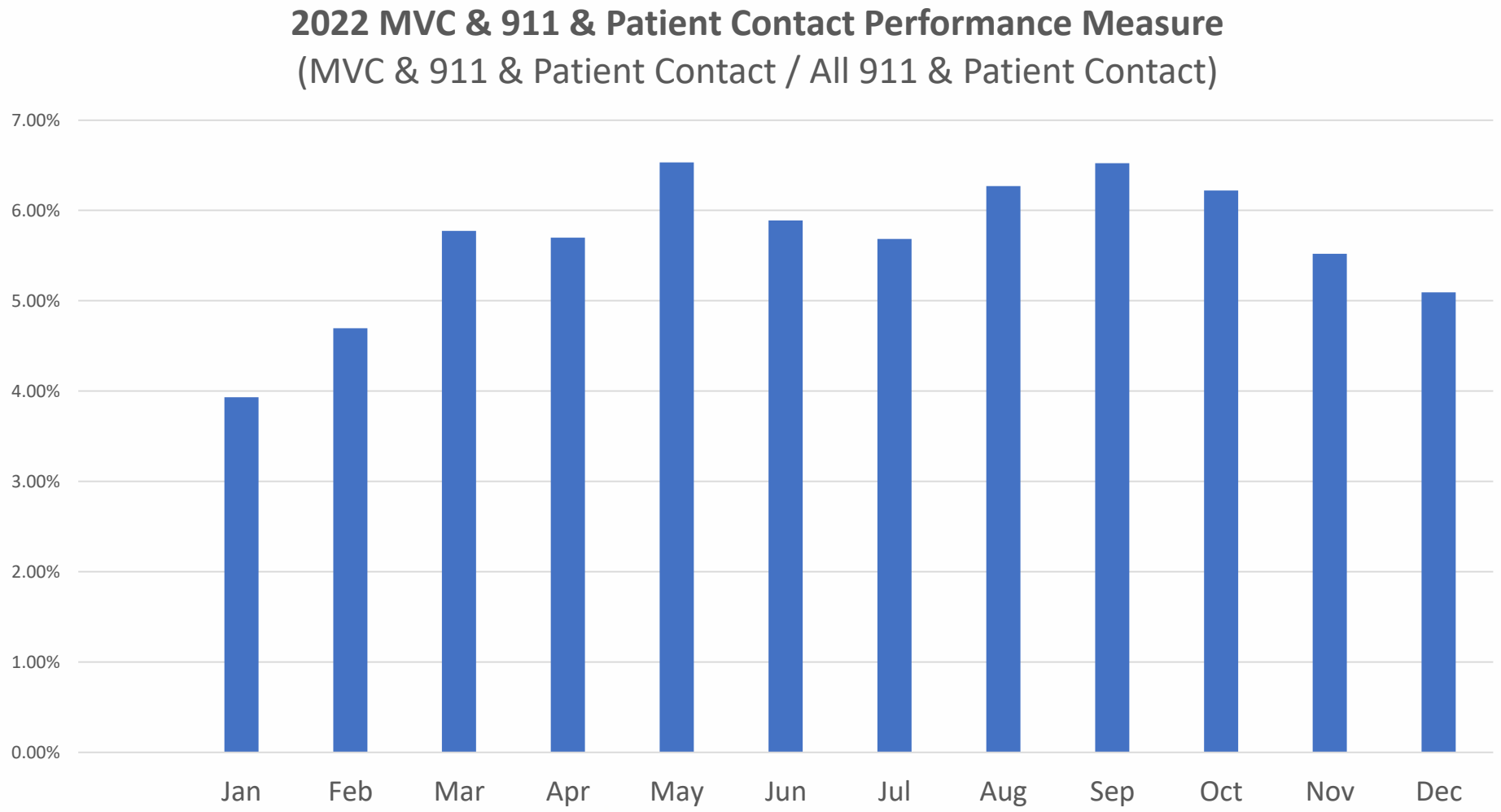

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NE MVC Scene Time Performance Measure

The duration between Unit Arrived on Scene Date Time (eTimes.06) and Unit Left Scene Date Time (eTimes.09) (20 min or 10 min) & (# of MVC & 911 call & had a patient)

# of MVC related injuries (eInjury.01 = MVC) & 911 Response (eResponse.05 = 911 Response (Scene)) & Patient Contact (Patient/Incident Disposition, eDisposition.12=indicates a patient was present)

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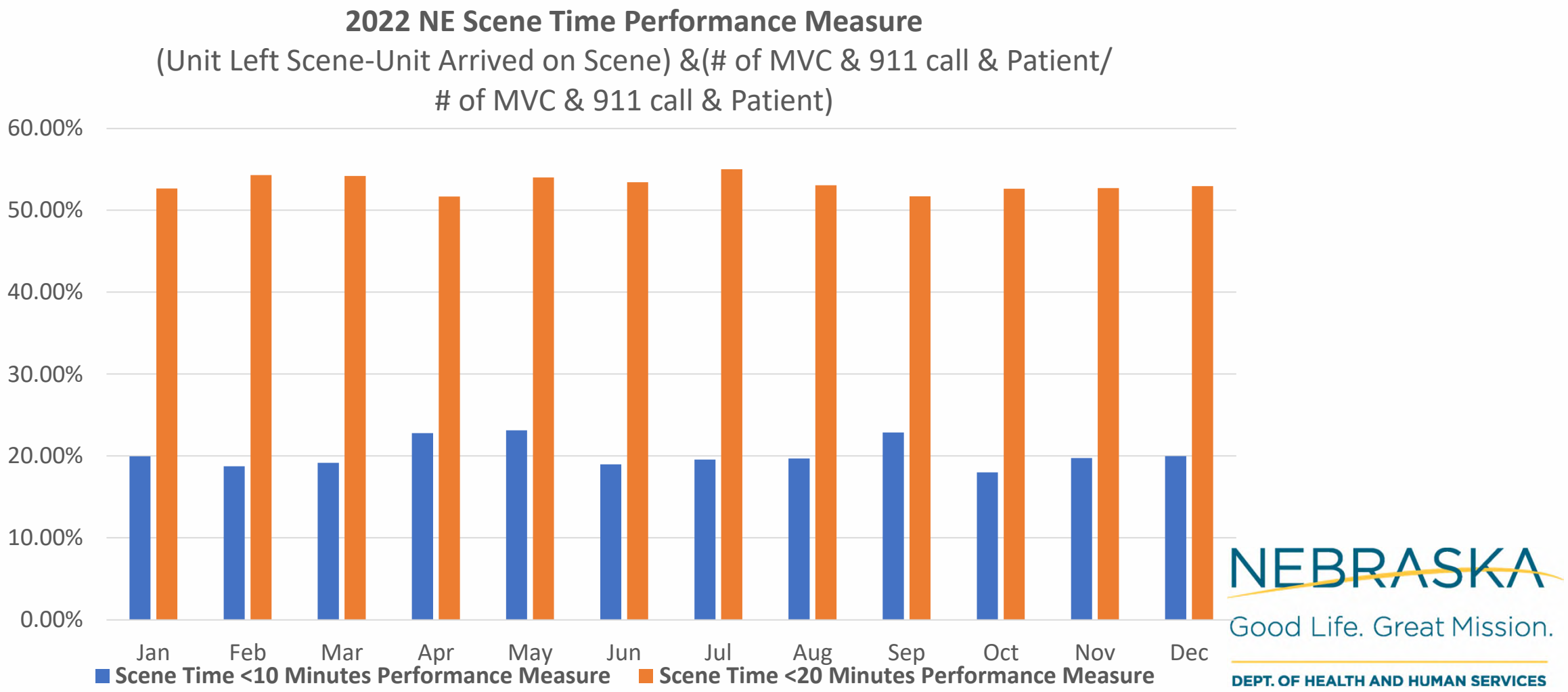

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NE MVC Pain Scale Score Performance Measure

(MVC (eInjury.01 = MVC) and 911 request (eResponse.05) & Patient) & (Pain Scale Score documented (eVitals.27) during the encounter or Pertinent Negative Recorded) &
(Total Glasgow Coma Score (GCS) (eVitals.23) between 8 and 15 or Level of Responsiveness (AVPU) (eVitals.26) = Alert or verbal)

MVC (eInjury.01 = MVC) & 911 request (eResponse.05) & Patient & (Total Glasgow Coma Score (GCS) (eVitals.23) between 8 and 15 or Level of Responsiveness (AVPU) eVitals.26 = Alert or Verbal)

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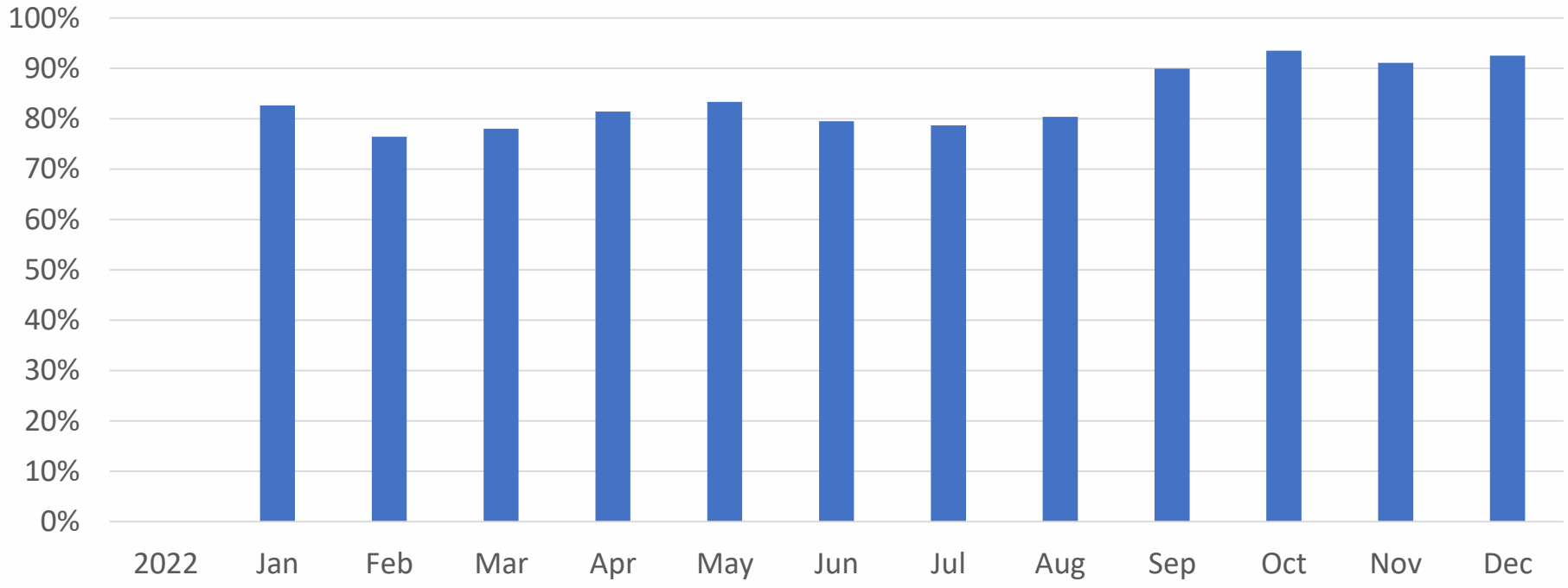
NE Emergency Health Systems

2022 NE MVC Pain Scale Score Performance Measure

(Patient with Pain Scale Score Documented or Pertinent Negative Recorded) & (GCS between 8 - 15 or AVPU = Alert or Verbal) & (# of MVC & 911 call & Patient/
# of MVC & 911 call & Patient & (GCS between 8 & 15



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NE MVC Trauma Activation Performance Measure

Trauma system activated (eDisposition.24 = Yes, Adult Trauma or Yes-Pediatric Trauma or Yes- Trauma (General)) & (Trauma Center Criteria (einjury.03) or Vehicular, Pedestrian, or Other Injury Risk Factor (eInjury.04) recorded) & MVC & 911 & Patient

---

Trauma Center Criteria (eInjury.03) or Vehicular, Pedestrian, or Other Injury Risk Factor (eInjury.04) & (eInjury.01 = MVC records only) & 911 calls & patient

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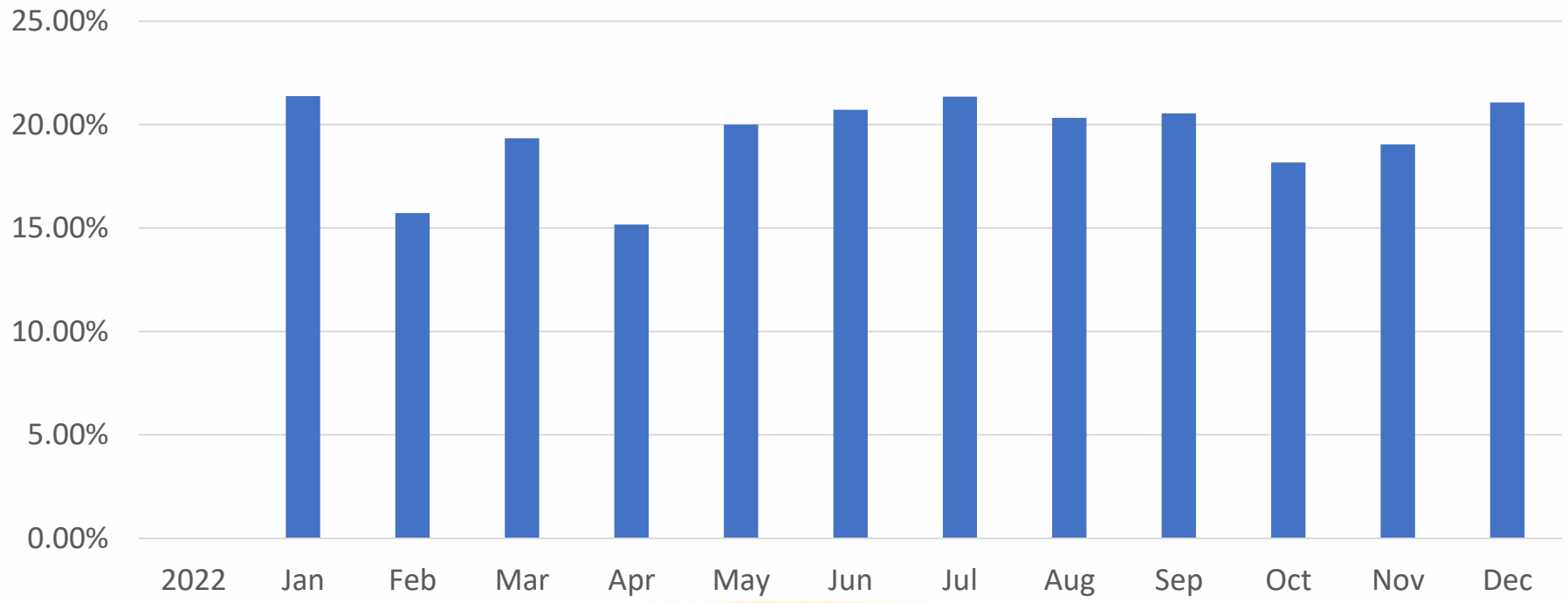
NE Emergency Health Systems

2022 NE Trauma Activation Performance Measure

(Trauma Activation & Trauma Center Criteria or Injury Risk Factor (eInjury.04) recorded & MVC & 911 & Patient/ Trauma Center Criteria (eInjury.03) or Injury Risk Factor (eInjury.04) & MVC & 911 & Patient)



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EMR Scope of Practice Suggestions

In view of the current shortage of EMTs and Paramedics it has been suggested the state make some changes to allow for adequate EMS coverage and care. One suggestion is to relook at the scope of practice for the Emergency Medical Responder. Here are some things which might be worth considering:

1. **Administration of Albuterol via Inhaler or Nebulizer**.
   RESPONSE: NO
   Both of these are allowed to be administrated in the school by faculty and other school staff with minimal training. With increased response time of EMTs this may be a life saving measure for certain patients. It is not a difficult procedure considering many parents and family members are trained how to use this medication. The possibility of overdosing on this medication certainly exists but if an EMR is only allowed 1 treatment of Albuterol before contacting medical direction overdosing should not be an issue. EMRs should have the skill to administer aerosolized and intranasal lifesaving medications in their scope of practice.
2. **Glucagon by nasal inhaler or autoinjector.**
   RESPONSE: NO
   Allowed for EMTs. Intranasal Narcan and Epinephrine Autoinjector are allowed for EMRs. Glucagon offers very few complications when given in error. It uses the same technique as Intranasal Narcan and Autoinjector Epinephrine and can be lifesaving and/or cognitive function saving in the rural communities with delayed EMT or ALS response times and long transport times.
3. **Oral Glucose Gel**.
   RESPONSE: NO
   Permitted for EMTs, however EMRs may only use milk or juice for hypoglycemia treatment. EMRs are taught to manage a patient airway including suctioning the same way as an EMT except for the use of supraglottic airways. EMRs should be competent in administering glucose gel. (Just an additional consideration: glucose gel is not a consistency or taste most patients appreciate. Frequently the patient spits the gel out and fails to swallow any of it or very little of it. One tablespoon of honey or a small tube of cake frosting is typically accepted better and gets absorbed through the mucus membranes or is more readily swallowed.)
4. Assessment Skills:
   RESPONSE: Already included and varies by licensure level. Maintain current recommendations. Assessment Skills which are not identified for EMRs to perform which they are actually taught and performing:
   a. **General Impression** – EMRs are taught to decide whether a patient needs rapid transport or not. This comes from a general impression.
   b. **Breathing status** (rate, rhythm, stridor, wheezes, retractions, accessory muscle use, chest symmetry)
   c. **Circulatory status** (Presence/absence of pulse, rate, rhythm, strength, and bleeding)
5. **Use of a non-invasive blood pressure monitoring (Automatic cuff).**
   RESPONSE: Yes, appropriate training
   This is not a complicated process. EMRs are taught to interpret blood pressures and an automatic BP cuff can be very helpful when crews are short staffed, or they find themselves in a noisy environment. EMRs are able to acquire and transmit a 12 Lead EKG which is much more

complicated then obtaining a BP with an automatic BP cuff. I suspect most EMRs are using automatic BP cuffs even though it is not within their scope of practice.

6. **Use of mechanical CPR device**.
   RESPONSE: Yes, appropriate training
   The LUCAS is not a complicated device and assures adequate compressions while transferring a patient down steps or to an awaiting ambulance. It also assures adequate compressions during a long transport time or when additional EMT help is delayed in their response time. The sooner adequate compressions are initiated the more likely one is to get ROSC.
7. **Application for heat and cold.**
   RESPONSE: Already able to do
   Currently in the state protocols for EMRs and should be updated on the EMS Comparison Skills Chart.
8. **Monitoring an established urinary catheter.**
   RESPONSE: NO
   should be something all levels are able to do. All care givers need to be aware that the urinary bag is never placed above the level of the heart since this can cause backflow into the bladder and increased potential for infection. All care providers should be aware of what areas are considered sterile and how to maintain the sterility. They should also be capable of reading the amount of urine output before and after transportation.
9. **Tracheal suctioning.**
   RESPONSE: NO
   falls into maintaining an open airway which can be lifesaving maneuver. EMRs are already taught how to perform oral suction. The principles are very similar except for the need to maintain a sterile suction catheter and the depth of insertion. As we see a delay in response by EMTs due to the lack of providers in the rural setting, this is a skill I would think would be instinctive to provide if a patient was having difficulty. It would be much better to include this in the EMR training so if faced with this situation the EMR level provider would know how to do this correctly.
10. **Utilize a glucose monitoring device.**
    RESPONSE: NO
    Something many of the lay public are able to perform with limited training. It is very helpful in evaluating any patient that has an altered mental status. This allows the care provider to know what the correct treatment should be and to differentiate between hypoglycemia, stroke, post ictal seizure, head injury, alcohol overdose etc. The problem occurs when the patient is assumed to have one of the later 4 conditions, when in fact it really is a hypoglycemic problem. If it is decided to allow EMRs to administer intranasal or autoinjector glucagon this would be very helpful information to have.
11. **Complicated Children.**
    RESPONSE: NO
    EMRs can assist with a normal childbirth but they are not covered in the protocols to **assist with a complicated childbirth.** Frequently one does not know the childbirth is complicated until one is well into the "Normal" childbirth labor. I am not sure what the EMR is supposed to do when they identify the delivery is complicated. The EMR cannot in good conscious walk away.

Wouldn't it be better to educate them in how to handle a prolapsed cord, a breech baby, shoulder dystocia etc?

12. **Pulse Oximeter Reading**.

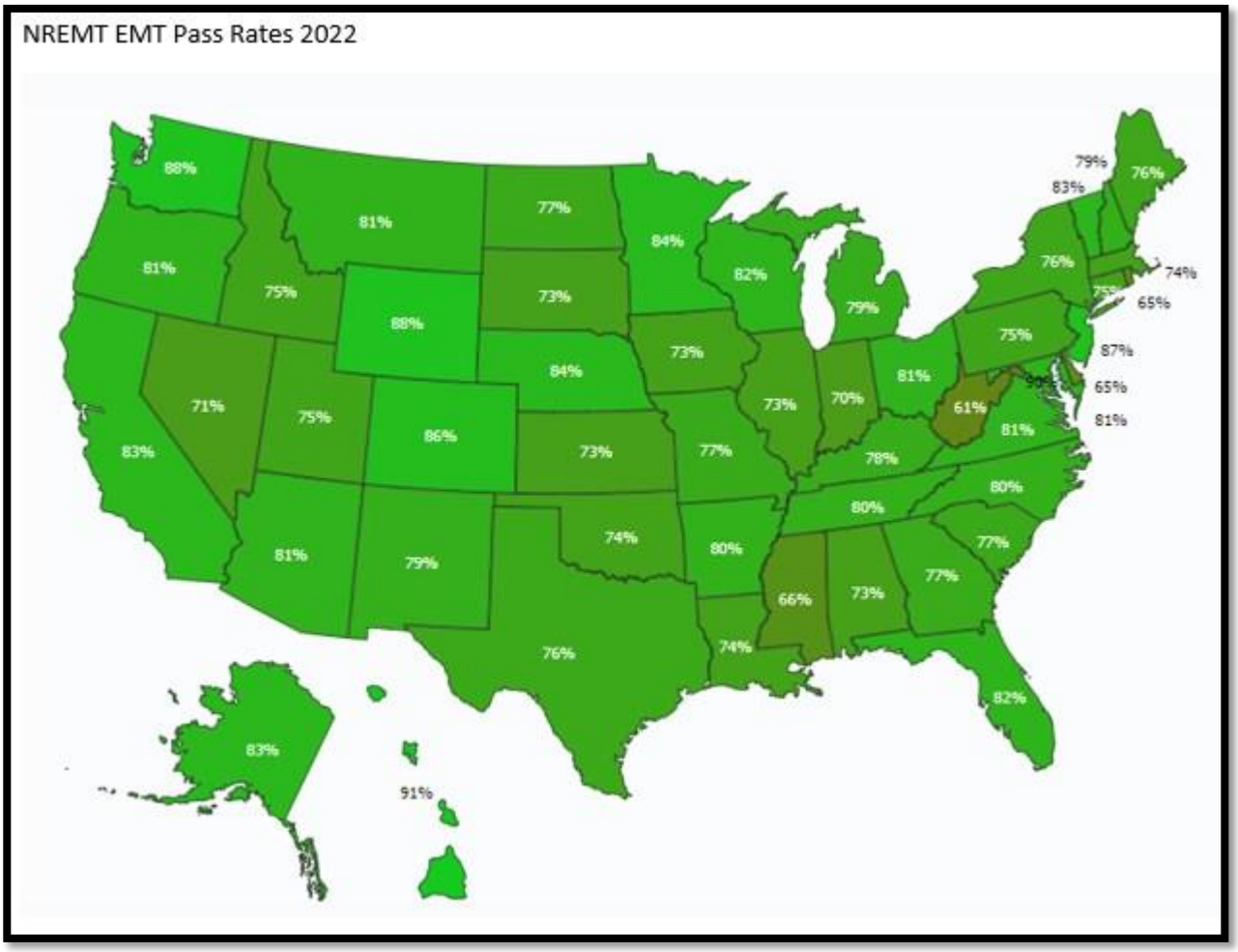
    RESPONSE: Yes, appropriate training

    EMRs are allowed to administer oxygen which is considered a medication/drug. They have no idea how to dose this drug without the use of a pulse oximeter. Why would we ask somebody to administer a medication without telling them the preferred dose? Oxygen and ventilation can be a life saving measure. It is important to utilize a pulse oximeter if we are following AHA standard so patients are not hyper-oxygenated and causing restriction of blood flow in an acute MI or stroke. I suspect most EMRs working with EMTs already understand both how to apply a pulse oximeter and the basics of dosing oxygen. This should be considered in their scope of practice.

Nebraska EMS Education – the facts

Based on the statistics from the National Registry of EMTs, Nebraska is well above the National average pass rate in all 3 provider levels. 46 of the 50 states require this exam for EMS licensure (accepted by all 50 states for licensure), establishing a consistent and validated competency standard. This demonstrates that passing the exam is not only achievable, but very likely. This data also demonstrates that our state and educational processes align with the best-practice policies set by all 50 states and continue to hold our medical providers to the national standard.

Year	EMR NREMT Pass rates		EMT NREMT Pass rates		Paramedic NREMT Pass rates	
	Nebraska	National	Nebraska	National	Nebraska	National
2017	**73%**	69%	82%	74%	92%	80%
2018	**80%**	71%	79%	74%	96%	80%
2019	**78%**	68%	71%	73%	95%	79%
2020	**97%**	71%	80%	71%	86%	76%
2021	**77%**	70%	86%	71%	96%	76%
2022	**93%**	68%	84%	73%	93%	77%



EMS Courses taught in Nebraska

January 2021-October 2023

Statistics from DHHS and training agency records

EMR	courses held	students enrolled	students completing a course
2021	4	36	33 (92%)
2022	4	22	21 (95.5%)
2023 (Jan- Oct)	3	48	29 (78%) with 11 in progress
3-year total	11	106	88.5%

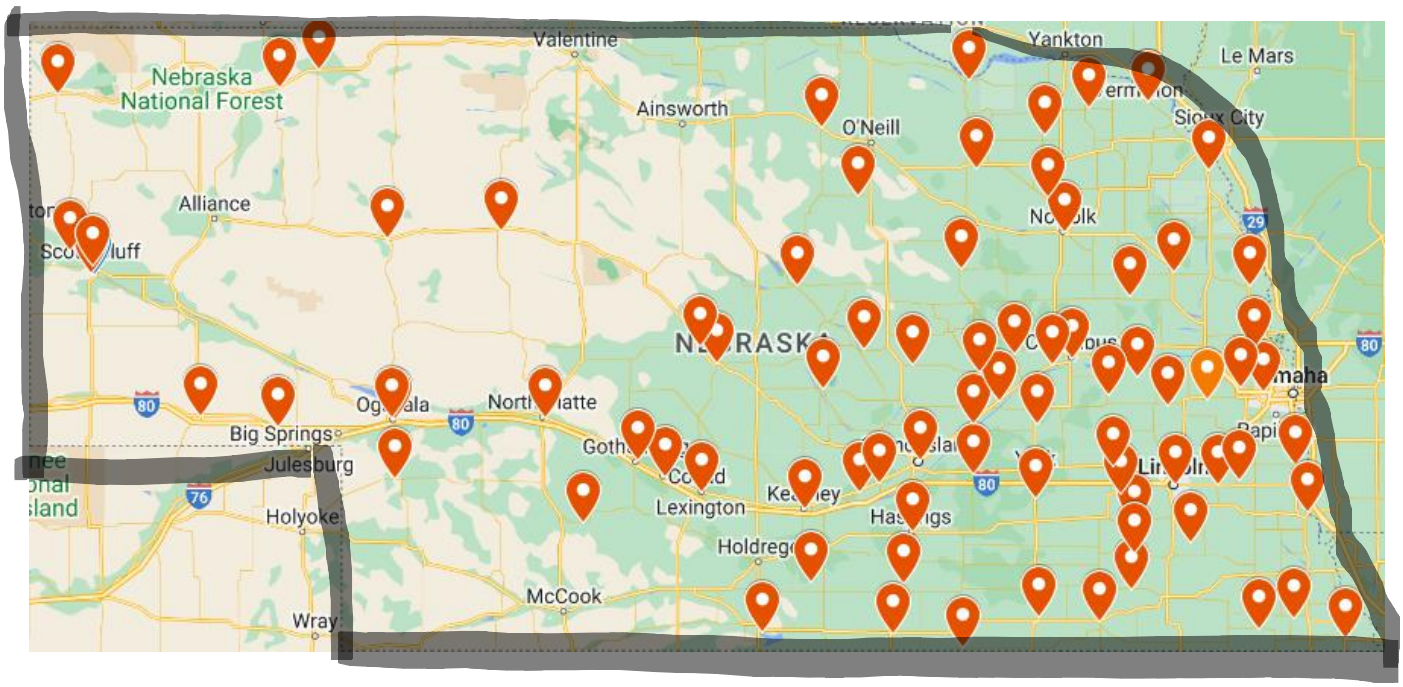
EMT	courses held	students enrolled	students completing a course
2021	57	572	452 (79%)
2022	49	524	424 (81%)
2023 (Jan- Oct)	37	424	203 (86.5%) With 165 in progress
3-year total	143	1,338	82%

AEMT	courses held	students enrolled	students completing a course
2021	2	19	16 (84%)
2022	4	21	12 (57%)
2023 (Jan- Oct)	1	13	All in progress
3-year total	7	53	70.5%

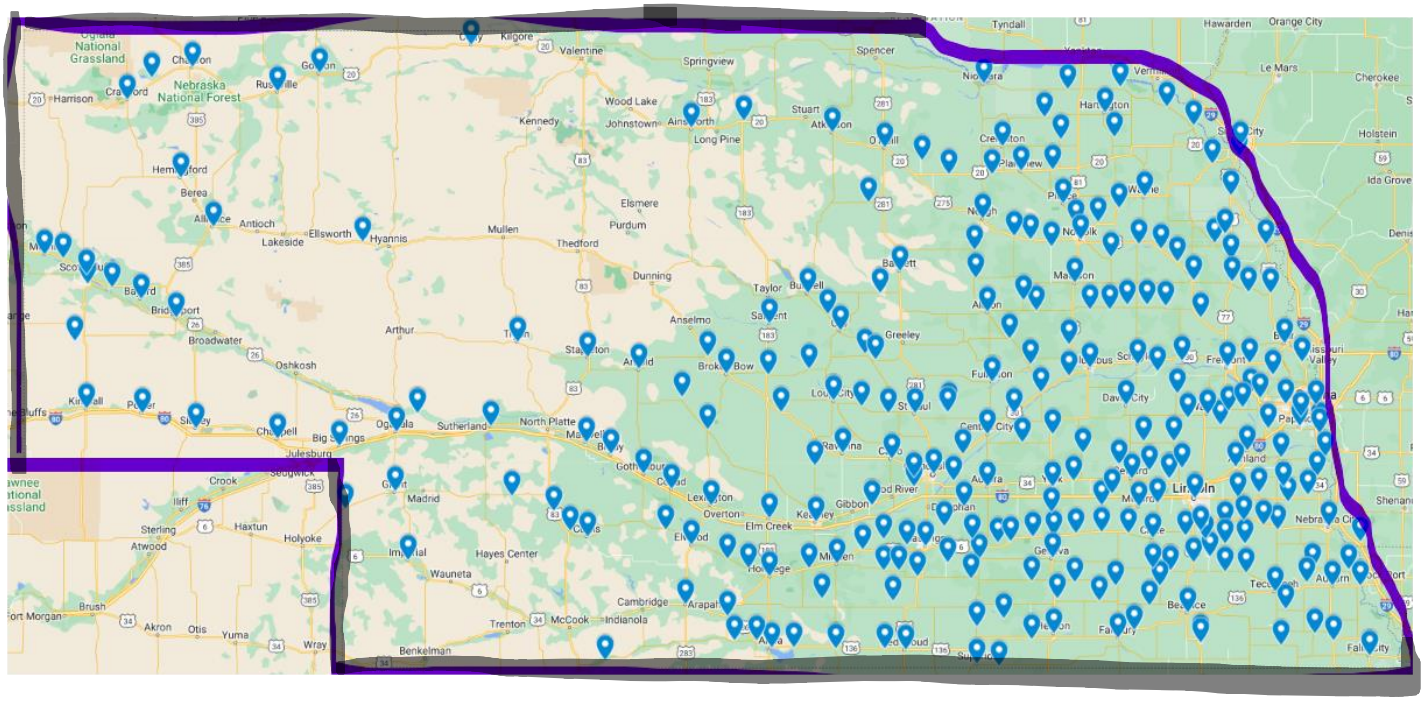
National EMS Compact

Because Nebraska EMS regulations require a NREMT certification for state licensure, EMS providers in the state of Nebraska are able to participate in the EMS compact. Much like a driver's license that allows a Nebraska driver to drive through other states, this compact allows EMS personnel to work across state boundaries in the performance of their EMS duties as assigned by an appropriate authority. The EMS Compact authorizes state EMS offices to afford immediate legal recognition to EMS personnel licensed in any other member state, such as in the case of a disaster. This would not be possible without our EMS providers meeting the competencies and licensure requirements established by the rest of the states.

Locations of EMS courses in Nebraska 2021-2023:



EMS students place of residence – 2021-2023



How EMS courses are offered in Nebraska

Nearly every training agency director and most EMS instructors have volunteered on a local volunteer fire service. We recognize the need for competent medical care in our rural communities and it is what fuels our passion to provide quality education to those who will be providing care for our friends and neighbors.

In response to the shortage of EMS providers across the nation, training agencies in Nebraska worked hard to make courses more available and easier to attend. Currently, nearly all Nebraska training agencies are offering EMS courses in traditional classroom formats as well as hybrid format. Hybrid learning is a blend of online work with hands-on skills labs, making courses much more accessible and reducing drive time and expenses.

- Hybrid learning makes quality education available to students who work odd schedules, travel, or live a distance from a college or training center. This makes it much easier for a training agency to meet the required minimum number of students and offer more courses in rural areas.
- Hybrid students learn at times and locations that are best for them, making learning less stressful and material easier to retain. Students can tailor their learning to what best fits their individual learning style.
- Course video lectures, quizzes, and study tools remain available to the student throughout the entire course.
- Every student participates in online discussions — less opportunity to be a non-participating student.
- Students feel responsible to "know" the information from the online portion of the course before coming to the hands-on lab sessions, making learning more important.
- Hands-on lab sessions reinforce what the student has learned online and builds critical thinking skills.

Financial assistance for EMS students

Grant Funds

Community colleges have many sources of grant dollars and scholarship monies available for students that qualify. One such grant is Gap funds that are readily available at all community colleges for EMS students (EMT and/or Paramedic). This grant money is easy to apply for and when awarded, can pay for 100% of the tuition and costs of the course with no repayment.

Sponsorship billing

Most community colleges work with EMS departments to funnel all or part of the course costs to the sponsoring department, so the students is not responsible to pay the full amount up front.

Pell grants and federal financial aid

Most community colleges have set up the EMS courses to qualify for Pell grants and Federal financial Aid should the student wish to take advantage of those resources or need to use the loans to provide living costs while attending classes.

Scope of Practice of Emergency Care Provider Decision-making Framework

Approved by the Nebraska Board of Emergency Medical Services on December 11, 2020

Adapted and used with permission from the *Journal of Nursing Regulation* 7(3); 19-21.
Ballard, K., Haggenson, D., Christiansen, L., Damgaard, G., Halstead, J.A., Jason, R.R., Alexander, M. (2016). Scope of nursing practice decision-making framework.

Adapted from the Department of Health and Human Services Nurse Licensing Scope of Practice developed by the Nebraska Board of Nursing.

U.S. Department
of Transportation
National Highway
Traffic Safety
Administration

NHTSA

DOT HS 813 151

August 2021

National EMS Scope of Practice Model 2019: Including Change Notices 1.0 and 2.0

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15. Supplementary Notes		

16. Abstract

The National EMS Scope of Practice Model supports a system of Emergency Medical Services personnel licensure—permission granted to a person by the State to perform certain restricted activities—and is a guide for States in developing their Scope of Practice legislation, rules, and regulations. The Practice Model is a consensus document, guided by data and expert opinion, that reflects the skills representing the *minimum* competencies of the levels of EMS personnel. The Practice Model has been used by States as a means to increase uniformity in EMS for more than a decade. This version includes updates from Change Notices 1.0 and 2.0 issued on March 29, 2021.

17. Key Words EMS, practice model, emergency services, scope of practice		**18. Distribution Statement** This document is available to the public from the National Technical Information Service, www.ntis.gov.	
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U.S. Department of Transportation
National Highway Traffic Safety Administration
ems.gov

NHTSA
1200 New Jersey Avenue SE.
Washington, DC 20590

Date: March 29, 2021

To: State EMS Directors

From: Jon R. Krohmer, M.D., FACEP
Director, Office of Emergency Medical Services

RE: 2019 National EMS Scope of Practice Model, Change Notices

The National EMS Scope of Practice Model (model) was first published in February 2007 by the National Highway Traffic Safety Administration's (NHTSA's) Office of Emergency Medical Services (EMS). The most recent version of the model was published by NHTSA in February 2019. The model was developed by the National Association of State EMS Officials (NASEMSO) with funding provided by NHTSA and the Health Resources and Services Administration (HRSA). Over the past 14 years, the model has provided guidance for States in developing their EMS Scope of Practice legislation, rules, and regulation. While the model provides national guidance, each State maintains the authority to regulate EMS within its border, and determine the scope of practice of State-licensed EMS clinicians.

Recognizing that the model may impact States' ability to urgently update their Scope of Practice rules, in 2016 the National EMS Advisory Council (NEMSAC) recommended that NHTSA develop a standardized urgent update process for the model. The Rapid Process for Emergent Changes to the National EMS Scope of Practice Model (rapid process) was developed by NASEMSO and published by NHTSA in September 2018.

Using the rapid process, in March 2021 NHTSA convened a subject matter expert panel (panel) to respond to the following questions: 1) Should immunizations via the intramuscular (IM) route be added to the emergency medical responder (EMR) and emergency medical technician (EMT) scope of practice levels?; 2) Should monoclonal antibody (MCA) infusion be added to the advanced EMT (AEMT) and paramedic scope of practice levels?; and 3) Should specimen collection via nasal swabbing be added to the EMR, EMT, AEMT, and paramedic scope of practice levels?

The panel considered the ability of EMRs and EMTs to perform the psychomotor skill of medication administration via the IM route and recommended that IM medication administration be added only to the EMT scope of practice as part of their common daily practice.

The panel considered the ability of EMRs and EMTs to administer medical director approved immunizations and recommended that immunizations during a public health emergency be added only to the EMT scope of practice.

The panel considered the ability of EMRs, EMTs, AEMTs, and Paramedics to perform the psychomotor skill of specimen collection via nasal swab and recommended that specimen collection via nasal swab be added only to the EMT, AEMT, and Paramedic scopes of practice as part of their common daily practice.

The panel did not issue a recommendation on MCA infusion.

Based on the panel's recommendations NHTSA used the rapid process to develop the two attached change notices on IM medication administration, vaccinations during a public health emergency, and specimen collection via nasal swab.

It should be noted that, although the recommendations address the psychomotor skills associated with these specific activities, the assumption of the panel in making the recommendations was that all associated educational activities, knowledge of indications and potential contraindications, other potential skills (e.g.: drawing the appropriate dose of medication up from an ampule or vial [single or multi-dose], supervised assessment of skill competency, and quality improvement activities) would be components of the entire program.

I hope you find these change notices useful to you in meeting the urgent needs of your patients and the practitioners you regulate. In the very near future we will publish a revised version of the model which incorporates these change notices. Please feel free to contact me should you have any questions.

2019 NATIONAL EMS SCOPE OF PRACTICE MODEL CHANGE NOTICES

Change Notice 1.0

March 29, 2021

The following changes to the National EMS Scope of Practice Model (February 2019) DOT HS 812 666 are effective immediately:

Page 35. Emergency Medical Technician Skill – Medication Administration - Route. The following has been added: **Intramuscular.**

Page 36. Emergency Medical Technician Medical Director Approved Medications. The following has been added: **Immunizations during a public health emergency. ***

*Note: the addition of this Medical Director Approved Medication to the Emergency Medical Technician level scope of practice also applies to the Advanced Emergency Medical Technician and Paramedic level scopes of practice.

BACKGROUND: At the request of the National Highway Traffic Safety Administration's (NHTSA's) Office of Emergency Medical Services (OEMS) a subject matter expert panel (the panel) considered the following questions to facilitate urgent changes to the 2019 National EMS Scope of Practice Model (Model) to add the intramuscular (IM) administration of immunizations to the Emergency Medical Responder (EMR) and Emergency Medical Technician (EMT) scopes of practice:

1. Is there evidence that the procedure or skill is beneficial to public health?
2. What is the clinical evidence that the new skill or medication as used by EMS clinicians will promote access to quality healthcare or improve patient outcomes?
3. Should the new skill or administration be specific to a public health emergency versus common daily practice?

METHODS: NHTSA convened the panel over the course of three meetings to review and discuss the available evidence.

DISCUSSION: The Food and Drug Administration (FDA) has issued emergency use authorizations (EUAs) for COVID-19 vaccines. Currently authorized COVID-19 vaccines are administered intramuscularly (IM). All COVID-19 vaccines currently available in the United States are effective at preventing severe illness or hospitalization from COVID-19.

The panel considered the ability of EMRs and EMTs to perform the psychomotor skill of medication administration via the IM route and recommended that IM medication administration be added only to the EMT scope of practice as part of their common daily practice.

The panel considered the ability of EMRs and EMTs to administer medical director approved immunizations and recommended that immunizations during a public health emergency be added only to the EMT scope of practice. EMTs shall only undertake this practice if they possess the necessary educational preparation, experience and knowledge to properly administer a medical director approved vaccine during a declared public health emergency. The execution of the procedures shall include the ability to identify an allergic reaction and the post-treatment management of administering a vaccine.

Information on current state EMS scopes of practice regarding vaccination can be accessed through a report published by the National Association of State EMS Officials, *EMS Personnel as Vaccinators: Status by State*, available at: https://nasemso.org/wp-content/uploads/COVID-Vaccination-Report.pdf.

2019 NATIONAL EMS SCOPE OF PRACTICE MODEL CHANGE NOTICES

Change Notice 2.0

March 29, 2021

The following changes to the National EMS Scope of Practice Model (February 2019) DOT HS 812 666 are effective immediately:

Page 37. Emergency Medical Technician Skill - Miscellaneous. The following has been added: **Specimen Collection via Nasal Swab. ***

*Note: the addition of this skill to the Emergency Medical Technician level scope of practice also applies to the Advanced Emergency Medical Technician and Paramedic level scopes of practice.

BACKGROUND: At the request of the National Highway Traffic Safety Administration's (NHTSA's) Office of Emergency Medical Services (OEMS) a subject matter expert panel (the panel) considered the following questions to facilitate urgent changes to the 2019 National EMS Scope of Practice Model (Model) to add specimen collection via nasal swabbing to the Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic level scopes of practice:

1. Is there evidence that the procedure or skill is beneficial to public health?
2. What is the clinical evidence that the new skill or medication as used by EMS practitioners will promote access to quality healthcare or improve patient outcomes?
3. Should the new skill or administration be specific to a public health emergency versus common daily practice?

METHODS: NHTSA convened the panel over the course of three meetings to review and discuss the available evidence.

DISCUSSION: The panel considered the ability of EMRs, EMTs, AEMTs, and Paramedics to perform the psychomotor skill of specimen collection via nasal swab and recommended that specimen collection via nasal swab be added only to the EMT, AEMT, and Paramedic scopes of practice as part of their common daily practice.

EMTs shall only undertake the practice if they possess the necessary educational preparation, experience and knowledge to properly conduct specimen collection via nasal swab.

Information on anterior nasal swab specimen collection for COVID-19 testing can be accessed through the Centers for Disease Control and Prevention (CDC) at: https://www.cdc.gov/coronavirus/2019-ncov/testing/How-To-Collect-Anterior-Nasal-Specimen-for-COVID-19.pdf.

Information on nasal mid-turbinate specimen collection for COVID-19 testing can be accessed through the CDC at https://www.cdc.gov/coronavirus/2019-ncov/testing/How-To-Collect-NMT-Specimen-for-COVID-19.pdf.

Table of Contents

This document was produced by the National Association of State EMS Officials (NASEMSO) with support from the U.S. Department of Transportation, National Highway Traffic Safety Administration, Office of Emergency Medical Services (OEMS) through Contract DTNH2216C00026, with supplemental funding from the Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Emergency Medical Services for Children (EMSC) Program. The opinions, findings, and conclusions expressed in this publication are those of the authors and not necessarily those of NHTSA or HRSA.

Executive Summary

The National EMS Scope of Practice Model (NHTSA, 2007) is a continuation of the commitment of the National Highway Traffic Safety Administration and the Health Resources and Services Administration (HRSA) to the implementation of the EMS Agenda for the Future ("EMS Agenda," NHTSA, 1996). It is part of an integrated, interdependent system, first proposed in the *EMS Education Agenda for the Future: A Systems Approach* ("Education Agenda," NHTSA, 2000) that endeavors to maximize efficiency, consistency of instructional quality, and student competence. It supports a system of EMS personnel licensure that is common in other allied health professions and is a guide for States in developing their scope of practice legislation, rules, and regulations.

> *Scope of practice—Defined parameters of various duties or services that may be provided by a person with specific credentials. Whether regulated by rule, statute, or court decision, it represents the limits of services a person may legally perform.*

State policymakers play a critical and longstanding role in occupational licensing policies, dating back to the late 19th century when the U. S. Supreme Court decision in *Dent v. West Virginia* (1889) established States' rights to regulate certain professions. Shortly after, States began developing their own systems of occupational regulation and licensing. Most recently (2015), in *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, the U.S. Supreme Court held that when a controlling number of decision makers on an occupational licensing board are market participants, it has immunity from antitrust law only when it is actively supervised by the State. Since the legal authority to practice can be obtained only from the State, the State licensure process provides a means for States to stop unlawful practice by unlicensed people. This affords title protection to EMS personnel that comply with State regulations, and protection of the public from people who have not met minimum standards.

The *Practice Model* has been used as a model by States to increase regulatory uniformity in EMS for over a decade. Core to this document and the practice of every licensed health professional is compliance with four domains intended to serve the legal and ethical obligation of States to ensure the public is protected from unqualified people.

A person may only perform a skill or role for which that person is:
EDUCATED (has been trained to perform the skill or role), **AND**
CERTIFIED (has demonstrated competence in the skill or role), **AND**
LICENSED (has legal authority issued by the State to perform the skill or role), **AND**
CREDENTIALED (has been authorized by medical director to perform the skill or role).

While many users of the 2018 *Practice Model* may be more interested in the list of psychomotor skills that appear as interpretive guidelines in Section VI of this report, this list is neither prescriptive nor finite. What is more important are the fundamental principles that underlie any professional scope of practice model as explained throughout the document. To be clear: Licensed practitioners are not permitted to perform any skill if they fail to conform with any of

the four domains related to that particular skill, including the demonstration of ongoing competency.

A panel of subject matter experts was selected to revise the *Practice Model* in 2017. Comprised of representatives from several national EMS organizations and the EMS public including experienced field personnel, EMS educators, EMS medical directors, EMS agency administrators, and State EMS regulators, the expert panel used the Grades of Recommendation Assessment, Development and Evaluation (GRADE) process to consider evidence and establish consensus on many topics. When the scientific literature was inconclusive, expert opinion was used to improve descriptions, roles, and attributes of each level that would support changes in practice by addressing two fundamental questions.

1. Is there evidence that the procedure or skill is beneficial to public health?
2. What is the clinical evidence that the new skill or technique as used by EMS personnel will promote access to quality health care or improve patient outcomes?

It is important to note that the expert panel was tasked to define recommended entry-level expectations to ensure a level of national consistency. In other words, the *Practice Model* suggests the minimum recommended practice requirements in advance of gaining field experience prior to supervised or individual work experience at the levels of an emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technician (AEMT), or paramedic.

National EMS Program Accreditation was identified in the *Education Agenda* as the means to "provide minimum program requirements for sponsorship, resources, students, operational policies, program evaluation, and curriculum" at all EMS levels. The Commission on Accreditation of Allied Health Education Programs (CAAHEP), the largest programmatic accreditor in the health sciences field, currently accredits more than 2,200 education programs in 30 health sciences fields including 611 at the paramedic level across all 50 States. The expert panel considered the evidence related to the value of National EMS Program Accreditation toward student and patient outcomes and encourages collaboration among stakeholder groups for full implementation of national EMS program accreditation at the AEMT level by 2025.

Finally, the United States is transforming its health care system to provide quality care leading to improved health outcomes achieved through interdisciplinary collaboration. EMS personnel are key to this transformation through innovative approaches in a variety of practice settings. The expert panel strongly supports the national call for the elimination of barriers for all professions to practice to the full extent of their education, training, and competence with a focus on collaborative teamwork to maximize and improve care throughout the health care system (Institute of Medicine of the National Academies, 2010).

I. Background

Overview of the EMS Profession

The *Practice Model* provides a resource for defining the practice of EMS personnel. EMS clinicians are atypical health care professionals in that they provide medical care in many environments, locations, and situations. Much of this care occurs in out-of-hospital settings with little onsite supervision. Physician medical directors provide medical oversight to ensure and maintain safe EMS practices. This is occasionally performed in-person by medical directors in the field or through electronic communications, but more commonly is accomplished through protocol development and quality improvement based on evidence-based treatment standards and resources such as this *Practice Model*. EMS personnel are not independent clinicians, but are expected to execute many treatment modalities based on their assessments and protocols in challenging situations. They must be able to exercise considerable judgment, problem-solving, and decision-making skills.

In the vast majority of communities, residents call for EMS by dialing 9-1-1 when they need emergency medical care, and the appropriate resources are dispatched. EMS personnel respond and provide care to the patient in the setting in which the patient became ill or injured, including the home, field, recreational, work, and industrial settings. Many of these are in high-risk situations such as on highways and freeways, in violent scenarios, and other unusual or atypical settings.

Many EMS personnel provide medical transportation services for patients requiring medical care while enroute to or between medical facilities, in both ground and air ambulance entities. These transport situations may originate from emergency scenes, or may be scheduled transports moving patients from one licensed facility to another. The complexity of care delivered by EMS personnel can range from very basic skills to exceptionally complex monitoring and interventions for very high-acuity patients.

Medical care at mass gatherings such as concerts or sporting events and high-risk activities like fireground[1] operations or law enforcement tactical operations are a growing expectation of EMS personnel. EMS personnel sometimes serve in emergency response or primary care roles combined with occupational settings in remote areas (off-shore oil rigs and wildland fires, etc.). EMS personnel also work in more traditional health care settings in hospitals, urgent care centers, doctor's offices, and long-term care facilities. Finally, EMS personnel are involved in numerous community and public health initiatives, such as working with health care systems to provide non-emergent care and follow-up to certain patient populations as well as providing immunizations, illness and injury prevention programs, and other health initiatives.

EMS is a local function and organized several ways. These include agencies that are volunteer, career, or a combination; agencies that are operated by government, health care system, or private entities; and agencies that are stand-alone fire-based or law enforcement-based EMS. Common models are municipal government (fire-based or third-service) or a contracted service with a private (profit or nonprofit) entity. Levels of licensure exist for EMS personnel, each offering different scopes of practice. EMS personnel provide medical care to those with

[1] Any place fire-fighting operations are being carried out.

emergent, urgent, and in some cases chronic medical needs. EMS is a component of the overall health care system, and delivers care as part of a system intended to reduce the morbidity and mortality associated with illness and injury. EMS care is enhanced through the linking with other community health resources and integration within the health care system.

The Evolution of the EMS Agenda for the Future

The original *Practice Model* was developed in 2007 as one part of the NHTSA and HRSA's commitment to the *EMS Agenda*. Released in 1996, the *EMS Agenda* established a long-term vision for the future of EMS in the United States:

> "EMS of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and it will be integrated with other health care professionals and public health and safety agencies. It will improve community health and result in a more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net."

NOTE: *The 1996* EMS Agenda *was revised in 2018* (www.ems.gov/projects/ems-agenda-2050.html).

As a follow-up to the *EMS Agenda*, the 2000 *EMS Education Agenda* called for the development of a system to support the education, certification and licensure of entry-level EMS personnel that facilitates national consistency:

> "The *Education Agenda* established a vision for the future of EMS education, and called for an improved structured system to educate the next generation of EMS personnel. The *Education Agenda* built on broad concepts from the 1996 [*EMS] Agenda* to create a vision for an educational system that will result in improved efficiency for the national EMS education process. This was to enhance consistency in education quality ultimately leading to greater entry-level graduate competence."

The *Education Agenda* proposed an EMS education system with five integrated components: National EMS Core Content, National EMS Scope of Practice Model, National EMS Education Standards, National EMS Certification, and National EMS Education Program Accreditation. The *National EMS Core Content* (NHTSA, 2005), released in 2004, defined the domain of out-of-hospital care. The 2007 *Practice Model* divided the core content into levels of practice, defining the minimum corresponding skills and knowledge for each level. Our nation has made great progress in implementing these documents over the preceding decade.

Several forces have combined to revise the *Practice Model*:

1. As States have widely implemented the *Practice Model*, many have chosen to add skills to their authorized scopes of practice beyond the floor called for in the national model.

2. EMS research is providing new evidence about the effectiveness of interventions in the out-of-hospital setting.
3. Our Nation is facing new health problems including explosive growth in opiate abuse, threats of violence and terrorism, and new challenges related to a growing population over age 65.
4. The National EMS Information System (NEMSIS) is maturing to provide information about what levels of EMS personnel are performing which skills and interventions.

The development and publication of the *Practice Model* represents a transition from the historical connection between scope of practice and the EMS National Standard Curricula. The *Practice Model* is a consensus document, guided by data and expert opinion, that reflects the skills representing the *minimum* competencies of the levels of EMS personnel.

This update of the *Practice Model* is a natural and expected activity in ensuring that our EMS personnel are prepared to meet the needs and expectations of the communities they serve.

Implementation of the 2007 National EMS Scope of Practice Model

EMS crews today are better equipped than ever for the worst kinds of emergencies, from cardiac arrests and gunshot victims to car crashes and other life-threatening emergencies. In its *Future of Emergency Care* series, the National Academies of Science, Engineering, and Medicine (formerly known as the Institute of Medicine) envisioned high integration of the emergency and trauma care systems to function effectively. "Operationally," the NASEM reported, "this means that all of the key players in a given region...must work together to make decisions, deploy resources, and monitor and adjust system operations based on performance feedback."

A system that attracted a generation of emergency care personnel depicted in the popular 1970's television series, "Emergency," is now faced with the realities of providing care in a fragmented health care system with limited resources, overcrowded emergency departments, inadequate mental health resources, a nationwide opioid epidemic, escalating domestic and street violence, hazardous material risks and exposures, high consequence infectious disease, and an aging population with complex needs. Moreover, there are increasing threats from terrorism and other mass casualty events that require 24/7 operational readiness along with constant non-urgent social, medical, and transport requests that were not fully contemplated in the 2007 *Practice Model*. These competing concerns illustrate a crucial need to find innovative strategies to improve EMS care delivery inside and outside the boundaries of an ambulance. The licensure of EMS personnel, like that of other health care licensure systems, is part of an integrated and comprehensive system to improve patient care and safety and to protect the public. The challenge facing the EMS community including regulators is to develop a system that establishes national standards for personnel licensure and their minimum competencies while remaining flexible enough to meet the unique needs of State and local jurisdictions.

According to the 2011 National EMS Assessment (Mears et al., 2012), 826,111 licensed EMS personnel encounter nearly 37 million patients a year in the United States and reflect a multi-billion-dollar enterprise. Implementing the 2007 *Practice Model* required consideration of funding, reimbursement, transition courses, grandfathering of current personnel, development of educational and instructional support material, workforce issues, labor negotiations, impact on volunteerism, and other important issues. Most States required legislative and rulemaking

changes but the effort resulted in four nationally recognized levels of EMS clinicians as described by the 2007 *Practice Model,* compared to at least 44 different levels of EMS personnel certification reported in the United States in 1996.

According to data collected by the National Association of State EMS Officials (NASEMSO) in 2013 and published in 2014, 100 percent of States use the *Practice Model* as the minimum allowable psychomotor skill set at the EMT and paramedic levels. Thirty-eight States are using the *Practice Model* as the minimum allowable psychomotor skill set at the EMR level and 44 States are using the *Practice Model* as the minimum allowable psychomotor skill set at the AEMT level. Several States have completed the transition of the Intermediate-85 level to AEMT. In December 2017, the National Registry of Emergency Medical Technicians (NREMT) announced plans to permanently retire the Intermediate-99 exam used by a handful of States as a State assessment exam. The effective date for this transition to be complete is December 31, 2019.

According to data collected by NASEMSO in 2014, 90 percent of States effectively require National EMS Program Accreditation at the Paramedic level.

As of March 31, 2018, CAAHEP lists accredited EMS programs at the paramedic level in all 50 States. There are 611 paramedic programs that have successfully completed the accreditation process and are fully accredited, a 92 percent increase in the number of nationally accredited paramedic programs from 2007. Another 78 paramedic programs each hold a Letter of Review from the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions, meaning that they are actively engaged in the accreditation process.

According to real-time data (National Registry of Emergency Medical Technicians, 2017) available from the NREMT:

- 23 States and the District of Columbia require National EMS Certification as a basis for initial State licensure at the EMR level. An additional 4 States use National EMS Certification as an optional or alternate entry process at the EMR level. There are 22 States that do not license EMRs.
- 42 States and the District of Columbia require National EMS Certification as a basis for initial State licensure at the EMT level. An additional 4 States use National EMS Certification as an optional or alternate entry process at the EMT level. Four States maintain a State-based or combination process for certification and licensure at this level.
- 36 States and the District of Columbia require National EMS Certification as a basis for initial State licensure at the AEMT level. An additional 4 States use National EMS Certification as an optional or alternate entry process at the AEMT level. Ten States do not license AEMT's.
- 45 States and the District of Columbia require National EMS Certification as a basis for initial State licensure at the paramedic level. An additional 3 States use National EMS Certification as an optional or alternate entry process at the paramedic level. Two States maintain State-based processes for certification and licensure at this level.

Approach to Revising the National EMS Scope of Practice Model

Since the original 2007 *Practice Model* document, the evidence for which interventions and treatments are useful and effective in EMS settings has expanded significantly. Similarly, growing interest in EMS research is putting a sharper focus on how specific interventions are affecting the care and outcomes of patients in out-of-hospital settings.

This 2018 document makes use of a "Patient, Population, or Problem, Intervention, Comparison, and Outcome" (PICO) model to examine five clinical topics relevant to EMS treatment. The topics were selected for a systematic review of literature for consideration as high-priority issues requiring analysis due to the frequency or need of the interventions being provided at different levels from the 2007 *Practice Model* in some States. These are:

1. Use of opioid antagonists by all levels of EMS personnel;
2. Therapeutic hypothermia in cardiac arrest (i.e., targeted temperature management);
3. Pharmacological pain management following an acute traumatic event;
4. Hemorrhage control (i.e., tourniquets and hemostatic dressings); and
5. CPAP/BiPAP at the EMT level.

Two constraints on using evidence to establish an EMS scope of practice are the following.

1. While evidence may tell us what is or is not effective, it generally does not suggest what levels of EMS personnel are appropriate to perform specific interventions.
2. There are still limitations on the evidence available for much of what is included in an EMS scope of practice.

Several suggestions were received during the national revision process to increase the EMS scope of practice at all levels. To address each of these suggestions, therapeutic benefits to the overall patient care and expected clinical outcomes were considered with the level of risk to patients, the economic burdens of additional hours of education, requirements to maintain competency, and level of supervision needed to complete the task/skill. Clinical acts that were viewed by the expert panel to require experience and additional training beyond the basic education program required for licensure while not providing significant measurable benefit were not adopted as a national model.

In 2017, NHTSA considered the administration of an opioid antagonist and hemorrhage control including tourniquets and wound packing to be urgent and published a change notice to add these skills at all levels. This information has been added to the *Practice Model*.

As the *2018 National EMS Scope of Practice Model* has been developed it has relied upon extensive literature review, systematic analysis of policy documents regarding health care licensing and patient safety, the input of an expert panel, and extensive public input.

Analysis and research on patient safety, scope of practice, and EMS personnel competency must remain a priority among the leadership of national associations, Federal agencies, and research institutions. When EMS data collection, subsequent analysis, and scientific conclusions are published and replicated, later versions of the *Practice Model* should be driven by those findings.

The Role of State Government

Each State has the authority and responsibility to regulate EMS within its borders and to determine the scope of practice of State-licensed EMS personnel. The *Practice Model* is a consensus-based document that was developed to improve the consistency of EMS personnel licensure levels and nomenclature among States; it does not have regulatory influence unless adopted by a State. However, the widespread use and adoption of the *Practice Model* suggests that it represents an accepted national standard. Any State that adopts a scope of practice that significantly deviates below or above this national model should be guided by a collaborative process that analyzes the potential benefit, safety risks, costs, and required training specific to the structure of the EMS system within that State.

The *Practice Model* identifies the psychomotor skills and knowledge necessary for the minimum competence of each nationally identified level of EMS personnel. This competence is assured by completion of a nationally accredited educational program and national certification. This model will be used to revise the National EMS Education Standards (NHTSA, 2009), national EMS certification exams, and national EMS educational program accreditation. Under this model, to be eligible for State licensure EMS personnel must be educated and verifiably competent in the minimum cognitive, affective, and psychomotor skills needed to ensure safe and effective practice at that level. Eligibility to practice is dependent on education, certification, State licensure, and credentialing by the physician medical director.

While each State has the right to establish its own levels of EMS personnel and their scopes of practice, staying as close to this model as possible, *and especially not going below it for any level*, will increase the consistency of the nomenclature and competencies of EMS personnel, facilitate reciprocity, improve professional mobility, standardize professional recognition, and decrease the necessity of each State developing its own education and certification materials. The *Education Standards*, national certification, national educational program accreditation, and publisher-developed instructional support material provide States with essential infrastructure support for each nationally defined EMS licensure level.

Some States permit licensed EMS personnel to perform skills and roles beyond the minimum skill set as they gain knowledge, additional education, experience, and (possibly) additional certification (See also Section III Specialty Care Delivered by Licensed EMS Personnel). Care must be taken to consider the level of cognition and critical thinking necessary to perform a skill safely. For instance, some skills may be simple to perform, but require considerable clinical judgment to know when they should or should not be performed.

The *Practice Model* will continue to serve EMS in the future as it is revised and updated to include changes in medical science, new technology, and research findings.

II. Understanding Professional Scope of Practice

Overview

"Scope of practice" is a legal description of the distinction between licensed health care personnel and the lay public as well as among the different levels of licensed health care professionals. It describes the authority vested by a State in people who are licensed in that State. In general, scopes of practice focus on activities regulated by law (for example, starting an intravenous line, administering a medication, etc.). This includes technical skills that if done improperly represent a significant hazard to the patient and therefore must be regulated for public protection. Scope of practice establishes which activities and procedures that would represent illegal activity if performed without a license and restricts the use of professional titles to people who are authorized by the State. In addition to drawing the boundaries between professionals and laypeople, scope of practice also defines the boundaries among professionals, creating either exclusive or overlapping domains of practice.

> *Scope of practice is a description of what a licensed person legally can and cannot do.*

This *Practice Model* should be used by the States to develop scope of practice legislation, rules, and regulations. The specific mechanism that each State uses to define the State's scope of practice for EMS personnel varies. State scopes of practice may be more specific than those included in this model and may specifically identify both the minimum and maximum skills and roles of each level of EMS licensure.

> *Generally, changing a law is more difficult than changing a regulation; changing a regulation is more difficult than changing a policy.*

Scopes of practice are typically defined in law, regulations, and/or policy documents. Some States include specific language within the law, regulation, or policy, while others refer to separate documents using a technique known as "incorporation by reference." The *Practice Model* provides a mechanism to implement comparable EMS scopes of practice between States.

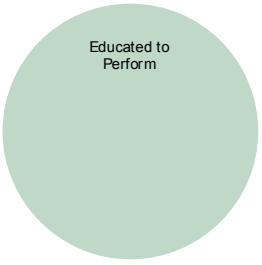
Scopes of practice need not define every activity of a licensed person (for example, lifting and moving patients, taking a blood pressure, direct pressure for bleeding control, etc.). The *Practice Model* includes suggested verbiage for the State scopes of practice in the section titled "EMS Personnel Scopes of Practice." The interpretive guidelines include a more detailed list of skills discussed by the expert panel. These skills, which generally should not appear in scope of practice regulatory documents, are included to provide the user with greater insight as to the deliberations and discussion of the group and are not intended to serve as a comprehensive list of permitted skills.

The Interdependent Relationship Between Education, Certification, Licensure, and Credentialing

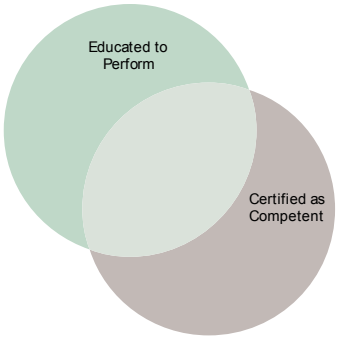
The *Practice Model* establishes a framework that ultimately determines the range of skills and roles that a person possessing a State EMS license is authorized to do on a given day in a given

EMS system. It is based on the notion that education, certification, licensure, and credentialing represent four separate but related activities.

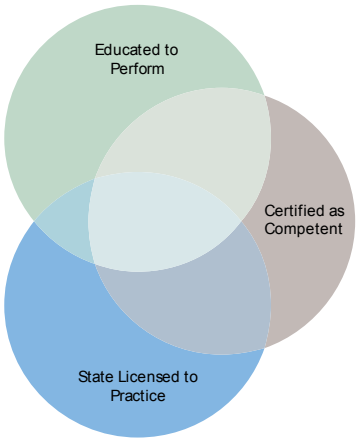
Education includes all the cognitive, psychomotor, and affective learning that people have undergone throughout their lives. This includes entry-level education, continuing professional education, and both formal and informal learning. Clearly, many people have extensive education that in some cases exceeds their EMS skills or roles.



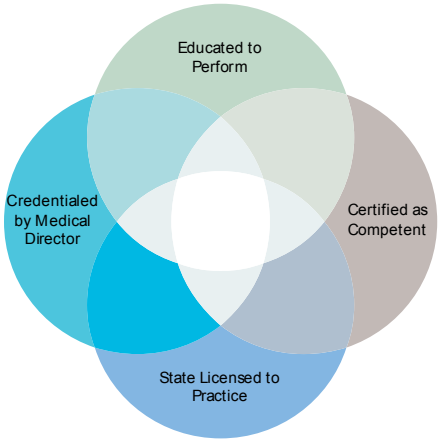
Certification is an external verification of the competencies that a person has achieved and typically involves an examination process. While certification exams can be set to any level of proficiency, in health care they are typically designed to verify that a person has achieved minimum competency to assure safe and effective patient care.



Licensure represents legal authority granted to a person by the State to perform certain restricted activities. Scope of practice represents the legal limits of the licensed person's performance. States have mechanisms to define the margins of what a person is legally permitted to perform. This authority granted by the State is defined as licensure in this document, but some States still use "certification" to describe the same granting of authority to practice for EMS personnel. In these cases, this State authority should not be confused with certification to verify competency as described in the preceding paragraph. Throughout this document, licensure will refer to the authority of the State to grant a person the ability to practice at a certain level of EMS practitioner, whether or not a State refers to this process as certification.



Credentialing is a clinical determination that is the responsibility of a physician medical director. It is the employer or affiliating organization's responsibility to act on the clinical credentialing status of EMS personnel in making employment and deployment decisions.



For every person, these four domains are of slightly different relative sizes. However, one concept remains constant: a person may only perform a skill or role for which that person is:

- educated (has been trained to perform the skill or role), AND
- certified (has demonstrated competence in the skill or role), AND
- licensed (has legal authority issued by the State to perform the skill or role), AND
- credentialed (has been authorized by medical director to perform the skill or role).

This relationship is represented graphically in Figure 1.

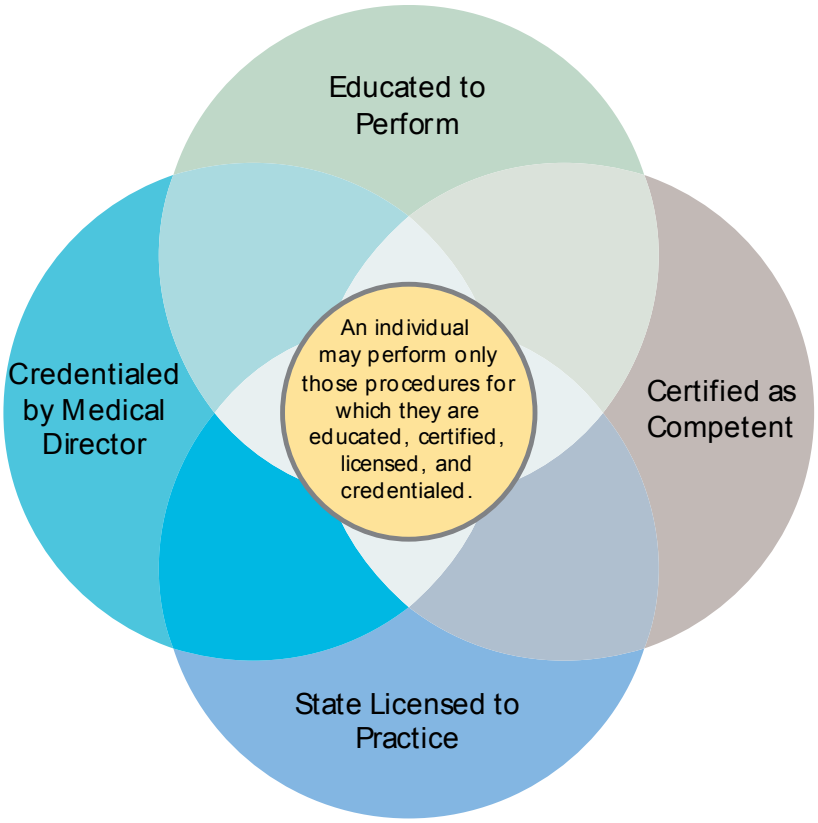


Figure 1. The relationship among education, certification, licensure, and credentialing

The center of Figure 1, where all the four elements overlap, represents skills and roles for which a person has been educated, certified, licensed by a State, and credentialed. This is the only acceptable region of performance, as it entails four overlapping and mutually dependent levels of public protection: education, certification, licensure, and credentialing. People may perform those roles and skills for which they are educated, certified, licensed, AND credentialed.

A significant risk to patient safety occurs when EMS personnel are placed into situations and roles for which they are not experientially or educationally prepared. It is the shared responsibility of medical oversight by a physician, clinical and administrative supervision, regulation, and quality assurance to ensure that EMS personnel are not placed in situations where they exceed the State's scope of practice. For the protection of the public, regulation must assure that EMS personnel are functioning within their scope of practice, level of education, certification, and credentialing process. Figure 2 illustrates the interconnections among education, certification of baseline competency, licensing by a regulating body, and credentialing by the medical director.

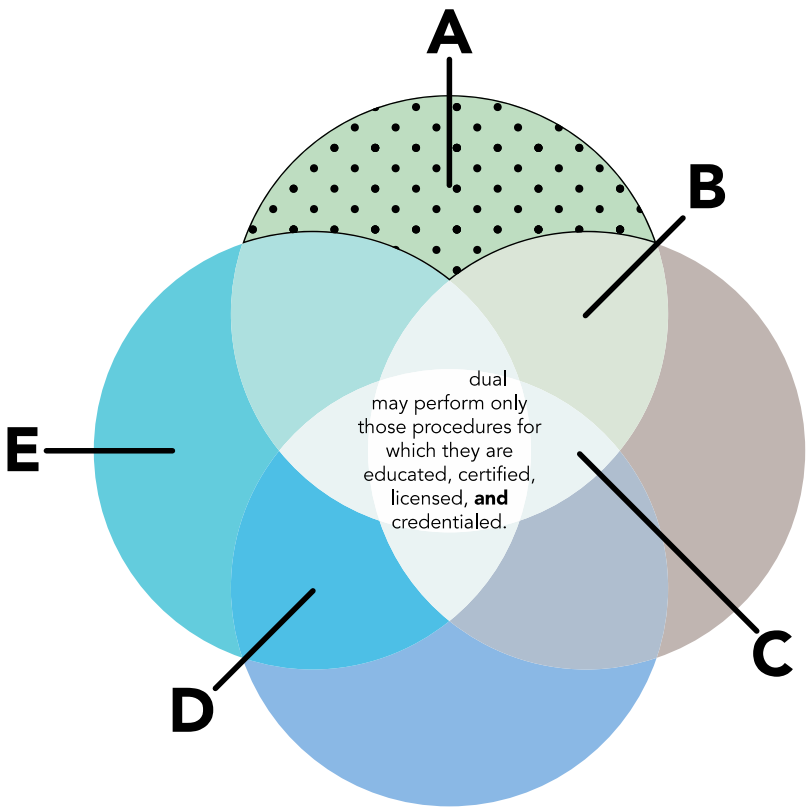
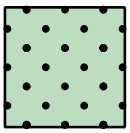
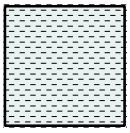


Figure 2. Skill and role situations not covered by all four elements for protection of the public



Region A: represents skills and roles for which a person has received education, but is neither certified, licensed, nor credentialed. For example, an EMT in a paramedic class is taught paramedic level skills; despite being trained, the EMT cannot perform those skills until such time that the person is certified, licensed, and credentialed by the local EMS medical director.

Region B: represents skills and roles in which a person has been educated and certified, but are not part of the State license and credentialing. For example, a paramedic who trained as a corpsman is educated and certified in basic suturing; however, the skill is not considered "core" in the civilian sector. It would now be out of that person's scope of practice, and cannot be performed without special review and authorization by the State and medical director.



Region C: represents skills and roles for which a person is educated, certified, and licensed, but has no local/jurisdictional credentialing. For example, an off-duty paramedic arriving at the scene of an incident outside of his jurisdiction usually is not credentialed to perform advanced skills. In this case, performing an advanced skill would represent a violation of his scope of practice.

Region D: represents skills or roles the State has authorized (licensed) but are not addressed by initial education programs or certification processes. These skills require local entities to assure the education and competency verification in addition to local credentialing. For example, rapid sequence induction for intubation (RSI) in some States is legally permitted, but usually not taught as part of the initial education, nor is it part of the certification process. Some people (for example, flight paramedics) may be authorized to perform RSI; however, this is only permissible if the local entity assumes the responsibility for satisfying the requirements of education and certification of competency. Credentialing remains mandatory, and additional processes may be needed to satisfy local physician medical direction that skills in this region are safe and appropriate. Nonetheless, all four domains must be accomplished before any skill or role can be authorized.

Region E: represents skills or roles that a medical director wants people to perform but for which they have not yet been educated, certified, or licensed to perform. Typically, skills and roles in this region are new or emerging interventions that have the potential to drive the future of EMS practice based on evolving evidence. Innovations such as waveform capnography, CPAP, and the use of naloxone by EMRs have all originated in this region. There is considerable State-to-State variability in dealing with this situation. Some States have regulations that restrict licensed people from functioning beyond their scope of practice. In others, regulatory mechanisms exist that enable local physicians to assume responsibility for the performance of new skills and roles performed by EMS providers. Most States fall somewhere between these extremes and have mechanisms by which local medical directors can obtain expansion/variance of a scope of practice if they can demonstrate the need and appropriate mechanism to reasonably assure patient safety. In these circumstances, if no process exists to obtain State level authorization for additional skills or roles, then items that fall in Region E cannot be practiced. Therefore, it is important that States recognize the need for innovation and progression within the field, and establish processes for Region E interventions to be performed; appropriate education, evaluation and certification under the medical director's oversight must occur prior to implementation. Only then can these new interventions work their way into the standardized education, certification, and licensing domains to become part of the ever-evolving standard of care.

In many States, day-to-day clarification of scopes of practice, management of an appeal process, or otherwise assuring the adequacy of medical direction is the role of the State EMS medical director. Some States have licensure boards, often consisting of medical directors, administrators, peers, and public representatives who help adjudicate and clarify scope of practice issues.

Scope of Practice Versus Standard of Care

Scope of practice does not define a standard of care, nor does it define what should be done in a given situation (i.e., it is not a practice guideline or protocol). It defines what is legally permitted to be done by some or all the licensed people at that level, not what must be done. Table 1 describes some of the differences between scope of practice and standard of care.

Table 1. Relationship between scope of practice and standard of care

	Scope of Practice	Standard of Care
Purpose	Deals with the question, "Are you/were you *allowed* to do it?"	Deals with the question, "Did you do the right thing and did you do it properly?"
Legal implications	Act of commission is a criminal offense.	Act of commission or omission not in conformance with the standard of care may lead to civil liability.
Variability	May vary from person to person. Does not vary based on circumstances.	Situational, depends on many variables.
Defined by	Established by statute, rules, regulations, precedent, and/or licensure board interpretations.	Determined by scope of practice, literature, expert witnesses, and juries.
Miscellaneous	It is difficult to regulate knowledge through scope of practice.	Used to evaluate the totality of circumstances. What would a reasonable EMS person do in the same or similar circumstances?

A Comprehensive Approach to Safe and Effective Out-of-Hospital Care

Scope of practice is only one part of health care regulation and regulation is only one component of a comprehensive approach to improved patient care and safety. The primary goal of State regulation of EMS personnel is to protect the public from harm by ensuring EMS personnel possess a minimum level of competency and professional behaviors. Safe and effective EMS care is the cumulative effect of a cascade of many individual decisions involving every level of EMS leadership, medical direction, supervision, management, and regulation. Safe and effective patient care is the first priority and shared responsibility of everyone in an EMS agency and the EMS system. Safe and effective care cannot be accomplished through any single activity, but is best accomplished with an integrated system of checks and balances. All components of this comprehensive approach to safe and effective patient care are mutually supportive of and dependent upon each other.

III. Special Considerations

Liability in EMS Licensing and Oversight

A license is the official or legal permission to engage in or perform a regulated activity. In the United States, State governments generally hold the authority to issue licenses including EMS licenses. This is important because States ultimately need to be able to halt EMS personnel from performing in ways that are dangerous or harmful to the public.

Licensing differs from certification in that certification is an affirmation of competence while licensing is the authorization to perform the regulated health care activity. EMS personnel most commonly function on behalf of some volunteer or career organization that acts in a supervisory relationship as their employer.

EMS personnel have functioned under the supervision of physician medical directors since the 1960s. This physician oversight has been invaluable in assuring and improving the quality of care provided by EMS personnel. The close relationship of EMS personnel and physicians in this evolving health care discipline and descriptions of medical direction in early EMS curricula has led to the impression and belief by some that medical direction physicians are extending their licenses to authorize EMS practice. The logic of that belief would be that if an EMS person acted incompetently or dangerously, the State would take an action on the physician medical director's license. Not only would that be ineffective in halting the EMS practitioner's practice, it would put at risk the physician who might be able to help correct whatever problem exists with the EMS practitioner's practice.

The concept that EMS personnel are somehow practicing "under the physician's license" is simply not accurate. The umbrella of physician supervision and collaboration can never be used to replace the certification, scope of practice and individual responsibility of licensed EMS personnel. EMS personnel hold their own licenses and the relevant State authority can restrict or remove those licenses to stop incompetent or dangerous practice.

EMS personnel do, however, practice under the oversight of physician medical directors, who are expected to provide appropriate supervision in the interest of public safety and are obligated to revoke or restrict local credentialing as appropriate. Failure to provide appropriate oversight can be determined to be inadequate supervision and expose the physician to professional liability. In this respect, physician medical directors can be accountable, not for individual acts of EMS personnel, but for their larger oversight role.

Scope of Practice for Special Populations

EMS personnel are expected to meet the urgent health care needs of all patients with consideration to age, race, gender, cultural, religious, and ethnic considerations consistent with their defined scope of practice. Recognized special populations include, but may not be limited to, children; older patients; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) patients; bariatric patients; patients with disabilities; and patients with limited access to health care due to geographic, demographic, socioeconomic, or other reasons.

Scope of Practice During Disasters, Public Health Emergencies, and Extraordinary Circumstances

The *Practice Model* is intended to cover a range of situations and circumstances where EMS personnel may provide emergency care. It is virtually impossible to create a scope of practice that considers every unique situation, extraordinary circumstance, and possible practice situation. In some cases, EMS personnel may be the only medically trained people at the scene of a disaster when other health care resources are overwhelmed. This document cannot account for every situation, but rather is designed to establish a system that works for entry-level personnel under normal circumstances. States may wish to modify or expand the scope of practice of EMS personnel in times of disaster or crisis with proper education, medical oversight, and quality assurance to reasonably protect patient safety.

Scope of Practice for EMS Personnel Functioning in Nontraditional Roles

The delivery of health care has been transformed over the last half-century by exponential and significant advances in medicine, research, and technology. The increasing portability and affordability of diagnostic and treatment equipment and the demand to increase care quality while reducing the cost of providing it has changed the demand for health care services in ways that were not envisioned with the passage of the National Traffic and Motor Vehicle and Safety Act of 1966 (Pub. L. No. 89-563, 80 Stat. 718). EMS personnel are identifying volunteer and career opportunities in a range of nontraditional settings that fulfill an important public health, public safety, and patient care need, such as large-scale concerts, sporting events and festivals, industrial, frontier and wilderness environments, wildland fire settings, community health, and more. Enabled by progressive rulemaking, occupational partners and innovative health care systems have been successfully using educated, experienced, and licensed EMS personnel in patient care settings, such as health clinics and hospitals for the past several years and they have become recognized as an invaluable member of the health care team. States with practice restrictions based on location, vehicle use, agency type, or transport provisions are encouraged to review existing laws, regulations, and policies to identify barriers that prevent EMS personnel from functioning in any setting at a level to the full extent of their education, certification, licensure, and credentialing.

Specialty Care Delivered by Licensed EMS Personnel

Specialization of EMS personnel continues to be an evolving area of interest to the national EMS community. This reflects a broader specialization trend that has occurred in medicine for over a century as well ongoing specialization in nursing and other allied health fields. In general, specialization occurs in response to an identified need for an expanded body of knowledge and skills that are best served by a formal supplemental educational and credentialing process. In many instances throughout health care the development and oversight of a specialty recognition process is led by health professionals through specialty boards and implemented in conjunction with State regulators. This approach effectively combines national consistency achieved through the specialty certification process with the legal authority to practice.

Specialty recognition, credentialing, or endorsement is the outcome of a formally defined process and mechanism for actively assessing that a person possesses and has mastered a unique body of knowledge *over and above entry-level* cognitive, affective, and psychomotor domains of learning and that the person can apply this knowledge and related skill set to improve care provided for

patients. Numerous health care and non-health care professions regulated by States have one or more specialty certification areas that have been defined, in part, by members of the profession itself. Several EMS specialties have emerged since the 2000 release of the *Education Agenda.*

Integration of specialty care requires appropriate educational preparation, a rigorous certification process, integration with State scope of practice and licensure regulations, and local credentialing by the medical director and EMS agency.

The legal authority for personnel to practice is established by State legislative action. Licensure authority prohibits anyone from practicing a profession unless they are licensed and authorized by the State, regardless of whether or not the person has been certified by a nongovernmental or private organization.

States often approach specialization policy though two mechanisms. The first is development of an additional licensure level beyond those described in this model. The second is to enact scope of practice regulations at the State level that allow for additional practice, often called an endorsement, in addition to an existing license level. This second approach is used extensively in the medical and nursing professions. Both approaches benefit from ongoing cooperation and coordination with nongovernmental specialty boards.

Military to Civilian EMS Transition

Military medics and corpsmen treat combat wounds in some of the harshest conditions that most civilian EMS personnel will likely never see and they are undoubtedly well qualified to serve domestic missions to achieve zero preventable deaths in the "war on trauma." While support for military-to-civilian EMS transition is broad, the cognitive, affective, and psychomotor coursework for military medical trainees is variable depending on the individual service member's military assignment, which makes determining related equivalency and awarding experiential credit for military service across five military branches somewhat complex. Much work has been done to identify pathways for military corpsmen to transition to civilian EMS positions.

- The U.S. Department of Defense has consolidated nearly all health care specialist training across the armed services branches to the operational center at the Medical Education and Training Campus (METC) at Fort Sam Houston, Texas.[2] METC is working to ensure that more service-required education and training programs satisfy the ever-increasing course completion requirements of the civilian sector.
- EMS programs are increasingly providing "advanced placement" evaluation and assistance to separating service members, particularly at the AEMT and paramedic levels.
- Over the next several years, health science training programs at METC will transition to the METC Branch Campus of the College of Allied Health Sciences at the Uniformed Services University (Bethesda, Maryland) so all military students will receive consistent and recognizable transcripts from a regionally accredited, degree-granting institution of higher education.

[2] Fort Sam Houston is one of four elements, along with Randolph Air Force Base, Lackland Air Force Base, and Martindale Army Airfield, that were merged in 2010 to create Joint Base San Antonio.

- States have developed updated models for conducting EMS personnel licensure evaluations including the integration of EMS licensees from other States and from the military setting.

Course completion of a program that meets or exceeds the *Education Standards* signifies that a person has fulfilled entry-level education requirements that lead to National EMS Certification provided by the National Registry of Emergency Medical Technicians. Active NREMT certification has been demonstrated to be the most expeditious path for military personnel to seek EMS licensure with the States.

IV. Description of Levels

Emergency Medical Responder

Description

The EMR is an out-of-hospital practitioner whose primary focus is to initiate immediate lifesaving care to patients while ensuring patient access to the emergency medical services system. EMRs possess the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and rely on an EMS or public safety agency or larger scene response that includes other higher-level medical personnel. When practicing in less populated areas, EMRs may have a low call volume coupled with being the only care personnel for prolonged periods awaiting arrival of higher levels of care. An EMR may assist, but should not be the highest-level person caring for a patient during ambulance transport. EMRs are often the first to arrive on scene. They must quickly assess patient needs, initiate treatment, and request additional resources.

Emergency medical responders:

- Function as part of a comprehensive EMS response, community, health, or public safety system with clinical protocols and medical oversight.
- Perform basic interventions with minimal equipment to manage life threats, medical, and psychological needs with minimal resources until other personnel can arrive.
- Are an important link in the 9-1-1 and emergency medical services systems.

Other Attributes

The focused and limited scope of this level makes it suitable for employee cross-training in settings where emergency medical care is not the EMR's primary job function. Examples include firefighters, law enforcement, lifeguards, backcountry guides, community responders, industrial workers, and similar jobs. EMRs advocate health and safety practices that may help reduce harm to the public.

Education Requirements

Successful completion of an EMR training program that is:

- Compliant with a uniform national standard for quality, and
- Approved by the State or U.S. Territory.

Primary Role

Initiate patient care within the emergency medical services system.

Type of Education

Vocational/technical setting:

- Certificate awarded for successful completion.

Critical Thinking

Within a limited set of protocol-driven, clearly defined principles.

Level of Supervision

General medical oversight required. Assist higher-level personnel at the scene and during transport.

Emergency Medical Technician

Description

An EMT is a health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, apply basic knowledge and skills necessary to provide patient care and medical transportation to/from an emergency or health care facility. Depending on patient's needs and/or system resources, EMTs are sometimes the highest level of care patients will receive during ambulance transport. An EMT is often paired with higher levels of personnel as part of an ambulance crew or other responding group. With proper supervision, an EMT may serve as a patient care team member in a hospital or health care setting to the full extent of the EMT's education, certification, licensure, and credentialing. In a community setting, an EMT might visit patients at home and make observations reported to a higher-level authority to help manage a patient's care. When practicing in less populated areas, EMTs may have low call volume coupled with being the only care personnel during prolonged transports. EMTs may provide minimal supervision of lower level personnel. EMTs can be the first to arrive on scene; they are expected to quickly assess patient conditions, provide stabilizing measures, and request additional resources, as needed.

Emergency medical technicians:

- Function as part of a comprehensive EMS response, community, health, or public safety system with defined clinical protocols and medical oversight.
- Perform interventions with the basic equipment typically found on an ambulance (Recommended Essential Equipment for Basic Life Support and Advanced Life Support Ground Ambulances 2020: A Joint Statement Position Statement, 2021) to manage life threats, medical, and psychological needs.
- Are an important link within the continuum of the emergency care system from an out-of-hospital response through the delivery of patients to definitive care.

Other Attributes

The majority of personnel in the EMS system are licensed at the EMT level. EMTs play many important roles and possess the knowledge and skill set to initially manage any emergency until a higher level of care can be accessed. In areas where AEMT or paramedic response is not available, the EMT may be the highest level of EMS personnel a patient encounters before reaching a hospital. EMTs advocate health and safety practices that may help reduce harm to the public.

Education Requirements

Successful completion of an EMT training program that is:

- Compliant with a uniform national standard for quality, and
- Approved by the State or U.S. Territory.

Primary Role

Provide basic patient care and medical transportation within the emergency care system.

Type of Education

Vocational/Technical setting:

- Diploma or certificate awarded for successful completion.

Critical Thinking

Within a limited set of protocol-driven, clearly defined principles that:

  - Engages in basic risk versus benefit analysis.
  - Participates in making decisions about patient care, transport destinations, the need for additional patient care resources, and similar judgments.

Level of Supervision

General medical oversight required. Some autonomy at basic life support level, assist higher-level personnel at the scene and during patient transport.

Advanced Emergency Medical Technician

Description

The AEMT is a health professional whose primary focus is to respond to, assess, and triage non-urgent, urgent, and emergent requests for medical care, apply basic and focused advanced knowledge and skills necessary to provide patient care and/or medical transportation, and facilitate access to a higher level of care when the needs of the patient exceed the capability level of the AEMT. The additional preparation beyond EMT prepares an AEMT to improve patient care in common emergency conditions for which reasonably safe, targeted, and evidence-based interventions exist. Interventions within the AEMT scope of practice may carry more risk if not performed properly than interventions authorized for the EMR/EMT levels. With proper supervision, an AEMT may serve as a patient care team member in a hospital or health care setting to the full extent of their education, certification, licensure, and credentialing. In a community setting an AEMT might visit patients at home and make observations that are reported to a higher-level authority to help manage a patient's care.

Advanced emergency medical technicians:

- Function as part of a comprehensive EMS response, community, health, or public safety system with medical oversight.

- Perform interventions with the basic and advanced equipment typically found on an ambulance.
- Perform focused advanced skills and pharmacological interventions that are engineered to mitigate specific life-threatening conditions, medical, and psychological conditions with a targeted set of skills beyond the level of an EMT.
- Function as an important link from the scene into the health care system.

Other Attributes

The learning objectives and additional clinical preparation for AEMTs exceed the level of EMTs. In areas where paramedic response is not available, the AEMT may be the highest level of EMS personnel a patient encounters before reaching a hospital. AEMTs advocate health and safety practices that may help reduce harm to the public.

Education Requirements

Successful completion of a nationally accredited or CAAHEP-accredited AEMT program that meets all other State/Territorial requirements. (The target for full implementation of AEMT program accreditation is January 1, 2025.)

Primary Role

Provide basic and focused advanced patient care; determine transportation needs in the health care system.

Type of Education

Vocational/technical or academic setting:

- Diploma, certificate, or associates degree awarded for successful completion.

Critical Thinking

Within a limited set of protocol-driven, clearly defined principles that:

  - Engages in basic risk versus benefit analysis.
  - Participates in making decisions about patient care, transport destinations, the need for additional patient care resources, and similar judgments.

Level of Supervision

Medical oversight required. Minimal autonomy for limited advanced skills. Provides some supervision of lower level personnel. Assist higher-level personnel at the scene and during transport.

Paramedic

Description

The paramedic is a health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, apply basic and advanced knowledge and skills necessary to determine patient physiologic, psychological, and

psychosocial needs, administer medications, interpret and use diagnostic findings to implement treatment, provide complex patient care, and facilitate referrals and/or access to a higher level of care when the needs of the patient exceed the capability level of the paramedic. A paramedic often serves as a patient care team member in a hospital or other health care setting to the full extent of the paramedic's education, certification, licensure, and credentialing. Paramedics may work in community settings where they take on additional responsibilities monitoring and evaluating the needs of at-risk patients, as well as intervening to mitigate conditions that could lead to poor outcomes. Paramedics help educate patients and the public in the prevention and/or management of medical, health, psychological, and safety issues.

Paramedics:

- Function as part of a comprehensive EMS response, community, health, or public safety system with advanced clinical protocols and medical oversight.
- Perform interventions with the basic and advanced equipment typically found on an ambulance, including diagnostic equipment approved by an agency medical director.
- May provide specialized interfacility care during transport.
- Are an important link in the continuum of health care.

Other Attributes

Paramedics commonly facilitate medical decisions at emergency scenes and during transport. Paramedics work in a variety of specialty care settings including ground and air ambulances, and in occupational, hospital, and community settings. Academic preparation enables paramedics to use a wide range of pharmacology, airway, and monitoring devices as well as use critical thinking skills to make complex judgments such as the need for transport from a field site, alternate destination decisions, the level of personnel appropriate for transporting a patient, and similar judgments. Due to the complexity of the paramedic scope of practice and the required integration of knowledge and skills, many training programs are moving towards advanced training at the Associate degree or higher level.

Education Requirements

Successful completion of a nationally accredited paramedic program that meets all other State requirements.

Primary Role

Provide advanced care in a variety of settings; interpretive and diagnostic capabilities; determine destination needs within the health care system; specialty transport.

Type of Education

Academic setting:

- Diploma, certificate, associate or bachelors/baccalaureate degree awarded for successful completion.

Critical Thinking

Within a set of protocol-driven, clearly defined principles that:

- Engages in complex risk versus benefit analysis
- Participates in making decisions about patient care, transport destinations, the need for additional patient care resources, and similar judgments

Level of Supervision

Paramedics operate with collaborative and accessible medical oversight, recognizing the need for autonomous decision-making. Frequently provides supervision and coordination of lower level personnel.

V. Depth and Breadth of Knowledge

> *"Breadth of learning refers to the full span of knowledge of a subject. Depth of learning refers to the extent to which specific topics are focused upon, amplified, and explored. Within any area of study, there will be both breadth and depth of learning, which increase as students advance their knowledge" (SUNY Empire State College, 2018).*

It is important to note that the *Practice Model* and *Education Standards* assume a progression of the three domains of learning (cognitive, affective, and psychomotor) that affect EMS practice from the EMR level through the paramedic level. That is, licensed personnel at each level are responsible for all knowledge, judgments, and skills at their level and all levels *preceding* their level. The *Practice Model* also assumes that EMS personnel not only receive requisite knowledge, but they can comprehend data, apply knowledge, analyze and synthesize information, and evaluate the outcomes of their actions.

Typically, scope of practice refers to the tasks and roles that licensed personnel are legally authorized to perform. In general, it does not describe the requisite knowledge necessary to perform those tasks and roles competently. As outlined in the *Education Agenda*, the responsibility for determining the knowledge necessary to safely perform skills, tasks, and roles falls to the EMS educators.

The increasing depth and breadth of cognitive, affective, and psychomotor material envisioned across each level of EMS licensure is graphically represented in Figure 3.

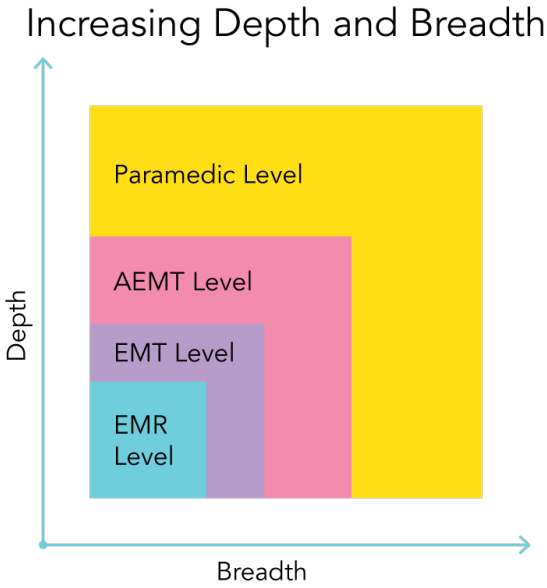


Figure 3. Increasing depth and breadth of knowledge from EMR through paramedic

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VI. Interpretive Guidelines

The interpretive guidelines are used to help guide the users of this document by providing additional insight into the discussions and deliberations that revolved around the decisions of the expert panel. These interpretive guidelines represent the collective opinions of the expert panel in June 2018 prior to incorporation of Change Notices 1.0 and 2.0 from March 29, 2021.

The interpretive guidelines are included to allow future users to apply similar methodology in deciding appropriateness of new interventions at each personnel level. They are illustrative and NOT all-inclusive.

I. Skill – Airway/Ventilation/Oxygenation

I. Skill – Airway/Ventilation/ Oxygenation	**EMR**	**EMT**	**AEMT**	**Paramedic**
Airway – nasal		X	X	X
Airway – oral	X	X	X	X
Airway – supraglottic			X	X
Bag-valve-mask (BVM)	X	X	X	X
CPAP		X	X	X
Chest decompression - needle				X
Chest tube placement – assist only				X
Chest tube – monitoring and management				X
Cricothyrotomy				X
End tidal CO_2 monitoring and interpretation of waveform capnography			X	X
Gastric decompression – NG Tube				X
Gastric decompression – OG Tube				X
Head tilt - chin lift	X	X	X	X
Endotracheal intubation				X
Jaw-thrust	X	X	X	X

I. Skill – Airway/Ventilation/ Oxygenation	EMR	EMT	AEMT	Paramedic
Mouth-to-barrier	X	X	X	X
Mouth-to-mask	X	X	X	X
Mouth-to-mouth	X	X	X	X
Mouth-to-nose	X	X	X	X
Mouth-to-stoma	X	X	X	X
Airway obstruction – dislodgement by direct laryngoscopy				X
Airway obstruction – manual dislodgement techniques	X	X	X	X
Oxygen therapy – High flow nasal cannula				X
Oxygen therapy – Humidifiers		X	X	X
Oxygen therapy – Nasal cannula	X	X	X	X
Oxygen therapy – Non-rebreather mask	X	X	X	X
Oxygen therapy – partial rebreather mask		X	X	X
Oxygen therapy – simple face mask		X	X	X
Oxygen therapy – Venturi mask		X	X	X
Pulse oximetry		X	X	X
Suctioning – Upper airway	X	X	X	X
Suctioning – tracheobronchial of an intubated patient			X	X

II. Skill – Cardiovascular/Circulation

II. Skill – Cardiovascular/ Circulation	EMR	EMT	AEMT	Paramedic
Cardiopulmonary resuscitation (CPR)	X	X	X	X

II. Skill – Cardiovascular/ Circulation	EMR	EMT	AEMT	Paramedic
Cardiac monitoring – 12-lead ECG acquisition and transmission		X	X	X
Cardiac monitoring – 12-lead electrocardiogram (interpretive)				X
Cardioversion – electrical				X
Defibrillation – automated / semi-automated	X	X	X	X
Defibrillation – manual				X
Hemorrhage control – direct pressure	X	X	X	X
Hemorrhage control – tourniquet	X	X	X	X
Hemorrhage control – wound packing	X	X	X	X
Transvenous cardiac pacing – monitoring and maintenance				X
Mechanical CPR device		X	X	X
Telemetric monitoring devices and transmission of clinical data, including video data		X	X	X
Transcutaneous pacing				X

III. Skill – Splinting, Spinal Motion Restriction, and Patient Restraint

III. Skill – Splinting, Spinal Motion Restriction (SMR), and Patient Restraint	EMR	EMT	AEMT	Paramedic
Cervical collar	X	X	X	X
Long spine board		X	X	X
Manual cervical stabilization	X	X	X	X
Seated SMR (KED, etc.)		X	X	X
Extremity stabilization - manual	X	X	X	X
Extremity splinting	X	X	X	X

III. Skill – Splinting, Spinal Motion Restriction (SMR), and Patient Restraint	EMR	EMT	AEMT	Paramedic
Splint – traction		X	X	X
Mechanical patient restraint		X	X	X
Emergency moves for endangered patients	X	X	X	X

IV. Skill – Medication Administration – Routes

IV. Skill – Medication Administration – Routes[3]	EMR	EMT	AEMT	Paramedic
Aerosolized/nebulized		X	X	X
Endotracheal tube				X
Inhaled		X	X	X
Intradermal				X
Intramuscular		X[4]	X	X
Intramuscular – auto-injector	X	X	X	X
Intranasal			X	X
Intranasal - unit-dosed, premeasured	X	X	X	X
Intraosseous – initiation, peds or adult			X	X
Intravenous			X	X
Mucosal/sublingual		X	X	X
Nasogastric				X
Oral		X	X	X

[3] Limited to Medical Director Approved Medications.
[4] Medical direction should ensure appropriate clinical experience and education, including the separate skills of medication preparation, medication dilution, filling a syringe from a multi-dose vial, and changing the needle on a syringe.

IV. Skill – Medication Administration – Routes[3]	EMR	EMT	AEMT	Paramedic
Rectal				X
Subcutaneous			X	X
Topical				X
Transdermal				X

V. Medical Director Approved Medications

V. Medical Director Approved Medications	EMR	EMT	AEMT	Paramedic
Use of epinephrine (auto-injector) for anaphylaxis (supplied and carried by the EMS agency)		X	X	X
Use of auto-injector antidotes for chemical/hazardous material exposures	X	X	X	X
Use of opioid antagonist auto-injector for suspected opioid overdose	X	X	X	X
Immunizations			X	X
Immunizations during a public health emergency		X	X	X
Inhaled – beta agonist/bronchodilator and anticholinergic for dyspnea and wheezing		X	X	X
Inhaled – monitor patient administered (i.e., nitrous oxide)			X	X
Intranasal - opioid antagonist for suspected opioid overdose	X	X	X	X
Intravenous			X[5]	X
Maintain infusion of blood or blood products				X
Oral aspirin for chest pain of suspected ischemic origin		X	X	X
Oral glucose for suspected hypoglycemia		X	X	X

[5] Limited to analgesia, antinausea/antiemetic, dextrose, epinephrine, glucagon, naloxone, and others defined by State/local protocol.

V. Medical Director Approved Medications	EMR	EMT	AEMT	Paramedic
Oral over-the-counter (OTC) analgesics for pain or fever		X	X	X
OTC medications, oral and topical				X
Parenteral analgesia for pain			X	X
Sublingual nitroglycerin for chest pain of suspected ischemic origin – limited to *patient's own prescribed medication*		X		
Sublingual nitroglycerin for chest pain of suspected ischemic origin			X	X
Thrombolytics				X

VI. Skill – IV Initiation/Maintenance Fluids

VI. Skill – IV Initiation/Maintenance Fluids	EMR	EMT	AEMT	Paramedic
Access indwelling catheters and implanted central IV ports				X
Central line – monitoring				X
Intraosseous – initiation, peds or adult			X	X
Intravenous access			X	X
Intravenous initiation - peripheral			X	X
Intravenous – maintenance of non-medicated IV fluids			X	X
Intravenous – maintenance of medicated IV fluids				X

VII. Skill – Miscellaneous

VII. Skill – Miscellaneous	EMR	EMT	AEMT	Paramedic
Assisted delivery (childbirth)	X	X	X	X
Assisted complicated delivery (childbirth)		X	X	X

VII. Skill – Miscellaneous	EMR	EMT	AEMT	Paramedic
Blood chemistry analysis				X
Blood pressure automated		X	X	X
Blood pressure – manual	X	X	X	X
Blood glucose monitoring		X	X	X
Eye irrigation	X	X	X	X
Eye irrigation –hands free irrigation using sterile eye irrigation device				X
Patient transport		X	X	X
Specimen collection via nasal swab[6]		X	X	X
Venous blood sampling			X	X

[6] Medical direction should ensure appropriate clinical experience to obtain an acceptable specimen in order to minimize inaccurate results.

VII. Definitions

academic—Based on formal education; scholarly; conventional.

academic institution—A body or establishment instituted for an educational purpose and providing college credits or awarding degrees.

accreditation—The granting of approval by an official review board after specific requirements have been met. The review board is non-governmental and the review is collegial and based on self-assessment, peer assessment, and judgment. The purpose of accreditation is student protection and public accountability.

advanced level care—Care that has greater potential benefit to the patient, but also greater potential risk to the patient if improperly or inappropriately performed, is more difficult to attain and maintain competency in, and requires significant background knowledge in basic and applied sciences. These include invasive and pharmacological interventions.

administered medication—The act of giving a medication to a patient that has been stocked and carried by EMS personnel. The patient may not have previously been determined by a physician to be an appropriate recipient of the medication.

certification—An external verification of the competencies that a person has achieved that typically involves an examination process.

continuing education—The continual process of life-long learning.

competence—The application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice role, within the context of public health, safety and welfare.

core content—The central elements of a professional field of study. The core content does not specify the course of study.

credentialing—A clinical determination that is the responsibility of a physician medical director that authorizes a practitioner to perform a skill or role.

curriculum—A particular course of study, often in a special field. For EMS education, it has traditionally included detailed lesson plans. (The responsibility for EMS curriculum has shifted to EMS educators and EMS programs based on the *Education Standards*.)

educational affiliation—An association with a learning institution (academic), the extent to which can vary greatly from recognition to integration.

entry-level competence—The level of competence expected of a person who is about to begin a career. Entry-level competence is sometimes defined as the minimum competence necessary to practice safely and effectively.

EMS system—Any specific arrangement of emergency medical personnel, equipment, and supplies designed to function in a coordinated fashion. May be local, regional, State, or national.

licensure—The legal authority granted to a person by the State to perform certain restricted activities. A license is generally considered a privilege and not a right.

National EMS Core Content—The document that defines the domain of out-of-hospital care.

National EMS Education Program Accreditation—The national accreditation process for institutions that sponsor EMS educational programs identified by the *Education Agenda*.

nationally recognized accrediting agency—An accrediting agency that the U.S. Secretary of Education recognizes under Title 34 CFR Part 602—The Secretary's Recognition of Accrediting Agencies.

National EMS Education Standards—The document that defines the terminal learning objectives for each Nationally defined EMS licensure level.

National EMS Scope of Practice Model—The document that defines scope of practice for each Nationally defined EMS licensure level.

outcome—The short-, intermediate-, or long-term consequence or visible result of treatment, particularly as it pertains to a patient's return to societal function.

practice analysis—A study conducted to determine the frequency and criticality of the tasks performed in practice.

registration—A listing of people who have met the requirements of the registration service.

registration agency—Agency traditionally responsible for the delivery of a product used to evaluate a chosen area. States may voluntarily adopt this product as part of their licensing process. The registration agency is also responsible for gathering and housing data to support the validity and reliability of their product.

regulation—Either a rule or a statute that prescribes the management, governance, or operating parameters for a given group; tends to be a function of administrative agencies to which a legislative body has delegated authority to promulgate rules/regulations to "regulate a given industry or profession." Most regulations are intended to protect the public health, safety, and welfare.

scope of practice—Defined parameters of various duties or services that may be provided by a person with specific credentials. Whether regulated by rule, statute, or court decision, it represents the limits of services a person may legally perform.

testing agency—Agency traditionally responsible for delivering a contracted examination. The responsibility of interpreting the results and defending the validity of those judgments is placed on the contractor.

vocational/technical—Refers to schools or programs specializing in the skilled trades, applied sciences, technology, and career preparation.

Appendix A: History of Occupational Regulation in EMS

The development of modern civilian EMS stems largely from lessons learned in providing medical care to soldiers injured in military conflict.

Building on these lessons, many rescue squads and ambulance services emerged in the civilian sector, often community-based in nature. Hospitals and funeral homes were also common sources of nascent response and transportation systems. While well-intentioned, most of these personnel were untrained, poorly equipped, unorganized, and unsophisticated. The systems were unregulated, and no State or national standards existed. By the 1960s, prehospital care in the United States had evolved into a patchwork of well-intentioned but uncoordinated efforts. This all changed in the mid-1960s.

In 1960, the President's Committee for Traffic Safety recognized the need to address "Health, Medical Care and Transportation of the Injured" to reduce the nation's highway fatalities and injuries.

In 1966, the National Academy of Sciences published a "white paper" report titled *Accidental Death and Disability: The Neglected Disease of Modern Society* (Committee on Trauma & Committee on Shock, 1966) that called for improved training of ambulance personnel. This report quantified the magnitude of traffic-related death and disability while vividly describing the deficiencies in prehospital care in the United States. The white paper made many recommendations regarding ambulance systems, including a call for ambulance standards, State-level policies and regulations, and adopting methodology for providing consistent ambulance services at the local level.

The Highway Safety Act of 1966 ((P.L. 89-564, 80 Stat. 731) required each State to have a highway safety program that complied with uniform Federal standards, including "emergency services." This provided the impetus for NHTSA's early leadership role in EMS system improvements. Initial NHTSA EMS efforts were focused on improving the education of prehospital personnel such as the writing of the National Standard Curricula (NSC). Funding was also provided to assist States with the development of State EMS offices. Subsequent NHTSA efforts were oriented toward comprehensive EMS system development and included, for instance, model State EMS legislation (Weingroff & Seabron, 2003).

The genesis of State EMS systems can also be traced to the early 1970s, when an unprecedented level of funding from the Federal Government and the Robert Wood Johnson Foundation prompted the establishment of regional EMS systems and demonstration projects throughout the country. The Emergency Medical Services Systems Act of 1973 (enacted by Congress as Title XII of the Public Health Service Act), yielded 8 years and over $300 million of investment in EMS systems planning and implementation. The availability of EMS personnel and their training were two components that eligible entities were required to focus on, resulting in the first generation of legislation and regulation of EMS personnel levels (NHTSA, 1996).

Beginning in 1971, NHTSA published the first 81-hour curriculum for training EMT-Ambulance personnel. Other NSC initiatives followed for EMT-paramedics and EMT-intermediates. These propelled EMS systems forward in terms of standardizing the preparation of people filling roles

in providing prehospital emergency care. The NSC gave detailed "how to teach this course" guidance down to the minute in how much time to spend on specific learning objectives. It was initially helpful to instructors who had never taught anyone to care for patients in the prehospital environment. The NSC became functionally synonymous with the *scope of practice* that EMS personnel could perform. EMS textbooks were published to align with the NSC. Many States referenced the NSC in their statutes and rules.

The practical effect of the NSC for EMS personnel was that an EMS person could generally do what they were taught to do. The practice and educational preparation of most other allied health professions begins with agreement on what a person in the job can do (i.e., a scope of practice) and then developing the education resources to prepare a qualified person to do that role. For EMS, education was driving practice and for all other professions, practice drives education.

As EMS systems began to mature, limitations of the NSC became increasingly evident. A few examples of these limitations included:

- **Integration of new technologies and evidence**. When automated external defibrillators (AEDs) became available and proved to be both reliable and effective for cardiac arrest resuscitation, there had to be an update to the NSC before use of AEDs could be widely taught to EMS personnel. The opposite was also true as EMS devices or practices began to be shown as harmful. The only way to remove content from teaching and practice was to revise the NSC.
- **The professionalism of EMS educators**. EMS courses began to be taught in many areas by experienced adult educators. These educators questioned the constraints of the NSC when they found they needed more or less time than what was called for. The NSC provided no flexibility for how to deliver EMS courses.
- **State EMS Office role conflict**. States have the responsibility of setting scopes of practice for all levels of health care personnel and those who adopted the NSC functionally handed off this responsibility to a national document. There was no effective way structurally for States to reference the NSC and make local adaptations to both teaching and practice.

As a practical matter, the NSC also proved difficult and expensive to update. Controversy on periodic revisions stemmed from debate about EMS practice rather than updates to the education program.

The development of the *EMS Agenda for the Future* and the follow-on *EMS Education Agenda for the Future: A Systems Approach* called for a new model of EMS education. Central to the new model was a National EMS Scope of Practice Model (SoPM) setting a floor on expectations for what people would be prepared to do in their roles. Once the SoPM was established, National EMS Education Standards were developed to guide instructors in the depth and breadth of content to be taught. The development of curricula on how best to teach the courses at each level is now left to individual instructors. EMS publishers provide an array of texts and other educational support material.

One function of State EMS offices was to ensure the competence of the State's EMS personnel. States employed many strategies to help assure safe and effective EMS practice, including

licensure and certification. Unfortunately, these terms developed multiple connotations in EMS. In some cases, the meanings differed from other disciplines, causing confusion and inconsistency at the national level.

In 1981, the Omnibus Budget Reconciliation Act (OBRA) eliminated the categorical Federal funding to States established by the 1973 EMS Systems Act in favor of block grants to States for preventive health and health services. This change shifted responsibility for EMS from the Federal to the State level (Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, 2007). By 1990 EMS in the United States had enjoyed many successes. Not only did EMS systems grow, but EMS became a career and volunteer activity for hundreds of thousands of talented, committed, and dedicated people. Emergency medical care was available to virtually every person in the country by simply dialing 9-1-1 from any telephone. Despite this progress, EMS was affected by many factors in the broader health care system.

In 1992, the National Association of EMS Physicians and the National Association of State EMS Directors saw a need for a long-term strategic direction for EMS, and the *EMS Agenda for the Future* was initiated with support from NHTSA and the Maternal and Child Health Bureau of the Health Resources and Services Administration. Published in 1996, the *EMS Agenda for the Future* proposed a bold vision for greater integration of EMS into the U.S. health care system.

In 1993, the National Registry of EMTs released the *National Emergency Medical Services Education and Practice Blueprint* (Brown et al., 1993) The *Blueprint* defined an EMS educational and training system that would provide both the flexibility and structure needed to guide the development of national standard training curricula and guide the issuance of licensure and certification by the individual States.

In 1998, the Pew Health Professions Commission Taskforce on Health Care Workforce Regulation published *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (Finocchio et al., 1998). The report recommended that a national policy advisory board develop standards, including model legislative language, for uniform scopes of practice authority for the health professions. The report emphasized the need for States to enact and implement scopes of practice that are nationally uniform and based on the standards and models developed by the national policy advisory body.

Also in 1998, demonstrating their commitment to the *EMS Agenda*, NHTSA and HRSA jointly supported a two-year project to develop an integrated system of EMS regulation, education, certification, licensure, and educational program accreditation. The result was the *EMS Education Agenda for the Future: A Systems Approach* (NHTSA, 2000), which recognized the need for a systematic approach to meet the needs of the current EMS system while moving toward the vision proposed in the 1996 *EMS Agenda for the Future*. The *EMS Education Agenda* called for a more traditional approach to licensing EMS personnel.

A coordinated national EMS system continues to be in the best interest of States, EMS personnel, and the public. State EMS offices, while working in cooperation with their stakeholders, should implement scope of practice regulations that are as close as possible to those described in the *National EMS Scope of Practice Model*. This will help with professional

recognition of EMS personnel, facilitate reciprocity, decrease confusion, and enable the development of high quality support systems to benefit the entire system.

Appendix B: Changes and Considerations From the 2007 Practice Model

The 2018 version of the *Practice Model* represents one frame of a motion picture of evolving EMS practice. Research and technology are constantly evolving and will continue to drive changes to EMS education and practice. Having the context for what did or did not change from the 2007 *Practice Model* may be useful in understanding some of the content in this document. The entire revision team deeply appreciates the thoughtful input received from the EMS community during multiple public reviews. While not every comment or suggestion was ultimately incorporated in the revision, all of them were considered and collectively played an important role in shaping the *2018 National EMS Scope of Practice Model*.

Much of the effort in updating the 2018 *Practice Model* was focused on describing the interdependence between education, certification, licensure and credentialing, and the narrative descriptions of each level, while attempting to more clearly document expectations in a way to minimize scope "creep" between the levels. While it is tempting to look at the specific list of skills included in the Interpretive Guidelines section, that list cannot be used to provide a complete understanding of the 2018 *Practice Model* for any level. The Interpretive Guidelines included in this document are intended to illustrate the kinds of skills and interventions personnel at various levels are educated, certified, licensed, and otherwise qualified to do. This does not mean that every person at a particular level will routinely do every skill on the Interpretive Guideline list. One example of this is the obtaining and transmitting 12-lead electrocardiograms (ECG) at the EMT level. The expert panel recognized the strong research evidence to support the value of this skill for improving patient outcomes, especially in rural settings; however, some systems have readily available paramedics and EMTs might not be used to provide this technology in such systems. The expert panel also recognized that the cost of technology might be prohibitive for some EMT level agencies. Accordingly, this is one example of a skill EMTs (and other levels of EMS personnel) will routinely be educated and tested about, but that preparation does not imply that the technology must or even should be available in every practice setting where EMTs function. In other words, such a task should be valued and permitted but not required if the necessary equipment and resources to complete the task are not available to personnel.

Scope of practice is not a clinical description of what should be done or how it should be done. These elements are a combination of education and medical direction. Each state has the authority and responsibility to establish the scopes of practice for their state. The increasing depth and breadth of cognitive, affective, and psychomotor material envisioned across each level of EMS licensure are used to help states define acceptable practice parameters.

The COVID-19 national public health emergency led to a reevaluation of the ability of EMTs to participate in the administration of disease countermeasures, such as the IM administration of vaccines. Educational programs should communicate and coordinate with their state EMS office prior to using the *National EMS Education Standards* to ensure that:

- the state has adopted the scope of practice levels consistent with the revised *Scope of Practice Model*.
- a transition process for existing EMS clinicians has been identified.

- adequate instruction, procedural, written, and/or digital support materials are in place for educational content delivery.
- certification is based on the *National EMS Education Standards.*
- a process has been identified for credentialing by an EMS medical director.
- supervisory capabilities are available to support the activity, intervention, and role.

As community needs evolve, states maintain the regulatory flexibility to permit licensees to exceed the *Practice Model* but they do so along with the need to develop learning objectives, educational content, competency measures, and a credentialing process to ensure safe practice.

Nomenclature

The expert panel considered a recommendation (Innovative Practices of the EMS Workforce, 2017) from the National EMS Advisory Council (NEMSAC) to recognize and use the term "paramedicine" to describe the professional discipline that is currently recognized as EMS. Because the national discussion on this important topic has just begun, the group ultimately did not support a change to nomenclature for the 2018 *Practice Model* revision. When greater consensus among national EMS organizations and other EMS stakeholders is achieved, the recommendation could be considered during the next revision cycle.

Academic Degree Requirements for Paramedics

Consideration was given by the expert panel to calling for an associate degree as an entry-level education requirement for paramedics. Arguments in favor of this change include recognition of the complexity and sometimes ambiguity inherent to paramedic practice, increasing the professional recognition of paramedics, a logical pathway towards better compensation, and comparability with other health care professions. Arguments against this change include the challenges of integrating associate degree academic preparation into fire, hospital or other non-academic institution based programs. Concerns were voiced that increasing academic preparation requirements could increase the cost of education, shrink the hiring pool of paramedics for employers and threaten existing paramedic level service delivery programs. The expert panel considers this topic as a subject worthy of further national debate and exploration. While the group clearly recognizes education as the foundation of any profession's scope of practice, the difficulty of considering transitional variables, such as grandfathering existing personnel and programs, workforce recruitment, and retention, was beyond the scope of this project.

Attendant Qualifications for Ambulance Transport

The expert panel was asked to evaluate the practice of EMRs serving as part of an ambulance crew, and more specifically as the primary care giver during ambulance transport; meaning an EMR attending to the patient in the back of an ambulance en route to a medical facility without a higher level of licensed EMS practitioner physically present in the same compartment as the patient.

While defining ambulance crew composition is outside the scope of this document, the expert panel did consider the lack of scientific evidence to support the use of EMRs to fulfill clinical staffing requirements during the transport phase of EMS care when it developed the description for an EMR in Section IV of this document. Considering the education, certification, licensing,

and credentialing processes pertaining to EMS practice, the expert panel reaffirms that while an EMR may be used to assist patient care in an ambulance, an EMT or higher level personnel must be physically present in the patient compartment and assume responsibility for the delivery of care during transport.

Patients transported by ambulance require ongoing assessment and treatment that is intended to ensure their continued safety and positive clinical outcomes. Patient condition during transport can decompensate quickly, requiring a greater depth and breadth of knowledge that enables EMS personnel to anticipate and interpret subtle physiologic changes and provide interventions that are not taught at the EMR level.

States are encouraged to help communities identify resources to ensure licensed practitioners at the EMT or higher levels are available to care for patients that require transport by an ambulance.

Portable Technologies

Exponential improvements and availability of portable technologies, such as left ventricular assist devices (LVAD), patient-controlled analgesia pumps, transport ventilators, etc., creates complex challenges for education and credentialing that did not exist a decade ago. Such patient care needs may be encountered by all levels of personnel in community and 9-1-1 settings and with patients originating in health care facilities during transfers. Even when the patient's condition would not require EMS interaction with a device or intervention during transport, the variability of circumstances under which EMS delivery systems will likely encounter these patients steered the expert panel away from a call for specific levels of EMS personnel to be qualified in managing complex technologies, including non-invasive diagnostic equipment (e.g., ultrasound.) The actions of EMS personnel regarding portable equipment and technologies have intentionally been left to local medical director credentialing.

Deletions/Updates

Evolution and fine-tuning of the Interpretive Guidelines to eliminate redundancy resulted in changes that may be perceived as certain skills being eliminated from the *Practice Model*. The only "true" deletions include military anti-shock trousers (MAST)/pneumatic anti-shock garment (PASG), spinal "immobilization" (this terminology has been revised), demand valves, carotid massage, automated transport ventilators at the EMT level (deferred to a decision by the medical director), and modified jaw thrust for trauma. Newer evidence suggests that these references are antiquated and/or no longer recommended. Spinal immobilization was amended to reflect current thinking on spinal motion restriction and additional skills were incorporated at all levels. The topic of "assisting" patients with their own prescribed medications was also revisited. The mechanical task of opening bottles or providing a drink of water aside, aid associated with placing a tablet in the patient's mouth, activating an inhaler, or delivering a dose of medication via autoinjector is clearly an act of medication administration. Administration of medication requires a thorough understanding of the drug, including how it moves through the body, when it needs to be administered, possible side effects and dangerous reactions, proper storage, handling, and disposal, and an entire process for confirming patient identification (for the prescription), route, dose, timing, expiration dates, and that the container contains the medication the label says is intended. Medication errors happen all too often in the United States, even when drugs are

given by professionals. In fact, medication errors are the cause of 1.3 million injuries each year. These errors are due to the wrong drug, dose, timing, or route of administration. Preparing, giving, and evaluating the effectiveness of prescription and non-prescription medication is not in the scope of practice for EMS personnel, with the exceptions described in the Interpretive Guidelines and those authorized by the State and physician medical director. References to "assist patients in taking their own prescribed medications" have been identified as confusing by educators and practitioners and the expert panel has advised they be removed from the *Practice Model*.

Other elements that were removed from the 2007 Interpretive Guidelines were intended to minimize redundancy and not intended to reflect removal from the *Practice Model*. Examples include cricoid pressure (considered to be a component of airway management) and therapeutic PEEP (considered to be a component of ventilator management at the paramedic level).

Additions to the Interpretive Guidelines

The expert panel considered several proposed additions to the Interpretive Guidelines and an NREMT Practice Analysis was used to evaluate the frequency and level of skills. Sensitive to the impact of increased didactic and psychomotor instruction that effectively translates to added course time and potential monetary expense to programs and student candidates, the expert panel considered changes in practice by addressing the following questions:

1. Is there evidence that the procedure or skill is beneficial to public health?
2. What is the clinical evidence that the new skill or technique as used by EMS personnel will promote access to quality health care or improve patient outcomes?
3. What is the appropriate level of education, certification, licensure, and credentialing needed to safely perform the task/skill?

Several suggestions received by the expert panel were felt to be above the level of entry-level personnel and were not included. In particular, interventions that are regularly performed by the lay public, such as self-administered medications, blood glucose monitoring, and pulse oximetry were considered at length. It is noted that patients receive health education and training from their primary care providers to perform activities that are tailored to their personal medical histories and response to prescribed interventions over time. The expert panel maintains that licensed people at all levels are highly accountable for the medical care they provide as well as the maintenance and calibration of medical equipment used during patient encounters. Health professionals are not only educated to provide interventions, they receive education in the associated risks and potential complications, related pharmacology (when medications are involved), and they are able to analyze the effectiveness of treatment. Perhaps the most critical difference between the lay public and EMS personnel assuming responsibility for a particular task/skill is that licensed people are taught to assimilate information and apply critical thinking skills to know when and when not to apply an intervention in particular scenarios. In the example of blood glucose monitoring, it is also important to note that the use of such devices by EMS personnel invokes the Federal-level Clinical Laboratory Improvement Amendments (42 CFR 493, Laboratory Requirements, 2011)) to the Public Health Services Act. In regard to pulse oximeters (that can be purchased inexpensively at discount stores), there is no evidence to support an assertion that a pulse oximeter in the hands of an EMR (or other level of EMS practitioner) is more effective than hands-on patient assessment in determining the need for

supplemental oxygen, although false readings from a variety of causes have resulted in undetected patient compromise and a false sense of security by users. Such equipment are adjuncts that should be used judiciously in conjunction with sound clinical judgment. Of the remaining tasks and skills, the expert panel deliberated which level was most appropriate to implement the task or skill.

The expert panel concluded that spinal motion restriction using cervical collars and basic splinting for suspected extremity fractures were appropriate additions to the *Practice Model* at the EMR level.

At the EMT level, the expert panel agreed on the administration of beta agonists and anticholinergics, oral over-the-counter (OTC) analgesics for pain or fever, blood glucose monitoring, continuous positive airway pressure (CPAP) devices, and pulse oximetry. The expert panel also agrees that there will be instances of lower-level personnel aiding higher levels, assisting with skills of the high-level personnel when the higher-level personnel does the key portion of the procedure, the assistance is authorized by the medical director, the assistance is in the direct presence and supervision of the higher-level personnel, and the assistance is permitted by the State.

The use of supraglottic airways (SGA) and waveform capnography at the EMT level was extensively debated. Several public commenters expressed lack of support on draft language that proposed to add them to the interpretive guidelines for EMTs during the national engagement period. The expert panel was evenly divided on the topic. Several "pros" and "cons" for adding SGA and waveform capnography for EMTs at the national level were considered. It was noted that several jurisdictions are already using SGA as a more definitive airway than the BVM although some panelists added that the BVM is not taught well or used effectively in many cases. Major "cons" point to a critical patient safety concern if an SGA is not placed properly or is not verified using waveform capnography. Many felt the education for SGA and waveform capnography would add significant time and increase expense to the EMT program, a consideration that was worrisome and expressed by the public and members of the expert panel. Others suggested that BVM ventilation may not be done well, but a misplaced advanced airway could lead to no ventilation and patient detriment or demise. Finally, a limited review of the literature highlights the fact there is a general lack of evidence that SGA improves outcomes in cardiac arrest or other etiologies over BVM ventilation. The expert panel concluded that while SGA and waveform capnography could successfully be taught and measured at the EMT level, it is an intervention that should be reserved for an experienced practitioner and therefore, is not a prudent addition as an entry-level skill to the *Practice Model* for an EMT now. Some States currently allow licensed EMTs to use SGA and/or waveform capnography although this activity is dependent on strict oversight by a physician medical director and is not permitted in all jurisdictions.

Additions to the AEMT level include monitoring and interpretation of waveform capnography, additional intravenous medications (such as epinephrine during cardiac arrest and ondansetron), and parenteral analgesia for pain.

The paramedic scope of practice was considered most in alignment with current practice, however, the expert panel recommended the addition of high-flow nasal cannula, and expanded use of OTC medications.

None of these changes should be considered "in effect" until officially adopted by the State licensing authority and medical director.

Appendix C: Legal Differences Between Certification and Licensure

Used with permission from the National Registry of Emergency Medical Technicians: www.nremt.org/rwd/public/document/certification_licensure

Although the general public continues to use the terms interchangeably, there are important functional distinctions between certification and licensure.

Certification

The federal government has defined "certification" as the process by which **a non-governmental organization grants recognition to an individual who has met predetermined qualifications specified by that organization**.[7] Similarly, the National Commission for Certifying Agencies defines certification as "a process, often voluntary, by which individuals who have demonstrated the level of knowledge and skill required in the profession, occupation, role, or skill are identified to the public and other stakeholders."

Accordingly, there are three hallmarks of certification (as functionally defined). Certification is:

1. a voluntary process;
2. done by a private organization; and
3. a way to provide the public information on those individuals who have successfully completed the certification process (usually entailing successful completion of educational and testing requirements) and demonstrated their ability to perform their profession competently.

Nearly every profession certifies its members in some way, but a prime example is medicine. Private certifying boards certify physician specialists. Although certification may assist a physician in obtaining hospital privileges, or participating as a preferred provider within a health insurer's network, it does not affect his legal authority to practice medicine. For instance, a surgeon can practice medicine in any state in which he is licensed regardless of whether or not he is certified by the American Board of Surgery.

Licensure

Licensure, on the other hand, is the state's grant of legal authority, pursuant to the state's police powers, to practice a profession within a designated scope of practice. Under the licensure system, states define, by statute, the tasks and function or scope of practice of a profession and provide that these tasks may be legally performed only by those who are licensed. As such, licensure prohibits anyone from practicing the profession who is not licensed, regardless of whether or not the individual has been certified by a private organization.

What if My State Certifies, Not Licenses, EMS Professionals?

Confusion between the terms "certification" and "licensure" arises because many states call their licensure processes "certification," particularly when they incorporate the standards and requirements of private certifying bodies in their licensing statutes and require that an individual

[7] 34 U.S.C. § 602. The Secretary's Recognition of Accrediting Agencies (2014). Available at www.govinfo.gov/content/pkg/CFR-2014-title34-vol3/pdf/CFR-2014-title34-vol3-part602.pdf

be certified in order to have state authorization to practice. The use of certification by the NREMT by some states as a basis for granting individuals the right to practice as EMTs and calling the authorization granted "certification" is an example of this practice. Nevertheless, certification by the National Registry, by itself, does not give an individual the right to practice.

Regardless of what descriptive title is used by a state agency, **if an occupation has a statutorily or regulatorily defined scope of practice and only individuals authorized by the state can perform those functions and activities**, **the authorized individuals are licensed. It does not matter if the authorization is called something other than a license**; **the authorization has the legal effect of a license**.

In summay, the NREMT is a private certifying organization. The various State EMS Offices or like agencies serve as the state licensing agencies. Certification by the NREMT is a distinct process from licensure; and it serves the important independent purpose of identifying for the public, state licensure agencies and employers, those individuals who have successfully completed the Registry's educational requirements and demonstrated their skills and abilities in the mandated examinations. Furthermore, the NREMT's tracking of adverse licensure actions and criminal convictions provides an important source of information, which protects the public and aids in the mobility of EMS providers.

Appendix D: Acknowledgements

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Appendix E: References

42 CFR 493, Laboratory Requirements (2011). Available at www.gpo.gov/fdsys/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap6A-subchapII-partF-subpart2-sec263a.pdf See also www.cms.gov/CLIA

American College of Surgeons Committee on Trauma, American College of Emergency Physicians, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee -EMSC Partnership for Children, American Academy of Pediatrics. (2012). *Equipment for ambulances*. Available at www.facs.org/~/media/files/quality%20programs/trauma/publications/ambulance.ashx

Brown, W. E., Chew, J., Dawson, D. E., Garrison, H. G., O'Keefe, M., & National Registry of Emergency Medical Technicians. (1993, September). *National emergency medical services education and practice blueprint*. National EMS Education and Practice Blueprint Project Task Force.

Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services. (2007). *Emergency medical services at the crossroads*. National Academies Press.

Committee on Trauma & Committee on Shock. (1966; commemorative edition 1977). *Accidental death and disability: The neglected disease of modern society* (Unnumbered report). National Highway Traffic Safety Administration. Available at www.ems.gov/pdf/1997-Reproduction-AccidentalDeathDissability.pdf

Dent v. West Virginia, 129 U.S. 114 (1889). Available at https://cdn.loc.gov/service/ll/usrep/usrep129/usrep129114/usrep129114.pdf

Department of Health, Education, and Welfare. (1971, June). *Report on licensure and related health personnel credentialing* (DHEW Publication No. HSM-72-11). Available at https://files.eric.ed.gov/fulltext/ED061420.pdf

Emergency Medical Services Systems Act of 1973. Pub. L. 93-154 87 Stat. 594-605. Available at www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg594.pdf

Finocchio, L., Dower, C., Blick, N., Gragnola, C., & Taskforce on Health Care Workforce Regulation. (1998). *Strengthening consumer protection: Priorities for health care workforce regulation*. Available at https://healthforce.ucsf.edu/sites/healthforce.-ucsf.edu/files/publication-pdf/4.1%20%28Report%29%201998-12_Strengthening_-Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf

Innovative Practices of the EMS Workforce [committee] (2017, August 15). *Changing the nomenclature of emergency medical services is necessary*. National EMS Advisory Council. Available at www.ems.gov/pdf/nemsac/NEMSAC_Final_Advisory_Changing_Nomenclature_EMS.pdf

Institute of Medicine of the National Academies. (2010). The future of nursing focus on scope of practice.

Mears, G., Armstrong, B., Fernandez, A. R., Mann, N. C., McGinnis, K., Mears, C. R., Sanddal, N. D., Sanddal, T. L., & Shofer, F. S. (2012, December). *2011 National EMS assessment*. National Highway Traffic Safety Administration. Available at www.ems.gov/pdf/2011/National_EMS_Assessment_Final_Draft_12202011.pdf

National Association of State EMS Officials. (2014). *Report to the National EMS Advisory Council on statewide implementation of the education agenda*.

National Commission for Certifying Agencies. (2004, September). *Standards for the accreditation of certification programs*. National Organization for Competency Assurance. Available at https://knappinternational.com/assets/uploads/pages/NCCA%20standards(1).pdf

National Highway Traffic Safety Administration. (1996). *National EMS agenda for the future* (Unnumbered report). Available at www.ems.gov/pdf/2010/EMSAgendaWeb_7-06-10.pdf%20

NHTSA. (2000). *National EMS education agenda for the future: A systems approach* (Unnumbered report). Available at www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/EMS_Education_Agenda.pdf

NHTSA. (2005, July). *National EMS core content* (Report No. DOT HS 809 898). Available at www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/National_EMS_Core_Content.pdf

NHTSA. (2007, February). *National EMS scope of practice model* (Report No. DOT HS 810 657). Available at www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/National_EMS_Scope_Practice_Model.pdf

NHTSA. (2009, January). *National Emergency Medical Services education standards* (Report No. DOT HS 811 077A). Available at www.ems.gov/pdf/National-EMS-Education-Standards-FINAL-Jan-2009.pdf

National Registry of Emergency Medical Technicians. (2017, April 13). *National Registry data, dashboard, & maps* (Web page and portal). Available at www.nremt.org/maps

National Traffic and Motor Vehicle Safety Act of 1966. Pub. L. No. 89-563, 80 Stat. 718 (1966). Available at www.gpo.gov/fdsys/pkg/STATUTE-80/pdf/STATUTE-80-Pg718.pdf

North Carolinas State Board of Dental Examiners v. FTC, 574 U.S. (2015). Available at www.supremecourt.gov/opinions/14pdf/13-534_19m2.pdf

SUNY Empire State College. (2018). *Breadth and depth of learning* (Web page). Available at www.esc.edu/degree-planning-academic-review/evaluator-resources/assessing-learning/breadth-and-depth/

Weingroff, R., F. & Seabron, S. (2003). *President Dwight D. Eisenhower and the Federal role in highway safety*. FHWA.

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NATIONAL EMERGENCY MEDICAL SERVICES

EDUCATION STANDARDS

NHTSA
NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

National EMS Education Standards 2021. Washington, DC: National Highway Traffic Safety Administration.

Technical Report Documentation Page

Table of Contents

Executive Summary

In 2009, the EMS community came together to create the original *National EMS Education Standards (*the *Standards)*. This represented a major step toward realizing the vision put forth in the 1996 *EMS Agenda for the Future* and was further outlined in the *EMS Education Agenda for the Future: A Systems Approach* four years later. This new version of the *Standards* builds on the foundation created by those landmark documents and other achievements of the last quarter-century, including *EMS Agenda 2050* and the *National Scope of Practice Model*.

The *National EMS Education Standards* outline the minimal competencies for entry-level EMS clinicians to perform their roles as outlined in the 2019 and 2021* updated *National EMS Scope of Practice Model*. The *Standards*, while a national effort, were intentionally created in a way that allows for diverse implementation methods to meet local needs and evolving educational practices. This less prescriptive format of the *Standards* allows for ongoing revision of EMS educational content consistent with scientific evidence, educational practices, and community standards of care.

Noteworthy revisions found in the 2021 edition of the *Standards* are based upon input and considerations obtained from numerous sources. These include stakeholder and public comments, national guidance documents (the original 2009 *National EMS Education Standards, EMS Agenda 2050,* and the 2019 and 2021* updated *National Scope of Practice Model*), the National Registry of EMT's practice analysis, technological advances, known and evolving best practices, and evidence-based medicine.

* As a result of the 2020-21 public health emergency, several changes were made under the urgent update process to the 2019 National EMS Scope of Practice Model which are reflected in these education standards.

The following areas within the *Standards* had notable revisions: public health; pediatrics; geriatrics, behavioral/psychiatric; cultural humility; EMS operations; pharmacology; and EMS safety, wellness and resilience. Input was provided and every suggestion or recommendation was considered. Revision and adjustments were based on a team discussion, with expert consultation when needed.

When applying the *Standards* to individual programs and classes, EMS educators have the freedom to develop their own curricula or use any of the wide variety of lesson plans and instructional resources that are available. This ensures that each program can specifically address individual and community needs.

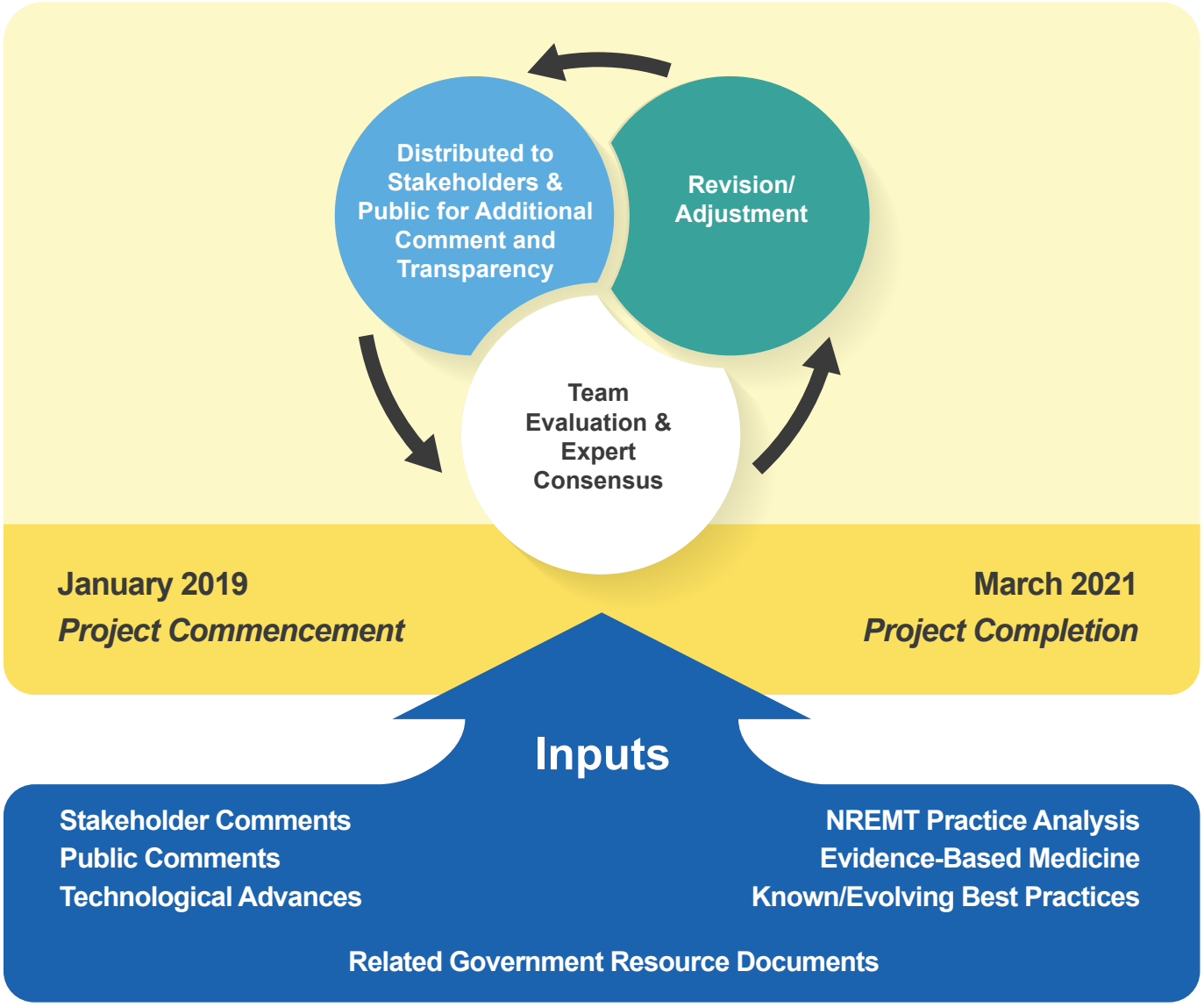
The *Standards* are not intended to stand as a comprehensive document guiding the entire development of EMS clinicians, but rather one part of a comprehensive system. EMS education programs will incorporate each element of the education system proposed in the *Education Agenda*.

These elements include:

- National EMS Core Content
- National EMS Scope of Practice Model
- National EMS Education Standards
- National EMS Certification
- National EMS Program Accreditation

This integrated system approach to EMS education is essential to achieving the goal of developing EMS clinicians across the country who are competent in the appropriate knowledge, skills, and abilities for their licensure level.

Revision Process



Introduction and the Evolution of EMS in the United States

EMS has evolved and grown significantly since the first organized, national effort to develop EMS systems began in the 1960s. Compared to colleagues in health care and public safety, EMS remains a young profession and continues to advance as we further define and enhance our structure, oversight and organization.

As EMS system operations have developed, so has EMS education. In the early 1970s, registered nurses and physicians taught most EMS programs. Few student and instructor resources related directly to prehospital emergency care. No standards existed to define what EMS clinicians should know and what they should be able to do. By the early 2000s, most of this original framework was being replaced, and national education standards and a scope of practice were defined for the first time. Today, the profession has become more sophisticated, and community expectations have increased. With health care, technology and science evolving faster than ever, it is also important to revisit these topics and update these guidelines more frequently.

EMS Agenda for the Future

In August 1996, the *EMS Agenda for the Future* (the *Agenda*) was published. Developed with funding from the National Highway Traffic Safety Administration and the Health Resources and Services Administration, and led by the National Association of EMS Physicians and the National Association of State EMS Directors, the *Agenda* brought together stakeholders from throughout EMS to create a unifying vision for emergency medical services in the United States.

The *Agenda* was designed to guide government and private organizations in EMS planning, development, and policymaking at the national, state and local levels. It addressed 14 attributes of EMS, including the EMS education system, and defined a vision for EMS education "based on research" and "conducted by qualified instructors" while employing "sound educational principles."

EMS Education Conference

Soon after publication of the *Agenda,* representatives of 30 EMS-related organizations met at an EMS Education Conference sponsored by NHTSA to identify the necessary steps for implementing that vision.

The EMS Education Conference resulted in several recommendations, including:

- *The National EMS Education and Practice Blueprint* (the *Blueprint*) is a valuable component of the EMS education system. A multidisciplinary panel, led by NHTSA, to identify core educational content more explicitly for each licensure level, should revise it.
- National EMS Education Standards are necessary but need not include specific declarative material or lesson plans. NHTSA should support and facilitate the development of national EMS Education Standards.
- The *Blueprint* and national EMS Education Standards should be revised periodically, with major revisions occurring every 5 to 7 years, and minor updates made every 2 to 3 years.

EMS Education Agenda for the Future

In 1998, NHTSA convened a group of educators who developed a document titled *EMS Education Agenda for the Future: A Systems Approach* (the *Education Agenda*). The EMS education system envisioned in the *EMS Agenda for the Future* was further defined and articulated in the *Education Agenda* (see Figure 1). The *Education Agenda*'s authors also stated that, to be most effective, each component in the EMS education system should be structured, coordinated and interdependent.

National EMS Core Content

The *National EMS Core Content* was published in 2005. Core Content defines the entire domain of out-of-hospital practice and identifies the universal body of knowledge and skills for EMS clinicians who do not function as independent practitioners.

Funded by NHTSA and HRSA, this project was led by the National Association of EMS Physicians and the American College of Emergency Physicians.

EMS Education Agenda for the Future: A Systems Approach

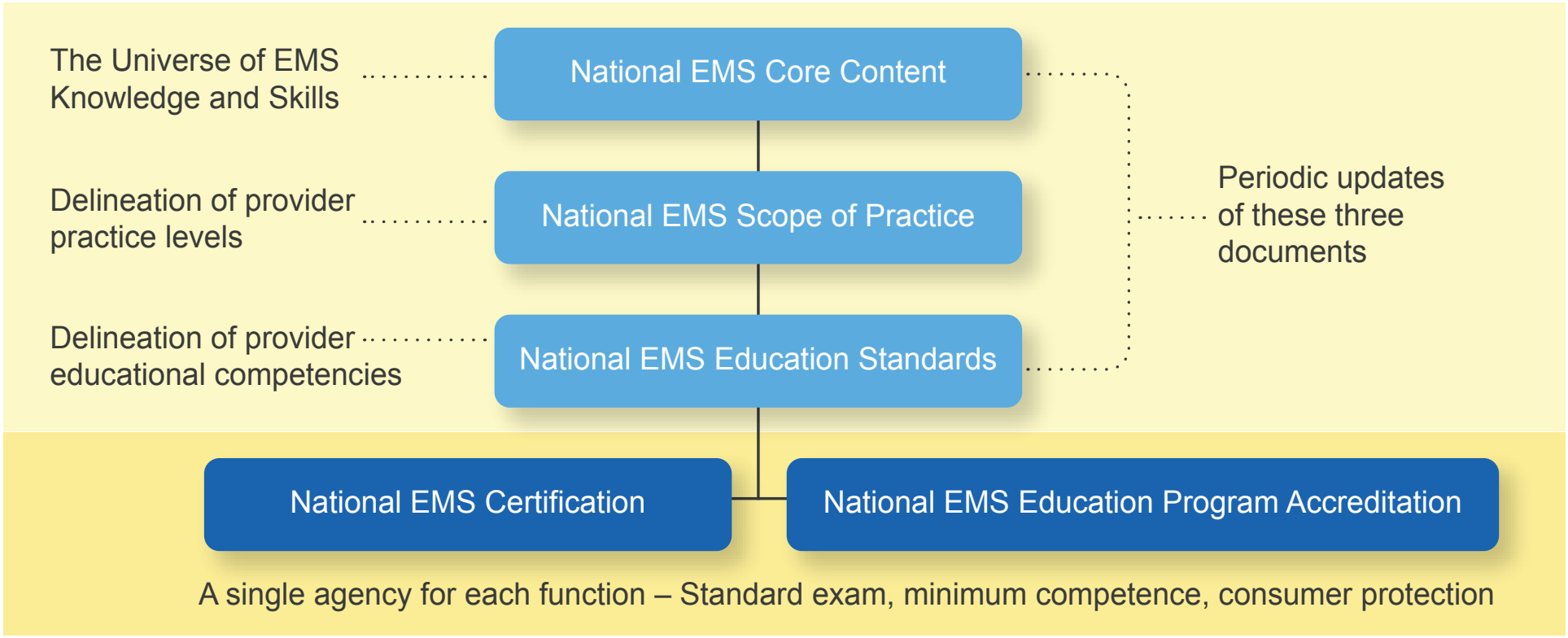


Figure 1: Model EMS System

National EMS Scope of Practice

The *National EMS Scope of Practice Model* (the *Scope of Practice*) is a consensus document that was published in 2007 and revised in 2019. This document defines four levels of EMS licensure—emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technician (AEMT) and paramedic—and delineates the practices and minimum competencies for each level. The *Scope of Practice* does not have regulatory authority but provides guidance to states. Adherence to the *Scope of Practice* would increase uniformity in EMS practice throughout the U.S. and facilitate reciprocity between states. Leadership for this project was delegated to the National Association of State EMS Officials and funded by NHTSA and HRSA.

The *Scope of Practice* further defines practice, suggests minimum educational preparation, and designates appropriate psychomotor skills at each level of licensure. Further, the document describes each level of licensure as distinct and distinguished by unique "skills, practice environment, knowledge, qualifications, services provided, risk, level of supervisory responsibility, and amount of autonomy and judgment/critical thinking/decision-making."

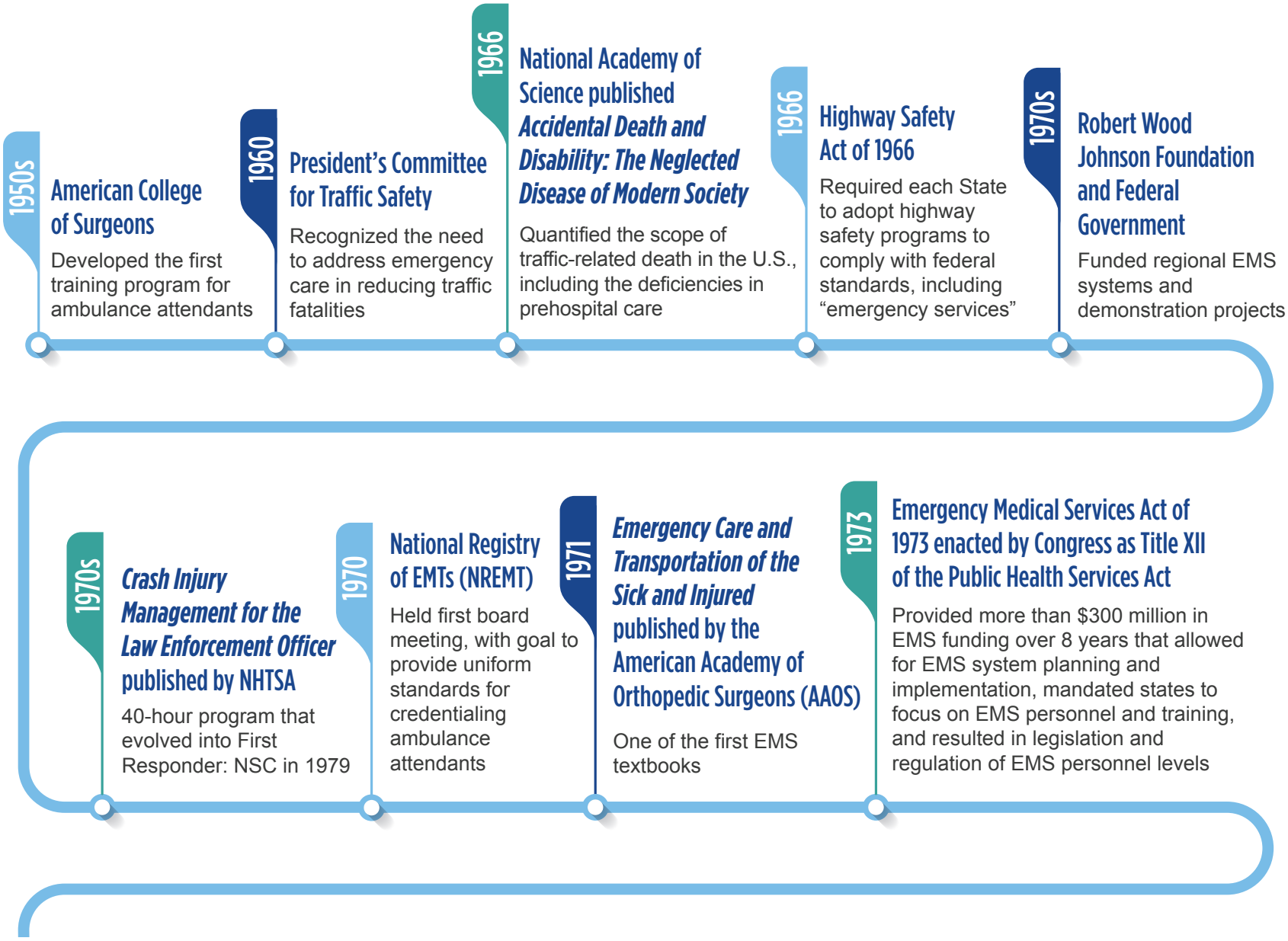
National EMS Education Standards

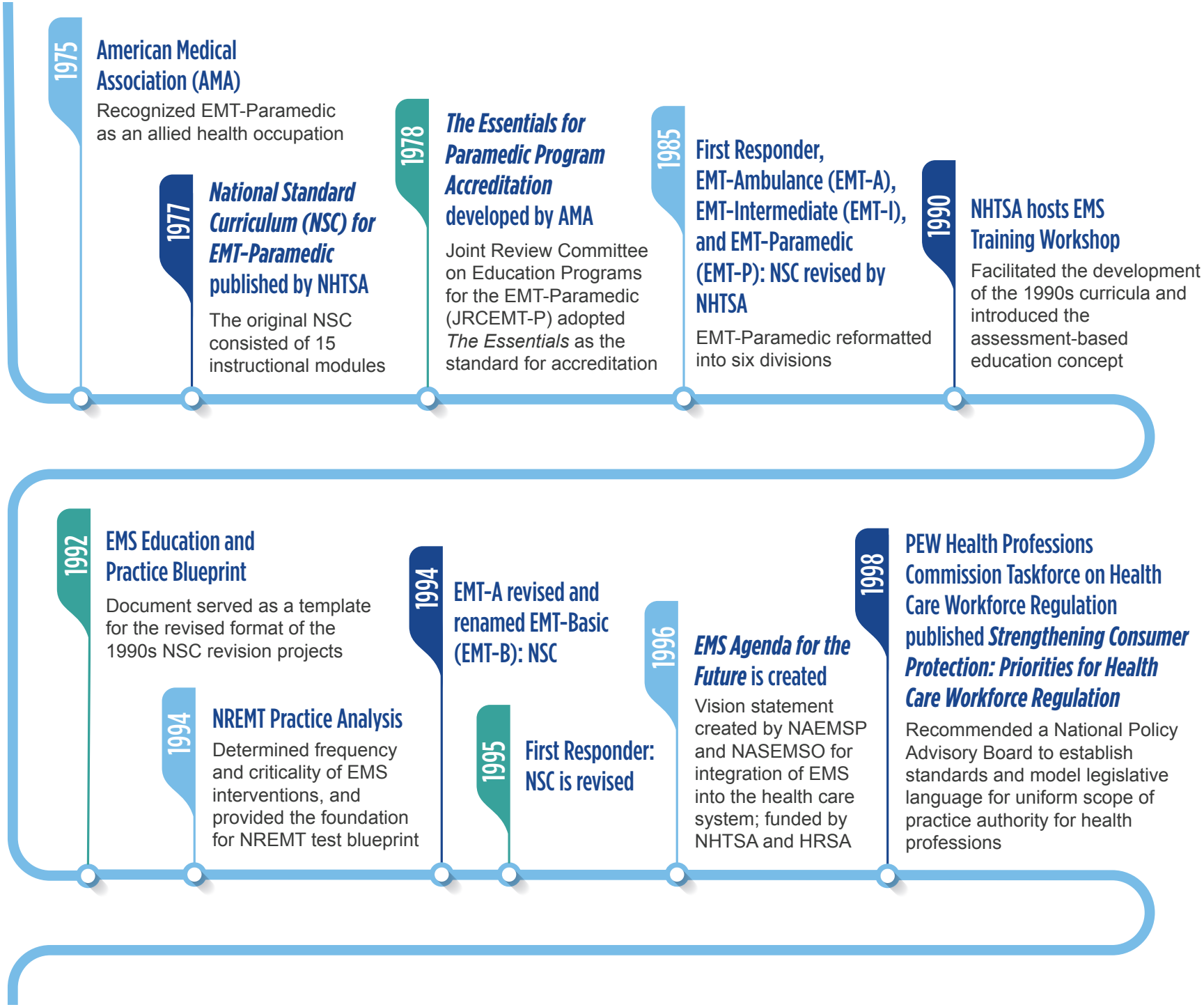
The *National EMS Education Standards* replaced the NHTSA National Standard Curricula at all licensure levels when first published in 2009. The *Standards* define the competencies, clinical behaviors, and judgments that should be met by entry-level EMS clinicians to meet practice guidelines defined in the *Scope of Practice*. Content and concepts defined in the *National EMS Core Content* are also integrated within the *Standards*. Leadership for this project was delegated to the RedFlash Group and National Association of EMS Educators, and funded by NHTSA and HRSA. With input from a large number of stakeholders, the team chose not to update the separate Instructional Guidelines for each clinician level originally published as companion documents to the 2009 Standards. Instead, the Instructional Guidelines have been incorporated within the *Standards*, replacing the need for those supplemental materials.

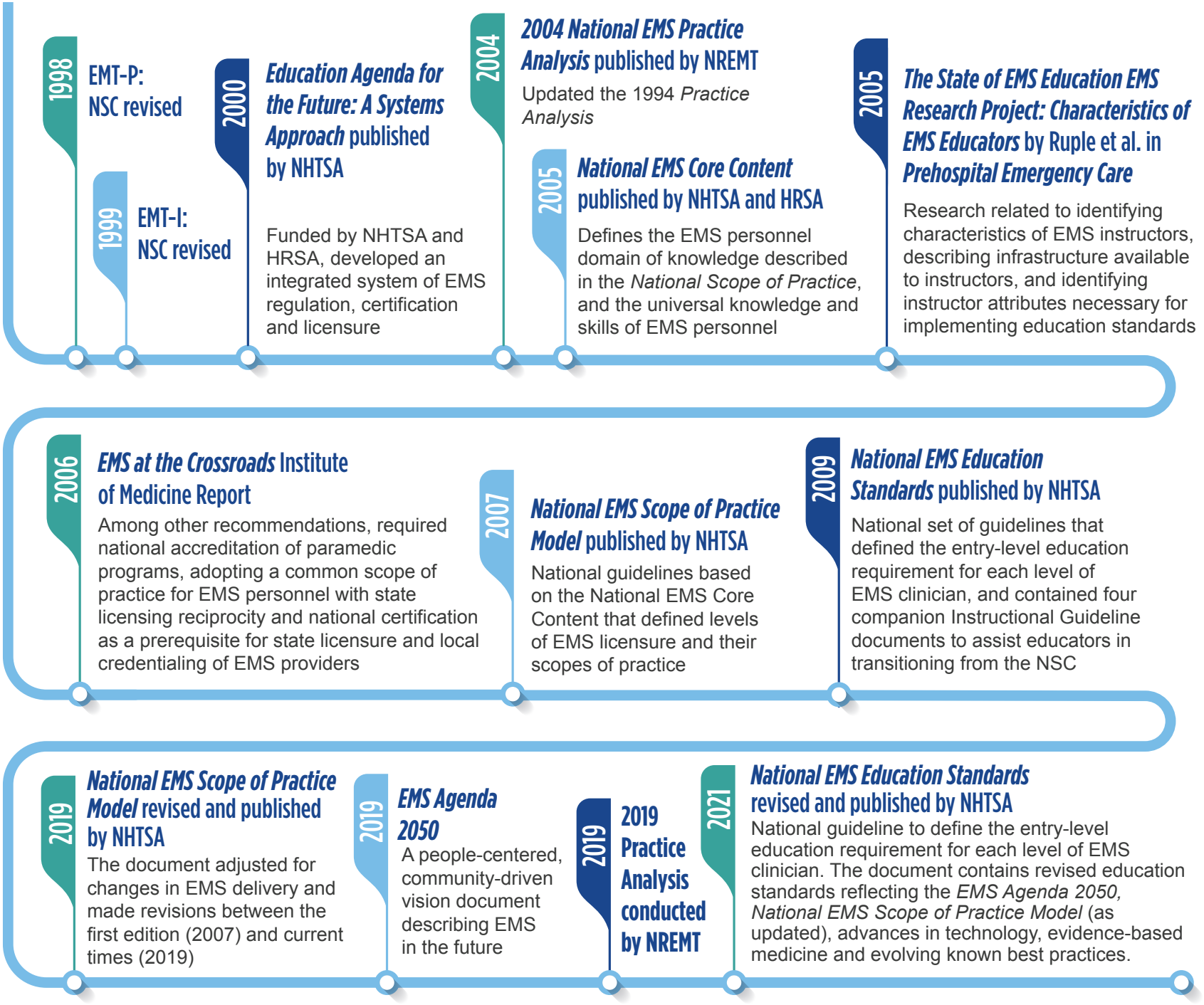
National EMS certification and national EMS education program accreditation are the "bookends" that support the other key elements of the system. The *Education Agenda* recommended an individual should graduate from a nationally accredited EMS education program to be eligible for National EMS Certification. Essential components of the *EMS Agenda* include a single National EMS Accreditation Agency and a single National EMS Certification Agency to ensure consistency and quality of EMS personnel.

A Brief History of EMS Education in the United States

This timeline outlines key events in the development of EMS education in the United States from the 1950s to the present.




1975
American Medical Association (AMA)
Recognized EMT-Paramedic as an allied health occupation
1977
National Standard Curriculum (NSC) for EMT-Paramedic published by NHTSA
The original NSC consisted of 15 instructional modules
1978
The Essentials for Paramedic Program Accreditation developed by AMA
Joint Review Committee on Education Programs for the EMT-Paramedic (JRCEMT-P) adopted The Essentials as the standard for accreditation
1985
First Responder, EMT-Ambulance (EMT-A), EMT-Intermediate (EMT-I), and EMT-Paramedic (EMT-P): NSC revised by NHTSA
EMT-Paramedic reformatted into six divisions
1990
NHTSA hosts EMS Training Workshop
Facilitated the development of the 1990s curricula and introduced the assessment-based education concept
1992
EMS Education and Practice Blueprint
Document served as a template for the revised format of the 1990s NSC revision projects
1994
NREMT Practice Analysis
Determined frequency and criticality of EMS interventions, and provided the foundation for NREMT test blueprint
1994
EMT-A revised and renamed EMT-Basic (EMT-B): NSC
1995
First Responder: NSC is revised
1996
EMS Agenda for the Future is created
Vision statement created by NAEMSP and NASEMSO for integration of EMS into the health care system; funded by NHTSA and HRSA
1998
PEW Health Professions Commission Taskforce on Health Care Workforce Regulation published Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation
Recommended a National Policy Advisory Board to establish standards and model legislative language for uniform scope of practice authority for health professions


1998
EMT-P: NSC revised
1999
EMT-I: NSC revised
2000
Education Agenda for the Future: A Systems Approach published by NHTSA
Funded by NHTSA and HRSA, developed an integrated system of EMS regulation, certification and licensure
2004
2004 National EMS Practice Analysis published by NREMT
Updated the 1994 Practice Analysis
2005
National EMS Core Content published by NHTSA and HRSA
Defines the EMS personnel domain of knowledge described in the National Scope of Practice, and the universal knowledge and skills of EMS personnel
2005
The State of EMS Education EMS Research Project: Characteristics of EMS Educators by Ruple et al. in Prehospital Emergency Care
Research related to identifying characteristics of EMS instructors, describing infrastructure available to instructors, and identifying instructor attributes necessary for implementing education standards
2006
EMS at the Crossroads Institute of Medicine Report
Among other recommendations, required national accreditation of paramedic programs, adopting a common scope of practice for EMS personnel with state licensing reciprocity and national certification as a prerequisite for state licensure and local credentialing of EMS providers
2007
National EMS Scope of Practice Model published by NHTSA
National guidelines based on the National EMS Core Content that defined levels of EMS licensure and their scopes of practice
2009
National EMS Education Standards published by NHTSA
National set of guidelines that defined the entry-level education requirement for each level of EMS clinician, and contained four companion Instructional Guideline documents to assist educators in transitioning from the NSC
2019
National EMS Scope of Practice Model revised and published by NHTSA
The document adjusted for changes in EMS delivery and made revisions between the first edition (2007) and current times (2019)
2019
EMS Agenda 2050
A people-centered, community-driven vision document describing EMS in the future
2019
2019 Practice Analysis conducted by NREMT
2021
National EMS Education Standards revised and published by NHTSA
National guideline to define the entry-level education requirement for each level of EMS clinician. The document contains revised education standards reflecting the EMS Agenda 2050, National EMS Scope of Practice Model (as updated), advances in technology, evidence-based medicine and evolving known best practices.

The National EMS Education Standards

Each statement in the *Standards* presumes that the expected knowledge and behaviors are within the scope of practice for that EMS licensure level, as defined by the *National EMS Scope of Practice Model.* Each competency applies to patients of all ages.

The *Standards* also assume there is a progression in practice from the emergency medical responder level to the paramedic level. That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level. For example, a paramedic is responsible for the knowledge and tasks described for the paramedic as well as the other three levels of licensure.

The National EMS Education Standards is comprised of four components (Table 1):

1. **Competency** (yellow) – This statement represents the minimum competency required for entry-level clinicians at each licensure level.
2. **Knowledge** (blue) – This represents an elaboration of the knowledge within each competency (when appropriate) that entry-level clinicians would need to master to achieve competency.
3. **Clinical Behaviors/Judgments** (green) – This section describes the clinical behaviors and judgments essential for entry-level EMS clinicians at each licensure level.
4. **Educational Infrastructure** (gray) – This section describes the support standards necessary for conducting EMS training programs at each licensure level.

Table 1: Format of National EMS Education Standards

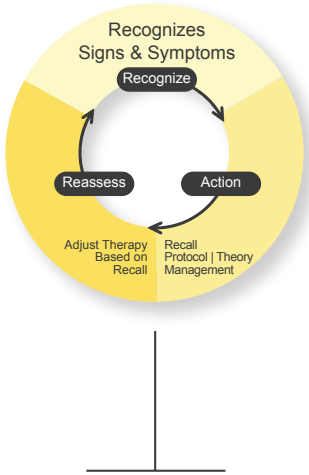
	EMR	EMT	AEMT	Paramedic
Content Area	Competency	Competency	Competency	Competency
Elaboration of Knowledge	Additional knowledge related to the competency	Additional knowledge related to the competency	Additional knowledge related to the competency	Additional knowledge related to the competency
	Clinical behaviors and judgments	Clinical behaviors and judgments	Clinical behaviors and judgments	Clinical behaviors and judgments
	Educational Infrastructure	Educational Infrastructure	Educational Infrastructure	Educational Infrastructure

The descriptors used to illustrate the increasing complexity of knowledge and behaviors through the progression of licensure levels originate, in part, from the *National EMS Scope of Practice Model*. These terms reflect the differences in the breadth, depth and actions required at each licensure level (Figures 2 and 2.1).

The *depth* of knowledge is the amount of detail a student needs to know about a particular topic. The *breadth* of knowledge refers to the number of topics or issues a student needs to learn in a particular competency. For example, EMS instructors need to ensure the emergency medical responder has a thorough understanding of how to use the bag valve mask (BVM) safely and effectively. The amount of detail the instructor provides about how to use that BVM represents the depth of knowledge. Some instructors might adjust their specific curriculum to provide slightly more information about the BVM compared to other instructors, but every graduating EMR will know how to use the device.

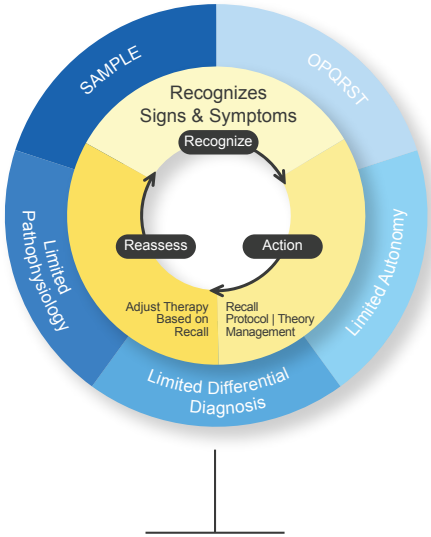
Figure 2: Depth/Breadth Terminology

Simple Breadth/ Simple Depth



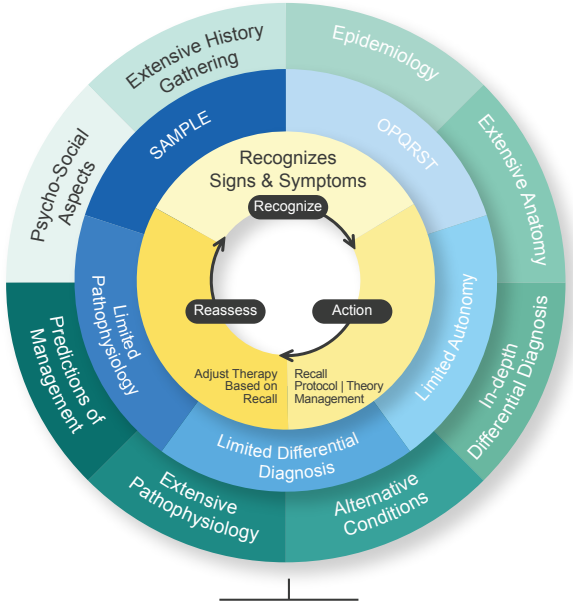
- Minimal Knowledge
- Minimal Range of Skills or Tasks

Foundational Breadth/ Fundamental Depth



- Elemental Knowledge
- Increased Range of Skills or Tasks

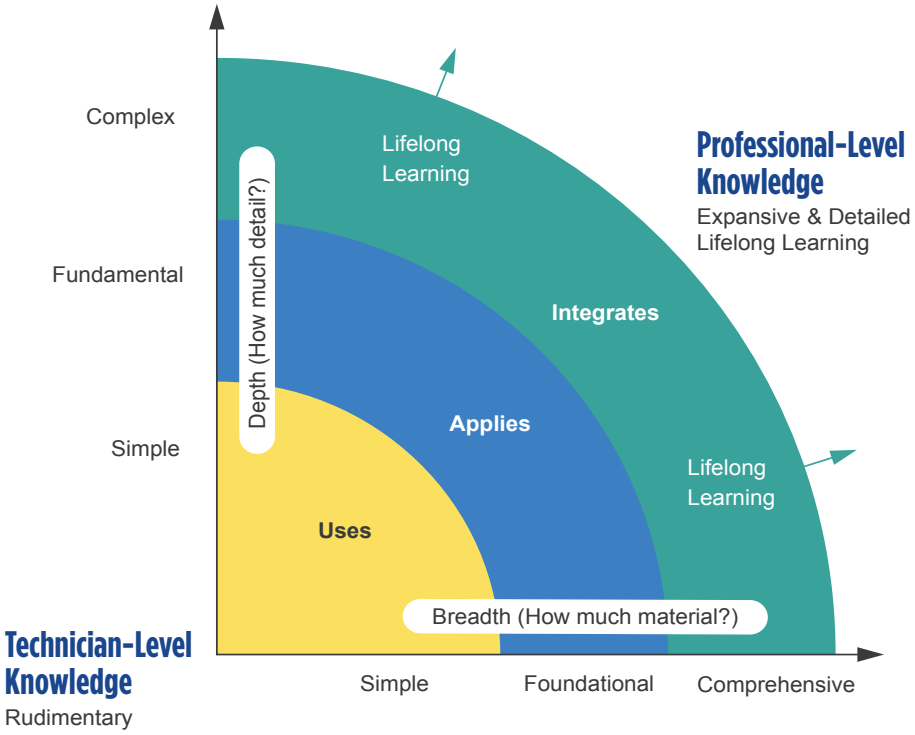
Comprehensive Breadth/ Complex Depth



- Deep Level of Knowledge
- Wide-Ranging, Broad and Extensive Skills or Tasks
- Lifelong Learning

Because of the limited scope of practice for the EMR (fewer tools in the airway box), the instructor may supplement BVM education with a few additional concepts (breadth) surrounding management of a patient's airway, such as airway anatomy and assessment. Supplementing the education with additional concepts adds to the breadth of the material, with each concept having its own level of detail (depth) limited only by the amount of the time the instructor has to teach the material. As more airway management tools are added to the toolbox for each licensure level (EMT, AEMT, paramedic), the level of detail will also change, and curriculum length will need to reflect this increased depth.

Figure 2.1: Depth/Breadth Terminology



To describe the intended depth of knowledge of a particular concept within a provider level, the revision team uses the terms *simple, fundamental* and *complex*. These terms can seem ambiguous and confusing when used in isolation (e.g., learning to correctly use a BVM is not a "simple" task). Instead, the meaning of each term is relative to the other terms. For example, knowledge that is categorized as "simple" is only simple relative to another curriculum that provides more detail, such as when comparing EMT to AEMT. EMT students may need a greater level of airway anatomy detail because the scope of practice is different. Scope of practice is even more different for the AEMT and paramedic student, who will need increasingly greater levels of airway anatomy detail (complex). Course directors, instructors, medical directors and local stakeholders can decide the precise level of detail based on community and student needs rather than establishing a single prescriptive curriculum for the entire nation.

Similarly, the intended breadth of knowledge surrounding a concept is reflected in the terms *simple, foundational* and *comprehensive*. As curricula include an increasing level of detail about the use of the BVM, airway assessment and airway anatomy, the increasing size of the toolbox reflected by the increased scope of practice necessitates a broader list of related subjects. For example, the addition of CPAP, nasopharyngeal airway and oxygen delivery devices at the EMT level broadens the curriculum for the EMT instructor. For instructors teaching paramedic students, the increased scope of practice broadens the knowledge base even more. Clearly, the use of CPAP requires the EMT to have an increased depth and more complex breadth of knowledge than the EMR, but not nearly as much as the paramedic.

EMS Personnel Licensure Levels

These licensure levels are from the *National EMS Scope of Practice Model.* Each educational level assumes mastery of previously stated competencies. Every clinician must demonstrate each competency within their scope of practice and for patients of all ages.

Emergency Medical Responder	Emergency Medical Technician	Advanced Emergency Medical Technician	Paramedic
The emergency medical responder (EMR) is an out-of-hospital practitioner whose primary focus is to initiate immediate lifesaving care to patients while ensuring patient access to the emergency medical services system. EMRs possess the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and rely on an EMS or public safety agency or larger scene response that includes other higher-level medical personnel. When practicing in less populated areas, EMRs may have a low call volume coupled with being the only care personnel for prolonged periods awaiting arrival of higher levels of care. EMRs may assist, but should not be the highest-level person caring for a patient during ambulance transport. EMRs are often the first to arrive on scene. They must quickly assess patient needs, initiate treatment and request additional resources.	An emergency medical technician (EMT) is a health professional whose primary focus is to respond to, assess and triage emergent, urgent and non-urgent requests for medical care, and to apply basic knowledge and skills necessary to provide patient care and medical transportation to/from an emergency or health care facility. Depending on a patient's needs and/or system resources, EMTs are sometimes the highest level of care a patient will receive during an ambulance transport. EMTs often are paired with higher levels of personnel as part of an ambulance crew or other responding group. With proper supervision, EMTs may serve as a patient care team member in a hospital or health care setting to the full extent of their education, certification, licensure and credentialing. In a community setting, an EMT might visit patients at home and make observations that are reported to a higher-level authority to help manage a patient's care. When practicing in less populated areas, EMTs may have low call volume coupled with being the only care personnel during prolonged transports. EMTs may provide minimal supervision of lower-level personnel. EMTs can be the first to arrive on scene; they are expected to quickly assess patient conditions, provide stabilizing measures and request additional resources as needed.	The advanced emergency medical technician (AEMT) is a health professional whose primary focus is to respond to, assess and triage non-urgent, urgent and emergent requests for medical care; apply basic and focused advanced knowledge and skills necessary to provide patient care and/or medical transportation; and facilitate access to a higher level of care when the needs of the patient exceed the capability level of the AEMT. The additional preparation beyond EMT prepares an AEMT to improve patient care in common emergency conditions for which reasonably safe, targeted and evidence-based interventions exist. Interventions within the AEMT scope of practice may carry more risk if not performed properly than interventions authorized for the EMR/EMT levels. With proper supervision, AEMTs may serve as a patient care team member in a hospital or health care setting to the full extent of their education, certification, licensure and credentialing. In a community setting, an AEMT might visit patients at home and make observations that are reported to a higher-level authority to help manage a patient's care.	The paramedic is a health professional whose primary focus is to respond to, assess and triage emergent, urgent and non-urgent requests for medical care; apply basic and advanced knowledge and skills necessary to determine patient physiologic, psychological, and psychosocial needs; administer medications, interpret and use diagnostic findings to implement treatment; provide complex patient care; and facilitate referrals and/or access to a higher level of care when the needs of the patient exceed the capability level of the paramedic. Paramedics often serve as a patient care team member in a hospital or other health care setting to the full extent of their education, certification, licensure and credentialing. Paramedics may work in community settings where they take on additional responsibilities monitoring and evaluating the needs of at-risk patients, as well as intervening to mitigate conditions that could lead to poor outcomes. Paramedics help educate patients and the public in the prevention and/or management of medical, health, psychological and safety issues.

About the Revised EMS Education Standards

2019 National EMS Scope of Practice Model Relationship

The recently released 2019 *National EMS Scope of Practice Model,* funded by NHTSA and HRSA, assembled experts to evaluate the scope of EMS practice for each of the four national practitioner levels (EMR, EMT, AEMT and paramedic). The 2019 *Scope of Practice Model* is the launching pad and guide for this revision of the *National EMS Education Standards*. The *Education Standards* reflect the 2019 and 2021 updated *Scope of Practice Model* and ensure practitioners receive the education and training they need to perform within their scopes and best serve their patients and communities.

The revision of the *National EMS Scope of Practice Model* and *National EMS Education Standards* are naturally interrelated, as one informs the other. As such, the team brought together to lead the revision of the *National EMS Education Standards* was funded by NHTSA and HRSA, and included 10 proven and renowned EMS educators. The *National EMS Scope of Practice Model,* recommendations from *EMS Agenda 2050*, known best practices, emerging technology, evidence-based medicine, information from the National EMS Database and societal issues were all considered. EMS stakeholder input and public comment were solicited and received multiple times throughout the revision process. The National Registry of EMTs also provided its Practice Analysis findings.

NREMT Practice Analysis

Several members of the EMS Education Standards Revision Team were involved in the NREMT's practice analysis working group. This process has informed the team regarding the most encountered EMS emergencies, according to the National EMS Database, made possible by the National EMS Information System (NEMSIS). In addition, the project revision team has reached out to NREMT throughout the revision project to obtain input and feedback. NREMT's practice analysis has been one of many critical resources consulted by the revision team.

Domains of EMS: Learning, Competency, Authorization and Operational/Local Qualification

The 2019 *National EMS Scope of Practice Model* identifies four domains within the "Professional Scope of Practice" and provides a structure for the differences between education, certification, licensure and credentialing (see definitions below). The EMS Education Standards Revision Team focused on education, or the learning domain.

- **Education, the learning domain** – This domain includes all didactic, psychomotor, and affective learning that an EMS learner should be taught during an EMS course to become an entry-level apprentice.

- **Certification, the competency verification domain** – This domain includes all external evaluation and verification processes that are led by an outside entity to ensure that a learner has achieved competency to be safe and effective when conducting duties as an entry-level EMS clinician. In most states, National Registry certification is used to verify competency.

- **Licensure, the legal authorization domain** – Licensure refers to the legal authority, granted by a state, to an individual to perform certain defined and restricted duties. The clinical duties usually vary from one state to the next. The term is not to be confused or referred to as "certification." As defined in the 2019 *Scope of Practice*

Model, certification and licensure are independent yet related processes. When state requirements are met, a state license is issued along with the legal authority to perform a role at the appropriate level of licensure.

- **Credentialing, the operational/local qualification domain** – Credentialing is the responsibility of the individual EMS organization and, in most cases, the medical director. Being that a learner has been educated, certified and licensed, the duty falls to the organization and local community to ensure that the EMS clinician is able to operate safely by following appropriate clinical and operational guidelines and philosophies set forth by the physician EMS medical director. Typically, this involves orientation courses with an evaluation and structured operational and clinical training programs. Credentialed providers have been taught and assessed on skills and actions that are beyond the entry-level education and training of an EMS school. For instance, if allowed by the state, ultrasound may be a role performed after proper credentialing by the local EMS medical director and jurisdiction, even though ultrasound is not included in the *National EMS Scope of Practice Model* or the *National EMS Education Standards*.

Because most EMS education programs teach students who will not all practice in the same organization, communities or even states, a one-size-fits-all education is not possible. The writing of a detailed national curricula for each of the four levels would be problematic. No educational institution can teach a learner every possible clinical or operational guideline or associated philosophy, nor can an educational entity train an individual about every clinical device used by EMS services across the nation. As a result, the credentialing process is a critical piece of preparing EMS clinicians to practice in their respective organizations after the completion of initial education and certification.

When a learner successfully concludes coursework and has satisfied a program's identified terminal requirements (Education Domain), the apprentice can then sit for an evaluation that provides verification of competency (Certification Domain). After successfully navigating the Licensure Domain with a state, a learner is deemed "entry-level." Finally, the entry-level clinician is ready for the Credentialing Domain of an employer, after which the learner is "job-ready." The term "entry-level" indicates that a learner has completed the education, certification, and licensure domains. "Job-ready" indicates that a learner has been credentialed by an employer and the local medical director, and is competent in the system's operational and clinical guidelines, policies and philosophies.

Common comments and recommendations that were received by the revision team addressed content areas that clearly did not apply to the entry-level education of an apprentice EMS clinician. Many suggestions fit within the credentialing domain and are not appropriate for national adoption at this time. The team worked hard to stay within the education domain for entry-level EMS clinicians.

Education Standards vs. Instructional Guidelines vs. Curriculum

The *National EMS Education Standards* outline the minimal competencies for entry-level EMS clinicians to achieve within the parameters outlined in the 2019 and 2021 updated *Scope of Practice Model*. Education programs should contemplate the *Standards* when developing curricula for national consistency. The *Standards'* format will allow diverse implementation methods to meet local needs and evolving education practices. The less prescriptive format of the *Standards* will also allow for ongoing revision of content consistent with scientific evidence, advances in technology, known "best practices" and community standards of care.

In general, the content of education standards can range from largely non-prescriptive to detailed and very prescriptive.

Non-Prescriptive Education Standards:

- increase teacher autonomy
- increase instructional flexibility
- increase responsiveness to student learning needs
- increase responsiveness to local needs and situations
- increase responsiveness to national trends

Prescriptive Education Standards:

- improve education consistency
- protect from societal harm that may result from low education expectations and/or low-quality instruction
- have been labeled as “burdensome checklists” by some educators and are problematic in medicine due to rapid changes in technology, scientific evidence and best practices

The *National EMS Education Standards* are not meant to stand as a comprehensive document guiding all of the development of EMS clinicians, but rather one part of a comprehensive system (Figure 3). EMS education programs will incorporate each element of the education system proposed in the *Education Agenda*. These elements include:

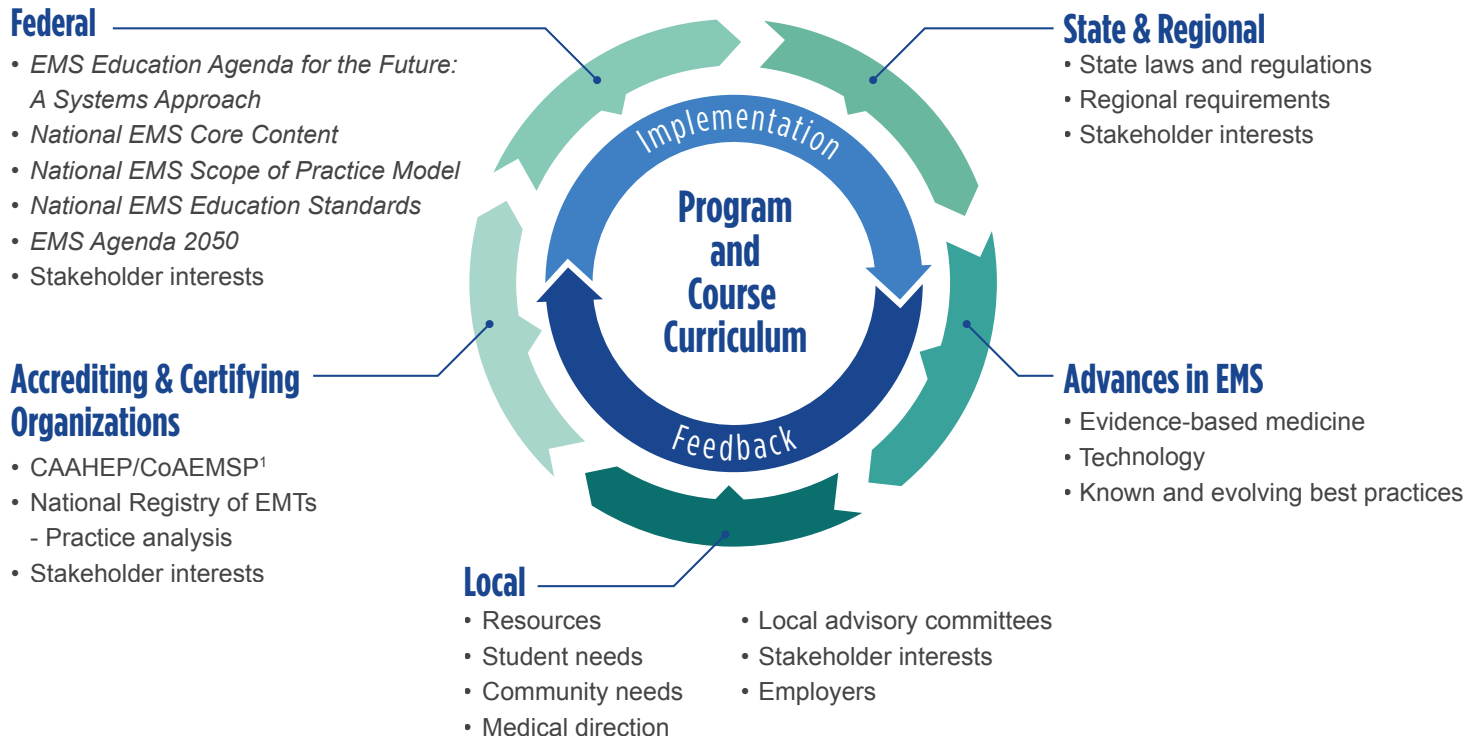
- National EMS Core Content
- National EMS Scope of Practice
- National EMS Education Standards
- National EMS Certification
- National EMS Program Accreditation

This integrated system is essential to achieving the goals of program efficiency, consistency of instructional quality and student competence as outlined in the *Education Agenda*.

While the *Education Standards* are developed at the national level, each state retains the right to wholly adopt the *Standards* or adopt and modify the *Education Standards* to fit a state’s unique needs. The *National EMS Education Standards* have been created to provide states with a vetted, consensus-driven foundation for EMS education. They also benefit clinicians by paving the way for national certification and easier transition from one locality or state to another.

Individual EMS educators and local communities select or create curricula based on a multitude of curriculum influencers. These influencers can also be strong mechanisms for education program accountability. Regional needs, accreditation standards and state and local policies and regulations are a few examples. Curricula design, implementation and adjustment are complex processes. Specific curricular content, instructional strategies and competency evaluation processes should be resolved at the education program level through implementation and feedback. Regulatory rules must be adhered to as well. Decisions on curriculum implementation are based on local situations, students’ needs and available resources. Figure 3 illustrates numerous inputs and points for accountability when curricula are designed, implemented and adjusted. Program directors, faculty and education institutions would be wise to consider each influence.

Figure 3: Influences on EMS Education Curriculum Development



1 CAAHEP: Commission on Accreditation of Allied Health Education Programs, CoAEMSP: Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions

Where are the Instructional Guidelines?

The 2009 instructional guidelines (IGs) were originally designed to help educators transition from the *National Standard Curricula* developed in the 1990s to the 2009 *Education Standards*.

When the revision team met, a discussion ensued regarding the ongoing usefulness of the IGs in their current form. It was agreed that the addition of the existing four IGs (EMR, EMT, AEMT and paramedic) to the *Education Standards* made the documents too cumbersome to be easily useful.

It was also evident that, while much of the IGs remained relevant, several sections had become outdated because of changes in evidence-based medicine, best practices or technology. Simultaneously, it was felt that it would be useful to have a level of specificity within the *Education Standards* rather than require educators to look in multiple places when seeking guidance to create curricula.

The resulting document combined elements of the IGs with the overarching principles of the *Education Standards*. A level of knowledge depth and breadth is provided for each section

of the *Standards*. At a glance, trained educators will be able to determine the extent of information to be provided to their students. The result is an enriched blueprint of the education and training of today's EMS clinicians.

Beyond the Scope of the Project

There are four areas that were frequently brought up by stakeholders but not part of the project. Specialty certification education (critical care paramedic, community paramedic, tactical medic); degree requirements at any clinician level; nomenclature of the EMS profession and clinicians; and continuing education requirements were beyond the scope of this effort. Instead, the focus was to align the *Education Standards* with the newly released 2019 *Scope of Practice Model*.

Degree Requirements

The revision team heard numerous comments regarding degree requirements. Clearly, some parties strongly desire degree requirements for paramedics. Others strongly oppose them. Currently, there is not an industry consensus for degree requirements for EMS personnel. In many cases, several significant EMS stakeholders and the "larger" EMS community take a more neutral position. Time will allow for further discussion and debate on the topic. Early in the process, the team was advised that the debate for or against degrees was beyond the scope of the project as the 2021 *National EMS Education Standards* do not address degree requirements.

The team also received recommendations for education related to deeper clinical subject matter, leadership and management, public health, education, social work, research, and other areas related to EMS systems. One national stakeholder called for courses in health systems science and value-based care. Suggested courses included:

- Health care system structure and processes
- Health care policy, economics, and management
- Clinical informatics and health information technology
- Public/population health
- Health system improvement and person-centered care
- Structure and processes beyond EMS
- Health care reimbursement and finance
- Health care quality and safety

AEMT Accreditation

The 2019 *National EMS Scope of Practice Model* subject matter expert panel recommended requiring AEMT program accreditation by January 1, 2025. The panel deliberated and came to a consensus on the matter with the involvement of 13 stakeholders and various independent contributors. Despite this understanding in 2019, the topic continues to be passionately debated. The *Education Standards* revision team supports this recommendation. The revision team deliberated the topic and concluded that accreditation is an original and identified goal of the *2000 EMS Education Agenda*. Through the use of collegial evaluation practices and the identification of recognized routines for establishing sound EMS education programs, program accreditation is expected to promote clinical and educational excellence by ensuring the availability of adequate resources and services for educators and their students.

Portable Technologies

During the public comment periods, many participants identified the need for education standards that covered new and

emerging technologies. There were specific and repeated recommendations for Point-of-Care Ultrasound (POCUS); the 2019 *Scope of Practice Model* subject matter experts directly addressed this skill and have determined that "portable technology" (which includes POCUS) has been left to the "credentialing" process of the EMS organization and medical director. The *Standards* revision team believes that the ideal time for use of these technologies is when a person has been educated, deemed competent, licensed and credentialed with knowledge and skill. The local EMS medical director should be involved in the selection of technologies. Widespread education based on specific technologies should be decided at the local or state level. Only after national adoption and inclusion in a practice analysis should technologies be included in the *National EMS Education Standards* and *National EMS Scope of Practice Model.*

Instructional Practices: Simulation, Shadowing & Interprofessional Education

Because education standards are not intended to be a curriculum, the instructional strategies of simulation, shadowing and interprofessional education are addressed here but not in the *Standards* themselves. The team does believe that an education program should implement numerous instructional techniques to accommodate the diversity of student learning needs inside and outside the EMS classroom. Using numerous instructional strategies will help reach every learner. A heavy reliance on the traditional lecture is not ideal and is not equitable, as some students learn better in different settings and every student benefits from experiencing other methods of instruction. Three types of instructional practices were identified by the public and various stakeholders: simulation, shadowing and interprofessional education. The team believes that each practice has merit and should be considered as an additional instructional strategy.

Simulation

EMS simulation begins in the classroom with educators creating realistic scenarios to train all levels of EMS personnel. The practice of allowing students to memorize and verbalize a check sheet is no longer acceptable and should be changed. Simulation has proven to increase critical thinking skills and reduce medical errors in our health care system. Simple to complex simulation comes in many forms, from table-top exercises and practicing intramuscular injections on an orange to standardized live patients and high-fidelity manikins. Cost will vary, but simulation does not have to be expensive to be successful. Simulation in EMS can achieve:

- The creation of a "safe-to-fail" environment in which students can make mistakes without dire consequences and learn from those mistakes
- Higher success rates on the NREMT psychomotor exams
- Enhanced understanding and more robust therapeutic communication
- Increased understanding and demonstration of affective domain competencies
- Improvement in critical thinking skills of entry-level personnel
- Improved safety, effectiveness and efficiency of services
- Substitution for infrequent or unattainable clinical scenarios

Shadowing

Shadowing a practicing clinician offers students experiential, hands-on learning opportunities, and many learners have a special affinity for it. Shadowing affords a prospective EMS

professional the chance to be immersed in the actual job environment, making it possible to see an experienced worker apply the skills and traits needed to accomplish the work.

Interprofessional Education

Health care is best when delivered in a cooperative team environment; collaboration can result in improved communications, thus reducing medical errors, reducing costs for patients and improving patient outcomes. Interprofessional Education is a proven instructional method that results in positive outcomes in clinical preparation, health care profession education and public safety. Interprofessional Education helps a learner realize how EMS fits into the larger "continuum of care" and plays a role in critical "systems of care." Learning how patients move through the health care system, from dispatch to discharge to follow-up care, plays a critical role in patient safety. Interaction with other health care providers and first responders during initial education will mutually enhance an understanding of everyone's roles in the system.

Out-of-hospital care is becoming more diverse and complex. As a result, individual EMS instructors may not possess the expertise or knowledge to teach all subjects within the revised *Standards*. When this occurs, a subject matter expert should be enlisted for the given topic. For instance, the public health section has been expanded and it would be a "best practice" to bring in a qualified content expert to cover the topic. Many areas related to EMS operations would also require a qualified content expert. Rescue operations have become extremely broad and specialized. Bodies of knowledge such as incident command, hazardous materials and other unique topics require experience and specialized knowledge for quality instruction. The instructor should have a proper background, relevant knowledge and a degree or a recognized and credible credential in the topic. It is recommended that the EMS educator work with the subject matter experts to ensure relevance of the content to the practice of prehospital medicine.

Eminence of the Affective Domain

Competence in the affective domain of learning is critical to the success of EMRs, EMTs, AEMTs and Paramedics. The *National EMS Education Standards* focus on the knowledge and skills that an entry-level practitioner needs to treat sick or injured patients. The third dimension needed for any skilled EMS clinician is related to values, attitude, professional behavior, compassion and a willingness to serve. Values provide the foundation for decisions, and attitudes reflect values and influence interpersonal dynamics. Professional behavior is a key component of medical practice, and compassion is a required characteristic of medical professionals supporting clinical knowledge and skill. A willingness to serve underlies all that a health care provider does.

The importance of affective domain competence cannot be overstated. Every EMS education program director and faculty member should consider this aspect of medical practice. Modeling and setting professional-level expectations for affective domains are part of the educational duty of an educator within career and technical school. From the very first day of class until course conclusion, the importance of teaching and evaluating affective domain competency to ensure graduates are fully prepared for professional practice should be identified as a high priority and a universal goal.

Sequence of Instruction

The order of the *National EMS Education Standards* does not imply any particular sequence of instruction. For example, some topics, such as public health, could be taught early on or later in a course, despite appearing early in these *Standards*. Other topics, such as basic assessment skills, would likely

come early in the clinician's education and precede concepts that build upon them. Curricular flow should be determined by the education program director, with input from faculty, medical direction and advisory committees.

Locally Identified Topics

The revision team recognized and heard numerous comments regarding clinical content that is of great local need and yet may not be essential as an item for the entire nation. As a result, the team believed it would be best to include a statement that some content should be locally determined and developed at the simple depth, simple breadth level (or higher when desired). This content should be identified, developed and implemented using a program medical director, advisory boards, the larger medical community or faculty judgement.

Implicit Expectations

For a given illness, condition, or traumatic injury, the implicit expectation is that an educational program will include instruction of the relevant anatomy, physiology, pathophysiology, assessments and accepted treatments. The team determined that this expectation is known by educators and repeating the statement in each section of the document is not required or desired.

Additional Resources

It is impossible for EMS instructors to know everything about the profession, and trying to stay up to date on the latest evidence-based guidelines, best practices, industry standards and research is a very difficult task. The resources found in Appendix A are intended as tools for educators to use as needed to remain current on changes in the field.

Two critical sources that educators should consider referencing as they create learning content are the National Model EMS Clinical Guidelines, maintained by the National Association of State EMS Officials (NASEMSO), and pre-hospital evidence-based guidelines, many of which are produced through the efforts of The Prehospital Guidelines Consortium, maintained by the National Association of EMS Physicians (NAEMSP). The guidance provided by these sources is a result of collaboration among many national EMS stakeholders intent on promoting consensus and evidence to inform a general standard of prehospital care.

Summary of Significant Changes to the EMS Education Standards

Behavioral/Psychiatric

Many, if not most EMS systems have seen a steady rise in behavioral emergencies and patients experiencing acute and chronic manifestations of psychiatric illnesses. Moreover, a lack of available in-patient beds at mental health facilities has resulted in EMS clinicians needing to manage these patients for longer periods of time and over longer distances.

As a result, the behavioral/psychiatric section of the *Education Standards* was revised to include more information regarding acute behavioral crisis and mental health disorders. Greater depth and breadth of knowledge were recommended for areas involving potential safety hazards to patients and EMS clinicians. Conversely, certain psychiatric disease and syndrome areas were revised and simplified.

Cultural Humility

Throughout health care and related fields, there has been a recognition of the importance of maintaining an awareness of the assumptions and biases related to cultural issues and how they may affect our patients, co-workers and students. Cultural humility is a lifelong, ongoing process of self-reflection and self-critique in which one learns about others' cultural identities and looks at how one's own background and social environment have shaped the individual. Cultural humility in EMS should address:

- **Education:** Are our EMS educators diverse? Does our student population reflect the community? Are our classrooms free of stereotypes? Do we understand our own biases and the differences between all of our students?
- **EMS workforce:** Are we creating a diversified and equitable workforce reflective of our population? Promoting cultural humility can help strengthen relationships among staff, leadership, patients and families and other health care personnel we interact with on a daily basis.
- **Patient care:** Are we teaching cultural competency and humility to our EMS students? After graduation, can our students provide culturally competent, equitable and medically appropriate prehospital care to each and every patient no matter their background? Cultural humility leads to higher-quality care and better communication and trust between patients and clinicians.

EMS Operations

EMS operations, while extremely important, are determined by a variety of factors, including the setting, the clinician's role and the EMS system design. Therefore, it is not possible to provide strict and straightforward training requirements that would be appropriate across these diverse settings. Next is a summary of the intent of each section of the EMS operations education standards. EMS educators and EMS institutions need to be able to work with local and state agencies to determine the appropriate level of knowledge that providers need to perform their duties safely and efficiently.

- **Principles of Safely Operating EMS Emergency Response Vehicles**

  The intent of this section is to give an overview of emergency response to ensure the safety of EMS personnel, patients and others during EMS response vehicle operations. This does not prepare the entry-level student to be an experienced and competent driver. Appropriate driver training designed for the entry-level provider must be completed as required by state and local regulations and is not intended to be part of a requirement to achieve national certification as an emergency medical responder. Information related to the clinical management of the patient during emergency response is found in the clinical sections of the *National EMS Education Standards* for each personnel level.

- **Incident Management**

  Information related to the clinical management of the patient within components of the Incident Management System is found in the clinical sections of the *National EMS Education Standards* for each licensure level. The material presented in this section should be delivered by an individual who has been trained and has the proper credentials to educate students in these areas. The material may be obtained in-person or through distance learning as determined by state and local requirements.

- **Mass Casualty Incidents**

  The intent of this section is to give an overview of operating during a mass casualty incident when a multiple casualty incident plan is activated. Information related to the clinical management of the patients during a multiple casualty incident is found in the clinical sections of the *National EMS Education Standards* for each licensure level. The depth and breadth of training that must be achieved by clinicians at each level should be determined by state and local requirements.

- **Landing Zone Operations**

  The intent of this section is to give an overview of operating safely in and around a landing zone during air medical operations and transport. The safety considerations of setting up and operating in a landing zone should be taught by properly trained experts who have the proper knowledge and experience in the area of air medical transportation. The depth and breadth of information that is needed by each level of clinician should be determined by state and local regulations. Information related to the clinical management of the patient being cared for during air medical operations is found in the clinical sections of the *National EMS Education Standards* for each licensure level.

- **Rescue Operations**

  The intent of this section is to provide an overview of rescue operations including, but not limited to, vehicle extrication, low/high angle, water, trench and confined space to ensure the safety of EMS personnel and patients during these events. This does not prepare the entry-level student to become competent or qualified to work in these rescue environments. Information related to the clinical management of the patient being cared for during rescue incidents is found in the clinical sections of the *National EMS Education Standards* for each personnel level.

- **Hazardous Materials**

  Information related to the clinical management of the patient exposed to hazardous materials is found in the clinical sections of the *National EMS Education Standards* for each personnel level. This information may be done as a corequisite or prerequisite, or as part of the entry-level course as determined by state and local requirements.

Training in this area should only be done by those properly trained and credentialed to provide the required training. Federal regulations require that, at a minimum, EMS personnel must be trained at the Hazardous Materials Awareness level. State and local regulations may have additional requirements that are above and beyond federal regulations. EMS educators should work in collaboration with local fire or emergency management authorities to determine the proper training level required and assuring that properly credentialed instructors are providing the training. The information contained in the hazardous materials awareness programs are above and beyond the scope of national EMS programs for the entry-level provider.

- **Mass Casualty Incidents Due to Active Threats and Disaster**

  The intent of this section is to give an overview of operating during a terrorist event or during a natural or man-made disaster. Instruction in this area should be done by properly trained and knowledgeable individuals in this area. State and local regulations may have additional requirements that are above and beyond federal regulations. Information related to the clinical management of patients exposed to a terrorist event or involved in a disaster is found in the clinical sections of the *National EMS Education Standards* for each personnel level.

Public Health

Since the release of the original *National EMS Education Standards* in 2009, EMS has made substantial progress from being viewed as simply a provider of medical transport to a true out-of-hospital health care resource. The changes to the public health section of the *Standards* reflect this evolution in EMS. Public health prevention and pandemic preparedness efforts are essential functions in the future as EMS continues to be at the crossroads between health care, public health and public safety. The EMS clinician of the future will be expected to integrate into pandemic plans, assist in vaccinations and act as the initial point of entry into robust community health programs.

The new standards are intended to prepare the entry-level provider to work alongside and collaboratively with specially trained community paramedics, social workers, public health organizations, health care entities, emergency management agencies and non-governmental organizations in their day-to-day duties, and lay the foundation for advancement into specialized roles.

Pharmacology

An EMS culture of safety is a universal goal within the industry. A key area for safety is the administration of medications in the prehospital setting. The lack of desired pharmacology competency among EMS program graduates was identified by the *EMS Scope of Practice* subject matter experts, in EMS evidenced-based literature and numerous other sources. When it comes to pediatric populations, EMS for Children identified a significant need for additional training in this area and called for specific teaching for pediatric dosing and troubleshooting abnormal situations. As a result, the pharmacology section has been expanded for EMR, EMT, AEMT and paramedics. It is not enough to solely teach pharmacology in a traditional didactic manner. This skill should include didactic, psychomotor and affective instruction. There should be significant opportunities to practice the skill before leaving the education program. Simulation and, ideally, actual patient encounters should be offered to students. Emphasis and specific focus should be given to psychomotor practice of adult, pediatric and geriatric medication administration due to the complexity of drug dosing and the chance of error.

EMS Safety, Wellness and Resilience

Workforce safety and wellness has been expanded to reflect principles of stress management, responder mental health, resilience and suicide prevention across all levels. With greater number of responders reporting thoughts of suicide, and suicide rates among first responders significantly exceeding those of the general population, a foundational level of knowledge is crucial to addressing this professional and occupational crisis. An overall greater emphasis on mental health resources is also recommended.

Standard safety precautions, use of personal protective equipment, illness and injury prevention, and lifting and moving patients continue to be emphasized at all levels of emergency responders. Other areas that have been added include crew resource management across all levels and disease transmission in the EMT, AEMT and paramedic curricula.

Pediatric and Geriatric Content Competencies

Individual sections for pediatrics and geriatrics have been removed, with education content addressing these special populations now incorporated throughout the education standards. This change is based on recommendations from pediatric-focused stakeholders, scientific evidence and consensus among clinical partners.

Concepts related to geriatric and pediatric patients deserve equitable attention and should be taught repeatedly throughout every section of a course resulting in an earlier assimilation of the content. Pediatric stakeholders reported that anxiety, unfamiliarity with pediatric patients and equipment, and discomfort on the part of rescuers calls for aggressive remedies. These findings may be associated with the low frequency and high acuity of pediatric encounters.

The need for better EMS assessment, diagnosis, treatment, safe medication administration, airway management and appropriate pain management has been identified. In every aspect of education, troubleshooting and critical thinking are required when clinical situations are confusing or problematic. As students acquire knowledge, skills and abilities, opportunities to compare and contrast pediatric, adult and geriatric populations will enhance and deepen learning.

During each section of the *Standards*, relevant pediatric and geriatric content should be discussed in detail as they aren't covered in a separate section. Incorporation of this special population information into the general content should improve the comfort level of students by making the care of these patients part of everyday operations.

EMS education should include knowledge from the cradle to the grave. Pediatric and geriatric topics should no longer be minimized, in comparison to "adult" topics, or relegated to an isolated component of an EMS course, which can create a perception that the content is somehow less important.

EMS education and care should be family-centered. Family-centered care is a clinical methodology for the planning, delivery and evaluation of health care which is established in an affirming partnership that collaboratively involves patients, families and the health care providers. Family-centered care represents a significant transition away from paternalistic medicine to that which is founded on pillars of respect, collaboration, information sharing and shared decision-making.

While family-centered care is often taught as an area of focus for children with special needs, it should be integrated into the care of all patients. In the case of children with special health care needs, the family's knowledge of a child's condition can be immensely valuable. Yet, even among children with

simple, acute medical emergencies, families and children often experience high levels of stress. Family-centered care seeks to help patients and families retain a sense of control. This includes providing opportunities for family members to be present during medical transport and invasive procedures. The approach recognizes that each family is unique, integral and essential for health care safety and quality. The values of collaboration, responsiveness and united decision-making are at the forefront of treatment. The beliefs, desires, and values from cultural backgrounds of the family and patient are considered and respected. Health care workers communicate with complete information and in an unbiased and respectful manner. When choices are made, decision-making involves all parties as coequal parts and decision-makers are known and informed, and health care clinicians listen to and honor patient and family choices. When family-centered care is optimal, there is high-quality care with safety, and family and patient satisfaction are achieved.

The reader will find phrases such as “include age-related variations in pediatric and geriatric patients” and “include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients.” These phrases are intended to remind and direct EMS educators to elevate the importance of geriatric and pediatric education within each section.

National EMS Education Standards

LEGEND

The first letter refers to **Breadth**, which can be:
- Simple (S)
- Foundational (F)
- Comprehensive (C)

The second letter refers to **Depth**, which can be:
- Simple (S)
- Fundamental (F)
- Complex (C)

For more information refer to Fig. 2 and Fig. 2.1 (Depth/Breadth Terminology) on p.11-12.

		EMR	EMT	AEMT	Paramedic
Preparatory	**Preparatory**	**Uses knowledge of the EMS system, safety/well-being of the EMR, medical/legal issues and ethical issues at the scene of an emergency while awaiting a higher level of care.**	**Applies knowledge of the EMS system, safety/well-being of the EMT, medical/legal and ethical issues to the provision of emergency care.**	**Applies knowledge of the EMS system, safety/well-being of the AEMT, medical/legal and ethical issues to the provision of emergency care.**	**Integrates knowledge of EMS systems, the safety/well-being of the paramedic, and medical/legal and ethical issues intended to improve the health of EMS personnel, patients and the community.**
	EMS Systems	• EMS systems (S,S) • Roles, responsibilities and professionalism of EMS personnel (S,S) • Quality improvement vs. quality assurance (S,S) • Role of medical oversight (S,S) • Culture of safety / patient safety (S,S) • Continuum of care (S,S)	• EMS systems (S,F) • Roles, responsibilities and professionalism of EMS personnel (F,F) • Quality improvement vs. quality assurance (S,F) • Role of medical oversight (S,S) • Culture of safety / patient safety (S,F) • Continuum of care (S,F) • History of EMS (S,F) • Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics (S,F) • MIH/CP and other EMS-related specialty roles (S,S)	• EMS systems (S,F) • Roles, responsibilities and professionalism of EMS personnel (F,F) • Quality improvement vs. quality assurance (F,F) • Role of medical oversight (F,F) • Culture of safety / patient safety (F,F) • Continuum of care (F,F) • History of EMS (S,F) • Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics (F,F) • MIH/CP and other EMS-related specialty roles (F,F)	• EMS systems (C,C) • Roles, responsibilities, and professionalism of EMS personnel (C,C) • Quality improvement vs. quality assurance (C,C) • Role of medical oversight (C,C) • Culture or safety / patient safety (C,C) • Continuum of care (F,F) • History of EMS (F,F) • Systems of care, e.g., Stroke, STEMI, Trauma, Pediatrics (C,C) • MIH/CP and other EMS-related specialty roles (F,F)

		EMR	EMT	AEMT	Paramedic
Preparatory	Workforce Safety and Wellness	• Standard safety precautions (S,S) • Personal protective equipment (S,S) • Lifting and moving patients (S,S) • Crew resource management (S,S) • Stress management (F,F) • Prevention of work-related injuries and illnesses (F,F) • Responder mental health, resilience and suicide prevention (F,F) • Wellness principles (F,F) • Disease transmission (S,S)	• Standard safety precautions (F,F) • Personal protective equipment (F,F) • Lifting and moving patients (F,F) • Crew resource management (F,F) • Stress management (F,F) • Prevention of work-related injuries and illnesses (F,F) • Responder mental health, resilience and suicide prevention (F,F) • Wellness principles (F,F) • Disease transmission (F,F)	• Standard safety precautions (F,F) • Personal protective equipment (F,F) • Lifting and moving patients (F,F) • Crew resource management (F,F) • Stress management (F,F) • Prevention of work-related injuries and illnesses (F,F) • Responder mental health, resilience and suicide prevention (F,F) • Wellness principles (F,F) • Disease transmission (F,F)	• Standard safety precautions (C,C) • Personal protective equipment (C,C) • Lifting and moving patients (C,C) • Crew resource management (F,F) • Stress management (C,C) • Prevention of work-related injuries and illnesses (C,C) • Responder mental health, resilience and suicide prevention (C,C) • Wellness principles (C,C) • Disease transmission (C,C)
	Research	• Impact of research on EMR care (S,S) • Data collection (S,S)	• Impact of research on EMT care (S,S) • Data collection (S,S) • Evidence-based decision making (S,S)	• Impact of research on AEMT care (S,S) • Data collection (S,S) • Evidence-based decision making (S,S)	• Impact of research on Paramedic care (S,S) • Data collection (S,S) • Evidence-based decision making (S,S) • Research principles to interpret literature and advocate evidence-based practice (F,F)
	Documentation	• Recording patient findings (S,S)	• Recording patient findings (S,S) • Principles of medical documentation and report writing (F,F) • Supporting medical necessity (S,S)	• Recording patient findings (S,S) • Principles of medical documentation and report writing (C,F) • Supporting medical necessity (S,S)	• Recording patient findings (S,S) • Principles of medical documentation and report writing (C,C) • Supporting medical necessity (S,S)
	EMS System Communication	• Call for resources (S,S) • Transfer care of the patient (S,S) • Interact within the team structure (S,S)	• EMS communication system (S,S) • Communication with other health care professionals to include cohesive and organized patient handoff (S,S) • Team communication and dynamics (S,S) • Telemetric monitoring devices and transmission of clinical data, including video data (S,S)	• EMS communication system (F,F) • Communication with other health care professionals to include cohesive and organized patient handoff (F,F) • Team communication and dynamics (F,F) • Telemetric monitoring devices and transmission of clinical data, including video data (S,S)	• EMS communication system (C,C) • Communication with other health care professionals to include cohesive and organized patient handoff (C,C) • Team communication and dynamics (C,C) • Telemetric monitoring devices and transmission of clinical data, including video data (S,S)

		EMR	EMT	AEMT	Paramedic
Preparatory	Therapeutic Communication	• Health care literacy (S,S) • Interviewing techniques (S,S) • Verbal defusing strategies (S,S) • Managing communication challenges (S,S) • Family centered care (S,S)	• Health care literacy (S,S) • Interviewing techniques (F,F) • Verbal defusing strategies (F,F) • Managing communication challenges (F,F) • Family centered care (F,F) • Adjusting communication strategies for age, stage of development, patients with special needs (S,S) • Non-discriminatory communication that addresses inherent or unconscious bias, is culturally aware and sensitive, and intended to improve patient outcome (S,S)	• Health care literacy (F,F) • Interviewing techniques (F,F) • Verbal defusing strategies (F,F) • Managing communication challenges (F,F) • Family centered care (F,F) • Adjusting communication strategies for age, stage of development, patients with special needs (S,S) • Non-discriminatory communication that addresses inherent or unconscious bias, is culturally aware and sensitive, and intended to improve patient outcome (S,S)	• Health care literacy (C,C) • Interviewing techniques (C,C) • Verbal defusing strategies (F,F) • Managing communication challenges (C,C) • Family centered care (F,F) • Adjusting communication strategies for age, stage of development, patients with special needs (C,C) • Non-discriminatory communication that addresses inherent or unconscious bias, is culturally aware and sensitive, and intended to improve patient outcome (C,C)
	Medical/Legal and Ethics	• Consent/refusal of care (S,S) • Confidentiality (S,S) • Advanced directives (S,S) • Tort and criminal actions (S,S) • Evidence preservation (S,S) • Statutory responsibilities (S,S) • Mandatory reporting (S,S) • Ethical principles/moral obligations (S,S) • End-of-life issues (S,S)	• Consent/involuntary consent/ refusal of care (F,F) • Confidentiality (F,F) • Advanced directives (F,F) • Tort and criminal actions (F,F) • Evidence preservation (F,F) • Statutory responsibilities (F,F) • Mandatory reporting (F,F) • Ethical principles/moral obligations (F,F) • End-of-life issues (S,S) • Patient rights/advocacy (S,S)	• Consent/involuntary consent/ refusal of care (F,F) • Confidentiality (F,F) • Advanced directives (F,F) • Tort and criminal actions (F,F) • Evidence preservation (F,F) • Statutory responsibilities (F,F) • Mandatory reporting (F,F) • Ethical principles/moral obligations (F,F) • End-of-life issues (S,S) • Patient rights/advocacy (S,S)	• Consent/involuntary consent/ refusal of care (C,C) • Confidentiality (C,C) • Advanced directives (C,C) • Tort and criminal actions (C,C) • Evidence preservation (F,F) • Statutory responsibilities (C,C) • Mandatory reporting (C,C) • Ethical principles/moral obligations (C,C) • End-of-life issues (C,C) • Health care regulation (C,C) • Patient rights/advocacy (C,C) • Ethical tests and decision making (C,C)

	EMR	EMT	AEMT	Paramedic
Anatomy and Physiology	Uses knowledge of the anatomy and function of the upper airway, heart, vessels, blood, lungs, skin, muscles and bones as the foundation of emergency care.	Applies knowledge of the anatomy and function of all human systems to the practice of EMS.	Integrates knowledge of the anatomy and physiology of the airway, respiratory and circulatory systems to the practice of EMS.	Integrates knowledge of the anatomy and physiology of all human systems

	EMR	EMT	AEMT	Paramedic
Medical Terminology	Uses medical and anatomical terms.	Uses anatomical and medical terms and abbreviations in written and oral communication with colleagues and other health care professionals.	Same as EMT Level	Integrates anatomical and medical terminology and abbreviations into written and oral communication with colleagues and other health care professionals.

	EMR	EMT	AEMT	Paramedic
Pathophysiology	Uses knowledge of shock and respiratory compromise to respond to life threats.	Applies knowledge of the pathophysiology of respiration and perfusion to patient assessment and management.	Applies knowledge of the pathophysiology of respiration and perfusion to patient assessment and management.	Integrates knowledge of pathophysiology of major human systems.

	EMR	EMT	AEMT	Paramedic
Life Span Development	Uses knowledge of age-related differences to assess and care for patients.	Applies knowledge of life span development to patient assessment and management.	Same as EMT Level	Integrates knowledge of life span development.

		EMR	EMT	AEMT	Paramedic
Public Health	**Public Health**	**Has an awareness of local public health resources and their role in public health.**	**Applies knowledge of the principles of public health epidemiology including public health emergencies, public health monitoring, health promotion and illness and injury prevention.**	**Same as EMT level**	**Applies knowledge of principles of public health and epidemiology including public health emergencies, health promotion and illness and injury prevention.**
	Public Health Overview	• EMS roles in public health (S,S) • Infection prevention and control (S,S) • Human trafficking (S,S)	• EMS roles in public health (S,S) • Infection prevention and control (S,S) • Human trafficking (S,S) • EMS EHR reporting and data collection (S,S) • Governmental/ nongovernmental roles & resources (S,S) • Public health mission and goals (S,S) • Social, geographic, economic, demographic determinants of health (S,S) • Patient and community education (S,S) • Injury prevention and wellness (S,S) • Unique pediatric, geriatric and special populations public health concerns (S,S) • Screenings and vaccinations/ immunizations (S,S)	• EMS roles in public health (S,S) • Infection prevention and control (S,S) • Human trafficking (S,S) • EMS EHR reporting and data collection (S,S) • Governmental/ nongovernmental roles & resources (S,S) • Public health mission and goals (S,S) • Social, geographic, economic, demographic determinants of health (S,S) • Patient and community education (S,S) • Injury prevention and wellness (S,S) • Unique pediatric, geriatric and special populations public health concerns (S,S) • Screenings and vaccinations/ immunizations (F,F) • Impacts of political, social and economic issues (F,F) • Infectious disease (F,F)	• EMS roles in public health (C,F) • Infection prevention and control (F,F) • Human trafficking (S,S) • EMS EHR reporting and data collection (S,S) • Governmental/ nongovernmental roles & resources (S,S) • Public health mission and goals (S,S) • Social, geographic, economic, demographic determinants of health (S,S) • Patient and community education (S,S) • Injury prevention and wellness (S,S) • Unique pediatric, geriatric and special populations public health concerns (S,S) • Screenings and vaccinations/ immunizations (C,F) • Impacts of political, social and economic issues (F,F) • Infectious disease (C,F) • Patient disposition, selecting destination, ambulance transport (C,F) • Bioinformatics (C,F)

		EMR	EMT	AEMT	Paramedic
Pharmacology	**Pharmacology**	**Uses knowledge of the medications that the EMR may administer in an emergency.**	**Applies knowledge of the medications the EMT may administer to a patient during an emergency and chronic or maintenance medications the patient may be taking.**	**Applies (to patient assessment and management) knowledge of the medications carried by AEMTs that may be administered to a patient during an emergency and chronic or maintenance medications the patient may be taking.**	**Integrates knowledge of pharmacology to formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient.**
	Principles of Pharmacology	• Medication safety (S,S) • Kinds of medications used during an emergency (S,S)	• Medication safety (F,F) • Medication legislation (F,F) • Naming (F,F) • Classifications (F,F) • Storage and security (F,F) • Medication interactions (S,S) • Adverse drug reactions (S,S) • Metabolism and excretion (F,F) • Mechanism of action (F,F) • Medication response relationships (F,F)	• Medication safety (C,C) • Medication legislation (C,C) • Naming (C,C) • Classifications (C,C) • Storage and security (C,C) • Medication interactions (C,C) • Adverse drug reactions (C,C) • Pharmacokinetics (C,C) • Pharmacodynamics (C,C) • Schedules (C,C)	• Medication safety (C,C) • Medication legislation (C,C) • Naming (C,C) • Classifications (C,C) • Storage and security (C,C) • Medication interactions (C,C) • Adverse drug reactions (C,C) • Pharmacokinetics (C,C) • Pharmacodynamics (C,C) • Schedules (C,C)
	Medication Administration	• Use a Medication Cross Check procedure (S,S) • Use an autoinjector (S,S) • Use a unit-dose, premeasured intranasal device (S,S) • Use of tools/resources to facilitate safe administration of weight-based dosing.	• Use a Medication Cross Check procedure (F,F) • Use an autoinjector (S,S) • Use a unit-dose, premeasured intranasal device (S,S) • Administer medications to a patient (F,F) • Provide pain management, including ethical and safety considerations (F,F) • Routes of administration (S,S)	• Use a Medication Cross Check procedure (F,F) • Use an autoinjector (S,S) • Use a unit-dose, premeasured intranasal device (S,S) • Administer medications to a patient (C,C) • Provide pain management, including ethical and safety considerations (C,C) • Routes of administration (C,C) • Resources for safe administration of weight-based dosing (F,F)	• Use a Medication Cross Check procedure (F,F) • Use an autoinjector (S,S) • Use a unit-dose, premeasured intranasal device (S,S) • Administer medications to a patient (C,C) • Provide pain management, including ethical and safety considerations (C,C) • Routes of administration (C,C) • Resources for safe administration of weight-based dosing (F,F)

		EMR	EMT	AEMT	Paramedic
Pharmacology	Acute Medications	• Names (S,S) • Effects (S,S) • Indications (S,S) • Contraindications (S,S) • Side effects (S,S) • Routes of administration (S,S) • Dosages (S,S)	• Names (F,S) • Effects (S,S) • Indications (F,S) • Contraindications (F,S) • Side effects (F,S) • Routes of administration (F,S) • Dosages (F,S) • Actions (F,S) • Complications (F,S) • Interactions (F,S)	• Names (C,C) • Effects (C,C) • Indications (C,C) • Contraindications (C,C) • Side effects (C,C) • Routes of administration (C,C) • Dosages (C,C) • Actions (C,C) • Complications (C,C) • Interactions (C,C)	• Names (C,C) • Effects (C,C) • Indications (C,C) • Contraindications (C,C) • Side effects (C,C) • Routes of administration (C,C) • Dosages (C,C) • Actions (C,C) • Complications (C,C) • Interactions (C,C)
	Chronic or Maintenance Medications	No knowledge related to this competency is applicable at this level.	Specific medication classes to be determined locally • Class names (S,S) • Class indications (S,S) • Class complications (S,S) • Class side effects (S,S) • Polypharmacy (S,S)	Specific medication classes to be determined locally • Class names (S,S) • Class indications (S,S) • Class complications (S,S) • Class side effects (S,S) • Polypharmacy (S,S)	Specific medication classes and examples to be determined locally • Class names (F,S) • Class indications (F,S) • Class complications (F,S) • Class side effects (F,S) • Polypharmacy (F,S)

		EMR	EMT	AEMT	Paramedic
Airway Management, Respiration and Ventilation	**Airway Management, Respiration and Ventilation**	**Applies knowledge of anatomy and physiology to assure a patent airway, adequate mechanical ventilation and respiration while awaiting additional EMS response for patients of all ages.**	**Applies knowledge of anatomy and physiology to patient assessment and management in order to assure a patent airway, adequate mechanical ventilation and respiration for patients of all ages.**	**Applies knowledge of upper airway anatomy and physiology to patient assessment and management in order to assure a patent airway, adequate mechanical ventilation and respiration for patients of all ages.**	**Integrates knowledge of anatomy, physiology and pathophysiology into the assessment to develop and implement a treatment plan with the goal of assuring a patent airway, adequate mechanical ventilation and respiration for patients of all ages.**
	Airway Management (Include age-related variations in pediatric and geriatric patients)	• Airway anatomy (F,S) • Airway assessment (F,S) • Techniques of assuring a patent airway (F,S)	• Airway anatomy (F,F) • Airway assessment (F,F) • Techniques of assuring a patent airway (F,F)	• Airway anatomy (F,F) • Airway assessment (F,F) • Techniques of assuring a patent airway (F,F)	• Airway anatomy (C,C) • Airway assessment (C,C) • Techniques of assuring a patent airway (C,C)
	Respiration (Include age-related variations in pediatric and geriatric patients)	• Anatomy of the respiratory system (F,S) • Physiology and pathophysiology of respiration (F,S) - Pulmonary ventilation - Oxygenation - Respiration • External • Internal • Cellular • Assessment and management of adequate and inadequate respiration (F,S) • Supplemental oxygen therapy (F,S)	• Anatomy of the respiratory system (F,F) • Physiology and pathophysiology of respiration (F,C) - Pulmonary ventilation - Oxygenation - Respiration • External • Internal • Cellular • Assessment and management of adequate and inadequate respiration (F,C) • Supplemental oxygen therapy (F,C)	• Anatomy of the respiratory system (C,F) • Physiology and pathophysiology of respiration (F,C) - Pulmonary ventilation - Oxygenation - Respiration • External • Internal • Cellular • Assessment and management of adequate and inadequate respiration (F,C) • Supplemental oxygen therapy (F,C)	• Anatomy of the respiratory system (C,C) • Physiology and pathophysiology of respiration (C,C) - Pulmonary ventilation - Oxygenation - Respiration • External • Internal • Cellular • Assessment and management of adequate and inadequate respiration (C,C) • Supplemental oxygen therapy (C,C)
	Ventilation (Include age-related variations in pediatric and geriatric patients)	• Assessment and management of adequate and inadequate ventilation (F,S) • Effect of ventilation on cardiac output (F,S)	• Assessment and management of adequate and inadequate ventilation (F,F) • Effect of ventilation on cardiac output (F,F)	• Assessment and management of adequate and inadequate ventilation (C,F) • Effect of ventilation on cardiac output (C,F)	• Assessment and management of adequate and inadequate ventilation (C,C) • Effect of ventilation on cardiac output (C,C)

		EMR	EMT	AEMT	Paramedic
Assessment	**Assessment**	**Use scene information and patient assessment findings to identify and manage immediate life threats and injuries within the scope of practice of the EMR.**	**Applies scene information and patient assessment findings (scene size up, primary and secondary assessment, patient history and reassessment) to guide emergency management.**	**Same as EMT Level**	**Integrate scene and patient assessment findings with knowledge of epidemiology and pathophysiology to form a field impression. This includes developing a list of differential diagnoses through clinical reasoning to modify the assessment and formulate a treatment plan.**
	Scene Assessment	• Scene safety/situational awareness (C,C) • Scene management (F,F) • Impact of the environment on patient care (F,F) • Addressing hazards (F,F) • Violence (F,F) • Need for additional or specialized resources (F,F) • Standard precautions (F,F) • Multiple patient situations (F,F)	• Scene safety/situational awareness (C,C) • Scene management (F,F) • Impact of the environment on patient care (F,F) • Addressing hazards (F,F) • Violence (F,F) • Need for additional or specialized resources (F,F) • Standard precautions (F,F) • Multiple patient situations (F,F)	• Scene safety/situational awareness (C,C) • Scene management (F,F) • Impact of the environment on patient care (F,F) • Addressing hazards (F,F) • Violence (F,F) • Need for additional or specialized resources (F,F) • Standard precautions (F,F) • Multiple patient situations (F,F)	• Scene safety/situational awareness (C,C) • Scene management (C,C) • Impact of the environment on patient care (C,C) • Addressing hazards (C,C) • Violence (C,C) • Need for additional or specialized resources (F,F) • Standard precautions (F,F) • Multiple patient situations (C,C)
	Primary Assessment (Include age-related variations in pediatric and geriatric patients)	• Primary assessment (S,S) • Begin interventions needed to preserve life (S,S)	• Primary assessment (F,S) • Integration of treatment/procedures needed to preserve life (F,S)	• Primary assessment (F,F) • Integration of treatment/procedures needed to preserve life (F,F)	• Primary assessment (C,C) • Integration of treatment/procedures needed to preserve life (C,C)

		EMR	EMT	AEMT	Paramedic
Assessment	History Taking (Include age-related variations in pediatric and geriatric patients)	• Determining the chief complaint (S,S) • Mechanism of injury/ nature of illness (S,S) • Associated signs and symptoms (S,S)	• Investigation of the chief complaint (F,F) • Mechanism of injury/nature of illness (F,F) • Associated signs and symptoms (F,F) • Past medical history (F,F) • Pertinent negatives (F,F)	• Investigation of the chief complaint (F,F) • Mechanism of injury/nature of illness (F,F) • Associated signs and symptoms (F,F) • Past medical history (F,F) • Pertinent negatives (F,F)	• Investigation of the chief complaint (C,C) • Mechanism of injury/nature of illness (C,C) • Associated signs and symptoms (C,C) • Past medical history (C,C) • Pertinent negatives (C,C) • Interviewing techniques (C,C) • Therapeutic communication and adaptive interview techniques (C,C)
	Secondary Assessment (Include age-related variations in pediatric and geriatric patients)	• Assessment of vital signs (S,S) • Assessment of pain (S,S) • Performing a rapid full body scan (S,S)	• Assessment of vital signs (F,F) • Assessment of pain (F,F) • Techniques of physical examination (F,F) - Respiratory system including breath sound quality - Cardiovascular system - Neurological system - Musculoskeletal system - Major anatomical regions	• Assessment of vital signs (C,F) • Assessment of pain (C,F) • Techniques of physical examination (C,F) - Respiratory system including breath sound quality - Cardiovascular system - Neurological system - Musculoskeletal system - Major anatomical regions	• Assessment of vital signs (C,C) • Assessment of pain (C,C) • Techniques of physical examination (C,C) - Respiratory system including breath sound quality - Cardiovascular system - Neurological system - Musculoskeletal system - Major anatomical regions
	Monitoring Devices	No knowledge related to this competency is applicable at this level.	• Pulse oximetry (S,S) • Non-invasive blood pressure (S,S) • Cardiac monitoring – 12 lead ECG acquisition and transmission (S,S) • Blood glucose determination (S,S)	• Pulse oximetry (S,S) • Non-invasive blood pressure (S,S) • Cardiac monitoring – 12 lead ECG acquisition and transmission (S,S) • Blood glucose determination (S,S) • End tidal CO_2 monitoring and interpretation of waveform capnography (S,S) • Venous blood sampling (S,S)	• Pulse oximetry (S,S) • Non-invasive blood pressure (S,S) • Cardiac monitoring – 12 lead ECG acquisition and transmission (F,F) • Blood glucose determination (S,S) • End tidal CO_2 monitoring and interpretation of waveform capnography (F,F) • Venous blood sampling (S,S) • 12-lead ECG interpretation (F,F) • Blood chemistry analysis (F,F)
	Reassessment (Include age-related variations in pediatric and geriatric patients)	• How and when to reassess patients (S,S)	• How and when to reassess patients (F,F)	• How and when to reassess patients (F,F)	• How and when to reassess patients (C,C)

		EMR	EMT	AEMT	Paramedic
Medicine	**Medicine**	**Recognizes and manages life threats based on assessment findings of a patient with a medical emergency while awaiting additional emergency response.**	**Applies knowledge to provide basic emergency care and transportation based on assessment findings for an acutely ill patient.**	**Applies knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for an acutely ill patient.**	**Integrates assessment findings with principles of epidemiology and pathophysiology to formulate a field impression and implement a treatment/ disposition plan for a patient with a medical complaint.**
Medicine	Medical Overview (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/ or emergencies associated with pediatric and geriatric patients)	• Assessment and management of a medical complaint (S,S)	• Pathophysiology, assessment, and management of a medical complaints to include (S,F) - Transport mode - Destination decisions	• Pathophysiology, assessment, and management of a medical complaints to include (F,F) - Transport mode - Destination decisions	• Pathophysiology, assessment, and management of a medical complaints to include (C,C) - Transport mode - Destination decisions
Medicine	Abdominal and Gastrointestinal Disorders (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/ or emergencies associated with pediatric and geriatric patients)	• Anatomy, presentations and management of shock associated with gastrointestinal bleeding (S,S)	• Acute and chronic gastrointestinal hemorrhage (F,F) • Other gastrointestinal disorders to be determined locally (S,S)	• Acute and chronic gastrointestinal hemorrhage (F,F) • Other gastrointestinal disorders to be determined locally (S,S)	• Acute and chronic gastrointestinal hemorrhage (C,C) • Bowel obstruction (C,C) • Liver and biliary tract disorders (F,F) • Pancreatitis (S,S) • Inflammatory disorders (S,S) • Peritonitis (S,S) • Other gastrointestinal disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	**Cardiovascular** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Chest pain (S,S)	• Acute coronary syndrome (F,F) • Hypertensive emergencies (S,S) • Aortic aneurysm/dissection (F,F) • Thromboembolism (F,F) • Heart failure (F,F) • Other cardiovascular disorders to be determined locally (S,S)	• Acute coronary syndrome (C,F) • Hypertensive emergencies (F,S) • Aortic aneurysm/dissection (F,F) • Thromboembolism (F,F) • Heart failure (F,F) • Other cardiovascular disorders to be determined locally (S,S)	• Acute coronary syndrome (C,C) • Hypertensive emergencies (C,C) • Aortic aneurysm/dissection (F,F) • Thromboembolism (F,F) • Heart failure (C,C) • Non-traumatic cardiac tamponade (C,C) • Cardiogenic shock (C,C) • Vascular disorders (C,C) • Cardiac rhythms (C,C) • Conditions that predispose patients to cardiac rhythm disturbances including WPW, Brugada, long QT syndrome and others (C,C) • Infectious diseases of the heart: endocarditis, myocarditis, pericarditis (F,F) • Congenital heart disease (F,F) • Hypertrophic cardiomyopathy (F,F) • Other cardiovascular disorders to be determined locally (S,S)
	Disorders of the Eyes, Ears, Nose, and Throat (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Epistaxis (S,S)	• Epistaxis (S,S) • Other eye, ear, nose and throat disorders to be determined locally (S,S)	• Epistaxis (F,F) • Post-surgical oropharyngeal hemorrhage (F,F) • Other eye, ear, nose and throat disorders to be determined locally (S,S)	• Epistaxis (F,F) • Post-surgical oropharyngeal hemorrhage (F,F) • Common or major diseases of the eyes, ears, nose and throat (F,F) • Other eye, ear, nose and throat disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	**Endocrine Disorders** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Awareness that diabetic emergencies cause altered mental status (S,S)	• Diabetic emergencies (F,F) • Other endocrine disorders to be determined locally (S,S)	• Diabetic emergencies (C,F) • Other endocrine disorders to be determined locally (S,S)	• Diabetic emergencies (C,C) • Chronic diabetes (C,C) • Adrenal disease (S,S) • Pituitary and thyroid disorders (S,S) • Inborn errors of metabolism (S,S) • Other endocrine disorders to be determined locally (S,S)
	Genitourinary/Renal (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Blood pressure assessment in hemodialysis patients (S,S)	• Complications related to renal dialysis (S,S) • Complications related to urinary catheter management (not insertion) (S,S) • Kidney stones (S,S) • Sexual assault (Female and Male) (F,F) • Other GI/Renal to be determined locally (S,S)	• Complications related to renal dialysis (F,S) • Complications related to urinary catheter management (not insertion) (S,S) • Kidney stones (F,S) • Sexual assault (Female and Male) (F,F) • Other GI/Renal to be determined locally (S,S)	• Complications of dialysis (C,C) • Complications related to urinary catheter management (not insertion) (S,S) • Renal calculi (C,C) • Sexual assault (Female and Male) (C,C) • Acute/chronic renal failure (C,C) • Acid base disturbances (C,C) • Fluid and electrolytes (C,C) • Infection (F,F) • Male genital tract conditions (F,F) • Other GI/Renal to be determined locally (S,S)
	Hematology (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	No knowledge related to this competency is applicable at this level.	• Sickle cell crisis (S,S) • Clotting disorders (S,S) • Other hematologic disorders to be determined locally (S,S)	• Sickle cell crisis (F,F) • Clotting disorders (S,S) • Other hematologic disorders to be determined locally (S,S)	• Sickle cell disease (C,C) • Coagulopathies (F,F) • Blood transfusion complications (F,F) • Hemostatic disorders (F,F) • Red blood cell disorders (F,F) • White blood cell disorders (F,F) • Other hematologic disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	**Immunology** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Anaphylactic reactions (S,S)	• Allergic and anaphylactic reactions (F,F) • Other immunological disorders to be determined locally (S,S)	• Allergic and anaphylactic reactions (C,C) • Systemic Inflammatory Response Syndrome (SIRS) (C,C) • Other immunological disorders to be determined locally (S,S)	• Allergic and anaphylactic reactions (C,C) • Systemic Inflammatory Response Syndrome (SIRS) (C,C) • Hypersensitivity (C,C) • Anaphylactoid reactions (C,C) • Collagen vascular disease (F,F) • Transplant-related problems (F,F) • Immunodeficiency syndromes (acquired or congenital) (F,F) • Other immunological disorders to be determined locally (S,S)
	Infectious Diseases (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Awareness of patient who may have an infectious disease (S,S) • How to disinfect and decontaminate equipment after treating a patient (S,S)	• Assessment and management of a patient who may have an infectious disease (S,S) • How to decontaminate the ambulance and equipment after treating a patient (S,S) • Sepsis and septic shock (S,S) • Other infectious diseases to be determined locally (S,S)	• Assessment and management of a patient who may have an infectious disease (S,S) • How to decontaminate the ambulance and equipment after treating a patient (S,S) • Sepsis and septic shock (F,F) • HIV (F,F) • Hepatitis B (F,F) • Antibiotic resistance (F,F) • Current infectious diseases prevalent in the community (F,F) • Vaccine-preventable diseases (F,F) • Other infectious diseases to be determined locally (S,S)	• Assessment and management of a patient who may have an infectious disease (S,S) • How to decontaminate the ambulance and equipment after treating a patient (S,S) • Sepsis and septic shock (C,C) • HIV-related disease (C,C) • Hepatitis (C,C) • Meningitis (C,C) • Antibiotic resistance (F,F) • Current infectious diseases prevalent in the community (F,F) • Vaccine-preventable diseases (C,C) • Viral diseases: RSV, Herpes zoster (F,F) • Sexually transmitted infections (F,F) • Tetanus (S,S) • Vector-borne diseases (S,S) • Tuberculosis (S,S) • Emerging infectious disease (S,S) • Other infectious diseases to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	**Neurology** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Decreased level of responsiveness (S,S) • Seizure (S,S) • Stroke (S,S)	• Decreased level of responsiveness (S,S) • Seizure (F,F) • Stroke (F,F) • Dementia vs. delirium (S,S) • Alzheimer's disease (S,S) • Headache (F,F) • Brief Resolved Unexplained Event (BRUE) (F,F) • Other neurological disorders to be determined locally (S,S)	• Decreased level of responsiveness (F,F) • Seizure (C,F) • Stroke (F,F) • Dementia vs. delirium (S,S) • Alzheimer's disease (S,S) • Headache (F,F) • Brief Resolved Unexplained Event (BRUE) (F,F) • Parkinson's disease (S,S) • Other neurological disorders to be determined locally (S,S)	• Decreased level of responsiveness (C,C) • Seizure (C,C) • Stroke (C,C) • Dementia vs. delirium (S,S) • Alzheimer's disease (S,S) • Headache (C,C) • Brief Resolved Unexplained Event (BRUE) (F,F) • Parkinson's disease (S,S) • Hydrocephalus – CSF diversion devices or shunts (F,F) • Other neurological disorders to be determined locally (S,S)
	Non-Traumatic Musculoskeletal Disorders (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Non-traumatic fractures (S,S)	• Non-traumatic fractures (F,F) • Other non-traumatic musculoskeletal disorders to be determined locally (S,S)	• Non-traumatic fractures (F,F) • Other non-traumatic musculoskeletal disorders to be determined locally (S,S)	• Non-traumatic fractures (F,F) • Disorders of the spine (F,F) • Joint abnormalities (F,F) • Muscle abnormalities (F,F) • Overuse syndromes (F,F) • Rhabdomyolysis (F,F) • Other non-traumatic musculoskeletal disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	Psychiatric or Behavioral Emergencies (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Recognition of behaviors that pose a risk to the EMR, patient or others • Recognition of suicide risk	• Basic principles of the mental health system (S,S) • Patterns of violence, abuse and neglect (S,S) • Acute psychosis (F,F) • Suicide ideation (F,F) • Excited delirium (F,F) • Anxiety (F,F) • Depression (F,F) • Medical fear (F,F) • Substance use disorder (F,F) • PTSD (F,F) • Other psychiatric/behavioral disorders to be determined locally (S,S)	• Basic principles of the mental health system (S,S) • Patterns of violence, abuse and neglect (F,F) • Acute psychosis (F,F) • Suicide ideation (C,C) • Excited delirium (F,F) • Anxiety (F,F) • Depression (F,F) • Medical fear (F,F) • Substance use disorder/ addictive behavior (C,C) • PTSD (F,F) • Other psychiatric/behavioral disorders to be determined locally (S,S)	• Basic principles of the mental health system (S,S) • Patterns of violence, abuse and neglect (C,C) • Suicide ideation (C,C) • Excited delirium (C,C) • Anxiety (C,C) • Depression (C,C) • Medical fear (F,F) • Substance use disorder/ addictive behavior (C,C) • PTSD (C,C) • Acute psychosis (C,C) • Cognitive disorders (F,F) • Thought disorders (F,F) • Mood disorders (F,F) • Neurotic disorders (F,F) • Somatoform disorders (F,F) • Factitious disorders (F,F) • Personality disorders (F,F) • Other psychiatric/behavior disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Medicine	**Respiratory** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Respiratory distress/failure/arrest (F,F) • Upper airway obstruction (S,S) • Lower airway disease: Asthma, bronchiolitis, pneumonia, chronic obstructive pulmonary disease (COPD) (S,S)	• Respiratory distress/failure/arrest (F,F) • Upper airway obstruction (F,F) • Lower airway disease: Asthma, bronchiolitis, pneumonia, chronic obstructive pulmonary disease (COPD) (F,F) • Spontaneous pneumothorax (F,F) • Pulmonary edema (F,F) • Other respiratory disorders to be determined locally (S,S)	• Respiratory distress/failure/arrest (F,F) • Upper airway diseases: foreign body, croup, epiglottitis (C,F) • Lower airway disease: Asthma, bronchiolitis, pneumonia, chronic obstructive pulmonary disease (COPD) (C,F) • Spontaneous pneumothorax (F,F) • Pulmonary edema (C,F) • Other respiratory disorders to be determined locally (S,S)	• Respiratory distress/failure/arrest (F,F) • Upper airway diseases: foreign body, croup, epiglottitis (C,C) • Lower airway disease: Asthma, bronchiolitis, pneumonia, chronic obstructive pulmonary disease (COPD), bronchopulmonary dysplasia (C,C) • Spontaneous pneumothorax (C,C) • Pulmonary edema (C,C) • Other respiratory disorders to be determined locally (S,S)
	Toxicology (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Carbon monoxide poisoning (S,S) • Nerve agent poisoning (S,S) • Opioid toxicity (S,S) • How and when to contact a poison control center (S,S)	• Carbon monoxide poisoning (S,S) • Nerve agent poisoning (S,S) • Opioid toxicity (S,S) • How and when to contact a poison control center (S,S) • Poisons (inhaled, ingested, injected, absorbed) (F,F) • Alcohol intoxication and withdrawal (F,F) • Other toxicological disorders to be determined locally (S,S)	• Carbon monoxide poisoning (S,S) • Nerve agent poisoning (S,S) • Opioid toxicity (F,F) • How and when to contact a poison control center (S,S) • Poisons (inhaled, ingested, injected, absorbed) (F,F) • Alcohol intoxication and withdrawal (F,F) • Other toxicological disorders to be determined locally (S,S)	• Carbon monoxide poisoning (C,C) • Nerve agent poisoning (S,S) • Opioid toxicity (F,F) • How and when to contact a poison control center (S,S) • Poisons (inhaled, ingested, injected, absorbed) (F,F) • Alcohol intoxication and withdrawal (C,C) • Toxidromes (C,C) - Cholinergic - Anticholinergic - Sympathomimetic - Sedative/hypnotics - Opioid - Corrosive - Knockdown • Chronic or maintenance medications (C,C) • Drugs of abuse (C,C) • Non-FDA approved medications and supplements (C,C) • Serotonin Syndrome (C,C) • Malignant Hyperthermia (C,C) • Other toxicological disorders to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Shock and Resuscitation	**Shock and Resuscitation**	**Uses assessment information to recognize shock, respiratory failure or arrest, and cardiac arrest based on assessment findings and manages the emergency while awaiting additional emergency response.**	**Applies knowledge of the causes, pathophysiology and management of shock, respiratory failure or arrest, cardiac failure or arrest, termination of resuscitative efforts and post resuscitation management.**	**Applies knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for a patient in shock, respiratory failure or arrest, cardiac failure or arrest, termination of resuscitative efforts and post resuscitation management.**	**Integrates knowledge of causes and pathophysiology into the management of cardiac arrest and peri-arrest states.**
	Shock (Include psychosocial aspects of age-related assessment and treatment modifications for pediatric and geriatric patients)	• Definition (S,S) • Physiologic response (S,S)	• Essential components in normal perfusion (F,S) • Physiologic response (S,S) • Types of shock (S,S) • Treatment of shock (S,S)	• Essential components in normal perfusion (F,F) • Physiologic response (F,F) • Types of shock (F,F) • Treatment of shock, hypoperfusion and dehydration (C,C) • Complications of shock (F,F) • Circulatory assist devices (F,F)	• Essential components in normal perfusion (C,C) • Physiologic response (C,C) • Types of shock (C,C) • Treatment of shock, hypoperfusion and dehydration (C,C) • Complications of shock (C,C) • Circulatory assist devices (C,C)
	Resuscitation from Cardiac Arrest (Include psychosocial aspects of age-related assessment and treatment modifications for pediatric and geriatric patients)	• Ethical issues in resuscitation (S,S) • CPR physiology (S,S) • Resuscitation system components (S,S) • Special arrest and peri-arrest situations (S,S)	• Ethical issues in resuscitation (C,C) • CPR physiology (F,F) • Resuscitation system components (F,F) • Special arrest and peri-arrest situations (F,F) • Postresuscitation support (F,F) • Termination of resuscitation (F,F)	• Ethical issues in resuscitation (C,C) • CPR physiology (F,F) • Resuscitation system components (F,F) • Special arrest and peri-arrest situations (F,F) • Postresuscitation support (C,C) • Termination of resuscitation (C,C)	• Ethical issues in resuscitation (C,C) • CPR physiology (C,C) • Resuscitation system components (C,C) • Special arrest and peri-arrest situations (C,C) • Postresuscitation support (C,C) • Termination of resuscitation (C,C) • Premorbid conditions (C,C)

		EMR	EMT	AEMT	Paramedic
Trauma	**Trauma**	**Uses knowledge to recognize and manage life threats based on assessment findings for an acutely injured patient while awaiting additional emergency medical response.**	**Applies knowledge to provide basic emergency care and transportation based on assessment findings for an acutely injured patient.**	**Applies knowledge to provide basic and selected advanced emergency care and transportation based on assessment findings for an acutely injured patient.**	**Integrates assessment findings with principles of epidemiology and pathophysiology to formulate a field impression to implement a treatment/ disposition plan for an acutely injured patient.**
	Trauma Overview (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	No knowledge related to this competency is applicable at this level.	• Trauma scoring (F,F) • Transport and destination issues (F,F) • Transport mode (F,F)	• Trauma scoring (F,F) • Transport and destination issues (F,F) • Transport mode (F,F)	• Trauma scoring (C,C) • Transport and destination issues (C,C) • Transport mode (F,F)
	Abdominal and Genitourinary Trauma (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Blunt versus penetrating mechanisms (S,S) • Evisceration (S,S) • Impaled object (S,S)	• Blunt versus penetrating mechanisms (F,S) • Evisceration (S,S) • Impaled object (S,S) • Solid and hollow organ injuries (F,S) • Injuries to the internal or external genitalia (F,S)	• Blunt versus penetrating mechanisms (F,F) • Evisceration (S,S) • Impaled object (S,S) • Solid and hollow organ injuries (F,F) • Injuries to the internal or external genitalia (F,F) • Vascular injury (F,F) • Retroperitoneal injuries (F,F)	• Blunt versus penetrating mechanisms (F,F) • Evisceration (S,S) • Impaled object (S,S) • Solid and hollow organ injuries (F,F) • Injuries to the internal or external genitalia (F,F) • Vascular injury (F,F) • Retroperitoneal injuries (F,F)
	Bleeding (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Bleeding (S,S)	• Bleeding (F,F)	• Bleeding (F,F) • Fluid resuscitation (C,C)	• Bleeding (F,F) • Fluid resuscitation (C,C)

		EMR	EMT	AEMT	Paramedic
Trauma	**Chest Trauma** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Blunt versus penetrating mechanisms (S,S) • Open chest wound (S,S) • Impaled object (S,S)	• Blunt versus penetrating mechanisms (F,S) • Open chest wound (S,S) • Impaled object (S,S) • Hemothorax (F,S) • Pneumothorax (F,S) • Cardiac tamponade (F,S) • Rib fractures (F,S) • Flail chest (F,S) • Commotio cordis (F,S)	• Blunt versus penetrating mechanisms (F,S) • Open chest wound (S,S) • Impaled object (S,S) • Hemothorax (F,F) • Pneumothorax (F,F) • Cardiac tamponade (F,F) • Rib fractures (F,F) • Flail chest (F,F) • Commotio cordis (F,S) • Traumatic aortic disruption (F,F) • Pulmonary contusion (F,F) • Blunt cardiac injury (F,F) • Traumatic asphyxia (F,F)	• Blunt versus penetrating mechanisms (F,S) • Open chest wound (S,S) • Impaled object (S,S) • Hemothorax (C,C) • Pneumothorax (C,C) • Cardiac tamponade (C,C) • Rib fractures (C,C) • Flail chest (C,C) • Commotio cordis (F,S) • Traumatic aortic disruption (C,C) • Pulmonary contusion (C,C) • Blunt cardiac injury (C,C) • Traumatic asphyxia (C,C) • Tracheobronchial disruption (C,C) • Diaphragmatic rupture (C,C)
	Environmental Emergencies (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Drowning (S,S) • Temperature-related illness (S,S) • Bites and envenomations (S,S) • Lightning injury (S,S) • Other environmental emergencies to be determined locally (S,S)	• Drowning (F,F) • Temperature-related illness (F,F) • Bites and envenomations (F,F) • Lightning injury (F,F) • Other environmental emergencies to be determined locally (S,S)	• Drowning (F,F) • Temperature-related illness (F,F) • Bites and envenomations (F,F) • Lightning injury (F,F) • Other environmental emergencies to be determined locally (S,S)	• Drowning (C,C) • Temperature-related illness (C,C) • Bites and envenomations (C,C) • Lightning injury (C,C) • Other environmental emergencies to be determined locally (S,S)

		EMR	EMT	AEMT	Paramedic
Trauma	Head, Facial, Neck, and Spine Trauma (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Life threats (S,S) • Spine trauma (S,S)	• Life threats (S,S) • Spine trauma (F,F) • Penetrating neck trauma (F,F) • Laryngotracheal injuries (F,F) • Shaken Baby Syndrome (F,F) • Facial fractures (S,S) • Skull fractures (S,S) • Foreign bodies in the eyes (S,S) • Globe rupture (S,S) • Dental trauma (S,S) • Severe epistaxis (S,S)	• Life threats (S,S) • Spine trauma (F,F) • Penetrating neck trauma (F,F) • Laryngotracheal injuries (C,F) • Shaken Baby Syndrome (F,F) • Facial fractures (C,F) • Skull fractures (S,S) • Foreign bodies in the eyes (S,S) • Globe rupture (S,S) • Dental trauma (S,S) • Severe epistaxis (S,S)	• Life threats (S,S) • Spine trauma (C,C) • Penetrating neck trauma (C,C) • Laryngotracheal injuries (C,C) • Shaken Baby Syndrome (F,F) • Facial fractures (C,F) • Skull fractures (C,C) • Foreign bodies in the eyes (S,S) • Globe rupture (S,S) • Dental trauma (S,S) • Severe epistaxis (S,S) • Unstable facial fractures (F,F) • Orbital fractures (F,F) • Perforated tympanic membrane (F,F) • Mandibular fractures (C,C)
	Multi-System Trauma (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Multi-system trauma (S,S)	• Multi-system trauma (F,F) • Blast injuries (F,F)	• Multi-system trauma (C,F) • Blast injuries (F,F)	• Multi-system trauma (C,C) • Blast injuries (C,C)
	Nervous System Trauma (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Traumatic brain injury (S,S)	• Traumatic brain injury (F,F) • Spinal cord injury (F,F)	• Traumatic brain injury (C,F) • Spinal cord injury (F,F)	• Traumatic brain injury (C,C) • Spinal cord injury (C,C) • Spinal shock (C,C) • Cauda equina syndrome (F,F) • Nerve root injury (F,F) • Peripheral nerve injury (F,F)

		EMR	EMT	AEMT	Paramedic
Trauma	**Orthopedic Trauma** (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Open fractures (S,S) • Closed fractures (S,S) • Dislocations (S,S) • Amputations (S,S)	• Open fractures (F,F) • Closed fractures (F,F) • Dislocations (F,F) • Amputations/replantation (F,F) • Upper and lower extremity orthopedic trauma (F,F) • Sprains/strains (F,F) • Pelvic fractures (F,F)	• Open fractures (F,F) • Closed fractures (F,F) • Dislocations (F,F) • Amputations/replantation (C,F) • Upper and lower extremity orthopedic trauma (F,F) • Sprains/strains (F,F) • Pelvic fractures (C,F)	• Open fractures (C,C) • Closed fractures (C,C) • Dislocations (C,C) • Amputations/replantation (C,F) • Upper and lower extremity orthopedic trauma (C,C) • Sprains/strains (F,F) • Pelvic fractures (C,F) • Pediatric fractures (F,F) • Tendon laceration/ transection/ rupture (Achilles and patellar) (F,F)
	Soft Tissue Trauma (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Wounds (avulsion, bite, laceration, puncture, incision) (S,S) • Burns (electrical, chemical, thermal) including inhalation injury (S,S) • Chemicals in the eye and on the skin (S,S)	• Wounds (avulsion, bite, laceration, puncture, incision) (F,F) • Burns (electrical, chemical, thermal, radiation) including inhalation injury (F,F) • Chemicals in the eye and on the skin (S,S) • Crush/compartment syndrome (S,S) • High-pressure injection injury (S,S)	• Wounds (avulsion, bite, laceration, puncture, incision) (F,F) • Burns (electrical, chemical, thermal, radiation) including inhalation injury (F,F) • Chemicals in the eye and on the skin (S,S) • Crush/compartment syndrome (F,S) • High-pressure injection injury (S,S)	• Wounds (avulsion, bite, laceration, puncture, incision) (C,C) • Burns (electrical, chemical, thermal, radiation) including inhalation injury (C,C) • Chemicals in the eye and on the skin (S,S) • Crush/compartment syndrome (C,C) • High-pressure injection injury (S,S)
	Special Considerations in Trauma	• Pregnant patient (S,S) • Pediatric patient (S,S) • Geriatric patient (S,S)	• Pregnant patient (F,F) • Pediatric patient (F,F) • Geriatric patient (F,F) • Cognitively impaired patient (F,F)	• Pregnant patient (C,F) • Pediatric patient (C,F) • Geriatric patient (C,F) • Cognitively impaired patient (C,F)	• Pregnant patient (C,C) • Pediatric patient (C,C) • Geriatric patient (C,C) • Cognitively impaired patient (C,C)

		EMR	EMT	AEMT	Paramedic
Special Patient Populations	**Special Patient Populations**	**Recognizes and manages life threats based on simple assessment findings for a patient with special needs while awaiting additional emergency response.**	**Applies knowledge of growth, development and aging and assessment findings to provide basic emergency care and transportation for a patient with special needs.**	**Applies knowledge of growth, development and aging and assessment findings to provide basic and selected advanced emergency care and transportation for a patient with special needs.**	**Integrates assessment findings with principles of pathophysiology and knowledge of psychosocial needs to formulate a field impression and implement a treatment/disposition plan for patients with special needs.**
	Gynecology (Include psychosocial aspects of age-related assessment and treatment modifications for the major or common diseases and/or emergencies associated with pediatric and geriatric patients)	• Shock associated with vaginal bleeding (S,S)	• Vaginal bleeding (F,F) • Infections (S,S) • Other gynecological disorders to be determined locally (S,S)	• Vaginal bleeding (F,F) • Infections (S,S) • Other gynecological disorders to be determined locally (S,S)	• Vaginal bleeding (C,C) • Infections (F,F) • Ovarian emergencies (F,F) • Vaginal foreign body (F,F) • Other gynecological disorders to be determined locally (S,S)
	Obstetrics	• Normal delivery (S,S) • Vaginal bleeding in the pregnant patient (S,S)	• Normal delivery (F,F) • Vaginal bleeding in the pregnant patient (S,S) • Normal pregnancy (anatomy and physiology) (F,F) • Pathophysiology of complications of pregnancy (F,F) • Assessment of the pregnant patient (F,F) • Abnormal delivery (nuchal cord, prolapsed cord, breech, shoulder dystocia, prematurity, multiparity) (F,F) • Third trimester and antepartum bleeding (placenta previa. placental abruption) (F,F) • Spontaneous abortion/ miscarriage (F,F) • Ectopic pregnancy (F,F) • Preeclampsia/eclampsia (F,F) • Postpartum complications (S,S)	• Normal delivery (F,F) • Vaginal bleeding in the pregnant patient (S,S) • Normal pregnancy (anatomy and physiology) (F,F) • Pathophysiology of complications of pregnancy (F,F) • Assessment of the pregnant patient (F,F) • Abnormal delivery (nuchal cord, prolapsed cord, breech, shoulder dystocia, prematurity, multiparity) (F,F) • Third trimester and antepartum bleeding (placenta previa. placental abruption) (F,F) • Spontaneous abortion/miscarriage (F,F) • Ectopic pregnancy (F,F) • Preeclampsia/eclampsia (F,F) • Postpartum complications (C,C)	• Normal delivery (C,C) • Vaginal bleeding in the pregnant patient (S,S) • Normal pregnancy (anatomy and physiology) (C,C) • Pathophysiology of complications of pregnancy (C,C) • Assessment of the pregnant patient (C,C) • Abnormal delivery (nuchal cord, prolapsed cord, breech, shoulder dystocia, prematurity, multiparity) (C,C) • Third trimester and antepartum bleeding (placenta previa. placental abruption) (F,F) • Spontaneous abortion/miscarriage (C,C) • Ectopic pregnancy (C,C) • Preeclampsia/eclampsia (C,C) • Postpartum complications (C,C) • High-risk pregnancy (C,C) • Complications of labor (fetal distress, premature rupture of membranes, rupture of uterus) (C,C) • Hyperemesis gravidarum (S,S) • Postpartum depression (S,S)

		EMR	EMT	AEMT	Paramedic
Special Patient Populations	Neonatal Care	• Newborn stabilization (S,S) • Neonatal resuscitation (S,S)	• Newborn stabilization (F,F) • Neonatal resuscitation (F,F)	• Newborn stabilization (F,F) • Neonatal resuscitation (F,F)	• Newborn stabilization (C,C) • Neonatal resuscitation (C,C) • Anatomy and physiology of neonatal circulation (C,C)
	Pediatrics	The Education Standards now integrate assessment, diagnostic, treatment and disposition modifications for pediatric-specific diseases and emergencies into each section of the document.			
	Geriatrics	The Education Standards now integrate assessment, diagnostic, treatment and disposition modifications for geriatric-specific diseases and emergencies into each section of the document			
	Patients with Special Challenges	• Recognizing and reporting abuse and neglect (S,S)	• Recognizing and reporting abuse and neglect (S,S) • Abuse/Intimate partner violence (S,S) • Neglect (S,S) • Child/dependent adult maltreatment (S,S) • Homelessness (S,S) • Poverty (S,S) • Bariatrics (S,S) • Technology dependent (locally determined) (S,S) • Hospice/ terminally ill (S,S) • Tracheostomy care/dysfunction (S,S) • Homecare (S,S) • Sensory deficit/loss (S,S) • Developmental disability (S,S) • Autism Spectrum Disorder (S,S) • Orthotics/prosthetics (S,S)	• Recognizing and reporting abuse and neglect (S,S) • Abuse/Intimate partner violence (F,F) • Neglect (F,F) • Child/dependent adult maltreatment (F,F) • Homelessness (F,F) • Poverty (F,F) • Bariatrics (F,F) • Technology dependent (locally determined) (F,F) • Hospice/ terminally ill (F,F) • Tracheostomy care/dysfunction (F,F) • Homecare (F,F) • Sensory deficit/loss (F,F) • Developmental disability (F,F) • Autism Spectrum Disorder (F,F) • Orthotics/prosthetics (S,S)	• Recognizing and reporting abuse and neglect (S,S) • Abuse/Intimate partner violence (C,C) • Neglect (C,C) • Child/dependent adult maltreatment (C,C) • Homelessness (F,F) • Poverty (C,C) • Bariatrics (C,C) • Technology dependent (vagal nerve stimulators, CSF diversion devices or shunts, VAD, pacemakers, gastric tubes and others to be locally determined) (C,C) • Hospice/ terminally ill (C,C) • Tracheostomy care/dysfunction (C,C) • Homecare (F,F) • Sensory deficit/loss (F,F) • Developmental disability (F,F) • Autism Spectrum Disorder (F,F) • Orthotics/prosthetics (S,S)

		EMR	EMT	AEMT	Paramedic
EMS Operations	**EMS Operations**	**Knowledge of operational roles and responsibilities to ensure patient, public and personnel safety**	**Same as EMR Level**	**Same as EMR Level**	**Same as EMR Level**
	Emergency Response Vehicles	• Risks and responsibilities of emergency response and radio communications (S,S) • Risks and responsibilities of operating emergency vehicles (S,S)	• Risks and responsibilities of emergency response and radio communications (S,S) • Risks and responsibilities of operating emergency vehicles (S,S) • Pediatric transport considerations (F,F) • Risks and responsibilities of transport (F,F)	• Risks and responsibilities of emergency response and radio communications (S,S) • Risks and responsibilities of operating emergency vehicles (S,S) • Pediatric transport considerations (F,F) • Risks and responsibilities of transport (F,F)	• Risks and responsibilities of emergency response and radio communications (S,S) • Risks and responsibilities of operating emergency vehicles (S,S) • Pediatric transport considerations (F,F) • Risks and responsibilities of transport (F,F)
	Incident Management (The extent of information presented in this area will vary at the regional and local level.)	• Establish and work within the incident management system (S,S)	• Establish and work within the incident management system (F,F) • Understand the principles of Crew Resource Management (F,F)	• Establish and work within the incident management system (F,F) • Understand the principles of Crew Resource Management (F,F)	• Establish and work within the incident management system (F,F) • Understand the principles of Crew Resource Management (F,F)
	Multiple Casualty Incidents (The extent of information presented in this area will vary at the regional and local level.)	• Operational goals (F,F) • Field triage (F,F)	• Operational goals (F,F) • Field triage (F,F) • Destination determination (F,F) • Treatment principles (F,F)	• Operational goals (F,F) • Field triage (F,F) • Destination determination (F,F) • Treatment principles (F,F)	• Operational goals (F,F) • Field triage (F,F) • Destination determination (F,F) • Treatment principles (F,F)
	Air Medical (The extent of information presented in this area will vary at the regional and local level.)	• Safe air medical operations (S,S) • Criteria for utilizing air medical response (S,S) • Medical risks/needs/advantages (S,S)	• Safe air medical operations (S,S) • Criteria for utilizing air medical response (S,S) • Medical risks/needs/advantages (F,F)	• Safe air medical operations (S,S) • Criteria for utilizing air medical response (S,S) • Medical risks/needs/advantages (F,F)	• Safe air medical operations (S,S) • Criteria for utilizing air medical response (S,S) • Medical risks/needs/advantages (F,F)

		EMR	EMT	AEMT	Paramedic
EMS Operations	Rescue Operations (The extent of information presented in this area will vary at the regional and local level.)	• Safety principles of rescue operations (S,S)	• Safety principles of rescue operations (S,S)	• Safety principles of rescue operations (S,S)	• Safety principles of rescue operations (S,S)
	Hazardous Materials (The extent of information presented in this area will vary at the regional and local level.)	• Risks and responsibilities of operating on the scene of a hazardous materials incident (S,S)	• Risks and responsibilities of operating on the scene of a hazardous materials incident (S,S)	• Risks and responsibilities of operating on the scene of a hazardous materials incident (S,S)	• Risks and responsibilities of operating on the scene of a hazardous materials incident (S,S)
	Mass Casualty Incidents due to Terrorism and Disaster (The extent of information presented in this area will vary at the regional and local level.)	• Risks and responsibilities of operating on the scene of a natural or man-made disaster (F,F)	• Risks and responsibilities of operating on the scene of a natural or man-made disaster (F,F)	• Risks and responsibilities of operating on the scene of a natural or man-made disaster (F,F)	• Risks and responsibilities of operating on the scene of a natural or man-made disaster (F,F)

Clinical Behavior/Judgment

	EMR	EMT	AEMT	Paramedic
Assessment	• Perform a simple assessment to identify life threats, identify injuries requiring spinal motion restriction and conditions requiring treatment within the scope of practice of the EMR:	• Perform a basic history and physical examination to identify acute complaints and monitor changes. • Formulate a field diagnosis based upon an actual and/or potential illness or injury.	• Perform a basic history and physical examination to identify acute complaints and monitor changes. • Formulate a field diagnosis based upon an actual and/or potential illness or injury.	• Perform a comprehensive history and physical examination to identify factors affecting the health and health needs of a patient. • Relate assessment findings to underlying pathological and physiological changes in the patient's condition. • Integrate and synthesize the multiple determinants of health and clinical care. • Formulate a field diagnosis based on an analysis of comprehensive assessment findings, anatomy, physiology, pathophysiology and epidemiology. • Perform health screening and referrals.
Therapeutic Communication and Cultural Humility	• Effectively communicates in a non-discriminatory manner that addresses inherent or unconscious bias, is culturally aware and sensitive, and intended to improve patient outcome.			
Psychomotor Skills	• Safely and effectively perform all psychomotor skills within the *National EMS Scope of Practice Model* AND state Scope of Practice at this level.			

Clinical Behavior/Judgment

	EMR	EMT	AEMT	Paramedic
Professionalism	Demonstrate professional affective domain behaviors including but not limited to: • Integrity • Empathy/compassion • Self-motivation • Appearance/personal hygiene • Self-confidence • Communications • Time management • Teamwork/diplomacy • Respect • Patient advocacy • Careful delivery of service • Lifelong learning			Is a role model of exemplary professional affective domain behaviors including but not limited to: • Integrity • Empathy/compassion • Self-motivation • Appearance/personal hygiene • Self-confidence • Communications • Time management • Teamwork/diplomacy • Respect • Patient advocacy • Careful delivery of service • Lifelong learning
Decision Making	• Initiates simple interventions based on assessment findings.	• Initiates interventions based on assessment findings intended to provide symptom relief (within the provider's scope of practice) while providing access to definitive care • Evaluates the effectiveness of interventions and modifies treatment plan accordingly.		• Performs interventions as part of a treatment plan intended to provide symptom relief and improve the overall health of the patient. • Evaluates the effectiveness of interventions and modifies treatment plan accordingly. • Evaluates decision making strategy for cognitive errors to enhance future critical thinking skills (metacognition)
Record Keeping	• Report and document assessment findings and interventions performed.	• Report and document assessment findings, interventions performed, and clinical decision making		
Team Dynamics	• Manage the scene until care is transferred to an EMS team member licensed at a higher level arrives.	• The entry-level clinician serves as a team member, while gaining the experience necessary to function as the team leader.		
Safety	• Ensure the safety of the rescuer, other public safety personnel, civilians and the patient.			

Educational Infrastructure

	EMR	EMT	AEMT[2]	Paramedic
Educational Facilities	• Facility sponsored or approved by sponsoring agency • Sponsoring agency commitment to diversity, equity and inclusion • ADA compliant facility • Sufficient space for class size • Controlled environment			Reference Committee on Accreditation for EMS Professions (CoAEMSP) Standards and Guidelines (www.coaemsp.org)[1]
Student Space	• Provide space sufficient for students to attend classroom sessions, take notes, and participate in classroom activities • Provide space for students to participate in kinematic learning and practice activities			
Instructional Resources	• Provide basic instructional support material • Provide audio, visual, and kinematic aids to support and supplement didactic instruction			
Instructor Preparation Resources	• Provide space for instructor preparation • Provide support equipment for instructor preparation			
Storage Space	• Provide adequate and secure storage space for instructional materials			

[1] *The National EMS Education Agenda for the Future*: A Systems Approach (2000) calls for national accreditation of Paramedic programs. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP). CAAHEP is the only national agency that offers Paramedic educational programmatic accreditation and is used or recognized by most states. Recognition of national accreditation remains the responsibility of each state.

[2] The 2019 and 2021 updated *National Scope of Practice Model* call for national accreditation of AEMT programs. The target for full implementation of AEMT program accreditation is January 1, 2025. Until that date, AEMT programs should reference the existing infrastructure suggestions within this document. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP).CAAHEP is the only national agency that offers EMS programmatic accreditation and is used or recognized by most states. Recognition of national accreditation remains the responsibility of each state.

Educational Infrastructure

	EMR	EMT	AEMT	Paramedic
Sponsorship	Sponsoring organizations shall be one of the following: • Accredited educational institution • Public safety organization • Accredited hospital, clinic or medical center, or • Other state approved institution or organization			Reference Committee on Accreditation for EMS Professions (CoAEMSP) Standards and Guidelines (www.coaemsp.org)[1]
Programmatic Approval	• Sponsoring organization shall have programmatic approval by authority having jurisdiction for program approval (state)			
Faculty	Course primary instructors should: • Be educated at a level higher than they are teaching; however, as a minimum, they must be educated at the level they are teaching • Have completed an approved instructor training program or equivalent			
Medical Director Oversight	• Provide medical oversight for all medical aspects of instruction			
Hospital/Clinical Experience	• None required at this level	• The student must demonstrate the ability to perform an adequate assessment and implement an adequate treatment plan. - These can be performed in an emergency department, ambulance, clinic, nursing home, doctor's office, on a standardized patient or in an alternative clinical environment when clinical access is not available.	• The student must demonstrate the ability to perform an adequate assessment and implement an adequate treatment plan.	

Educational Infrastructure

	EMR	EMT	AEMT	Paramedic
Field Experience	• None required at this level	• The student should participate in and document patient contacts in a field experience in an ambulance, mobile health care experience, or simulated environment when ambulance experience is not available as approved by the medical director and program director. This may occur in an ambulance, ambulance experience, or simulated environment when ambulance experiences are not available.	• The student must participate in and document both patient contacts and team leadership roles in a field experience approved by the medical director and program director.	Reference Committee on Accreditation for EMS Professions (CoAEMSP) Standards and Guidelines (www.coaemsp.org)[1]
Course Length	• Instructors may use a variety of formats to deliver content including but not limited to: - Independent student preparation - Synchronous or asynchronous instruction - Face-to-face instruction - Pre- or co-requisites • **Course length should be based on competency, not hours** - Consensus opinion is that students should need a minimum of 48 didactic and laboratory clock hours to cover the material.	• Instructors may use a variety of formats to deliver content including but not limited to: - Independent student preparation - Synchronous or asynchronous instruction - Face-to-face instruction - Pre- or co-requisites • **Course length should be based on competency, not hours** - Consensus opinion is that students should need a minimum of 150 clock hours including the four integrated phases of education (didactic, laboratory, clinical and field) to cover the material	• Instructors may use a variety of formats to deliver content including but not limited to: - Independent student preparation - Synchronous or asynchronous instruction - Face-to-face instruction - Pre- or co-requisites • **Course length should be based on competency, not hours** - Consensus opinion is that students should need a minimum of 200 clock hours beyond EMT requirements including the four integrated phases of education (didactic, laboratory, clinical and field) to cover the material	
Course Design	• Provide the following components of instruction: - Didactic instruction - Skills laboratories	• Provide the following components of instruction: - Didactic instruction - Skills laboratories - Hospital/clinical experience - Field experience		
Student Assessment	• Perform knowledge, skill and professional behavior evaluation based on educational standards and program objectives • Provide several methods of assessing achievement • Provide assessment that measures, as a minimum, entry-level competency in all domains			
Program Evaluation	• Provide evaluation of program instructional effectiveness • Provide evaluation of organizational and administrative effectiveness of program			

Glossary

Academic institution – Body or establishment instituted for an educational purpose that provides college credit or awards degrees.

Accreditation – The granting of approval by an official review board after meeting specific requirements. Typical requisites may cover areas such as program structure, processes, resources and student evaluation. The review board is nongovernmental and the review is collegial and based on self-assessment, peer assessment and judgment. The purpose of accreditation is student protection and public accountability. Additionally, accreditation can provide consistent quality education evaluation for a program's continual improvement and provides for a more consistent and uniform graduate competency.

Advanced-level care – Care that has greater potential benefit to the patient, but also greater potential risk to the patient if improperly or inappropriately performed. It is more difficult to attain and maintain competency in and requires significant background knowledge in basic and applied sciences. This level of care includes invasive and pharmacological interventions.

Affective domain – Describes learning in terms of feelings/emotions, attitudes and values. Additionally, the affective domain covers many professional behaviors that are required by an EMS clinician to perform his or her role as a health care provider. (NAEMSE, 2020)

Asynchronous instruction/learning – An instructional method that allows the learner to use a self-directed and self-paced learning format to move through the content of the course. In this type of instruction, learner-to-learner and learner-to-instructor interactions are independent of time and place. Communications and submission of work typically follow a schedule while learners and instructors do not interact at the same time.

Certification – The issuing of a certificate by a private agency based upon deemed competency established through standards adopted by that agency and met by the individual.

Cognitive domain – Describes learning that takes place through the process of thinking—it deals with facts and knowledge. (NAEMSE, 2020)

Competency – Expected behavior or knowledge to be achieved within a defined area of practice.

Credential – Generic term referring to all forms of professional qualification.

Credentialing – The umbrella term that includes the concepts of accreditation, licensure, registration and professional certification. Credentialing can establish criteria for fairness, quality, competence, and/or safety for professional services provided by authorized individuals, for products or for educational endeavors. Credentialing is the process by which an entity, authorized and qualified to do so, grants formal recognition to or records the recognition status of individuals, organizations, institutions, programs, processes, services or products that meet predetermined and standardized criteria. (NOCA, 2006)

Credentialing agency – An organization that certifies an institution's or individual's authority or claim of competence in a course of study or completion of objectives.

Curriculum – A particular course of study, often in a specialized field. For EMS education, it has traditionally included instructional techniques, detailed lesson plans with identified objectives and

numerous forms of learner evaluation. Curriculum is developed and adopted at the education program based upon National EMS Education Standards and state and local regulatory requirements. The use of local advisory groups can help tailor education to a local community's needs.

Didactic – The instructional theory, the lesson content. (NAEMSE, 2020)

Distributive education – A generic term used to describe a variety of learning delivery methods that attempt to accommodate a geographical separation (at least for some of the time) of the instructor and learners. Distributed education includes computer and web-based instruction, distance learning through television or video, web-based seminars, video conferencing and electronic and traditional educational models.

Domains – A category of learning. (See Affective domain, Cognitive domain, and Psychomotor domain.) (NAEMSE, 2020)

Entry-level competence – The level of competence expected of an individual who is about to begin a career. The minimum competence necessary to practice safely and effectively.

Health screening – A test or exam performed to find a condition before symptoms begin. Screening tests may help find diseases or conditions early when they may be easier to treat. (Medline Plus definition)

Instructional Guidelines – An emeritus resource document that provided crossover guidance for instructional content within the 2009 National EMS Education Standards.

Licensure – The act of granting an entity permission to do something that the entity could not legally do without such permission. Licensing is generally viewed by legislative bodies as a regulatory effort to protect the public from potential harm. In the health care delivery system, an individual who is licensed tends to enjoy a certain amount of autonomy in delivering health care services. Conversely, the licensed individual must satisfy ongoing requirements that ensure certain minimum levels of expertise. A license is generally considered a privilege, not a right.

Medical oversight – Physician review and approval of clinical content and matters relevant to medical authority.

National EMS Core Content – The document that defines the domain of out-of-hospital care.

National EMS Education Program Accreditation – The accreditation process for institutions that sponsor EMS educational programs.

National EMS Education Standards – The document that defines the entry-level terminal knowledge content (depth and breadth), clinical behavior/judgement, and educational infrastructure for each licensure level.

National EMS Scope of Practice Model – The document that defines the scope of practice of the various levels of EMS licensure.

Patient simulation – An alternative to a human patient to help students improve patient assessment and management skills; a high-fidelity patient simulator provides realistic simulation that responds physiologically to student therapies. These simulators have realistic features such as chests that rise and fall with respirations, pupils that react to light, pulses that can be palpated, etc.

Post-graduate internship and/or experience – Experience gained after the student has completed and graduated from school.

Practice analysis – A study conducted to determine the frequency and criticality of the tasks performed in practice.

Preceptor – A clinical teacher or instructor who is responsible for evaluating and ensuring student progress during hospital and field experiences. This individual typically has training to be able to function effectively in the role.

Primary instructor – A person who possesses the appropriate academic and/or allied health credentials and understanding of the principles and theories of education, and the required instructional experience necessary to provide quality instruction to students. (NAEMSE, 2020)

Program director – The individual responsible for an educational program or programs.

Psychomotor domain – Describes learning that takes place through the attainment of skills and bodily or kinesthetic movements. (NAEMSE, 2020)

Registration agency – An agency that is traditionally responsible for providing a product used to evaluate a chosen area. States may voluntarily adopt this product as part of their licensing process. The registration agency is also responsible for gathering and housing data to support the validity and reliability of its product.

Regulation – A rule or a statue that prescribes the management, governance or operation parameters for a given group; tends to be a function of administrative agencies to which a legislative body has delegated authority to promulgate rules and regulations to "regulate a given industry or profession." Most regulations are intended to protect public health, safety and welfare.

Scope of practice – The description of what a licensed individual legally can and cannot perform.

Standardized patient – An individual who has been thoroughly trained to accurately simulate a real patient with a medical condition; a standardized patient plays the role of a patient for students learning patient assessment, history taking skills, communication skills and other skills.

Standard of care – The domain of acceptable practice, as defined by scope of practice, current evidence, industry consensus and experts. Standard of care can vary depending on the independent variables of each situation.

Synchronous instruction – Instructional method whereby learners and instructors interact at the same time, either in the classroom or via a computer-driven course. This method allows for more immediate learner guidance and feedback using face-to-face, instant text-based messaging or real-time voice communications.

Team leader – Someone who leads the call and provides guidance and direction for setting priorities, scene and patient assessment and management. The team leader may not actually perform all the interventions but may assign others to do so.

References

National Association of EMS Physicians, (Kuehl, A. E., Ed.), Prehospital Systems and Medical Oversight, Third Edition. 2002. Dubuque, IA: Kendall/Hunt Publishing Company.

National Association of EMS Educators. (2020). *Foundations of Education, An EMS Approach, Third Edition.* Burlington, MA: Jones and Bartlett Learning.

National Organization for Competency Assurance. (2006). *NOCA's Basic Guide to Credentialing Terminology.* Washington, DC: National Organization for Competency Assurance.

Ruple, J. A., et al. (2004). State of EMS Education Research Project. *Prehospital Emergency Care,* 9, 203-212.

Ruple, J. A., et al. (2006). Commonalities of the EMS Education Workforce (2004) in the United States. *Prehospital Emergency Care,* 10, 229-238.

NHTSA. (1996). *Emergency Medical Services, Agenda for the Future.* Washington, DC: National Highway Traffic Safety Administration. http://www.nhtsa.dot.gov/people/injury/ems/agenda/emsman.html

NHTSA. (2019). *Emergency Medical Services Agenda 2050.* Washington, DC: National Highway Traffic Safety Administration. https://www.ems.gov/pdf/EMS-Agenda-2050.pdf

NHTSA. (2005*). Emergency Medical Services Core Content.* Washington, DC: National Highway Traffic Safety Administration. http://www.nhtsa.dot.gov/people/injury/ems/EMSCoreContent/images/EMSCoreContent.pdf

NHTSA and Health Resources and Services Administration. (2000). *Emergency Medical Services Education Agenda for the Future: A Systems Approach*. Washington, DC: National Highway Traffic Safety Administration. https://www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/EMS_Education_Agenda.pdf

NHTSA and Health Resources and Services Administration. (2007). *National EMS Scope of Practice Model*. Washington, DC: National Highway Traffic Safety Administration. https://www.ems.gov/education/EMSScope.pdf

NHTSA and Health Resources and Services Administration. (2019). *National EMS Scope of Practice Model.* Washington, DC, US Department of Transportation. https://www.ems.gov/pdf/National_EMS_Scope_of_Practice_Model_2019.pdf

NHTSA and Health Resources and Services Administration. (2021). *National EMS Scope of Practice Model*. Washington, DC, US Department of Transportation. https://www.ems.gov/pdf/National_EMS_Scope_of_Practice_Model_2019_Change_Notices_1_and%20_2_August_2021.pdf

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American Ambulance Association

American College of Emergency Physicians

American College of Surgeons Committee on Trauma

Association of Air Medical Services

Association of Critical Care Transport

Commission on Accreditation of Ambulance Services

Commission on Accreditation of Medical Transport Systems

Committee on Accreditation of Educational Programs for the EMS Professions/Commission on Accreditation of Allied Health Education Programs

Congress of Mobile Medical Professionals

EMS for Children (Health Resources and Services Administration, Maternal Child and Health Bureau)

EMS for Children Innovation & Improvement Center

Emergency Nurses Association

Georgia Department of Public Health

International Association of EMS Chiefs

International Association of Fire Chiefs

International Association of Fire Fighters

International Association of Flight & Critical Care Paramedics

State of Minnesota EMS Regulatory Board

National Association of EMS Physicians

National Association of EMTs

National Association of State EMS Officials

National EMS Management Association

National Fire Protection Agency

National Registry of EMTs

National Volunteer Fire Council

New Hampshire Department of Safety, Division of Fire Standards and Training and EMS

New Jersey State EMS Council, 17th District

North Carolina Office of EMS

US Army

US Air Force

Project Meetings

- First Development Meeting – May 2-3, 2019, Pittsburgh, PA
- Association Liaison/Stakeholder Call – July 15, 2019
- Second Development Meeting – October 3-4, 2019, Washington, DC
- Instructional Guideline Revision Meeting – January 30-February 1, 2020, Hurst, TX
- Association Liaison/Stakeholder Call – August 11, 2020
- Revision Meeting (virtual) – October 9, 2020
- Third Development Meeting (virtual) – January 28, 2021

Public Comment Periods

- August 16-September 20, 2019
- February 17-March 17, 2020
- November 13-December 14, 2020

Appendix A: Resources for EMS

National Organizations:

American Academy of Emergency Medicine (AAEM): https://www.aaem.org/

American Academy of Pediatrics (AAP): https://www.aap.org/en-us/Pages/Default.aspx

American Academy of Orthopedic Surgeons (AAOS): https://www.aaos.org/

American Ambulance Association (AAA): https://ambulance.org

American College of Emergency Physicians (ACEP): https://www.acep.org/

American College of Surgeons Committee on Trauma (ACS COT): https://www.facs.org/Quality-Programs/Trauma

American Medical Association (AMA): https://www.ama-assn.org/

American Public Health Association (APHA): https://www.apha.org/

American Trauma Society (ATS): https://www.amtrauma.org/

Association of Air Medical Services (AAMS): https://aams.org/

Association of State and Territorial Health Officials (ASTHO): https://www.astho.org/

Center for Disease Control: https//www.cdc.gov/

Commission on Accreditation of Allied Health Education Programs (CAAHEP): https://www.caahep.org/

Commission on Accreditation of Ambulance Services (CAAS): https://www.caas.org/

Commission of Accreditation of Medical Transport Systems (CAMTS): https://www.camts.org/International

National Organizations:

Commission of Accreditation of Medical Transport Systems (CAMTS): https://www.camts.org/International

Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP): https://coaemsp.org/

Emergency Nurses Association (ENA): https://www.ena.org/

International Academies of Emergency Dispatch (IAED): https://www.emergencydispatch.org/home

International Association of Emergency Managers (IAEM): https://www.iaem.org/

International Association of EMS Chiefs (IAEMSC): https://www.iaemsc.org/

International Association of EMTs and Paramedics (IAEP): https://www.iaep.org/

International Association of Fire Chiefs (IAFC): https://www.iafc.org/

International Association of Firefighters: https://www.iaff.org/

International Association of Flight & Critical Care Paramedics (IAFCCP): https://www.iafccp.org/

National Association of County & City Health Officials (NACCHO): https://www.naccho.org/about

National Association of EMS Educators (NAEMSE): https://naemse.org/

National Association of EMS Officials (NASEMSO): https://nasemso.org/

National Association of EMS Physicians (NAEMSP): https://naemsp.org/

National Association of Emergency Medical Technicians (NAEMT): https://naemt.org/

National EMS Advisory Council: https://www.ems.gov/memsac.html

National EMS Management Association (NEMSMA): https://www.nemsma.org/

National Organizations:

National EMS Quality Alliance (NEMSQA): https://www.nemsqa.org/

National Fire Protection Association (NFPA): https://www.nfpa.org/

National Organization of State Offices of Rural Health (NOSORH): https://nosorh.org/

National Registry of Emergency Medical Technicians (NREMT): https://www.nremt.org

National Volunteer Fire Council (NVFC): https://www.nvfc.org/about/

Safe States Alliance: https://www.safestates.org/

Society for Academic Emergency Medicine: https://www.saem.org/home

Federal Agencies:

Federal Interagency Committee on EMS (FICEMS): https://www.ems.gov/ficems.html

Department of Transportation: https://www.transportation.gov/

- Federal Highway Administration (FHWA): https://ops.fhwa.dot.gov/eto_tim_pse/preparedness/tim/index.htm
- National Highway Traffic Safety Administration (NHTSA): https://www.ems.gov/

Department of Homeland Security **(DHS):** https://www.dhs.gov/

- U.S. Fire Administration (USFA): https://www.usfa.fema.gov/

Department of Health and Human Services **(DHHS):** https://www.hhs.gov/

- Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov/
- Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/
- National Institute for Occupational Safety and Health (NIOSH): https://www.cdc.gov/niosh/index.htm

Federal Agencies:

Centers for Medicare & Medicaid Services (CMS): https://www.cms.gov/

Health Resources & Services Administration (HRSA): https://www.hrsa.gov/

Indian Health Service (IHS): https://www.ihs.gov/

National Institutes of Health (NIH): https://www.nih.gov/

Office of the Assistant Secretary for Preparedness and Response (ASPR): https://www.phe.gov/about/aspr/Pages/default.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/

Federal Communications Commission **(FCC):** https://www.fcc.gov/

Department of Defense **(DoD):** https://dod.defense.gov/

- Office of the Assistant Secretary of Defense for Health Affairs: https://www.health.mil/About-MHS/OASDHA

Department of the Interior **(DOI):** https://www.doi.gov/

- National Park Service (NPS): https://www.nps.gov/index.htm

Department of Agriculture **(USDA):** https://www.usda.gov/

- U.S. Forest Service (USFS): https://www.fs.usda.gov/

Department of Labor **(DOL):** https://www.dol.gov/

Other Sources:

Occupational Safety and Health Administration (OSHA): https://www.osha.gov/

National Highway Traffic Safety Administration (NHTSA): www.EMS.gov

American Heart Association ECC: https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines

EMSC Innovation and Improvement Center (EIIC): https://emscimprovement.center/

National EMS Advisory Council (NEMSAC): https://www.ems.gov/nemsac.html

National EMS Information System (NEMSIS): https://nemsis.org/

Prehospital Care Research Forum: https://www.cpc.mednet.ucla.edu/pcrf

Prehospital Guidelines Consortium: http://prehospitalguidelines.org/

December 9, 2021

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Office of Emergency Health Systems (OEHS)
Emergency Medical Responder Data
Board of Emergency Medical Services
December 8, 2023, Meeting

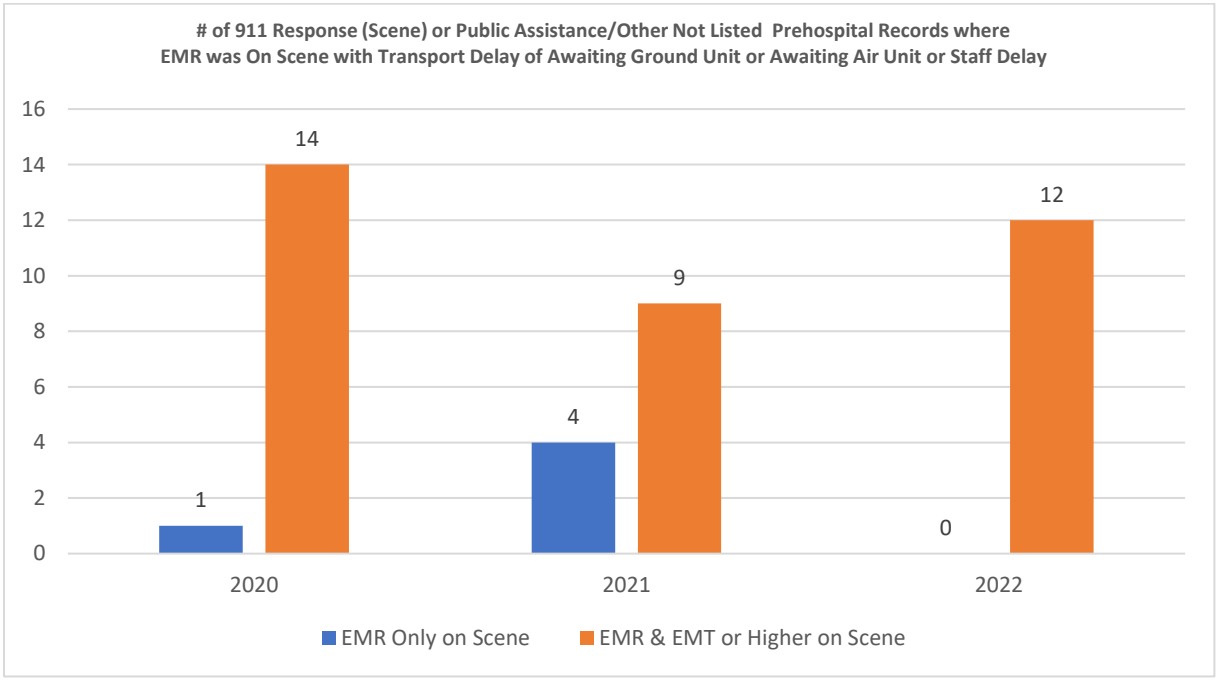
The State of Nebraska currently has 334 licensed Emergency Medical Responders (EMR) as of Friday, December 1, 2023. Of the 334 licensed EMRs, 263 of on the roster of a Nebraska licensed Emergency Medical Service. Additionally, eNARSIS runs were evaluated to determine the **approximate** number of responses that EMRs have been on the during the corresponding time frames. The break down is shown below:

Service Name	Total	Sum of Count of EMR Responses 2023 Calls	Sum of Count of EMR Responses 2022 Calls	Sum of Count of EMR Responses 2021 Calls
Albion Fire And Rescue	1	3	7	2
Allen-Waterbury Vol. Fire & Rescue Dept	2	2	0	0
American Red Cross	8	0	0	0
Ansley Vol. Fire & Rescue	1	0	0	0
Antelope Memorial Hospital Ambulance Service	1	0	0	0
Battle Creek Vol Fire Dept	1	7	1	3
Beatrice Rural Fire Dept. / EMS	3	0	0	0
Beaver City Ambulance	1	0	2	0
Beaver Crossing V.F.D.	1	0	0	0
Beaver Valley Rural Fire Dist.	2	1	0	0
Bellwood Vol. Fire Dept.	1	0	0	0
Benedict Volunteer Fire & Rescue Dept.	2	0	0	0
Big Springs Vol. Fire And Rescue	1	7	28	19
Bloomfield Ambulance Service	1	0	0	0
Boyd County Amb. Service	2	1	2	5
Bradshaw Fire - Rescue Dept.	2	0	0	0
Broadwater Vol. Fire Dept.	3	0	0	0
Brown County Amb. Association	1	34	76	69
Bruning Fire And Rescue	1	0	0	0
Burwell Vol. Fire Dept.	2	3	2	10
Campbell Rural Fire District	3	0	0	0
Carleton Ambulance	1	0	0	1
Cedar Rapids Rescue Squad	1	21	17	24
Cherry County Hospital Ambulance	1	0	5	2
Chester Vol. Amb. & Rescue Ser.	2	0	1	3
City of Laurel Ambulance	1	2	5	5
Clarkson Rescue Squad	4	2	6	2
Clay Center Volunteer Ambulance	4	6	46	56
Clearwater Vol. Fire And Rescue	3	4	8	2

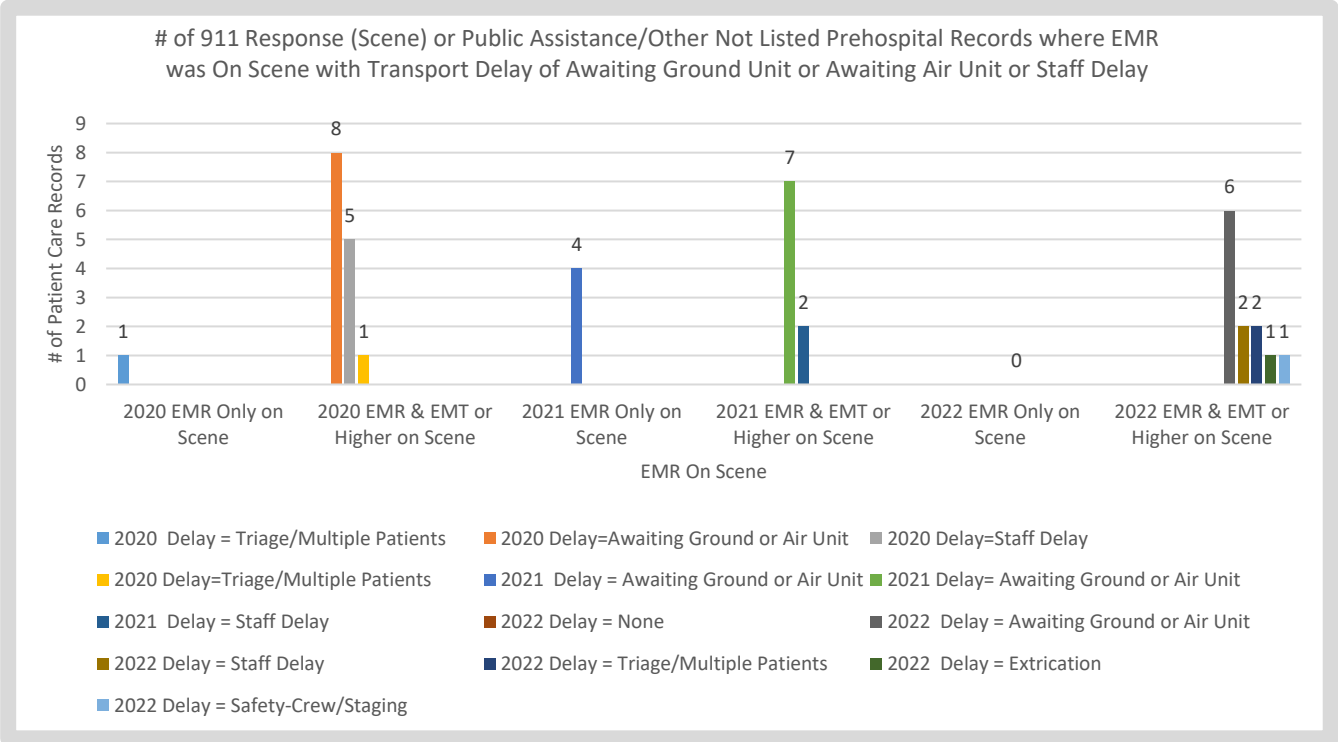
Cortland Fire & Rescue	2	0	0	0
Creighton Ambulance Service	3	33	41	17
Creston Rescue Unit	1	0	1	0
Crofton Rescue	4	8	6	12
Culbertson Rescue Squad	2	42	18	31
David City Vol. Fire Dept/Rescue	7	0	0	0
Daykin Rescue Unit	1	0	0	0
Dixon Vol Fire & Rescue	2	0	3	14
Doniphan Quick Response Team	2	0	5	12
Dorchester Vol. Fire And Rescue	1	0	2	0
Dundy County Ambulance / Benkelman	1	17	10	26
Dwight Vol. Fire And Rescue	2	0	0	1
Elba Volunteer Fire Dept.	4	5	7	5
Elgin Fire & Rescue Service	1	2	3	5
Ericson Fire And First Responder	4	2	2	5
Eustis Rescue Squad	2	3	1	9
Fairfield Vol. Fire Dept.	2	7	9	9
Firth Rural Fire District	1	0	0	0
Franklin Vol. Fire Dept.	5	0	50	60
Friend Rescue Squad	1	0	0	0
Frontier County Ambulance Service - Curtis	1	4	3	6
Fullerton Rescue Squad	2	9	0	0
Genoa Rescue Squad	2	18	2	6
Gering Volunteer Fire Department	2	0	1	0
Grafton Rural Fire District	1	0	0	0
Greeley Vol. Rescue Unit	2	0	2	6
Guide Rock Volunteer Rescue	2	0	0	0
Hastings Rural Fire Department	1	0	18	17
Hay Springs Vol. Fire/Rescue	1	0	0	0
Hebron Vol. Fire Dept./Rescue	1	8	5	0
Herman Rescue Squad	1	0	0	0
Hooper Fire Dist.	2	0	0	0
Howells Rescue Squad	5	8	13	3
Humboldt Rescue	1	17	25	0
Johnson County Amb -Cook Rescue	2	0	0	0
Johnson Lake Emergency Association	8	0	0	0
Kearney Volunteer Fire Department	7	0	3	1
Lawrence Fire Department & Rescue Service	1	0	0	0
Leigh Rescue Unit	7	0	5	0
Linwood Volunteer Fire & Rescue	4	30	0	0
Loup County Ambulance	1	4	2	0
Malcolm Fire & Rescue	2	0	0	0
MARC Rescue Squad	3	1	2	0
Martinsburg Emergency Responders	5	0	0	3
Merna Emergency Medical Services	2	0	0	0
Milligan Rescue	1	0	0	0
Mullen Ambulance Service	1	0	0	0
Nelson Vol. Fire Dept./Rescue Ser.	1	6	0	0
Newman Grove Rescue Unit	2	0	0	0
North Bend Volunteer Fire Dept.	1	1	0	0

Nucor Steel - Nebraska	1	6	0	0
Ohiowa Rescue	2	0	0	0
Orchard Fire And Rescue	1	0	0	0
Palmer Rescue Squad	2	4	0	0
Pawnee County Ambulance	1	0	0	0
Pender Rescue	2	0	0	0
Petersburg Fire & Rescue	5	0	0	0
Pickrell Fire & Rescue	4	0	0	0
Pierce Rescue Service	7	45	0	0
Pleasant Dale Rural Volunteer Fire Dept.	2	0	0	0
Pleasanton Vol. Fire & Rescue Squad	3	1	0	0
Polk Volunteer Fire Department	3	4	0	0
Ponca Rescue Service	1	0	0	0
Prague Rescue Squad	1	1	0	0
Randolph Rescue Unit	1	27	0	0
Regional West Medical Center	2	0	0	0
Rising City Vol. Fire Dept.	1	1	0	0
Sargent Ambulance Service	2	1	0	0
Schuyler Rescue Squad	2	67	0	0
Scotia Rescue Unit	3	0	2	6
Scribner Rescue Squad	6	52	0	0
Shelby Rescue Squad	3	0	0	0
Shelton Vol. Fire And Rescue	1	0	0	0
Spalding Rescue Squad	2	0	0	0
Spencer Vol. Rescue Unit	1	3	0	0
Springview Rescue	1	0	0	0
St Edward Fire & Rescue Dept.	2	16	0	0
St Libory Emergency Medical Service	4	0	0	0
Stromsburg Ambulance Service	3	26	0	0
Sumner Rescue Unit	2	0	0	0
Trumbull Rural Fire District	1	0	0	0
Ulysses Vol. Fire Dept.	1	1	0	0
Waco Volunteer Fire Department	3	0	0	0
Wakefield Rescue Unit	1	2	0	0
Waverly Fire and Rescue	1	0	0	0
Western Rescue Unit	1	0	0	0
Wheeler County Rescue Unit	3	0	0	1
Wolbach Rescue Squad	2	0	0	0
Wymore EMS	1	1	0	0
York Fire Dept.	1	0	0	0
Grand Total	263	576	447	458

OEHS reviewed data submitted to the eNARSIS system. OEHS staff specifically pulled runs reported to the state that reported an EMR was on a 911, public assistance, other type of call where there was a scene delay due to waiting a ground, air, or staff delay. This was analyzed for the 2020, 2021, and 2022 calendar years. The below table reflects the data that was reviewed:



The data is then further broken down to give the specific reasons as to why there was a delay. The categories of Triage/Multiple Patients, Safety-Crew, and Extrication also had a delay reason of waiting for ground or air unit. These data elements were broken down for clarity.



EMR Ambulance Certification Curriculum

Curriculum Guidance: *Review curriculum and identify components to modify for agency specific policies, operations, and equipment.*

Ambulance operations orientation:

	Review state laws relating to the operation of the ambulance and privileges in any or all the following: speed, warning lights, sirens, right-of-way, parking, turning.*

Discuss the following topics with the EMR:

- An ambulance operator must have a valid driver's license and may be required to complete a training program and/or add an additional endorsement to their driver's license.
- Privileges granted under the law to the operators of ambulances apply when the vehicle is responding to an emergency or is involved in the emergency transport of a sick or injured person.
- When the ambulance is not on an emergency call, the laws that apply to the operation of nonemergency vehicles also apply to the ambulance. *(Check state statutes to see which apply)*

While responding to an emergency, you may:

- Park the vehicle anywhere if it does not damage personal property or endanger lives.
- Proceed past red stop signals, flashing red stop signals, and stop signs. Some states require that emergency vehicle operators come to a full stop then proceed with caution. Other states required only that an operator slow down and proceed with caution.
- Exceed the posted speed limit as long as life and property are not endangered. Some states will place limitations in miles per hour over the posted limit (e.g., ten to fifteen miles an hour over the posted speed limit).
- Pass other vehicles in no-passing zones after properly signaling, ensuring the way is clear, and taking precautions to avoid endangering life and property. This does not include passing a school bus with its red lights blinking. Wait for the bus driver to clear the children and turn off the red lights of the bus.
- With proper caution and signals, disregard regulations that govern direction of travel and turning in specific directions.

	List contributing factors of unsafe driving conditions.*

Review the following contributing factors with the EMR:

- Driving with lights and sirens involves high risk.
- Inclement weather.
- Poor condition of streets and roadways.
- Distractions in and outside the vehicle.
- Nighttime (limited visibility).

	Discuss "Due Regard For Safety of Others" while operating an emergency vehicle.*

Make sure the EMR understands:

- Laws state that if an emergency vehicle operator does not drive with due regard for the safety of others, he/she must be prepared to pay the consequences, such as tickets, lawsuits, or even time in jail.
- Even though certain privileges are granted during an emergency, the exemptions granted do not provide immunity to the operator in cases of reckless driving or disregard for the safety of others.

	Discuss various situations that may affect a response to a call.*

The EMR should be familiar with the following situations that may affect their response to a call.

- Day of the week: Weekdays usually have heavier traffic because of the work commute.
- Time of Day: In larger cities, traffic over major roads tends to be heavy in all directions during commuter hours.
- Weather: Adverse weather conditions reduce driving speeds, and thus increase response times. A heavy snowfall can temporarily prevent any response at all.
- Road Maintenance and construction: Traffic can be seriously impeded by road construction and maintenance activities. Be aware of area road construction and plan responses as needed.
- Railroads: Freight trains can slow and even completely block traffic in certain areas. Some communities may use a secondary response system on the other side of the train tracks that splits the town in half.
- Bridges and Tunnels: Traffic over bridges and through tunnels slows during rush hours. Collisions—including ambulance collisions—tend to occur when the drivers forget that bridges freeze before roadways.
- Schools and school buses: School zones slow the flow of traffic. Emergency vehicle should never pass a stopped school bus with its red lights flashing. Wait for the school bus driver to signal you to proceed by turning off the lights. The operator of every emergency vehicle should slow down when approaching a school or playground. Obey the directions given by school crossing guards.

***Completion of an EVOC course will also meet the requirements listed above.**

Identify what is essential for completion of a call.

(The content of this objective will vary agency to agency.) Topics to discuss with the EMR for this objective could include:

- Information needed to complete and submit a PCR.
- Required signatures on the PCR.
- Proper process for cleaning equipment that was used on the call.
- Remaking and cleaning the gurney.
- How to request items for restock.

Orientation of agency's ambulance and equipment.

(The training for this objective will vary agency to agency.) Upon completion of this objective the EMR should be able to:

- Demonstrate how to operate equipment in the back of the ambulance within their scope of practice.
- Demonstrate how to safely load and unload a patient.
- Discuss safe practices while providing patient care in a moving ambulance (securing equipment, using seatbelts etc…).

Patient assessment and report:

Explain the rational for appropriate documentation of patient assessment and personal information.

The prehospital care report (PCR) has many functions. It is the record of patient care, serves as a legal document, provides information for administrative functions, aides education and research, and contributes to quality improvement. It is important that the information is correct and precise. We also suggest that you take time to discuss the expectations of the narrative portion of a PCR with the EMR. Discussion should include but is not limited to:

- Including objective and subjective information within the PCR.
- Including pertinent negatives.
- Avoiding radio codes and nonstandard abbreviations.
- The report needs to be written legibly and everything spelled correctly.
- "If you didn't write it down, it didn't happen."

Discuss the importance of ongoing monitoring of the patient and their vital signs while in the back of the ambulance.

Discuss the following items with the EMR:

- The importance of reassessing the patient's condition, vital signs and response to any interventions.
- How multiple sets of vital signs will allow the patient care giver to observe trends in the patient's condition.
- How to use these findings, to institute new treatments or adjust treatments they have already started.
- Why any trends that are noticed during transport should be included in the PCR and report to hospital staff.
- Reassessing vital signs every 15 minutes for stable patients and 5 minutes for critical or unstable patients.

Review information needed to complete a prehospital care report.

(This section will be agency specific.) Topics that you could review with the EMR include:

- The information required to complete a PCR.
- How to document a patient refusal or a non-transport call.
- If a mistake is made on a PCR, the proper procedure to correct it. (i.e. strike through and initial, an addendum after the report is complete, etc…).

Review how to call into the receiving hospital to notify of incoming transfer, discuss what information needs to be included in this radio report.

(This will be hospital and agency specific training.) It is suggested that the EMR be familiar with:

- How to notify the receiving facility of the incoming transport.
- Information needed to be included/excluded in this report.

It may be helpful to create scenarios and ask the EMR to give a mock radio report as if they were calling in to the hospital.

Discuss the importance of giving an accurate and complete verbal report to receiving staff at the facility.

Discuss the following topics with the EMR:

- Information that should be included in the verbal report to the receiving staff at the hospital. Such as:
  - Current status of the patient.
  - Any interventions given.
  - Response to any interventions.
  - Last set of vital signs.
  - Any allergies the patient may have, etc.

Completion of the following optional modules:	
	C-Collar
	Jaw Thrust
	Joint or Long Bone Injury*
	Spinal Immobilization (seated)*
	Spinal Immobilization (Long Board)*
*Skills that require a formal psychomotor exam.	

Submit by Email | Print Form

Addendum to Medical Supervision Plan for Optional Modules

Click Here For On-line OM Instructions

EMS Agency Name _____ Date _____

Optional modules (OMs) are skills identified by the EMS Physician Commission that exceed the floor level Scope of Practice for EMS personnel and may be adopted by the agency medical director. Instructions and requirements to add optional modules to agency personnel are available on the Idaho EMS web site www.idahoems.org or click on the link tile. This form may be submitted as an OM Addendum for Bureau approval when signed by the medical director. Please check the box next to each OM for the level of provider that will be trained and credentialed for this agency. Proof of credentialing by the agency medical director must be submitted to the EMS Bureau prior to individuals practicing the optional module skills.

BLS or higher agency license

EMR-2011

☐ C-Collar	2,OM	☐ Epinephrine (Adrenaline)	2,4,OM
☐ Extremity Splinting	2,OM	☐ Intramuscular (IM)	2,OM
☐ Jaw Thrust - Modified (Trauma)	OM	☐ Spinal Immobilization Long Board	2,OM
☐ Spinal Immobilization Seated	2,OM	☐ Taser Barb Removal	OM
☐ Vaccine Administration	5,OM		

EMT-2011

☐ 12-lead EKG Data Acquisition	2,OM	☐ Advanced airway devices not intended to be inserted in the trachea (Adult)	2,3,OM
☐ Blood Glucose Monitoring	2,4,OM	☐ CO Oximetry	2,4,OM
☐ CPAP	2,OM	☐ End Tidal CO2 Monitoring/Capnography	2,3,OM
☐ Glucagon	2,4,OM	☐ Impedance Threshold Device	OM
☐ Inhaled Beta Agonist (MDI)	2,OM	☐ Inhaled Beta Agonist (SVN)	2,OM
☐ Intramuscular (IM)	2,OM	☐ Intraosseous - Adult	2,4,OM
☐ Intraosseous - Pediatric	2,4,OM	☐ IV Fluid infusion - Non -medicated	2,OM
☐ Lidocaine Administration-IO adjunct only	4,OM	☐ Pelvic Immobilization Device Subcutaneous	OM
☐ Peripheral IV Initiation (includes EJ)	2,OM	☐ Injection	2,OM
☐ Suctioning - Tracheal via advanced airway	2,OM	☐ Taser Barb Removal	OM
Vaccine Administration	5,OM	Venous Blood Sampling	2,OM

Medical Director for this EMS agency, I have approved the checked OMs for training, credentialing and practice.

Medical Director Signature _____ Date _____

ILS or higher agency license

AEMT-85

☐ 12-lead EKG Data Acquisition	2,OM	☐ Acetylsalicylic acid (Aspirin) for suspected cardiac chest pain only	OM
☐ CO Oximetry	2,4,OM	☐ CPAP	2,OM
☐ End Tidal CO2 Monitoring/Capnography	2,OM	☐ Epinephrine (Adrenaline)	2,4,OM
☐ Glucagon	2,4,OM	☐ Impedance Threshold Device	OM
☐ Intramuscular (IM)	2,OM	☐ Intraosseous - Adult	2,4,OM
☐ Intraosseous - Pediatric	2,4,OM	☐ Lidocaine Administration-IO adjunct only	4,OM
☐ Pelvic Immobilization Device	OM	☐ Pulse Oximetry	2,OM
☐ Subcutaneous Injection	2,OM	☐ Taser Barb Removal	OM
		☐ Vaccine Administration	5,OM

AEMT-2011

☐ 12-lead EKG Data Acquisition	2,OM	☐ CO Oximetry	2,4,OM
☐ CPAP	2,OM	☐ End Tidal CO2 Monitoring/Capnography	2,OM
☐ Impedance Threshold Device	OM	☐ Lidocaine Administration-IO adjunct only	4,OM
☐ Nitroglycerin Paste	OM	☐ Pelvic Immobilization Device	OM
☐ Taser Barb Removal	OM	☐ Topical Medication Administration	OM
☐ Venous Blood Sampling	OM		

ALS or higher agency license

Paramedic-2011

☐ CO Oximetry	OM	☐ Cricothyrotomy - Surgical	2,OM
☐ Impedance Threshold Device	OM	☐ Intubation- Medication Assisted (RSI, paralytics)	2,3,OM
☐ IV Programmable Volume Infusion Device	2,OM		
☐ Taser Barb Removal	OM	☐ Pelvic Immobilization Device	OM

CC Paramedic-2011

☐ Central Line Placement	2,3,OM	☐ Chest Tube Placement	2,3,OM
☐ Pericardiocentesis	2,3,OM	☐ Umbilical Initiation	2,3,OM
☐ Urinary Catheterization	2,3,OM		

2,OM requires training approved by the Bureau
3,OM requires additional standards approved by the EMSPC
4,OM requires EMSPC protocol use
5,OM Just In Time Training
Note - OMs that require examination as a floor skill at a higher level will require examination at the OM skill level.

Received	Processed	Verification checks
		- MD Signature - Agency license level - PERCS Compliance

As Medical Director for this EMS agency, I have approved the checked OMs for training, credentialing and practice.

Medical Director Signature _____ Date _____

IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Public Health – Bureau of Emergency Medical Services

16.01.07 – Emergency Medical Services (EMS) – Personnel Licensing Requirements

Who does this rule apply to?
Any person or agency involved in the Emergency Medical Services industry and stakeholders.

What is the purpose of this rule?
These rules include requirements and standards for certification and licensure of emergency medical personnel, the establishment of fees for licensure, renewals of licensure, and education criteria for needed skills to perform duties of specific types of licensure. Emergency medical personnel licensed under these rules work or provide EMS services for agencies licensed by the state.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statute passed by the Idaho Legislature:

Public Assistance and Welfare -
- Section 56-1023, Idaho Code – Department of Health and Welfare: Rules

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Bureau of Emergency Medical Services
2224 East Old Penitentiary Road
Boise, ID 83712-8249

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-4000 or 1-877-554-3367
Fax: (208) 334-4015
Email: IdahoEMS@dhw.idaho.gov
Webpage: http://idahoems.org

Table of Contents

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. (3-15-22)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.01.07, "Emergency Medical Services (EMS) – Personnel Licensing Requirements." (3-15-22)

02. Scope. These rules include requirements and standards for certification and licensure of emergency medical personnel, the establishment of fees for licensure, renewals of licensure, and education criteria for needed skills to perform duties of specific types of licensure. Emergency medical personnel licensed under these rules work or provide EMS services for agencies licensed by the state. (3-15-22)

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Licensed EMS personnel must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," to include: (3-15-22)

01. Initial Licensure. An individual applying for initial licensure described in Section 110 of these rules. (3-15-22)

02. Reinstatement of Licensure. An individual applying for reinstatement of licensure described in Section 131 of these rules. (3-15-22)

03. Certificate of Eligibility. An individual applying for a certificate of eligibility described in Section 150 of these rules. (3-15-22)

04. Additional Criminal Background Check. The EMS Bureau may require an updated or additional criminal background check at any time, without expense to the candidate, if there is cause to believe new or additional information will be disclosed. (3-15-22)

010. DEFINITIONS.
For the purposes of this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions" apply. (3-15-22)

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR PERSONNEL LICENSING VIOLATIONS.
Investigation of complaints and disciplinary actions for personnel licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." (3-15-22)

076. ADMINISTRATIVE ACTION IMPOSED FOR LICENSE OR CERTIFICATION.
Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." (3-15-22)

077. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS PERSONNEL.

01. Method of Treatment. EMS personnel must practice medically acceptable methods of treatment and must not endeavor to extend their practice beyond their competence and the authority vested in them by the medical director. EMS personnel must not perform any medical procedure or provide medication that deviated from or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." (3-15-22)

02. Knowledge and Proficiency. EMS personnel must maintain standards of knowledge and

proficiency as required by this chapter of rules and IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." (3-15-22)

03. Respect for the Patient. EMS personnel must provide all services with respect for the dignity of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. (3-15-22)

04. Confidentiality. EMS personnel must hold in strict confidence all privileged information concerning the patient except as disclosure or use of this information is permitted or required by law or Department rule. (3-15-22)

05. Conflict of Interest. EMS personnel must not accept gratuities for preferential consideration of the patient and must guard against conflicts of interest. (3-15-22)

06. Professionalism. EMS personnel must uphold the dignity and honor of the profession and abide by its ethical principles and must be familiar with existing laws governing the practice of emergency medical services and comply with those laws. EMS personnel must never perform duties of the profession while under the influence of alcohol, illegal substances, or legal drugs or medication causing impairment of function. (3-15-22)

07. Cooperation and Participation. EMS personnel must cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public. (3-15-22)

08. Ethical Responsibility. EMS personnel must refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. Misrepresentation in an application or documentation for licensure by means of concealment of a material fact is a violation of ethical responsibility. (3-15-22)

09. Integrity. EMS personnel must act with honesty and integrity and assure that reports, applications and documentation for which they are responsible are free of fraudulent and false information. (3-15-22)

078. -- 089. (RESERVED)

090. ADVANCE DO NOT RESUSCITATE (DNR) DIRECTIVES.
Licensed EMS personnel must follow the DNR protocol established by the Department. (3-15-22)

091. -- 099. (RESERVED)

PERSONNEL LICENSURE REQUIREMENTS
(Sections 100-199)

100. PERSONNEL LICENSURE REQUIRED.
Any individual who provides emergency medical care must obtain and maintain a current EMS personnel license issued by the EMS Bureau, or recognition by the EMS Bureau described under Section 140 of these rules. The levels of Idaho personnel licensure are: (3-15-22)

01. Emergency Medical Responder (EMR). (3-15-22)

02. Emergency Medical Technician (EMT). (3-15-22)

03. Advanced Emergency Medical Technician (AEMT). (3-15-22)

04. Paramedic. (3-15-22)

101. AFFILIATION REQUIRED TO PRACTICE.
Licensed EMS personnel must be affiliated with an EMS agency, and only practice under the supervision of the agency medical director as required in IDAPA 16.02.02, "Idaho Emergency Medicaid Services (EMS) Physician

Commission." (3-15-22)

102. (RESERVED)

103. RECOGNITION OF EMS PERSONNEL LICENSURE INTERSTATE COMPACT (REPLICA).

01. Licensed EMS Personnel from a REPLICA Member State. An individual who possesses a current, valid, and unrestricted EMS personnel license from a REPLICA member state whose primary affiliation is an Idaho-licensed EMS agency: (3-15-22)

a. Must apply for Idaho EMS licensure within ninety (90) days of affiliation with an Idaho EMS agency. (3-15-22)

b. May affiliate and respond with the Idaho-licensed EMS agency during the initial ninety (90) day period. (3-15-22)

c. Will be issued an Idaho EMS personnel license at the same level of licensure as the REPLICA home state license upon payment of any applicable licensure fee in accordance with Section 111 of these rules. (3-15-22)

02. Out-of-State Primary Affiliation. If EMS personnel licensed in another REPLICA state claim an EMS agency in that state as their primary affiliation, Idaho licensure is not required. (3-15-22)

104. (RESERVED)

105. APPLICATION AND INSTRUCTIONS FOR EMS PERSONNEL LICENSURE.
A personnel license or certificate of eligibility application and instructions may be obtained from the EMS Bureau, see online at: http://www.idahoems.org. (3-15-22)

106. TIME FRAME FOR PERSONNEL LICENSURE AFTER SUCCESSFUL COMPLETION OF EDUCATION COURSE.
An individual who has successfully completed an EMS education course is eligible to attempt the standardized examination for the appropriate level of licensure. (3-15-22)

01. Complete Standardized Examination. A candidate must successfully complete all components of the standardized examination within twenty-four (24) months of completing an EMS training course in order to be eligible for an Idaho EMS personnel license. (3-15-22)

02. Standardized Examination Not Completed. If all components of the standardized examination are not successfully completed period within twenty-four (24) months of course completion, the candidate must repeat the initial training course and all components of the standardized examination in order to be eligible for an Idaho EMS personnel license. (3-15-22)

107. LICENSURE OF MEMBERS OF THE MILITARY, VETERANS, AND SPOUSES.
A member of the military, a veteran, or a spouse of any such person who possesses a current, valid, and unrestricted EMS personnel license in another state, district, or territory of the United States is eligible for EMS personnel licensure in Idaho as follows: (3-15-22)

01. Licensure in REPLICA Member State. A member of the military, a veteran, or a spouse of such a person who possesses a REPLICA member state EMS personnel license is eligible for licensure in Idaho under Section 103 of these rules. (3-15-22)

02. Licensure in Non-REPLICA Member State. A member of the military, a veteran, or a spouse of such a person who possesses an EMS personnel license from a state that is not a REPLICA member state is eligible for licensure by endorsement in Idaho under Section 108 of these rules. (3-15-22)

108. QUALIFICATIONS FOR LICENSURE BY ENDORSEMENT -- MEMBERS OF THE MILITARY, VETERANS, AND SPOUSES.
Members of the military, veterans, and their spouses may apply to the EMS Bureau for licensure by endorsement provided they meet the following: (3-15-22)

01. Military, Veteran, or Spouse. Are a member of the military, a veteran, or a spouse of any such person. (3-15-22)

02. Graduation Required. Have successfully completed an education program that is substantially equivalent to the approved education course recognized by the EMS Bureau under IDAPA 16.01.05, "Emergency Medical Services -- Education, Instructor, and Examination Requirements." (3-15-22)

03. Licensing Examination. Successfully complete, or have successfully completed, the same standardized examination for the level of licensure on the application required under IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." (3-15-22)

04. License from Another Jurisdiction. Possess a current, valid, and unrestricted EMS personnel license, at the same or higher level as the Idaho license being requested, from another state, district, or territory of the United States. The license of any individual subject to official investigation or disciplinary proceedings is not considered current, valid, and unrestricted. (3-15-22)

05. Criminal History and Background Check. Successfully complete a criminal history and background check in accordance with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial or revocation of licensure. (3-15-22)

06. Declaration of Previous Applications and Licensures. Declare each state or jurisdiction in which they have ever applied for, been denied, or held an EMS license or certification. (3-15-22)

07. Authorization for Release of Information. Provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. (3-15-22)

08. Provide Current Affiliation with EMS Agency. Declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. (3-15-22)

09. Valid Identification. Have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the armed forces of the United States. (3-15-22)

10. Submit Required Licensure Fee. Submit the applicable initial licensure fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. (3-15-22)

109. (RESERVED)

110. INITIAL PERSONNEL LICENSURE.
Upon successful completion of an approved education course recognized by the EMS Bureau under IDAPA 16.01.05, "Emergency Medical Services -- Education, Instructor, and Examination Requirements," an individual may apply to the EMS Bureau for licensure. The candidate must meet the following: (3-15-22)

01. Candidate Age Requirements. An individual applying for licensure must meet the following age requirements: (3-15-22)

a. An EMR and EMT candidate must be either sixteen (16) or seventeen (17) years old with parental or legal guardian consent, or eighteen (18) years old. (3-15-22)

b. An AEMT and Paramedic candidate must be eighteen (18) year old. (3-15-22)

02. Declaration of Previous Applications and Licensures. A candidate must declare each state or jurisdiction in which they have applied for, been denied, or held an EMS license or certification. (3-15-22)

03. Authorization for Release of Information. A candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. (3-15-22)

04. Provide Current Affiliation with EMS Agency. A candidate must declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. (3-15-22)

05. Valid Identification. A candidate must have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the Armed Forces of the United States. (3-15-22)

06. Criminal History and Background Check. A candidate must successfully complete a criminal history and background check according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial or revocation of licensure. (3-15-22)

07. Pass Standardized Examination. A candidate must successfully complete the standardized examination for the level of licensure on the application required under IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." (3-15-22)

a. A candidate for EMR licensure must have successfully completed the standardized examination at the EMR level or higher within the preceding thirty-six (36) months. (3-15-22)

b. A candidate for EMT licensure must have successfully completed the standardized examination at the EMT level or higher within the preceding thirty-six (36) months. (3-15-22)

c. A candidate for AEMT licensure must have successfully completed the standardized examination at the AEMT level or higher within the preceding twenty-four (24) months. (3-15-22)

d. A candidate for Paramedic licensure must have successfully completed the standardized examination at the Paramedic level within the preceding twenty-four (24) months. (3-15-22)

08. Standardized Exam Attempts For Initial Licensure. A candidate for initial licensure is allowed to attempt to successfully pass the standardized exam as follows: (3-15-22)

a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. (3-15-22)

b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-15-22)

c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-15-22)

d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-15-22)

09. Submit Required Licensure Fee. A candidate must submit the applicable initial licensure fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. (3-15-22)

111. APPLICATION FEES FOR PERSONNEL LICENSURE.

01. Initial Licensure. A candidate applying for an initial personnel license must submit the following license fee at time of application: (3-15-22)

a. EMR and EMT have no license fee. (3-15-22)

b. AEMT and Paramedic license fee is thirty-five dollars ($35). (3-15-22)

02. Renewal. A candidate applying for personnel license renewal must submit the following amount at the time of application: (3-15-22)

a. EMR and EMT have no license renewal fee. (3-15-22)

b. AEMT and Paramedic license renewal fee is twenty-five dollars ($25). (3-15-22)

03. Reinstatement. A candidate applying for a personnel license reinstatement must pay the following amount at the time of application: (3-15-22)

a. EMR and EMT have no reinstatement fee. (3-15-22)

b. AEMT and Paramedic reinstatement fee is thirty-five dollars ($35). (3-15-22)

112. -- 114. (RESERVED)

115. EMS PERSONNEL LICENSE DURATION.
Duration of a personnel license is determined using the following specified time intervals. (3-15-22)

01. Initial License Duration for EMR and EMT Level Licensure. EMR and EMT personnel licenses expire on March 31 or September 30. Expiration dates for EMR and EMT initial licenses are set for not less than thirty-six (36) months and not more than forty-two (42) months from the date of successful certification examination completion in order to establish an expiration date of March 31 or September 30. (3-15-22)

02. Initial License Duration for AEMT and Paramedic Level Licensure. AEMT and Paramedic personnel licenses expire on March 31 or September 30. Expiration dates for AEMT and Paramedic initial licenses are set for not less than twenty-four (24) months and not more than thirty (30) months from the date of successful certification examination completion in order to establish an expiration date of March 31 or September 30. (3-15-22)

03. EMS Personnel License Renewal Duration for EMR and EMT Level Licensure. An EMR and EMT level personnel license is renewed for three (3) years. (3-15-22)

04. EMS Personnel License Renewal Duration for AEMT and Paramedic Level Licensure. An AEMT and Paramedic level personnel license is renewed for two (2) years. (3-15-22)

05. EMS REPLICA Licensure Duration. EMS personnel from another REPLICA state who become licensed in Idaho will have their Idaho EMS license expire March 31 or September 30 following the expiration of their EMS license from the original state. (3-15-22)

116. PERSONNEL LICENSE TRANSITION.
Personnel licensed at the AEMT level can opt to either transition to the AEMT-2011 level, or they may remain at the AEMT-1985 level. (3-15-22)

117. (RESERVED)

118. REPLICA EXPIRATION.
EMS personnel from another REPLICA state who become licensed in Idaho will have their Idaho license expire in March or September following the expiration of their license in the original state. (3-15-22)

119. (RESERVED)

120. PERSONNEL LICENSE RENEWAL.
Licensed personnel must provide documentation that they meet the following requirements: (3-15-22)

01. Documentation of Affiliation with EMS Agency. A candidate applying for renewal of licensure must be affiliated with a licensed EMS agency which functions at, or above, the level of licensure being renewed. Documentation that the license holder is currently credentialed or undergoing credentialing by an affiliating EMS agency medical director must be submitted as assurance of affiliation for license renewal. (3-15-22)

02. Documentation of Continuing Education for Level of Licensure Renewal. A candidate for renewal of licensure must provide documentation of continuing education consistent with the license holder's level of licensure. All continuing education and skill proficiency requirements must be completed under the provisions in Sections 300 through 325 of these rules. The time frame for continuing education courses must meet the following requirements: (3-15-22)

a. All continuing education and skill proficiency requirements for renewal of an initial Idaho personnel license must be completed as follows: (3-15-22)

i. For EMR or EMT, within the thirty-six (36) months preceding expiration. (3-15-22)

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding expiration. (3-15-22)

b. All continuing education and skill proficiency requirements for successive licenses must be completed between the effective and expiration dates of the license being renewed, or according to Section 116 or 125 of these rules. (3-15-22)

c. All continuing education and skill proficiency requirements for renewal of licenses obtained through conversion of a Certificate of Eligibility must be completed as follows: (3-15-22)

i. For EMR or EMT, within the thirty-six (36) months preceding expiration. (3-15-22)

ii. For AEMT and Paramedic, within the twenty-four (24) months preceding expiration. (3-15-22)

d. A licensee certified by a national EMS certification body may petition the Department to review the certification standards under which the licensee was certified. The Department may waive specific duplicated continuing educational requirements where appropriate. When an external education requirement is found to be more rigorous than these rules, the Department may elect to renew a license based on that education. (3-15-22)

03. Declarations of Convictions or Adjudications. A candidate for renewal of licensure must provide a declaration of any misdemeanor or felony adjudications. (3-15-22)

04. Time Frame for Application of Licensure Renewals. Documentation of license renewal requirements is due to the EMS Bureau prior to the license expiration date. Failure to submit a complete renewal application by the license expiration date renders the license invalid and the individual must not practice or represent himself as a license holder. (3-15-22)

05. Submit Required Licensure Renewal Fees. A candidate must submit the applicable license renewal fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. (3-15-22)

121. -- 124. (RESERVED)

125. SUBMISSION OF EMS PERSONNEL LICENSURE APPLICATION AND DOCUMENTATION.
Each EMS personnel license holder or candidate is responsible for meeting license renewal requirements and submitting completed license renewal documentation to the EMS Bureau by the current license expiration date.

(3-15-22)

01. Early Submission for License Renewal. (3-15-22)

a. Licensed EMS personnel may submit renewal application and documentation to the EMS Bureau up to six (6) months prior to the current license expiration date. (3-15-22)

b. Continuing education (CE) taken after early submission of a renewal application may be counted as CE for the next licensure cycle. Prior to the expiration date of the current license, the licensee must submit written notification to the EMS Bureau of the intention to use those CE hours for the next licensure cycle. (3-15-22)

02. EMS Personnel License Expiration Date Falls on a Non-Work Day. When a license expiration date falls on a weekend, holiday, or other day the EMS Bureau is closed, the EMS Bureau will accept applications until the close of the next regular business day following the non-work day. (3-15-22)

126. -- 129. (RESERVED)

130. LAPSED LICENSE.
Licensed personnel who fail to submit a complete renewal application prior to the expiration date of their license cannot practice or represent themselves as licensed EMS personnel. (3-15-22)

01. Failure to Submit an Application and Renewal Documentation. No grace periods or extensions to an expiration date may be granted. After the expiration date the EMS personnel license will no longer be valid. (3-15-22)

02. Application Under Review by the EMS Bureau. Provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline, a personnel license does not lapse while under review by the EMS Bureau. (3-15-22)

03. Failure to Provide Application Information Requested by the EMS Bureau. After the expiration date of a license, a candidate for license renewal who does not provide the information requested by the EMS Bureau within twenty-one (21) days from the date of notification to the last known address, will be considered to have a lapsed license. (3-15-22)

04. Reinstatement of Lapsed EMS Personnel License. In order to reinstate at lapsed license, a candidate must submit an application for license reinstatement to the EMS Bureau within twenty-four (24) months of the expiration date of the lapsed license. (3-15-22)

05. Reinstatement of an EMS Personnel License Lapsed for More Than Twenty-Four Months. An individual whose license has been lapsed for more than twenty-four (24) months must retake and successfully complete an initial education course for the level of licensure for reinstatement. The individual must then meet all requirements in Section 110 of these rules for an initial personnel license. (3-15-22)

131. REINSTATEMENT OF A LAPSED EMS PERSONNEL LICENSE.
An individual desiring to reinstate a lapsed personnel license must provide documentation that he meets the following requirements: (3-15-22)

01. Declaration of Previous Applications and Licensures. A reinstatement candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification. (3-15-22)

02. Authorization for Release of Information. A reinstatement candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. (3-15-22)

03. Provide Current Affiliation with EMS Agency. A reinstatement candidate must declare all organizations in which they are allowed to practice as licensed personnel. The candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the

candidate. (3-15-22)

04. Documentation of Continuing Education for Lapsed License Reinstatement. A candidate for reinstatement of a lapsed license must provide documentation of continuing education consistent with the license holder's lapsed license. Continuing education requirements are provided in Sections 300 through 325 of these rules. The time frame for meeting the continuing education requirements for reinstatement are as follows: (3-15-22)

a. The candidate must meet continuing education requirements under Sections 320 through 325 of these rules for the last valid licensure cycle; and (3-15-22)

b. Additional continuing education hours in any combination of categories and venues, proportionate to the amount of time since the expiration date of the lapsed license, as follows: (3-15-22)

i. EMR -- Three-quarters (3/4) of one (1) hour of continuing education per month of lapsed time. (3-15-22)

ii. EMT -- One and one-half (1 ½) hours of continuing education per month of lapsed time. (3-15-22)

iii. AEMT -- Two and one-quarter (2 ¼) hours of continuing education per month of lapsed time. (3-15-22)

iv. Paramedic -- Three (3) hours of continuing education per month of lapsed time. (3-15-22)

05. Valid Identification for Reinstatement of Lapsed License. A reinstatement candidate must have a valid state driver's license, an Idaho identification card which is issued by a county driver's license examining station, or identification card issued by the Armed Forces of the United States. (3-15-22)

06. Criminal History and Background Check for Reinstatement of Lapsed License. A reinstatement candidate must successfully complete a criminal background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under IDAPA 16.05.06 will result in denial of reinstatement of licensure. (3-15-22)

07. Competency Certification. The Medical Director of the reinstatement candidate's affiliating EMS agency must certify that he has actively assessed the reinstatement candidate's competency in both the psychomotor and cognitive domains and found that the reinstatement candidate meets the baseline competency requirements for the level of the lapsed license. (3-15-22)

08. Submit Required Licensure Fee for Reinstatement. A candidate must submit the applicable reinstatement license fee provided in Section 111 of these rules. A candidate for reinstatement of an EMR or EMT level of licensure has no fee requirement. (3-15-22)

09. Expiration Date of a Reinstated License. The expiration date for a lapsed license that is reinstated is determined as provided in Section 115 of these rules. (3-15-22)

132. -- 139. (RESERVED)

140. RECOGNITION OF REGISTRATION, CERTIFICATION, OR LICENSURE FROM OTHER JURISDICTIONS.

01. EMS Personnel Licensed or Certified in Other States. An individual, possessing an EMS personnel license or certification from a state other than Idaho, must have prior recognition or reciprocity granted by the EMS Bureau prior to providing emergency medical care in Idaho. The following applies: (3-15-22)

a. An individual certified or licensed in a state that has an interstate compact with Idaho that allows reciprocal recognition of EMS personnel may practice as licensed personnel as defined in the interstate compact. (3-15-22)

b. An individual who is currently licensed or certified by another state to provide emergency medical care can apply to the EMS Bureau for limited recognition to practice in Idaho as provided in Subsection 140.02 of this rule. (3-15-22)

02. Limited Recognition in Idaho. An individual, who is currently licensed or certified by another state to provide emergency medical care and applies to practice EMS within the confines of a specific incident, may be granted limited recognition by the EMS Bureau. Limited recognition allows an individual to practice EMS in Idaho only within the confines of the specific incident for which it was issued and only for a specified period of time not to exceed the duration of the incident for which it was issued. (3-15-22)

03. Personnel with NREMT Registration or Current EMS Certification. An individual, possessing a current NREMT registration or a current EMS certification or license from another state at or above the level of licensure they are seeking in Idaho, is eligible for an Idaho EMS personnel licensure if they satisfy the requirements in Section 110 of these rules. (3-15-22)

04. Personnel Licensure Candidate Trained in Other States. A candidate trained outside of Idaho must apply for and obtain an Idaho EMS license as required in Section 110 of these rules prior to providing emergency medical care in Idaho. A declaration that the candidate is fully eligible for EMS licensure in the state in which they were trained, must be obtained from the EMS licensing authority in that state and submitted to the EMS Bureau. (3-15-22)

141. -- 144. (RESERVED)

145. CHANGES TO AN EXISTING LICENSE.

01. Surrender of a Current EMS Personnel License. An individual who possesses a current EMS personnel license may surrender that license at any time by submitting a letter of intent and their license to the EMS Bureau. (3-15-22)

02. Surrender of License to Prevent Investigation or Disciplinary Action. Surrendering or expiration of a license does not prevent an investigation or disciplinary action against the individual. (3-15-22)

03. Relinquish a Current EMS Personnel License for a Lower Level License. An individual who possesses a current license may relinquish that license and receive a license at a lower level with the same expiration date as the original license. The individual must have current affiliation with a licensed EMS agency which functions at, or higher than, the level of licensure being sought. (3-15-22)

04. Relinquishment of a License to a Lower Level License to Prevent Investigation or Disciplinary Action. Relinquishing a personnel license does not prevent an investigation or disciplinary action against the individual. (3-15-22)

05. Reporting Requirements for Changes in Status. Licensed personnel must notify the EMS Bureau within thirty (30) days of a change in name, mailing address, telephone number or agency affiliation. (3-15-22)

06. Personnel License Duration Shortened. The EMS Bureau will issue a license with a shortened licensure duration upon the request of the license holder. (3-15-22)

146. MULTIPLE LICENSES.
An individual may hold more than one (1) level of personnel licensure in Idaho, but can only renew one (1) personnel license at one (1) level. (3-15-22)

147. -- 149. (RESERVED)

150. CERTIFICATE OF ELIGIBILITY REQUIREMENTS.

01. Personnel Licensure Requirements are Met. An individual, who has successfully completed an

approved course, and meets all requirements for EMS personnel licensure required in Section 110 of these rules, except for obtaining an agency affiliation provided in Subsection 110.04 of these rules, may apply to the EMS Bureau for a certificate of eligibility. (3-15-22)

02. Certificate of Eligibility Duration. Duration of a certificate of eligibility is determined using the specified time intervals of the personnel licensure level requirements in Section 115 of these rules. (3-15-22)

03. Criminal History and Background Check. An individual applying for a certificate of eligibility must successfully complete a criminal history and background check within the six (6) months prior to the issuance or renewal of a certificate of eligibility, according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial of a certificate of eligibility. (3-15-22)

04. Renewal of Certificate of Eligibility. An individual must provide documentation that the following requirements have been met in order to renew a certificate of eligibility: (3-15-22)

a. Continuing education requirements for the level of licensure listed under the license renewal requirements in Section 120 of these rules have been met; and (3-15-22)

b. Successful completion of the standardized examination designated by the EMS Bureau for the certificate of eligibility. (3-15-22)

05. Revocation of Certificate of Eligibility. The EMS Bureau will revoke a certificate of eligibility if the certificate holder is determined to no longer meet eligibility requirements or has obtained a personnel license. (3-15-22)

151. AMBULANCE CERTIFICATION.

01. Ambulance Certification is Required. In order for a licensed EMR to serve as the sole patient care provider who is delivering patient care, the EMR must possess a current ambulance certification issued by the EMS Bureau. (3-15-22)

02. Ambulance Certification Requirements. A licensed EMR applying for and meeting the requirements defined in this section of rule will be issued an ambulance certification. The requirements for ambulance certification are: (3-15-22)

a. Have a valid, unrestricted EMR license; (3-15-22)

b. Have successfully completed an ambulance certification training program, examination, and credentialing; (3-15-22)

03. Duration of Certification. Ambulance certifications are valid as long as the license holder is continually licensed. (3-15-22)

04. Disciplinary and Corrective Action. The Department may impose disciplinary and corrective actions on an ambulance certification based on the procedures for administrative license actions described in IDAPA 16.01.12, "Emergency Medical Services (EMS) – Complaints, Investigations, and Disciplinary Actions." (3-15-22)

152. -- 174. (RESERVED)

175. EMS BUREAU REVIEW OF APPLICATIONS.

01. Review of License Applications. The EMS Bureau reviews each application for completeness and accuracy. Random applications are selected for audit by the EMS Bureau. Applications will also be audited when information declared on the application appears incomplete, inaccurate, or fraudulent. (3-15-22)

02. EMS Bureau Review of Renewal Application. A personnel license does not expire while under

review by the EMS Bureau, provided the license renewal candidate submitted the renewal application to the EMS Bureau prior to the application deadline required under Section 130 of these rules. (3-15-22)

176. -- 299. (RESERVED)

CONTINUING EDUCATIONAL AND SKILLS PROFICIENCY REQUIREMENTS FOR PERSONNEL LICENSURE (Sections 300-399)

300. CONTINUING EDUCATION AND SKILLS PROFICIENCY.

01. Continuing Education Must Meet Objectives of Initial Course Curriculum. All continuing education and skills proficiency assurance must be consistent with the objectives of the initial course curriculum or be a logical progression of those objectives. (3-15-22)

02. Documentation of Continuing Education. Licensed personnel must maintain documentation of all continuing education as follows: (3-15-22)

a. An EMR and EMT must maintain documentation of continuing education for four (4) years. (3-15-22)

b. An AEMT and Paramedic must maintain documentation of continuing education for three (3) years. (3-15-22)

03. Transition to New Scope of Practice. Education required to transition to a new scope of practice must meet the following: (3-15-22)

a. Within the same level of licensure, all transition education may count on an hour-for-hour basis in the appropriate categories within a single venue. When transition education hours exceed seventy-five percent (75%) of the total continuing education hours required, all continuing education hours can be in a single venue; and (3-15-22)

b. Education must be completed during a single license duration. (3-15-22)

301. CONTINUING EDUCATION RECORDS ARE SUBJECT TO AUDIT.

The EMS Bureau reserves the right to audit continuing education records to verify that renewal requirements have been met. (3-15-22)

01. Documentation Record. All documentation for continuing education hours must include: (3-15-22)

a. Name of attendee; (3-15-22)

b. Date education was completed; and (3-15-22)

c. Education sponsor or instructor. (3-15-22)

02. Proof of Completion. The following are acceptable formats for proof of completion of continuing education: (3-15-22)

a. Signed course roster; (3-15-22)

b. Certificate of completion; (3-15-22)

c. Electronic verification of completion of on-line course; (3-15-22)

d. Verification of attendance from EMS conference; (3-15-22)

e. Verification or proof of providing instruction; or (3-15-22)

f. Agency training record validated by agency administrator. (3-15-22)

302. -- 304. (RESERVED)

305. CONTINUING EDUCATION CATEGORIES FOR PERSONNEL LICENSURE RENEWAL.

01. Airway. (3-15-22)

02. Cardiovascular. (3-15-22)

03. Trauma. (3-15-22)

04. Medical. (3-15-22)

05. Operations. (3-15-22)

06. Pediatrics. (3-15-22)

306. -- 309. (RESERVED)

310. VENUES OF CONTINUING EDUCATION FOR PERSONNEL LICENSURE RENEWAL.
Continuing education for all personnel must include at least two (2) of the venues described in Subsections 310.01 through 310.12 of this rule for each licensure period. (3-15-22)

01. Structured Classroom Sessions. (3-15-22)

02. Refresher Programs. Refresher programs that revisit the original curriculum and have an evaluation component (3-15-22)

03. Nationally Recognized Courses. (3-15-22)

04. Regional and National Conferences. (3-15-22)

05. Teaching Continuing Education Topics. The continuing education topics being taught must fall under the categories in Section 305 of these rules. (3-15-22)

06. Agency Medical Director-Approved Self-Study or Directed Study. This venue is not allowed to be used for a certificate of eligibility continuing education requirement. (3-15-22)

07. Case Reviews and Grand Rounds. (3-15-22)

08. Distributed Education. This venue includes distance and blended education using computer, video, audio, Internet, and CD resources (3-15-22)

09. Journal Article Review with an Evaluation Instrument. (3-15-22)

10. Author or Co-Author an EMS-Related Article in a Nationally Recognized Publication. (3-15-22)

11. Simulation Training. (3-15-22)

12. Evaluator at a State or National Psychomotor Exam. (3-15-22)

311. -- 319. (RESERVED)

320. LICENSE RENEWAL CONTINUING EDUCATION REQUIREMENTS.
A license renewal candidate must provide documentation of the following continuing education hours provided in the table below during each licensure period. (3-15-22)

TABLE 320
LICENSE RENEWAL CONTINUING EDUCATION (CE) REQUIREMENTS

CE CATEGORIES	EMR 24 TOTAL CE Hours	EMT 48 TOTAL CE Hours	AEMT 54 TOTAL CE Hours	PARAMEDIC 72 TOTAL CE Hours
An individual must complete at least 1 hour of continuing education in each category.				
Airway, Respiration, and Ventilation	No more than 7 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 14 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 16 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 22 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.
Cardiovascular				
Trauma				
Medical				
Operations: Landing Zone & Extrication Awareness				
Pediatrics	2 hours	4 hours	6 hours	8 hours

(3-15-22)

321. -- 324. (RESERVED)

325. LICENSE RENEWAL SKILLS PROFICIENCY REQUIREMENTS.
A license renewal candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the licensure level consistent with the scope of practice provided in IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." (3-15-22)

326. -- 999. (RESERVED)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9761 Revised | **Related Change Request (CR) #: CR 9761**

Related CR Release Date: September 12, 2016 | **Effective Date: January 1, 2016**

Related CR Transmittal #: R226BP | **Implementation Date: December 12, 2016**

Ambulance Staffing Requirements

Note: This article was revised on September 13, 2016, due to a revised Change Request (CR). The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Part B ambulance services provided to Medicare beneficiaries.

Provider Action Needed

CR 9761 manualizes the Calendar Year (CY) 2016 revisions to the ambulance staffing requirements (80 FR 71078-71080) and provides clarifications on the definitions for ground ambulance services for Advanced Life Support, Level 1 (ALS1), ALS assessment, application for ALS, Level 2 (ALS2), Specialty Care Transport (SCT), Paramedic Intercept (PI), emergency response, and inter-facility transportation. Please make sure your billing staff is aware of these revisions.

Background

In the CY 2016 Physician Fee Schedule Final Rule (80 FR 71078-71080), the Centers for Medicare & Medicaid Services (CMS) finalized without modification their proposals to revise:

1. 42 CFR 410.41(b) and the definition of Basic Life Support (BLS) in 42 CFR 414.605, to require that all Medicare covered ambulance transports be staffed by at least two people who meet both the requirements of state and local laws where the services are being furnished, and the current Medicare requirements;
2. 42 CFR 410.41(b) and the definition of BLS in 42 CFR 414.605 to clarify that for BLS vehicles, one of the staff members must be certified at a minimum as an EMT-Basic; and
3. To delete the last sentence in the definition of BLS in 42 CFR 414.605, which sets forth examples of certain state law provisions.

CR9761 updates Chapter 10, Sections 10.1.2; 30.1; and 30.1.1 of the "Medicare Benefit Policy Manual" (Pub. 100-02) to incorporate these revisions.

Key Points of CR9761

BLS Vehicles

BLS ambulances must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where, at least one of whom must be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state or within a state.

ALS Vehicles

Advanced Life Support (ALS) vehicles must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where at least one of whom must meet the vehicle staff requirements above for BLS vehicles and be certified as an EMT-Intermediate or an EMT-Paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.

Ambulance Services

There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note that "ground" refers to both land and water transportation.) All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations and manual provisions.

Advanced Life Support, Level 1 (ALS1)

Definition: ALS1 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

ALS Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time

of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

ALS Intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1 (ALS1) - Emergency

Definition: When medically necessary, the provision of ALS1 services, in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2)

Definition: ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) **or** ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Application: Crystalloid fluids include but are not necessarily limited to 5 percent Dextrose in water (often referred to as D5W), Saline and Lactated Ringer's. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example, intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to

meet the ALS2 level of payment. For example, if the local protocol for the treatment of Supraventricular Tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a "standard" or "protocol" dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication 3 times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal 3 times Y. Thus, if 3 administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

Examples of drug administration that help explain this policy are in the revised manual sections that are attached to CR9761.

ALS Personnel

Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

Specialty Care Transport (SCT)

Definition: Specialty Care Transport (SCT) is the Inter-facility Transportation (as defined below) of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

Application: SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT.

To be clear, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a State, then that service does **not** qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a State requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

Paramedic Intercept (PI)

Definition: Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only Basic Life Support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all the requirements in the following three conditions are met:

I. The intercept service(s) is:

- Furnished in a rural area (as defined below) ;
- Furnished under a contract with one or more volunteer ambulance services; and,
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

II. The volunteer ambulance service involved must:

- Meet Medicare's certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and,
- Be prohibited by state law from billing anyone for any service.

III. The entity furnishing the ALS paramedic intercept service must:

- Meet Medicare's certification requirements for furnishing ALS services; and,
- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register. See the "Medicare Claims Processing Manual," **Chapter 15**, "Ambulance," Section 20.1.4 for payment of paramedic intercept services.

Inter-facility Transportation

For purposes of SCT payment, an inter-facility transportation is one in which the origin and destination are one of the following:

- A hospital or Skilled Nursing Facility (SNF) that participates in the Medicare program, or
- A hospital-based facility that meets Medicare's requirements for provider-based status.

Emergency Response

Definition: Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport.

Additional Information

The official instruction, CR9761, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R226BP.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html**.

Document History

Date of Change	Description
September 13, 2016	The article was revised due to a revised CR. The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed.
September 10, 2016	Initial article released

NEBRASKA OPEN MEETINGS ACT

84-1407. Act, how cited.

Sections 84-1407 to 84-1414 shall be known and may be cited as the Open Meetings Act.

Source: Laws 2004, LB 821, § 34.

84-1408. Declaration of intent; meetings open to public.

It is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret.

Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of Nebraska, federal statutes, and the Open Meetings Act.

Source: Laws 1975, LB 325, § 1; Laws 1996, LB 900, § 1071; Laws 2004, LB 821, § 35.
Annotations

- Nebraska's public meetings laws do not apply to school board deliberations pertaining solely to disputed adjudicative facts. McQuinn v. Douglas Cty. Sch. Dist. No. 66, 259 Neb. 720, 612 N.W.2d 198 (2000).
- The primary purpose of the public meetings law is to ensure that public policy is formulated at open meetings. Marks v. Judicial Nominating Comm., 236 Neb. 429, 461 N.W.2d 551 (1990).
- The public meetings law is broadly interpreted and liberally construed to obtain the objective of openness in favor of the public, and provisions permitting closed sessions must be narrowly and strictly construed. Grein v. Board of Education of Fremont, 216 Neb. 158, 343 N.W.2d 718 (1984).
- A county board of equalization is a public body whose meetings shall be open to the public. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).

84-1409. Terms, defined.

For purposes of the Open Meetings Act, unless the context otherwise requires:

(1)(a) Public body means (i) governing bodies of all political subdivisions of the State of Nebraska, (ii) governing bodies of all agencies, created by the Constitution of Nebraska, statute, or otherwise pursuant to law, of the executive department of the State of Nebraska, (iii) all independent boards, commissions, bureaus, committees, councils, subunits, or any other bodies created by the Constitution of Nebraska, statute, or otherwise pursuant to law, (iv) all study or

advisory committees of the executive department of the State of Nebraska whether having continuing existence or appointed as special committees with limited existence, (v) advisory committees of the bodies referred to in subdivisions (i), (ii), and (iii) of this subdivision, and (vi) instrumentalities exercising essentially public functions; and

(b) Public body does not include (i) subcommittees of such bodies unless a quorum of the public body attends a subcommittee meeting or unless such subcommittees are holding hearings, making policy, or taking formal action on behalf of their parent body, except that all meetings of any subcommittee established under section 81-15,175 are subject to the Open Meetings Act, and (ii) entities conducting judicial proceedings unless a court or other judicial body is exercising rulemaking authority, deliberating, or deciding upon the issuance of administrative orders;

(2) Meeting means all regular, special, or called meetings, formal or informal, of any public body for the purposes of briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body; and

(3) Videoconferencing means conducting a meeting involving participants at two or more locations through the use of audio-video equipment which allows participants at each location to hear and see each meeting participant at each other location, including public input. Interaction between meeting participants shall be possible at all meeting locations.

Source: Laws 1975, LB 325, § 2; Laws 1983, LB 43, § 1; Laws 1989, LB 429, § 42; Laws 1989, LB 311, § 14; Laws 1992, LB 1019, § 124; Laws 1993, LB 635, § 1; Laws 1996, LB 1044, § 978; Laws 1997, LB 798, § 37; Laws 2004, LB 821, § 36; Laws 2007, LB296, § 810; Laws 2011, LB366, § 2.

Annotations

- A township is a political subdivision, and as such, a township board is subject to the provisions of the public meetings laws. Steenblock v. Elkhorn Township Bd., 245 Neb. 722, 515 N.W.2d 128 (1994).
- A county agricultural society is a public body to which the provisions of the Nebraska public meetings law are applicable. Nixon v. Madison Co. Ag. Soc'y, 217 Neb. 37, 348 N.W.2d 119 (1984).
- Failure by a public governing body, as defined under section 84-1409, R.R.S.1943, to take and record a roll call vote on an action, as required by section 84-1413(2), R.S.Supp.,1980, grants any citizen the right to sue for the purpose of having the action declared void. In this case such failure could not be later corrected by a nunc pro tunc order because there was no showing that a roll call vote on the disputed action was actually taken, and even if it was the record showed it was not recorded until over a year later. Sections 23-1301, R.R.S.1943, and 23-1302, R.R.S.1943, make it the duty of the county clerk to record proceedings of the board of county commissioners. State ex rel. Schuler v. Dunbar, 208 Neb. 69, 302 N.W.2d 674 (1981).

- As an administrative agency of the county, a county board of equalization is a public body. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- The electors of a township at their annual meeting are a public body under the Open Meetings Act. State ex rel. Newman v. Columbus Township Bd., 15 Neb. App. 656, 735 N.W.2d 399 (2007).
- The meeting at issue in this case was a "meeting" within the parameters of subsection (2) of this section because it involved the discussion of public business, the formation of tentative policy, or the taking of any action of the public power district. Hansmeyer v. Nebraska Pub. Power Dist., 6 Neb. App. 889, 578 N.W.2d 476 (1998).
- Informational sessions in which the governmental body hears reports are briefings. Johnson v. Nebraska Environmental Control Council, 2 Neb. App. 263, 509 N.W.2d 21 (1993).

84-1410. Closed session; when; purpose; reasons listed; procedure; right to challenge; prohibited acts; chance meetings, conventions, or workshops.

(1) Any public body may hold a closed session by the affirmative vote of a majority of its voting members if a closed session is clearly necessary for the protection of the public interest or for the prevention of needless injury to the reputation of an individual and if such individual has not requested a public meeting. The subject matter and the reason necessitating the closed session shall be identified in the motion to close. Closed sessions may be held for, but shall not be limited to, such reasons as:

(a) Strategy sessions with respect to collective bargaining, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body;

(b) Discussion regarding deployment of security personnel or devices;

(c) Investigative proceedings regarding allegations of criminal misconduct;

(d) Evaluation of the job performance of a person when necessary to prevent needless injury to the reputation of a person and if such person has not requested a public meeting;

(e) For the Community Trust created under section 81-1801.02, discussion regarding the amounts to be paid to individuals who have suffered from a tragedy of violence or natural disaster; or

(f) For public hospitals, governing board peer review activities, professional review activities, review and discussion of medical staff investigations or disciplinary actions, and any strategy session concerning transactional negotiations with any referral source that is required by federal law to be conducted at arms length.

Nothing in this section shall permit a closed meeting for discussion of the appointment or election of a new member to any public body.

(2) The vote to hold a closed session shall be taken in open session. The entire motion, the vote of each member on the question of holding a closed session, and the time when the closed session commenced and concluded shall be recorded in the minutes. If the motion to close passes, then the presiding officer immediately prior to the closed session shall restate on the record the limitation of the subject matter of the closed session. The public body holding such a closed session shall restrict its consideration of matters during the closed portions to only those purposes set forth in the motion to close as the reason for the closed session. The meeting shall be reconvened in open session before any formal action may be taken. For purposes of this section, formal action shall mean a collective decision or a collective commitment or promise to make a decision on any question, motion, proposal, resolution, order, or ordinance or formation of a position or policy but shall not include negotiating guidance given by members of the public body to legal counsel or other negotiators in closed sessions authorized under subdivision (1)(a) of this section.

(3) Any member of any public body shall have the right to challenge the continuation of a closed session if the member determines that the session has exceeded the reason stated in the original motion to hold a closed session or if the member contends that the closed session is neither clearly necessary for (a) the protection of the public interest or (b) the prevention of needless injury to the reputation of an individual. Such challenge shall be overruled only by a majority vote of the members of the public body. Such challenge and its disposition shall be recorded in the minutes.

(4) Nothing in this section shall be construed to require that any meeting be closed to the public. No person or public body shall fail to invite a portion of its members to a meeting, and no public body shall designate itself a subcommittee of the whole body for the purpose of circumventing the Open Meetings Act. No closed session, informal meeting, chance meeting, social gathering, email, fax, or other electronic communication shall be used for the purpose of circumventing the requirements of the act.

(5) The act does not apply to chance meetings or to attendance at or travel to conventions or workshops of members of a public body at which there is no meeting of the body then intentionally convened, if there is no vote or other action taken regarding any matter over which the public body has supervision, control, jurisdiction, or advisory power.

Source: Laws 1975, LB 325, § 3; Laws 1983, LB 43, § 2; Laws 1985, LB 117, § 1; Laws 1992, LB 1019, § 125; Laws 1994, LB 621, § 1; Laws 1996, LB 900, § 1072; Laws 2004, LB 821, § 37; Laws 2004, LB 1179, § 1; Laws 2006, LB 898, § 1; Laws 2011, LB390, § 29; Laws 2012, LB995, § 17.

Annotations

- There is no absolute discovery privilege for communications that occur during a closed session. State ex rel. Upper Republican NRD v. District Judges, 273 Neb. 148, 728 N.W.2d 275 (2007).
- If a person present at a meeting observes a public meetings law violation in the form of an improper closed session and fails to object, that person waives his or her right to object at a later date. Wasikowski v. Nebraska Quality Jobs Bd., 264 Neb. 403, 648 N.W.2d 756 (2002).
- The public interest mentioned in this section is that shared by citizens in general and by the community at large concerning pecuniary or legal rights and liabilities. Grein v. Board of Education, 216 Neb. 158, 343 N.W.2d 718 (1984).
- Hearing in closed executive session was contrary to this section since there was no showing of necessity or reason under subdivision (1)(a), (b), or (c), but did not result in reversal of board decision. Simonds v. Board of Examiners, 213 Neb. 259, 329 N.W.2d 92 (1983).
- Negotiations for the purchase of land need not be conducted at an open meeting but the deliberations of a city council as to whether an offer to purchase real estate should be made should take place in an open meeting. Pokorny v. City of Schuyler, 202 Neb. 334, 275 N.W.2d 281 (1979).
- Public meeting law was not violated where the Board of Regents of the University of Nebraska voted to hold a closed session to consider the university president's resignation, and also discussed the appointment of an interim president during such session. Meyer v. Board of Regents, 1 Neb. App. 893, 510 N.W.2d 450 (1993).

84-1411. Meetings of public body; notice; contents; when available; right to modify; duties concerning notice; videoconferencing or telephone conferencing authorized; emergency meeting without notice; appearance before public body.

(1) Each public body shall give reasonable advance publicized notice of the time and place of each meeting by a method designated by each public body and recorded in its minutes. Such notice shall be transmitted to all members of the public body and to the public. Such notice shall contain an agenda of subjects known at the time of the publicized notice or a statement that the agenda, which shall be kept continually current, shall be readily available for public inspection at the principal office of the public body during normal business hours. Agenda items shall be sufficiently descriptive to give the public reasonable notice of the matters to be considered at the meeting. Except for items of an emergency nature, the agenda shall not be altered later than (a) twenty-four hours before the scheduled commencement of the meeting or (b) forty-eight hours before the scheduled commencement of a meeting of a city council or village board scheduled outside the corporate limits of the municipality. The public body shall have the right to modify the agenda to include items of an emergency nature only at such public meeting.

(2) A meeting of a state agency, state board, state commission, state council, or state committee, of an advisory committee of any such state entity, of an organization created under the Interlocal

Cooperation Act, the Joint Public Agency Act, or the Municipal Cooperative Financing Act, of the governing body of a public power district having a chartered territory of more than one county in this state, of the governing body of a public power and irrigation district having a chartered territory of more than one county in this state, of a board of an educational service unit, of the Educational Service Unit Coordinating Council, of the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act, or of a community college board of governors may be held by means of videoconferencing or, in the case of the Judicial Resources Commission in those cases specified in section 24-1204, by telephone conference, if:

(a) Reasonable advance publicized notice is given;

(b) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio or visual recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if videoconferencing or telephone conferencing was not used;

(c) At least one copy of all documents being considered is available to the public at each site of the videoconference or telephone conference;

(d) At least one member of the state entity, advisory committee, board, council, or governing body is present at each site of the videoconference or telephone conference, except that a member of an organization created under the Interlocal Cooperation Act that sells electricity or natural gas at wholesale on a multistate basis, an organization created under the Municipal Cooperative Financing Act, or a governing body of a risk management pool or an advisory committee of such organization or pool may designate a nonvoting designee, who shall not be included as part of the quorum, to be present at any site; and

(e)(i) Except as provided in subdivision (2)(e)(ii) of this section, no more than one-half of the state entity's, advisory committee's, board's, council's, or governing body's meetings in a calendar year are held by videoconference or telephone conference; or

(ii) In the case of an organization created under the Interlocal Cooperation Act that sells electricity or natural gas at wholesale on a multistate basis or an organization created under the Municipal Cooperative Financing Act, such organization holds at least one meeting each calendar year that is not by videoconferencing or telephone conferencing.

Videoconferencing, telephone conferencing, or conferencing by other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.

(3) A meeting of a board of an educational service unit, of the Educational Service Unit Coordinating Council, of the governing body of an entity formed under the Interlocal Cooperation Act, the Joint Public Agency Act, or the Municipal Cooperative Financing Act, of the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act, of a community college board of governors, of the governing body of a public power district, of the governing body of a public

power and irrigation district, or of the Nebraska Brand Committee may be held by telephone conference call if:

(a) The territory represented by the educational service unit, member educational service units, community college board of governors, public power district, public power and irrigation district, Nebraska Brand Committee, or member public agencies of the entity or pool covers more than one county;

(b) Reasonable advance publicized notice is given which identifies each telephone conference location at which there will be present: (i) A member of the educational service unit board, council, community college board of governors, governing body of a public power district, governing body of a public power and irrigation district, Nebraska Brand Committee, or entity's or pool's governing body; or (ii) A nonvoting designee designated under subdivision (3)(f) of this section;

(c) All telephone conference meeting sites identified in the notice are located within public buildings used by members of the educational service unit board, council, community college board of governors, governing body of the public power district, governing body of the public power and irrigation district, Nebraska Brand Committee, or entity or pool or at a place which will accommodate the anticipated audience;

(d) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if a telephone conference call was not used;

(e) At least one copy of all documents being considered is available to the public at each site of the telephone conference call;

(f) At least one member of the educational service unit board, council, community college board of governors, governing body of the public power district, governing body of the public power and irrigation district, Nebraska Brand Committee, or governing body of the entity or pool is present at each site of the telephone conference call identified in the public notice, except that a member of an organization created under the Interlocal Cooperation Act that sells electricity or natural gas at wholesale on a multistate basis, an organization created under the Municipal Cooperative Financing Act, or a governing body of a risk management pool or an advisory committee of such organization or pool may designate a nonvoting designee, who shall not be included as part of the quorum, to be present at any site;

(g) The telephone conference call lasts no more than five hours; and

(h) No more than one-half of the board's, council's, governing body's, committee's, entity's, or pool's meetings in a calendar year are held by telephone conference call, except that:

(i) The governing body of a risk management pool that meets at least quarterly and the advisory committees of the governing body may each hold more than one-half of its meetings by

telephone conference call if the governing body's quarterly meetings are not held by telephone conference call or videoconferencing; and

(ii) An organization created under the Interlocal Cooperation Act that sells electricity or natural gas at wholesale on a multistate basis or an organization created under the Municipal Cooperative Financing Act may hold more than one-half of its meetings by telephone conference call if the organization holds at least one meeting each calendar year that is not by videoconferencing or telephone conference call.

Nothing in this subsection shall prevent the participation of consultants, members of the press, and other nonmembers of the governing body at sites not identified in the public notice. Telephone conference calls, emails, faxes, or other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.

(4) The secretary or other designee of each public body shall maintain a list of the news media requesting notification of meetings and shall make reasonable efforts to provide advance notification to them of the time and place of each meeting and the subjects to be discussed at that meeting.

(5) When it is necessary to hold an emergency meeting without reasonable advance public notice, the nature of the emergency shall be stated in the minutes and any formal action taken in such meeting shall pertain only to the emergency. Such emergency meetings may be held by means of electronic or telecommunication equipment. The provisions of subsection (4) of this section shall be complied with in conducting emergency meetings. Complete minutes of such emergency meetings specifying the nature of the emergency and any formal action taken at the meeting shall be made available to the public by no later than the end of the next regular business day.

(6) A public body may allow a member of the public or any other witness other than a member of the public body to appear before the public body by means of video or telecommunications equipment.

Source: Laws 1975, LB 325, § 4; Laws 1983, LB 43, § 3; Laws 1987, LB 663, § 25; Laws 1993, LB 635, § 2; Laws 1996, LB 469, § 6; Laws 1996, LB 1161, § 1; Laws 1999, LB 47, § 2; Laws 1999, LB 87, § 100; Laws 1999, LB 461, § 1; Laws 2000, LB 968, § 85; Laws 2004, LB 821, § 38; Laws 2004, LB 1179, § 2; Laws 2006, LB 898, § 2; Laws 2007, LB199, § 9; Laws 2009, LB361, § 2; Laws 2012, LB735, § 1; Laws 2013, LB510, § 1; Laws 2017, LB318, § 1; Laws 2019, LB212, § 5.
Effective Date: September 1, 2019

Cross References

- **Intergovernmental Risk Management Act,** see section 44-4301.
- **Interlocal Cooperation Act,** see section 13-801.
- **Joint Public Agency Act,** see section 13-2501.
- **Municipal Cooperative Financing Act,** see section 18-2401.

Annotations

- Under subsection (1) of this section, the Legislature has imposed only two conditions on the public body's notification method of a public meeting: (1) It must give reasonable advance publicized notice of the time and place of each meeting and (2) it must be recorded in the public body's minutes. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007).
- An emergency is "(a)ny event or occasional combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency; a sudden or unexpected happening; an unforeseen occurrence or condition." Steenblock v. Elkhorn Township Bd., 245 Neb. 722, 515 N.W.2d 128 (1994).
- An agenda which gives reasonable notice of the matters to be considered at a meeting of a city council complies with the requirements of this section. Pokorny v. City of Schuyler, 202 Neb. 334, 275 N.W.2d 281 (1979).
- When notice is required, a notice of a special meeting of a city council posted in three public places at 10:00 p.m. on the day preceding the meeting is not reasonable advance publicized notice of a meeting as is required by this section. Pokorny v. City of Schuyler, 202 Neb. 334, 275 N.W.2d 281 (1979).
- Teacher waived right to object to lack of public notice in board of education employment hearing by voluntary participation in the hearing without objection. Alexander v. School Dist. No. 17, 197 Neb. 251, 248 N.W.2d 335 (1976).
- A county board of commissioners and a county board of equalization are not required to give separate notices when the notice states only the time and place that the boards meet and directs a citizen to where the agendas for each board can be found. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- A county board of equalization is a public body which is required to give advanced publicized notice of its meetings. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- Notice of recessed and reconvened meetings must be given in the same fashion as the original meeting. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- True notice of a meeting is not given by burying such in the minutes of a prior board proceeding. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- An agenda notice which merely stated "work order reports" was an inadequate notice under this section because it did not give interested persons knowledge that plans for a 345 kv transmission line through the district was going to be discussed and voted upon at the meeting. Inadequate agenda notice under this section meant there was a substantial violation of the public meeting laws; however, later actions by the board of directors cured the defects in notice, and such actions were in substantial compliance with the statute. Hansmeyer v. Nebraska Pub. Power Dist., 6 Neb. App. 889, 578 N.W.2d 476 (1998).

84-1412. Meetings of public body; rights of public; public body; powers and duties.

(1) Subject to the Open Meetings Act, the public has the right to attend and the right to speak at meetings of public bodies, and all or any part of a meeting of a public body, except for closed sessions called pursuant to section 84-1410, may be videotaped, televised, photographed, broadcast, or recorded by any person in attendance by means of a tape recorder, camera, video equipment, or any other means of pictorial or sonic reproduction or in writing.

(2) It shall not be a violation of subsection (1) of this section for any public body to make and enforce reasonable rules and regulations regarding the conduct of persons attending, speaking at, videotaping, televising, photographing, broadcasting, or recording its meetings. A body may not be required to allow citizens to speak at each meeting, but it may not forbid public participation at all meetings.

(3) No public body shall require members of the public to identify themselves as a condition for admission to the meeting nor shall such body require that the name of any member of the public be placed on the agenda prior to such meeting in order to speak about items on the agenda. The body may require any member of the public desiring to address the body to identify himself or herself.

(4) No public body shall, for the purpose of circumventing the Open Meetings Act, hold a meeting in a place known by the body to be too small to accommodate the anticipated audience.

(5) No public body shall be deemed in violation of this section if it holds its meeting in its traditional meeting place which is located in this state.

(6) No public body shall be deemed in violation of this section if it holds a meeting outside of this state if, but only if:

(a) A member entity of the public body is located outside of this state and the meeting is in that member's jurisdiction;

(b) All out-of-state locations identified in the notice are located within public buildings used by members of the entity or at a place which will accommodate the anticipated audience;

(c) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including making a telephone conference call available at an instate location to members, the public, or the press, if requested twenty-four hours in advance;

(d) No more than twenty-five percent of the public body's meetings in a calendar year are held out-of-state;

(e) Out-of-state meetings are not used to circumvent any of the public government purposes established in the Open Meetings Act;

(f) Reasonable arrangements are made to provide viewing at other instate locations for a videoconference meeting if requested fourteen days in advance and if economically and reasonably available in the area; and

(g) The public body publishes notice of the out-of-state meeting at least twenty-one days before the date of the meeting in a legal newspaper of statewide circulation.

(7) The public body shall, upon request, make a reasonable effort to accommodate the public's right to hear the discussion and testimony presented at the meeting.

(8) Public bodies shall make available at the meeting or the instate location for a telephone conference call or videoconference, for examination and copying by members of the public, at least one copy of all reproducible written material to be discussed at an open meeting. Public bodies shall make available at least one current copy of the Open Meetings Act posted in the meeting room at a location accessible to members of the public. At the beginning of the meeting, the public shall be informed about the location of the posted information.

Source: Laws 1975, LB 325, § 5; Laws 1983, LB 43, § 4; Laws 1985, LB 117, § 2; Laws 1987, LB 324, § 5; Laws 1996, LB 900, § 1073; Laws 2001, LB 250, § 2; Laws 2004, LB 821, § 39; Laws 2006, LB 898, § 3; Laws 2008, LB962, § 1.

Annotations

- To preserve an objection that a public body failed to make documents available at a public meeting as required by subsection (8) of this section, a person who attends a public meeting must not only object to the violation, but must make that objection to the public body or to a member of the public body. Stoetzel & Sons v. City of Hastings, 265 Neb. 637, 658 N.W.2d 636 (2003).

84-1413. Meetings; minutes; roll call vote; secret ballot; when.

(1) Each public body shall keep minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed.

(2) Any action taken on any question or motion duly moved and seconded shall be by roll call vote of the public body in open session, and the record shall state how each member voted or if the member was absent or not voting. The requirements of a roll call or viva voce vote shall be satisfied by a public body which utilizes an electronic voting device which allows the yeas and nays of each member of such public body to be readily seen by the public.

(3) The vote to elect leadership within a public body may be taken by secret ballot, but the total number of votes for each candidate shall be recorded in the minutes.

(4) The minutes of all meetings and evidence and documentation received or disclosed in open session shall be public records and open to public inspection during normal business hours.

(5) Minutes shall be written, except as provided in subsection (6) of this section, and available for inspection within ten working days or prior to the next convened meeting, whichever occurs earlier, except that cities of the second class and villages may have an additional ten working days if the employee responsible for writing the minutes is absent due to a serious illness or emergency.

(6) Minutes of the meetings of the board of a school district or educational service unit may be kept as an electronic record.

Source: Laws 1975, LB 325, § 6; Laws 1978, LB 609, § 3; Laws 1979, LB 86, § 9; Laws 1987, LB 663, § 26; Laws 2005, LB 501, § 1; Laws 2009, LB361, § 3; Laws 2015, LB365, § 2; Laws 2016, LB876, § 1.

Annotations

- If a person present at a meeting observes and fails to object to an alleged public meetings laws violation in the form of a failure to conduct rollcall votes before taking actions on questions or motions pending, that person waives his or her right to object at a later date. Hauser v. Nebraska Police Stds. Adv. Council, 264 Neb. 944, 653 N.W.2d 240 (2002).
- Subsection (2) of this section does not require the record to state that the vote was by roll call, but requires only that the record show if and how each member voted. Neither does the statute set a time limit for recording the results of a vote, after which no corrections of the record can be made. If no intervening rights of third persons have arisen, a board of county commissioners has power to correct the record of the proceedings had at a previous meeting so as to make them speak the truth, particularly where the correction supplies some omitted fact or action and is done not to contradict or change the original record but to have the record show that a certain action was taken or thing done, which the original record fails to show. State ex rel. Schuler v. Dunbar, 214 Neb. 85, 333 N.W.2d 652 (1983).
- Failure by a public governing body, as defined under section 84-1409, R.R.S.1943, to take and record a roll call vote on an action, as required by section 84-1413(2), R.S.Supp.,1980, grants any citizen the right to sue for the purpose of having the action declared void. In this case such failure could not be later corrected by a nunc pro tunc order because there was no showing that a roll call vote on the disputed action was actually taken, and even if it was the record showed it was not recorded until over a year later. Sections 23-1301, R.R.S.1943, and 23-1302, R.R.S.1943, make it the duty of the county clerk to record proceedings of the board of county commissioners. State ex rel. Schuler v. Dunbar, 208 Neb. 69, 302 N.W.2d 674 (1981).
- There is no requirement that a public body make a record of where notice was published or posted. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).

84-1414. Unlawful action by public body; declared void or voidable by district court; when; duty to enforce open meeting laws; citizen's suit; procedure; violations; penalties.

(1) Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in violation of the Open Meetings Act shall be declared void by the district court if the suit is commenced within one hundred twenty days of the meeting of the public body at which the alleged violation occurred. Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in substantial violation of the Open Meetings Act shall be voidable by the district court if the suit is commenced more than one hundred twenty days after but within one year of the meeting of the public body in which the alleged violation occurred. A suit to void any final action shall be commenced within one year of the action.

(2) The Attorney General and the county attorney of the county in which the public body ordinarily meets shall enforce the Open Meetings Act.

(3) Any citizen of this state may commence a suit in the district court of the county in which the public body ordinarily meets or in which the plaintiff resides for the purpose of requiring compliance with or preventing violations of the Open Meetings Act, for the purpose of declaring an action of a public body void, or for the purpose of determining the applicability of the act to discussions or decisions of the public body. It shall not be a defense that the citizen attended the meeting and failed to object at such time. The court may order payment of reasonable attorney's fees and court costs to a successful plaintiff in a suit brought under this section.

(4) Any member of a public body who knowingly violates or conspires to violate or who attends or remains at a meeting knowing that the public body is in violation of any provision of the Open Meetings Act shall be guilty of a Class IV misdemeanor for a first offense and a Class III misdemeanor for a second or subsequent offense.

Source: Laws 1975, LB 325, § 9; Laws 1977, LB 39, § 318; Laws 1983, LB 43, § 5; Laws 1992, LB 1019, § 126; Laws 1994, LB 621, § 2; Laws 1996, LB 900, § 1074; Laws 2004, LB 821, § 40; Laws 2006, LB 898, § 4.

Annotations

- The Legislature has granted standing to a broad scope of its citizens for the very limited purpose of challenging meetings allegedly in violation of the Open Meetings Act, so that they may help police the public policy embodied by the act. Schauer v. Grooms, 280 Neb. 426, 786 N.W.2d 909 (2010).
- Any citizen of the state may commence an action to declare a public body's action void. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007).
- The reading of ordinances constitutes a formal action under subsection (1) of this section. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007).

- If a person present at a meeting observes a public meetings law violation in the form of an improper closed session and fails to object, that person waives his or her right to object at a later date. Wasikowski v. Nebraska Quality Jobs Bd., 264 Neb. 403, 648 N.W.2d 756 (2002).
- Under the Public Meetings Act, a county lacks capacity to maintain an action to declare its official conduct "void" for noncompliance with the act. County of York v. Johnson, 230 Neb. 403, 432 N.W.2d 215 (1988).
- When a petitioner under this section is successful in the district court, that court may allow attorney fees. Tracy Corp. II v. Nebraska Pub. Serv. Comm., 218 Neb. 900, 360 N.W.2d 485 (1984).
- Informal discussions between the Tax Commissioner and the State Board of Equalization in which instructions were clarified, with such clarification leading to the amendment of hearing notices, did not constitute a public meeting subject to the provisions of this section. Box Butte County v. State Board of Equalization and Assessment, 206 Neb. 696, 295 N.W.2d 670 (1980).
- The right to collaterally attack an order made in contravention of the Public Meeting Act must occur within a period of one year as is specifically provided by this section. Witt v. School District No. 70, 202 Neb. 63, 273 N.W.2d 669 (1979).
- Statutory change, requiring "publicized notice" for board of education employment hearings, occurring between dates meeting scheduled and conducted, held not to void proceedings. Alexander v. School Dist. No. 17, 197 Neb. 251, 248 N.W.2d 335 (1976).
- Voiding an entire meeting is a proper remedy for violations of the Open Meetings Act. Once a meeting has been declared void pursuant to Nebraska's public meetings law, board members are prohibited from considering any information obtained at the illegal meeting. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (2009).
- Actions by the board of directors were merely voidable under this section, and not void. Pursuant to subsection (3) of this section, the plaintiffs were awarded partial attorney fees because they were successful in having the court declare that the board of directors was in substantial violation of the statute, even though the plaintiffs did not get the relief requested of having the board's actions declared void. Hansmeyer v. Nebraska Pub. Power Dist., 6 Neb. App. 889, 578 N.W.2d 476 (1998).

Source: http://nebraskalegislature.gov/laws/display_html.php?begin_section=84-1407&end_section=84-1414

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