DIRECTOR'S REPORT ON THE PROPOSAL TO MAKE CHANGES IN EMS SCOPE OF PRACTICE

Date: **October 7, 2019**

To: **The Speaker of the Nebraska Legislature**
The Chairperson of the Executive Board of the Legislature
The Chairperson and Members of the Legislative Health and Human Services Committee

From: **Gary J. Anthone, MD**
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Introduction

The Regulation of Health Professions Act (as defined in Neb. Rev. Stat., Section 71-6201, et. seq.) is commonly referred to as the Credentialing Review Program. The Department of Health and Human Services Division of Public Health administers this Act. As Chief Medical Officer I am presenting this report under the authority of this Act.

Description of the Issue under Review

There are two EMS proposals under review: 1) A critical care paramedic proposal, and, 2) A community para-medicine proposal. Both are attached as follows:

The Critical Care Paramedic Proposal (1)

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

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

- Education - trained to do
- Certified - certified as competent
- Licensed - has been granted legal authority to practice

- Credentialed - has been authorized by physician medical director to perform role

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

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

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

- Critical Care Paramedic Licensure - 2 (Alaska and Connecticut)
- Critical Care Paramedic Certified - 1 (Colorado)
- Critical Care Paramedic Endorsement - 8 (Iowa, Kentucky, Massachusetts, Montana, New Hampshire, Oklahoma, Tennessee, and Wisconsin)
- Expanded Scope of Practice Designated - 3 (California, Michigan, and Pennsylvania)

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

- Advanced clinical patient assessment (analysis and synthesis of clinical information)
- Chest Tube Thoracostomy - acute insertion
- Transvenous or Epicardial Pacing (management of)
- Hemodynamic monitoring (pulmonary artery catheter, central venous pressure)
- Intra-aortic Balloon Pump monitoring
- Invasive Cardiac Assist Device monitoring
- Extracorporeal Membrane Oxygenation monitoring
- Venous Central Line - obtaining
- Arterial Line monitoring

- Intracranial Pressure monitoring
- Ventilators - multimodal, with blender, that are used on patients requiring pressure control, pressure support, or other advanced settings
- Radiology films
- Point of Care Ultrasound - FAST exams
- Obstetric Fetal Monitoring
- Polypharmacy - complex infusions

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

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

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

There are no statutory limitations or restrictions on critical care transport, because it is not a recognized or regulated occupation. As a result, patients are potentially at risk due to a lack of consistent oversight and minimum education, certification, licensure, and credentialing requirements. Nebraska Model EMS Protocols do not address the critical care aspects of the patients being cared for during these transports.

The Community Para-medicine Proposal (2)

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

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

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

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

EMT, AEMT, EMT-I or Paramedic) to work in a variety of health care settings (i.e. nursing home, hospital, etc.) and to provide care in non-emergent situations, is essential for the benefit of patients and the healthcare system.

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

Community Para-medicine (CP) programs are not currently recognized in statutes or regulations. CP programs with formal associations with hospitals have been piloted in Nebraska. Because CP is not recognized, no services have been officially recognized. No statutory limitations exist because the practice is not recognized in statutes. Not advancing the Community Para-medicine proposal may result in continued gaps in healthcare, potential return visits to the emergency room and/or admissions or readmissions to hospitals, resulting in less effective care and increased costs for the patient and the entire healthcare system.

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

Summary of Technical Committee and Board of Health Recommendations

The technical review committee members recommended in favor of both components of the EMS proposal. The Board of Health also recommended in favor of both components of the EMS proposal. I concur with these recommendations, and below are my comments regarding my reasons for supporting the proposal.

The Director's Recommendations on the Proposal

Discussion on the six statutory criteria as they relate to the EMS proposal:

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

There is clearly a need in Nebraska for additional services in the areas of critical care and community health. It is clear that there are gaps in these services especially in remote rural areas of our state. EMS paramedics are already expected to be able to utilize advanced life-saving technologies safely and effectively. Unfortunately, current EMS educational and training requirements do not yet require education and training in the utilization of these advanced technologies and associated procedures. The current EMS proposal would establish and mandate this education and training. The community health component of the EMS proposal would help to prevent needless visits to the hospital by patients whose needs do not rise to the level of needing emergency transport to an ER. Often times their needs could be better taken care of at home, for example. The current EMS proposal pertinent to this aspect of care holds promise of reducing the number of needless transports to hospital ERs, thereby lowering healthcare costs.

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

The proposal holds promise of significantly enhancing access to advanced para-medicine services in our state. The proposal would also enhance access to non-emergency alternatives for those patients who, for example, have long-term, chronic conditions that call for something other than yet another trip to a local "ER".

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

My review of the record indicated to me that the applicant group is determined and dedicated to ensuring that those who would be providing advanced critical care para-medicine would be well-trained to do so and that they would be appropriately educated, trained, and certified to perform all of the skills associated with this service.

Likewise, my review of the record indicates that the applicant group is just as determined to

ensuring that those who provide community para-medicine services are also well-prepared to reliably and competently provide their proposed new scope of practice as well.

The experiences of other states such as Colorado, for example, are helpful in clarifying how proposals such as this can be made to work for the benefit of the public in a safe and reliable manner. It would be advisable for us to carefully study how other states such as Colorado have gone about implementing similar proposals so that we not waste time and resources reinventing the wheel, as it were, as well as avoiding the growing pains associated with having to pioneer these kinds of changes.

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

In their proposal the applicant group clarifies that they are well aware that those paramedics who would be providing the additional services under the terms of the proposal are going to need additional training to safely and competently deliver the services associated with these scope of practice changes. My review of the record has convinced me that the applicants are very much dedicated to ensuring that those who would be providing the new services in question are competent to do so, safely and effectively.

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

This aspect of the proposal is a little less clear than the provisions of it pertinent to "up-front" education and training. A great deal of the post-educational and training dimension of the proposal is not yet defined which has caused some distress among groups with concerns about the proposal. However, I am confident that the applicant group will work to create a post-professional process that provides solid continuing competency training for Nebraska's para-medicine professionals.

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

Under the terms of the proposal physician medical directors would maintain oversight responsibility over those paramedics who would be providing the advanced EMS services in question, which, essentially, is how oversight works now. Nothing would change in this regard, and, there is no reason to believe that this system of oversight would work any less well under the terms of the proposal than how it does now.

Final thoughts:

My review of information pertinent to the education and training that would be provided to EMS paramedics under the terms of the applicants' proposal has convinced me that this education and training would prepare EMS paramedics to provide the additional scope elements defined in the proposal safely and effectively.