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Legislative Council (30 August 2016) Capitol 412E
Question 1: Background EMT Licensing and Continuing Education Standards
[volunteers provide 80% EMS]
[In-kind $44-72 mil/year—just responders—not other support personnel]

Over-riding issues:

- *"Increasing complexity of care"??*
- Initial EMT Education + Training too long? First responder pretty short (49h)
- Ongoing increased in number of hours (by 250+%) by what "we" think is needed—who is we and how do we know?
  - Same at national level
- Who/how sets Continuing Education agenda---by # hours of….
- How determine needs for Continuing Education needs?
  - ?run reviews
  - Guess
- Who approves Continuing Education agenda?? ?? do med directors sign off on all cont ed and relicensure—how do they know?
- Call volume increasing 4-7%/year—why??
- How accredit *competencies* of students and faculty—QA
- Funding Assistance Program cut by $300K ($2.2 mil to $1.9 mil/year)
- Yesterday—today—tomorrow

Chronology:

- 1966
  - *Accidental Death and Disability* and *Health in the Dirt*
  - Hearse ambulances by Funeral Director
  - US Highway Safety Act
- 1968
  - Farrington/Anast—*Emergency Care and Transportation of the Injured and Ill*, Am Coll Ortho Surg
    - Bible (orange book)
    - "Emergency Medical Technician"
  - WI—6 instructors plus physicians around state
  - +5 years
- 1973
  - US EMS Act
    - Establish NHTSA
    - Project 40—block grants
    - Health Services Areas
    - Must demonstrate all 15 components to be funded
      - Education
      - Evaluation!!!—didn't happen
  - WI Act 321
    - Licensing of EMTs (Basic/paramedic)
    - EMS Section
    - EMS Examining Council
    - EMT-P Madison/Milwaukee using Project 40→ $s
    - Renewed 1975 and 1977---NOT 1979!!! → For US-EMS Act
- 1989!!!! Act 102 (gap 15 years)
  - Funding Assistance Program ($2.2 million/year to basic sevices+)

- Request National Highway Traffic Safety Agency Technical Assistance Team (NHTSA-TAT) evaluation
- 1990 NHTSA-TAT
  - Resources ($s) from Department of Transportation (DOT) not DHS
  - Recommendations picked up by Leg Council (1992-1993) included
    - Appoint Lead agency
    - Develop EMS Advisory Committee
    - State Medical Director
    - Single *data* system and Uniform *data* collection
    - *Mandatory* evaluation
    - Quality Assurance at all levels
    - Communicators
    - Inter-facility transfers
    - Develop Trauma system
- 1991
  - Funding to EMS cut by Department
  - Secretary buried TAT report
- 1992-1993 Leg Council
  - Recommendations
    - EMS Board with powers of Board
    - Establish/employ State Medical Director
    - Establish Physician Advisory Committee to … (PAC)
    - 10 reports to Legislature
      - By 31 Dec 94—Regionalization
      - By 30 June 95—Uniform data collection
      - By 31 December 1995—8 others (See attached)
- 1994
  - Act 251
    - As proposed by Leg Council
    - Continuing education hours and alternative delivery methods
  - Act 16
    - EMS "Advisory" Board—no powers
    - State Medical Director (0.5FTE @ $50K from DOT!!!)
  - Regionalization Report "to Legislature" submitted to DHS
    - Recommend regionalization of EMS
    - Advantages
      - QA with *improved data collection and analysis*—analysis not possible at local level
      - More hosp involvement
      - Decrease overall costs
      - System = entry thru ED
      - Warn impending problem with recruitment and retention of volunteers
      - Many others
    - Sent back to Board for more information--Not passed on to Legislature
- 1996—Regionalization II (October)
  - ? form new state agency (EMS/Fire/Law enforcement)
  - Increasing levels of care with decreasing resources
  - Regional vs Local *data*
  - Improve quality of Education and Training
  - Increase hospital involvement
  - Volunteers contribute in-kind $44-80 mil/year ($10/hr)
  - Reports never sent to legislature by Dept
- 1999

- Scope of Practice document
  - Standards for Educators and Medical Directors
  - Eliminate EMT designation→Levels I-IV
  - Modular system for advancement to higher levels
  - Paramedic additions: Flight, Primary care (community); Critical Care Transport, Management, Education, HazMat, Disaster, and Communicator

- 2001 NHTSA-TAT
  - Bureau status!!!
  - Bureau authority to approve training centers and courses [by whom??]
  - Instructor training program by administrative rule
  - Adopt National EMS Curriculum with modifications
  - First Responder (FR) definition standardized
  - Unable to cert FR due to lack of $s
  - Had some bridge courses
  - Short staff—unable to implement
    - Technical assistance
    - Data support—collection and analysis
    - FR cert
    - Communicator trg
    - Verification of trg centers
  - Recommendations
    - ? ability to comply WI Educational System with "agenda for Future"
    - Develop mechanism to obtain and utilize data re: qualifications of instructors
    - Need bridge courses from entry FR to paramedic
    - Conduct random audits for quality and reliability for relicensure
    - Recruitment and retention ongoing issue—only pockets
    - Develop programs for recruitment and retention of volunteers
- 2005 GAO Report (requested by Finegold/Collins)
  - Retention of infrequently used
    - Medical skills
    - Training
    - Management
    - Budgeting
    - Personnel
    - Organization
  - ??clinical experiences
  - Increased demand for services with decreased resources
- 2012 NHTSA TAT
  - Now at Unit level (no longer a Section)
  - EMT-I not part of EMS Educational Agenda
  - EMT-B Certification require completion of initial Education and Training + National Registry
    - Faculty required to complete formal educational program authorized by Department
    - Plans in place for transitions
  - Challenge to maintain quality education program due to decreasing $ ($126/credit=1/3 costs) with decreased resources
  - Progressive Increase in education time (equiv of 40 sessions compared top 10)
  - Non-traditional clinicals
  - ? ability of volunteers to maintain effectiveness and availability
  - Recommendations
    - Minimize classroom hours—distributive learning etc to reach competencies
    - Alternate clinical sites
    - Comprehensive evaluation of instructors
    - "Study recruitment and retention of volunteers"

- 2015
    - Modify requirements for minimum Ambulance personnel to one EMT-B and a First Responder!!

?? When Medical Director cut by DHS from 0.5FTE to 0.25FTE??

"Eminence-based"

Question 2: Comments on appropriateness of standards and adequate training of EMTs

- Don't know
    - Data without analysis—
    - No outcome info from hospitals except trauma
    - ? run reviews by….. amalgamate by region
- Are standards too high for EMTs and too low for FR?
- Experience levels too low
- Hospitals: lack of feedback—loss of patients/revenue
- Trauma vs rest of EMS
- Pediatrics vs rest of EMS
- Many Committed volunteers want to do more!!!

Question 3: Suggestions for Revision of Training Requirements

- Very low experience levels
- No EMT-B and FR—(college plus high school football)---decrease Education and Training by 45%!!
- Use Basic-Basic + modular upgrades
- Modular transition to higher levels with appropriate utilization if service approves and provides supplies/equipment—see Scope of Practice document
- Education and Training must be based on *data analysis* not on theory—CQI + Med director-=-regional
    - Continuing Ed based on needs
    - *Data analysis* by…..—used to identify needs
    - Need access to outcome *data*—not run *data*—need to know "so what?"—requires change in legislation
    - Hospital involvement in CQI
    - Competence regardless of how get there—should be many options
    - Monitoring of quality of Education and Training – how/who determines
    - Non-traditional clinicals (i.e., simulation)—initial and continuing education
    - Instructors at Masters+ level
- Regionalization--- an EMS System
    - FR+FR in non-transport emergency response vehicle with simultaneous dispatch of EMT-B/I/P ambulance
    - Regional communicators
    - Hospitals and outcomes

??Regions = Public health or trauma or HealthCare Coalition????

Institute of Medicine: "*without reliable information*, hard to determine in systematic way:

- Extent providing appropriate, timely care; and
- What ought to do to improve performance and patient outcomes".