FINAL REPORT OF RECOMMENDATIONS AND FINDINGS

By the Technical Review Committee
For the Review of the Application for a Change in Scope of
Practice by the Board of Emergency Medical
Services of Nebraska

To the Nebraska State Board of Health, the
Director of the Department of Health and Human Services Regulation
and Licensure, and the Legislature

May 2, 2001

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INTRODUCTION

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

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

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

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SUMMARY OF THE APPLICANTS' PROPOSAL

The scope of practice of paramedics and EMT-Is would be expanded to allow these practitioners to provide their services in hospital emergency rooms and in health clinics that have appropriate technology and support staff available to provide emergency care. Currently, these practitioners are defined in statute under the Emergency Medical Services Act of 1998 (Sections 71-5172 through 71-51,102) as "out-of-hospital emergency care providers." The proposal would create two new certification classifications of EMS providers, and these would be as follows:

1) Emergency medical technician-intermediate clinician, and;
2) Emergency medical technician-paramedic clinician.

These new classifications of EMS providers would be statutorily permitted to work in hospital or health clinic emergency rooms. Currently existing EMS classifications such as first responders, emergency medical technicians, emergency medical technician-intermediates, and emergency medical technician-paramedics would continue to be statutorily prohibited from working in emergency rooms of health care facilities.

Emergency medical technician-intermediate clinicians would be defined as follows:

> An EMT-I who has completed the 1998 NHTSA, DOT NSC EMT-I course and is state certified or an EMT-I who has completed the EMT-I bridge course, and who has completed a clinician course for training to practice in an emergency department of a health care facility.

Emergency medical technician-paramedic clinicians would be defined as follows:

> A paramedic who has completed all of the requirements to be a paramedic plus who has also completed the additional new requirements associated with the new clinician course.

Under the terms of the proposal EMS practitioners must satisfy the following requirements in order to be certified under these new provider classifications:

1) Successfully complete a clinician course that would be developed and approved by the Board of Emergency Medicine.
2) Pass an examination based upon the clinician course that would either be developed by the BEMS with input from EMS provider groups and employers, or would be developed by each employing facility subject to the approval of the BEMS.

The original proposal contained two optional ways in which training and examination issues could be managed, and these options 1 and 2 as listed below. A third option was identified by the committee members during the review:

Option 1) Create two new state certification classifications (Paramedic Clinician, and EMTI Clinician) with the curriculum being developed by a clinician task force operating under the auspices of the Board of Emergency Medical Services. Examinations would be developed by each health facility that conducts a clinician course subject to the approval of the BEMS to ensure that each exam follows course objectives before it is administered by the facilities.

Option 2) Create two new state certification classifications (Paramedic Clinician, and EMTI Clinician) with the curriculum and the examination developed by a clinician task force under the auspices of the Board of Emergency Medical Services.

Option 3) During committee deliberations, the committee members identified an alternative to the proposal which is the idea of creating enabling legislation that would provide hospitals and health clinics the authority to train, test, and employ paramedics and EMTIs for work in emergency rooms. This alternative would not involve the creation of any new credentialing categories, new curricula, or additional examinations, but would require eliminating "out-of-hospital" terminology that is part of the current EMS statute as far as paramedics and EMTIs are concerned.

SUMMARY OF COMMITTEE CONCLUSIONS AND RECOMMENDATIONS

During the fourth meeting of the technical committee the committee members with the permission of the applicant group adopted the following alternative to the original proposal:

> Create "enabling" legislation that would remove the restrictions placed on EMT-I and paramedic practice by current statutory language that defines these practitioners as "out-of-hospital" providers. Such "enabling" legislation would allow hospitals and qualifying health clinics to employ the services of these providers in emergency rooms in their facilities. This concept would not involve the creation of any new professional classifications, course curricula, or examination processes beyond what currently exists. Whatever additional training would be needed to prepare these providers for emergency room work would be provided by each employing facility.

These changes made in the proposal constitute an amendment to the applicants' original proposal. The adoption by the committee members of this alternative, and its acceptance by the applicant group meant that the alternative would constitute from this time onward the final version of the proposal for the purposes of the credentialing review program.

The committee members then took the following actions on this amended version of the proposal using the four criteria of the credentialing review statute that deals with scope of practice. It was moved and seconded that the proposal satisfies the first criterion which asks the committee to determine whether or not there is harm or great potential for harm to the public health and welfare inherent in the current practice situation of the profession in question. The committee members voted 3 to 2 with one abstention that the proposal as amended satisfies this criterion.

It was moved and seconded that the proposal satisfies the second criterion which asks the committee members to determine whether or not the proposal would create a new source of harm to the public health and welfare. The committee members voted 5 to 0 with one abstention that the proposal satisfies this criterion.

It was moved and seconded that the proposal satisfies the third criterion which asks the committee members to determine whether or not the proposal would benefit the public health and welfare. The committee members voted 5 to 0 with one abstention that the proposal satisfies this criterion.

It was moved and seconded that the proposal satisfies the fourth criterion which asks the committee members whether or not the current proposal would be the most cost-effective means of addressing the harm to the public identified by the applicant group. The committee members voted 5 to 0 with one abstention that the proposal satisfies this criterion.

By virtue of these four votes the committee members decided to recommend in favor of the proposal as amended.

DISCUSSION OF ISSUES RAISED BY THE PROPOSAL

1) ACCESS TO EMERGENCY CARE SERVICES

1) Is there significant potential for harm inherent in the current practice situation of emergency care providers in rural areas of Nebraska? If so, would the applicants' proposal be able to improve this situation?

The applicants stated that the services of paramedics is needed in rural health clinics in order to provide advanced life support in medically under served areas. The applicants stated that the addition of their services to emergency care in health clinics would reduce the need for long-distance transport of acute care patients in rural areas. Applicant group testifiers informed the committee members that transport distances of seventy miles in one direction are not unusual in rural areas of western Nebraska. (Minutes of the Second Committee Meeting, February 5, 2001; The Transcript of the Public Hearing, Page 14)

At the public hearing one applicant testifier informed the committee members that those who employ EMS providers in rural areas frequently cannot afford to employ a paramedic solely for the purpose of working on an ambulance, and that the proposal by adding to the range of services that a paramedic can provide would make it more cost-effective for rural communities to employ the services of paramedics. (The Transcript of the Public Hearing, Pages 14 and 15)

The applicants stated that there is a need in many rural areas for the services of paramedics to serve on long distance transports of patients who require advanced life support. This would make it less necessary to utilize nurses for this purpose and thereby keep their services where they are most needed, namely, in the local hospitals and clinics. (The Transcript of the Public Hearing, Pages 15 and 16)

At the public hearing one applicant testifier informed the committee members that the shortage of nurses in rural areas has resulted in significant delays in transport and transfer of patients, and that the proposal would offer some hope of addressing this problem. (The Transcript of the Public Hearing, Page 37)

At the public hearing another applicant testifier commented that the current situation of EMS in Nebraska has resulted in a two-tier system wherein urban areas have access to advanced emergency medical care, and remote rural areas of the state do not have access to this level of

emergency care. This testifier noted that this is particularly problematical given that rural transport times are often many times greater than is the case in urban areas where there is good access to ALS services. (The Transcript of the Public Hearing, Page 62)

The applicants were asked about the geographical distribution of paramedics in Nebraska, and what might be the impact of the proposal on this distribution. The applicants responded that most paramedics live and work near and along the I-80 corridor and in the larger towns and cities, and that this is because these are the areas where employment opportunities are the greatest. The applicants commented that the proposal would provide new opportunities for paramedics to seek employment in health clinics and hospitals in smaller communities away from the I-80 corridor. (Minutes of the Second Committee Meeting, February 5, 2001)

2) Is there significant potential for harm to the public in the current practice situation of EMTIs and paramedics wherein they are statutorily limited to providing services only in situations that are "out-of-hospital"? Would the applicants' proposal be able to improve this situation?

The applicants stated that their proposal is designed to address problems in the emergency services delivery system stemming from an acute nursing shortage. Nursing shortages have caused several hospitals in rural Nebraska to approach the Board of EMS requesting that EMTs and paramedics be allowed to work in the emergency departments and clinics of health care facilities. (The Applicants' Proposal, Pages 10 and 11)

The applicants informed the committee members that the results of studies of the statistical relationship between nurse staffing and mortality rates have shown that mortality rates double when hospital departments are understaffed, and that such understaffing situations are occurring in emergency rooms currently in Nebraska. The applicants stated that many hospital emergency rooms in Nebraska are not continuously staffed or have "skeleton" staffing patterns due to the nursing shortage. Additionally, the applicants stated that in many smaller rural hospitals, the emergency department is not routinely staffed, and that nurses must be called from other departments to provide care in the emergency department on an as-needed basis. (The Applicants' Proposal, Pages 10 and 11)

During committee deliberations the applicants were asked if paramedics are allowed to provide their services according to their current scope of practice within a hospital setting, but outside of an "ER." The applicants responded that they can as long as they strictly limit themselves to the scope of their training, but whether this circumstance would actually occur would depend on whether it is hospital policy to employ EMS personnel as part of a hospital-operated service program. (Minutes of the Second Committee Meeting, February 5, 2001)

2) WHAT ARE THE THREE OPTIONS IDENTIFIED TO ADDRESS THESE ACCESS TO CARE PROBLEMS?

Option 1) Create two new state certification classifications (Paramedic Clinician, and EMTI Clinician) with the curriculum being developed by a clinician task force operating under the auspices of the Board of Emergency Medical Services. Examinations would be developed by each health facility that conducts a clinician course subject to the approval of the BEMS to ensure that each exam follows course objectives before it is administered by the facilities.

Option 2) Create two new state certification classifications (Paramedic Clinician, and EMTI Clinician) with the curriculum and the examination developed by a clinician task force under the auspices of the Board of Emergency Medical Services.

Option 3) Create enabling legislation that would allow hospitals and health clinics the authority to train, test, and employ paramedics and EMTIs.

The first two options are described in the applicants' proposal. The third option was developed by the committee members during their second meeting, and under this concept legislation would be proposed that would allow hospitals the option of employing paramedics and EMT-Is to work in their "ERs" as part of hospital service programs. This concept would not involve the creation of new EMS service categories.

There was agreement among a majority of committee members and the applicant group that this idea holds promise of by-passing the dilemmas associated with exam validation and exam standardization associated with a state credentialing process. Under this idea, all training, testing, and skill maintenance activities pertinent to the emergency room functions in question would be exclusively the responsibility of the employing hospital,

and the standards applied to the employment of EMS practitioners would be those of the agency that accredits each hospital. (Minutes of the Second Committee Meeting, February 5, 2001)

3) HOW WELL WOULD THESE OPTIONS ADDRESS THE ACCESS PROBLEMS IDENTIFIED AND HOW COST-EFFECTIVE WOULD THEY BE?

COMPARISONS ON THE THREE OPTIONS BY THE COMMITTEE

During their discussions on the three options during their fourth meeting, the committee members reached the following consensus regarding these options:

Option 1) The state certification proposal with state curriculum and facility-based examinations.

1) The course curriculum developed by the board would provide the basis for standardization of training and functions provided by the EMS personnel in question, but,

2) Facility-based examinations for a state credential would create significant problems in the area of examination validity for a state credential. There would be great variation from facility to facility in examination content and methodology, and the BEMS would only check to ensure that each exam minimally addressed course objectives.

3) Determining which facilities would have the ability to both conduct the training course and develop and administer examinations for EMS personnel might prove to be a difficult process.

Option 2) The state certification proposal with state curriculum and state board examination programs.

1) Standardization of training and examination would be ensured by this proposal, assuming validation of the examination, but,

2) Costs of developing and validating an examination would be prohibitive, and that without such validation, the board would be vulnerable to lawsuits. Also, third-party payers might not reimburse for the services of these providers if there is a concern about the validity of the examination process upon which the new credentialing categories are based.

Option 3) The concept of "enabling" legislation.

1) This concept would necessitate that the terminology of the EMS statute be revised so as to define the two EMS practitioner categories under review by the services they provide, and by their training rather than in terms of practice settings.

2) There would be no need for any additional state credentialing or associated training or examination programs for the EMS providers in question, nor would there be a need for any additional state regulations for the facilities that might employ them.

The applicants responded to this idea by stating that the applicant group could support this concept if the committee members chose to take the review in this direction. (Minutes of the Second Committee Meeting, February 5, 2001)

At the public hearing one applicant testifier commented that the best way to address the issue of training and testing of EMS personnel is to have the entire training and testing process under the control and discretion of the physician medical director of each facility rather than attempt to codify these processes in state statute with all the complications that the latter approach would have pertinent to test development and validation. Each medical director would know what their particular facility needs from the EMS providers they are employing. This way flexibility of services would be maximized and costs to the state would be minimized. (The Transcript of the Public Hearing, Pages 64, 65, and 66)

GENERAL COMMENTS ON THE COST-EFFECTIVENESS OF THE IDEA OF EMPLOYING EMS PERSONNEL IN EMERGENCY ROOMS

The applicants were asked about the geographical distribution of paramedics in Nebraska, and what might be the impact of the proposal on this distribution. The applicants responded that most paramedics live and work near and along the I-80 corridor and in the larger towns and cities, and that this is because these are the areas where employment opportunities are the greatest. The applicants commented that the proposal would provide new opportunities for paramedics to seek employment in health clinics and hospitals in smaller communities away from the I-80 corridor. (Minutes of the Second Committee Meeting, February 5, 2001)

Cost-Effectiveness of the Proposal for Facilities

Pertinent to the hospital as a potential work setting for paramedics, the committee members were informed that being employed by a hospital and being credentialed by a hospital are two different things, and that these situations differ according to whom the practitioner in question is accountable. Under the hospital employment scenario, for example, a paramedic would need to be trained to do more than just emergency room work. Comment was made that it is unclear what additional training a paramedic or EMT-I would need in order to be a hospital employee. A hospital employee commented that the most likely scenario pertinent to the status of paramedics in hospitals would be that they would be hospital employees rather than merely practitioners credentialed by hospitals (but not hospital employees per se). (Minutes of the Second Committee Meeting, February 5, 2001)

The committee members were informed that approximately sixty-percent of the work in a hospital emergency room is not urgent, and comprises such things as broken bones, cuts, abrasions, bruises, for example. One committee member expressed doubt about the ability of the EMS personnel under review to contribute to the care of patients with non-urgent conditions. (Minutes of the Second Committee Meeting, February 5, 2001)

During committee deliberations the applicants were asked to clarify what the skill sets associated with the expanded scope paramedics and EMT-Intermediates would be. Comment was made by one committee member that a significantly broader set of skills than is typically possessed by EMS providers would be necessary in order to make employing these providers cost-effective for health care facilities. The applicants responded by stating that paramedics and EMT-Is are trained only in acute care, and are not currently prepared to provide other kinds of care. (Minutes of the Second Committee Meeting, February 5, 2001)

Cost-Effectiveness for the Public (Rural or Urban)

The applicants commented that allowing paramedics and EMT-Is to work in hospital "ERs" and health clinics would positively impact the number of qualified medical personnel available to render immediate aid to sick and injured patients. Utilizing the services of these EMS providers would also facilitate the protection of the public due to the fact that less qualified personnel would not have to be used as frequently in the emergency room. (The Applicants' Proposal. Page 20) The applicants stated that the medical background of these EMS providers allows for ease of additional training, and their skills in administering treatment or directing resuscitation measures in an acute emergency situation would make these providers useful elsewhere in a hospital or clinic as well. (The Applicants' Proposal, Page 20)

The applicants stated that using these EMS providers in hospital and clinic contexts would benefit the public by speeding up the identification of patient conditions, by providing more efficient and timely access to the medical system upon arrival at an emergency room, by enhancing continuity of care, and by easing the strain on nursing staff. (The Applicants' Proposal, Pages 14 and 15)

At the public hearing one applicant testifier commented that the current proposal to allow the EMS providers in question to work only in emergency rooms is too restrictive, and that there is a need to apply the skills and knowledge of these practitioners in any area of a hospital where their skills could be applied. This testifier noted that this kind of flexibility is of utmost importance in small rural hospitals that are chronically understaffed, and that these EMS personnel could be used as monitoring techs in ICUs and as phlebotomists in the laboratory, for example. (The Transcript of the Public Hearing, Page 63)

At the public hearing one applicant testifier stated that the EMS personnel under review could provide their services anywhere in a hospital safely and effectively as long as they practice under the following guidelines:

1) That they practice under RN direction and supervision,
2) That their functions be only those an RN can delegate and that these functions be provided under delegated order,
3) That their functions be specifically approved by the employing facility, and,
4) That competency standards be established and implemented for these EMS employees as part of an continuous review process. (The Transcript of the Public Hearing, Page 52)

At the public hearing one applicant testifier commented that if rural clinics and rural hospitals were allowed to hire paramedics in their emergency rooms, recruitment and retention of such providers would be more effective. (The Transcript of the Public Hearing, Page 9)

This testifier also stated that employing paramedics in the emergency rooms of rural hospitals would greatly enhance the timeliness of care in these facilities. The paramedic could be used as an RN extender to initiate assessment and doing vital signs so that treatment could begin as soon as the nurse and/or physician is ready. (The Transcript of the Public Hearing, Page 9)

At the public hearing one opponent testifier expressed concern about how regulations pertinent to hospital based paramedics would be enforced, and asked how EMS providers would function when each individual facility makes its own

decisions about what medications and treatments these providers can utilize? This testifier questioned whether we would be improving patient care by adding yet another category of provider to the service mix in hospitals that requires close oversight by nurses who are often already overburdened. (The Transcript of the Public Hearing, Page 91)

During committee deliberations one committee member commented that the current proposal runs the risk of lowering standards of care by eroding the position of RNs in hospitals without significantly improving access to quality emergency care in medically under served areas.
(The Minutes of the Second Committee Meeting, February 5, 2001)

During committee deliberations the role that protocols would likely play under the proposed new scope of practice was discussed. The applicants were asked to discuss how a set of protocols for those doing the proposed scope would apply in contexts as different as large urban hospitals, small rural hospitals, and health clinics in rural areas of Nebraska. The applicants responded that the treatment protocols that are applied vary depending on the extent of oversight that is directly available at a particular facility. They added that such things as starting an "IV" would not be part of any "standing orders" in a facility where necessary oversight is not available. (The Minutes of the Second Committee Meeting, February 5, 2001)

During committee deliberations the applicants were asked about difficulties that would be encountered by facilities in maintaining an appropriate skill level for EMS providers. The applicants responded that maintaining an appropriate skill level would be a problem, but that this should be no greater problem than already exists vis-à-vis other health care providers such as nurses or PAs, for example. (The Minutes of the Second Committee Meeting, February 5, 2001)

Cost-Effectiveness of the Proposal for Serving Rural Areas

One committee member expressed doubt that the current proposal would be able to significantly improve access to emergency medical services in remote rural areas of our state. This committee member commented that EMS providers like other health professionals in our state seem to be located in disproportionately large numbers along the I-80 corridor, and that there is little reason to believe that the proposal is going to significantly impact this aspect of health care demographics in Nebraska. This committee member added that other attempts to address these kinds of access problems have been attempted by other health care professions by proposing various scope of practice changes to get more providers into rural areas, and that these efforts have never been very successful. (Minutes of the Second Committee Meeting, February 5, 2001)

One applicant testifier informed the committee members that one possible solution to the problem of limited access to EMS services (particularly ALS services) in remote rural areas is the concept of the critical access hospital which centralizes emergency services in its service area within the hospital itself. This would make it possible to establish a paid ambulance service for the area, and thereby significantly increase the number of EMS providers in the these rural areas. This testifier commented that the statutory restrictions on EMS providers that in effect prohibit them from working in health care facilities makes it difficult to achieve this objective. (The Transcript of the Public Hearing, Page 63)

During committee deliberations the applicants were asked why they are committed to the idea of including health clinics in the proposal. The applicants responded that they are concerned about the need for more licensed people in health clinics in remote rural areas to handle emergency situations, and perform such vital life saving tasks as starting "IVs." The applicants stated that paramedics could provide this kind of capability for health clinics. One physician commented that paramedics should not be doing "IVs" unless oversight by both a nurse and a physician is present, and that protocols alone would not provide sufficient direction in such a circumstance. (The Minutes of the Second Committee Meeting, February 5, 2001)

Comment was made by the applicant representative on the committee that the services of paramedics is needed in rural health clinics to provide advanced life support in medically under served areas. This added dimension to emergency care could reduce the need for long-distance transport of acute care patients. (The Minutes of the Second Committee Meeting, February 5, 2001)

Training, Examination, and Employment Issues

The applicants summarized and commented on the two exam options described in the proposal (Pages 21 and 22, Question #47), and pointed out the strengths and weaknesses of these options. Option one would establish a facility-based exam process wherein the facility would develop and administer an exam subject to BEMS approval. Option two would involve the development and validation of a state-wide credentialing examination. The applicants stated that the latter option would in all likelihood be prohibitively expensive, while the first option would produce results that are difficult to standardize and validate. (Minutes of the Second Committee Meeting, February 5, 2001)

The committee members agreed that it is important that whoever employs the services of the EMS personnel under review must abide by all professional licensure laws, as well as any other laws and regulations that define standards

pertinent to emergency services in health care facilities. The committee members agreed that it is important that adequate training and testing be provided to ensure that the EMS providers in question provide their services in a manner consistent with appropriate standards of care. (Minutes of the Fourth Committee Meeting, April 4, 2001)

4) QUALITY OF CARE AND STANDARDS OF CARE

Education and Training of EMS Providers and the Proposal

A Testifier with concerns about the proposal informed the committee members that current educational requirements for EMTs is 175 hours of didactic education, and that a paramedic receives up to 500 hours of didactic education. This testifier went on to state that clinical hours for EMS providers range from 50 hours to 250 hours. This testifier then stated that this education does not prepare these practitioners for patient counseling of any kind, and that because of this, they would have difficulty satisfying all of the criteria for working in a health clinic as defined in Nebraska statutes 71-416. (Letter from Nancy S. Gondringer, R.N., President of the Nebraska Nurses Association)

Another testifier with concerns about the proposal informed the committee members that paramedics do not receive "pharmacokinetic education." This testifier stated that this is a concern because in a busy "ER" paramedics cannot always receive the direction that they would need, and often the protocols could not be adequate to help them deal with the needs of a patient in immediate need of complex and powerful medications. (Letter from Mark A. Hansen, R.N.)

The applicants responded to these kinds of concerns by stating that EMS practitioners employed by hospitals and clinics would always be working under the direct supervision and direction of nurses, and that they would not be allowed to use complex medications or therapies that are beyond their scope of education and training unless a nurse or a physician provides them with specific detailed direction and accompanying oversight pertinent to such medications and therapies. (The Minutes of the Fourth Committee Meeting, February 5, 2001)

Health Clinics and the Proposal

During committee deliberations the applicants were asked why health clinics were included in their proposal, and concern was expressed by some committee members that adequate supervision of EMS providers in these settings might not always be present. The applicants responded that the Board of EMS was petitioned to include health clinics in the proposal, and added that some EMS professionals believe that including these facilities would provide medically underserved areas of Nebraska with an important means of delivering emergency medical services in a more timely manner than under the current situation. (The Minutes of the Second Committee Meeting, February 5, 2001)

The applicants provided the committee members with a document containing a statutory definition of health clinics under Nebraska law. This document clarified that under Nebraska law,

> "Health clinic means a facility where advice, counseling, diagnosis, treatment, surgery, care, or services relating to the preservation or maintenance of health are provided on an outpatient basis for a period of less than twenty-four consecutive hours to persons not residing or confined at such facility. Health clinic includes, but is not limited to, an ambulatory surgical center or a public health clinic." (Nebraska Revised Statutes, 71-416)

The applicants responded to concerns expressed about supervision in health clinics by stating that under the proposal, paramedics would be required to follow standing protocols in health clinic settings regardless of the supervisory situation. Comment was made that standing protocols don't work very well where oversight by physicians or nurses is either not continuous or absent, and that wherever "OJT" is a vital component of training, it is best that this occur in settings where physicians and/or nurses are always present, and that hospitals can meet this criterion much more consistently than clinics.
(The Minutes of the Second Committee Meeting, February 5, 2001)

Another testifier with concerns about EMS providers working in health clinics stated that their ability to function safely and effectively in such practice situations is "highly problematical." This testifier commented that there is a "total void" in paramedic training pertinent to the management of diseases and illnesses in an ongoing manner, and that the entire focus of their training and skills is in the area of intervention in emergency situations. This testifier stated that he would be opposed to the inclusion of these practitioners working in health clinics unless they could be brought under direct physician supervision as well as physician approved protocols in each clinic. (Letter from James McHugh, Vice President, Outpatient Services/Medical Staff at Regional West Medical Center, Scottsbluff, Nebraska)

This same testifier added that it is "highly doubtful" that the services of paramedics could be billed for third-party reimbursement in federally designated rural health clinics since they do not meet the definition of "mid-level provider" mandated by the federal government for reimbursement of physician extenders in these contexts. (Letter from James McHugh, Vice President, Outpatient Services/Medical Staff at Regional West Medical Center, Scottsbluff, Nebraska)

Oversight of EMS Providers under the Proposal

Pertinent to oversight of EMS providers under the proposed scope, one committee member commented that not all RNs would be able to oversee the work of paramedics because not all RNs possess all of the specific training and skills pertinent to emergency care (such as intubation, e.g.). The applicants responded that RNs are capable of overseeing the provision of emergency care by EMS personnel regardless of whether they have mastered a particular skill pertinent to the care provided by such personnel. (The Minutes of the Second Committee Meeting, February 5, 2001)

During committee deliberations the applicants were asked what differences would likely occur regarding supervision of EMS providers in small rural hospitals as compared with larger urban hospitals. The applicants responded by stating that RN oversight of these providers would be the "bottom line" for any hospital emergency room regardless of its size or location, and the EMS personnel in question would function like RN extenders in facilities where there is a shortage of RNs. (The Minutes of the Second Committee Meeting, February 5, 2001)

Another applicant testifier stated that RNs under the proposal would always have the ultimate supervisory authority over EMS providers, and that the addition of these providers to emergency room delivery of care would have the benefit of freeing the nurse to focus on overall management of a patients' condition. EMS providers then could be used to get patients to where they need to be, check vital signs, and initiate care. This testifier commented that it is important to see this scenario for emergency room care in terms of a team concept rather than focusing on each type or practitioner as if they are working in isolation. This testifier indicated that quality of care in this kind of setting stems as much from how well the team is working together as it does on the specific skills of each practitioner. (The Transcript of the Public Hearing, Pages 18 and 19)

Nursing Issues and the Proposal

One applicant testifier commented that the proposal would lighten the workload for nurses. Nurses would have more time to oversee the total care that patients receive. (The Transcript of the Public Hearing, Page 44)

The applicants were asked whether the proposal might have the impact of discouraging prospective nursing candidates from pursuing a career as an RN because of the added oversight responsibilities inherent in it. The applicants responded that they did not foresee the proposal having a negative impact on the availability of RNs, and added that passing the proposal would add to the need to have RNs present in hospital emergency rooms. (The Minutes of the Second Committee Meeting, February 5, 2001)

One opponent testifier commented that the proposal would increase nurses' liability concerns and increase their work load at a time when hospital-based nurses are already overburdened. The proposal in the judgment of this testifier would result in nurses having less time for their primary duties in providing patient care, and increase the amount of time they spend providing oversight for other health care workers. This testifier commented that this would add to an already undesirable situation for nurses who already have significant oversight responsibilities pertinent to unlicensed personnel that are employed by hospitals. (The Transcript of the Public Hearing, Page 90)

The applicants responded to concerns about the potential liability of supervising nurses by stating that current statutes and rules and regulations clarify that it is the provider of care per se that is liable for any errors they commit, not those who supervise them. (The Minutes of the Second Committee Meeting, February 5, 2001)
One applicant testifier informed the committee that paramedic practitioners would be liable for their own actions under the terms of their licensing statute. (The Transcript of the Public Hearing, Page 106)

The applicants stated that one risk of the proposal is that it might result in health care facilities hiring fewer nurses. The applicants acknowledged that studies have been done that indicate that there is a national trend toward hiring non-nursing personnel to staff hospital departments to supplement nursing staff, and that this can be a source of increased morbidity. The applicants went on to state that other studies have examined the use of non-nursing personnel in emergency departments and have concluded that as long as certain principles are followed (including a nurse to non-nurse ratio of approximately three to one) that emergency room work load problems can be addressed in a manner consistent with quality of care. The applicants added that the Emergency Nurses Association has written a position paper in support of the utilization of non-nursing personnel in emergency departments as long as educational, supervisory, and staffing ratio issues are addressed in a manner consistent with public safety. (The Applicants' Proposal, Pages 15 and 16; Also, Exhibit #4 in the appended documentation)

The Role of Protocols under the Proposal

The committee members discussed the role that protocols would likely play under the proposal. The applicants were asked to discuss how a set of protocols for those doing the proposed scope would apply in contexts as different as large urban hospitals, small rural hospitals, and health clinics in rural areas of Nebraska. The applicants responded that the treatment protocols that are applied vary depending on the extent of oversight that is directly available at a particular facility. The applicants added that such things as starting an "IV" would not be part of any "standing orders" in a facility where necessary oversight is not available. (The Minutes of the Second Committee Meeting, February 5, 2001)

One committee member expressed the concern that the current proposal runs the risk of lowering standards of care by eroding the position of RNs in hospitals without significantly improving access to quality emergency care in medically under served areas.

(The Minutes of the Second Committee Meeting, February 5, 2001)

The applicants stated that their proposal makes a significant effort to mitigate potential harm by mandating additional training that specifically focuses on work in an emergency room context. Additionally, the applicants stated that by requiring oversight of EMS personnel employed in emergency room by nurses, their proposal would minimize potential for new harm and maximize benefits to patient care. (Page 17, The Applicants' Proposal)

One testifier commented that in a hospital emergency department paramedics would be a "superb addition" to the personnel pool. This testifier added that it is vital that these practitioners function under physicians' protocols, and that the physician per se be available as backup support for the paramedic. (Letter from James McHugh, Vice President, Outpatient Services/Medical Staff at Regional West Medical Center, Scottsbluff, Nebraska)

Continuing Competency under the Proposal

During committee deliberations the applicants were asked about difficulties that would be encountered by facilities in maintaining an appropriate skill level for EMS providers. The applicants responded by stating that maintaining an appropriate skill level would be a problem, but that this should not be any greater problem than already exists vis-a-vis other health care providers such as nurses or PAs, for example. (The Minutes of the Second Committee Meeting, February 5, 2001)

COMMITTEE CONCLUSIONS AND RECOMMENDATIONS

The committee members met on April 4, 2001 to formulate their recommendations on the proposal. **All information in this section was generated by information from this fourth meeting.**

Before the committee members could formulate their recommendations on the proposal, it was necessary for them to select from **the three options described on pages 9 through 11 of this report. Committee member Dalton moved and committee member Coulter seconded that the proposal be amended so as to adopt the third option which calls for creating enabling legislation that would grant hospitals and health clinics that satisfy health and safety standards defined in statutes and rules and regulations pertinent to such facilities the authority to train, test, and employ paramedics and EMTIs in their emergency rooms. The committee members passed this motion by voice vote, unanimously.**

The adoption of the third option meant that this option would be the version of the proposal to which the committee members would apply the four criteria.

During the discussion on this motion, the applicant group clarified that the purpose of the motion adopting the third option is to define how the idea of expanding the work settings of EMTIs and paramedics would be accomplished, and who would be primarily responsible for ensuring that these practitioners practice safely and effectively.

During the discussion on this motion, there was a consensus among the committee members that the third option was the most cost-effective of the three options under review, and that the other options involved examination development and validation costs that would have been prohibitive. Concern was expressed by some committee members about the inability of the third option to establish uniformity of practice for EMS personnel working in emergency rooms. The applicants responded to these concerns by stating that there is currently a unified baseline curriculum and training process for EMTIs and paramedics, and that this core training should help to provide a foundation for uniformity of practice for their emergency room work. The applicants added that the kinds of additional skills and knowledge that they would need to work in an emergency room would be essentially the same from one facility to another, and that the realities of emergency room work would create a de facto uniformity of practice for these providers.

Concern was expressed by some committee members about the implications of option three for oversight of EMS providers in rural health clinics wherein emergency care might occur. These committee members were concerned that there be reasonable assurance that oversight by RNs of EMS providers would be required in these contexts. The applicants responded that current statutes pertinent to facility licensure require RN oversight of emergency room employees under physician and/or medical director protocols for all emergency room care.
Concern was expressed by some committee members regarding the ability of some medical

directors to provide adequate training for EMS employees. The applicants commented that the fact that both of the EMS groups under review have clearly defined scopes of practice and educational and training regimens helps to address concerns about the competency of some medical directors.

The committee members then discussed each of the four criteria of the credentialing review statute pertinent to scope of practice reviews beginning with criterion one. The discussions on the substance of the proposal and the issues raised by the proposal that occurred at this meeting are incorporated under the discussions on the criteria.

Criterion one states,

> The present scope of practice or limitations on the scope of practice creates a situation of harm or danger to the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Before voting on this criterion, the committee members reviewed the first criterion and discussed how it relates to the applicants' proposal. There was a consensus among the committee members that the wording of this criterion does not relate very well to the realities of the current review since what is being reviewed is a proposal for a change in practice setting rather than a change in scope of practice per se. The committee members indicated that for the purpose of this review, the first criterion needed to be interpreted so as to ask whether or not, "The present practice settings or limitations on practice settings create a situation of harm or danger to the health, safety, or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument." The committee members decided that this interpretation of the first criterion would be the one they would use when they took action on this criterion.

Consistent with the above consensus regarding the interpretation of the first criterion, committee member Rourke moved and committee member Coulter seconded that the proposal satisfies the first criterion. Voting aye were Dalton, Coulter, and Beckman. Voting nay were Rourke, and Billups. Chairperson Nelson abstained from voting, and committee member Lear was not present. By this vote the committee members determined that the proposal as amended satisfies the first criterion which means that they determined that there is significant harm or potential for significant harm in the current practice situation of EMS providers.

During the discussion on this criterion, one committee member commented that to argue that the current restrictions on EMS practice settings is a source of "harm" or "potential harm" to the public health and welfare is essentially to argue that current access to care problems in emergency rooms is due to the fact that EMS providers aren't allowed to work in emergency rooms which is not a logical argument. Another committee member commented that to give the proposal due consideration on this criterion, the committee needs to widen the scope of what is

meant by "harm" to include economic issues raised during the review, specifically, those associated with the inability of rural EMS units to establish and maintain advanced life support services. Some committee members commented that if the harm issue were looked at this way, the argument could be made that ALS is not available in rural areas at least in part because of current restrictions on EMS practice settings. These committee members noted that some testifiers at the public hearing stated that the practice restrictions in question have made it nearly impossible for rural EMS units to afford to employ EMTIs and paramedics because they could not use their services in a cost-effective manner.

The committee members then discussed the second criterion.

Criterion two states,

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

Before voting on this criterion, the committee members reviewed the criterion and discussed how it relates to the applicants' proposal. The committee members then took action on the second criterion. Committee member Billups moved and committee member Rourke seconded that the proposal satisfies the second criterion. Voting aye were Dalton, Rourke, Coulter, Billups, and Beckman. Chairperson Nelson abstained from voting, and committee member Lear was not present. By this vote the committee members determined that the proposal satisfies the second criterion which means that the committee members determined that the applicants' proposal as amended does not create significant new harm to the public health and welfare.

The committee members agreed that information that they had received during the review indicated that health care facilities have already had experience with utilizing the services of EMS providers in emergency units, and that this can be done safely and effectively if due attention is given to training, oversight, delegation, and protocols by those responsible for supervising these practitioners.

One committee member advised the applicant group to remember that even though their proposal is not intentionally a scope of practice expansion, EMS providers working in emergency rooms will find themselves performing duties pertinent to chronic care that they are not trained to perform under the terms of their current licensure requirements.

The committee members then discussed the third criterion.

Criterion three states,

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

Before voting on this criterion, the committee members reviewed the criterion and discussed how it relates to the applicants' proposal. Committee member Rourke moved and committee member Billups seconded that the proposal satisfies the third criterion. Voting aye were Dalton, Rourke, Coulter, Billups, and Beckman. Chairperson Nelson abstained from voting, and committee member Lear was not present. By this vote the committee members determined that the proposal satisfies the third criterion which means that the committee members determined that the applicants' proposal as amended would benefit the public health and welfare.

The committee members noted that at the public hearing representatives of rural hospitals were overwhelmingly in support of some version of the proposal, and that these representatives had indicated that the proposal would greatly add to the ability of rural hospitals to provide flexible, and yet, safe and effective services.

The committee members then discussed the fourth criterion.

Criterion four states,

> The public cannot be effectively protected by other means in a more cost-effective manner.

Before voting on this criterion, the committee members reviewed the criterion and discussed how it relates to the applicants' proposal. Committee member Coulter moved and committee member Beckman seconded that the proposal satisfies the fourth criterion. Voting aye were Dalton, Rourke, Coulter, Billups, and Beckman. Chairperson Nelson abstained from voting, and committee member Lear was not present. By this vote the committee members determined that the proposal satisfies the fourth criterion which means that the committee members determined that the applicants' proposal as amended is the most cost-effective means of addressing the problems raised by the applicant group.

The committee members agreed that the proposal as amended would be unlikely to create any new administrative costs for health care facilities, nor would it create any new complications or difficulties pertinent to the hiring and training of personnel to work in emergency rooms beyond those that already exist.

By these four votes the committee members recommended in favor of the applicants' proposal as amended.

OVERVIEW OF COMMITTEE PROCEEDINGS

The committee members met for the first time on January 10, 2001 in Lincoln, in the Nebraska State Office Building. The committee members received an orientation regarding their duties and responsibilities under the Credentialing Review Program.

The committee members held their second meeting on February 5, 2001 in Lincoln, in the Nebraska State Office Building. The committee members thoroughly discussed the applicants' proposal, and generated questions and issues that they wanted discussed further at the next phase of the review process which is the public hearing.

The committee members met for their third meeting on March 7, 2001 in Kearney, Nebraska at the Buffalo County Extension Building. This meeting was the public hearing on the proposal during which both proponents and opponents were each given one hour to present their testimony. Individual testifiers were given ten minutes to present their testimony. There was also a rebuttal period after the formal presentations for testifiers to address comments made by other testifiers during the formal presentation period. A public comment period lasting ten days beyond the date of the public hearing was also provided for during which the committee members could receive additional comments in writing from interested parties.

The committee members met for their fourth meeting on April 4, 2001 in Lincoln, in the Nebraska State Office Building. The committee members formulated their recommendations on the proposal at this meeting by taking action on each of the four criteria of the credentialing review statute pertinent to scope of practice proposals.

The committee members met for their fifth meeting on May 2, 2001 in Lincoln, in the Nebraska State Office Building. The committee members made corrections to the draft report of recommendations, and then, approved the corrected version of the report as the official document embodying the recommendations of the committee members on the proposal. The committee members then adjourned sine die.