



MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

**EMERGENCY MEDICAL SERVICES
COMMISSION MEETING MINUTES**

DATE: December 18, 2015
TIME: 10:30am
LOCATION: Fishers City Hall
One Municipal Drive
Fishers, IN 46038

MEMBERS PRESENT:

Michael Lockard	(General Public)
G. Lee Turpen II	(Private Ambulance)
Darin Hoggatt	(Paramedics)
Stephen Champion	(Medical Doctor)
John Zartman	(Training Institution)
Myron Mackey	(EMTs)
Mike Garvey	(Indiana State EMS Director)
Melanie Jane Craigin	(Hospital EMS)
Terri Hamilton	(Volunteer EMS)
Sara Brown	(Trauma Phycsian)
Charles Valentine	(Municipal Fire)

MEMBERS NOT PRESENT:

Sue Dunham	(Emergency Nurses)
Matthew McCullough	(Volunteer Fire and EMS)

OTHERS PRESENT: Field Staff, Dr. Michael Olinger (EMS State Medical Director), Robin Stump, Tony Pagano, Candice Hilton, and members of the EMS Community.



CALL TO ORDER AND ROLL CALL

Meeting called to order at 10:35 am by Chairman Lee Turpen. Ms. Candice Hilton called roll and announced quorum.

ADOPTION OF MINUTES

- a. October 16, 2015 meeting minutes

A motion was made by Commissioner Mackey to approve the minutes as written. The motion was seconded by Commissioner Zartman. A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

INDIANA DEPARTMENT OF HEALTH

- a. Trauma Registry (see attachment #1) Mrs. Katie Hokanson reported for the Indiana Department of Health. Mrs. Hokanson briefly went over the Narcan report. No action required and none taken at this time.
- b. "In the Process" applications- Mrs. Hokanson reported that there were three hospitals that submitted to become "In the Process" hospitals. The Trauma committee is recommending that the EMS Commission approve the applications. The hospitals are Reid Health for Level III trauma center, Franciscan St. Anthony of Crown Point for Level III trauma center, and Terre Haute Regional for Level II trauma center.

A motion was made by Commissioner Zartman to approve all three hospital's applications to be "in the process" hospitals. The motion was seconded by Commissioner Champion. A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Commissioner Lockard asked how many hospitals are currently "in the process". Mrs. Hokanson stated that including the three new hospitals that were voted in today there are 19 trauma hospitals, 11 are verified, and 4 "in the process". Mrs. Hokanson stated that Community Health North, East, and South have removed themselves from the "in process" process. Mrs. Hokanson stated that there has been one (1) reviews with Good Samaritan, Community Anderson, and Methodist North Lake Gary everything looks like it is on track with all three hospitals at this time.

Mrs. Hokanson stated that Mr. Art Logsdon, Dr. Jon Judy, the Indiana Department of Health's Chief Medical Consultant and she all attended the Children's Safety Collaborative in Boston, which involves 26 states and territories. They focus on the 5 topics of teen driving safety, interpersonal violence, child passenger safety, falls, and suicide or self-harm. The meeting covered where the markers were for each state, what programs are in place to address these issues and what can be done to move these markers further. Mrs. Hokanson stated that as progress is being made she will keep the Commission updated.

Mrs. Hokanson stated that the Trauma Committee has really started focusing on regional trauma systems. Initial meetings has taken place with Districts 1, 6 and 7 to discuss the development of a regional trauma system. District 3 and 8 has met on their own to start discussing the development of a regional trauma system. District 10 has done a good job in developing their regional trauma system.

Mrs. Katie Hokanson introduced their new Injury Prevention Program Coordinator Ms. Lauren Savitskas. She will be focusing on older adult falls, and child passenger safety. Mrs. Hokanson stated that they would love to hear about what everyone is doing in the areas of older adult falls and child passenger safety as well as other areas of injury prevention.

Mrs. Katie Hokanson stated that Dr. Olinger and she have has some initial conversations about the 3rd annual Medical Directors Conference. Mrs. Hokanson stated that as more information is made available she will share it with the EMS Commission.

Mrs. Hokanson stated that Robin Swanskin from IU Health North asked her to make the EMS Commission aware they are studying the stemi piece. Robin has sent a note out to the EMS providers in the North IU health area to ask that they get their run sheets in on a timely fashion. Mrs. Hokanson stated she would not be surprised if we hear this from other hospitals as well.

EMS FOR CHILDREN (EMSC)

No report given at this meeting

TECHNICAL ADVISORY COMMITTEE (TAC)

- a. Report – Mr. Leon Bell, Chairman of the TAC, reported out for the TAC. (see attachment # 2 includes minutes and attachments)

Waiver Tool - Chairman Bell briefly went over the waiver tool. Commissioner Lockard commented on the spreadsheet.

A motion was made by Commissioner Lockard to have staff beta test the waiver tool and the TAC make improvements with the feedback from staff. The motion was seconded by Commissioner Hamilton. . A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Glucometer training program – the power point that is in the Commission packet. The TAC proposes that this placed in Acadis in the LMS system so that it is available for use as an educational tool. This program is for currently certified individuals. The TAC is recommending both the power point and 51 page document.

A motion was made by Commissioner Mackey to approve the program and for the TAC to develop a 10 question quiz to go with the powerpoint. The motion was seconded by Commissioner Zartman. . A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Primary Instructor program and testing- Chairman Bell discussed the recommendations from the TAC regarding the Primary Instructor exam and the Primary Instructor exam. The TAC is recommending that the passing written Primary Instructor written exam score be moved to 80%.

A motion was made by Commissioner Zartman to accept the TAC recommendation and make the passing score for the Primary Instructor written exam to 80%. The motion was seconded by Commissioner Lockard. . A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Chairman Bell discussed the recommendation from the TAC to have a state PI class. Discussion followed.

A motion was made by Commissioner Zartman to send this issue to TAC to develop a proposal for the Commission at their next meeting to identify the structure content, the structure format, and the key element people and institutions that would be willing to take the pilot program on. The motion was seconded by Commissioner Mackey. Discussion followed. . A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Chairman Bell discussed the recommendation from the TAC to make the PI written exam pass score to 80% and to make the Pre PI (EMT) written exam pass score be moved to 80%.

A motion was made by Commissioner Zartman to approve the pass score for the PI written exam and the Pre-PI written exam pass score both be moved to 80%. The motion was seconded by Commissioner Mackey. Discussion followed. . A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Chairman Bell discussed the PI manual update. Discussion followed.

A motion was made by Commissioner Zartman to have a committee formed to have the PI manual reviewed for any needed updates or changes. The motion was seconded by Commissioner Mackey. A vote was taken Commissioner Zartman voted to pass the motion, Commissioner Lockard voted to pass the motion, Commissioner Craigin voted to pass the motion, Chairman Turpen voted to pass the motion, Commissioner Mackey voted to pass the motion, Commissioner Hoggatt voted to pass the motion, Commissioner Brown voted to pass the motion, Commissioner Hamilton voted to pass the motion, Commissioner Champion voted to pass the motion, Commissioner McCullough and Commissioner Dunham were not present, Vice Chairman Valentine did not vote. The motion passed.

Chairman Turpen called for a brief break at 11:43am

Chairman Turpen reconvened the meeting at 11:57am

Vice Chairman Charles Valentine arrived at 12pm so it is no longer necessary to call roll for the vote on motions.

INDIANA EMERGENCY MEDICAL SERVICES ASSOCIATION (IEMSA)

Mr. Faril Ward reported for the IEMSA. Mr. Ward announced that the legislative breakfast is scheduled for January 28th from 7:30am – 10:30am in the north part of the atrium in the state house. Issues that will be discussed will be some changes in the green light law to more closely resemble the blue light law. There has been progress in finding a professional director for IEMSA and an announcement should be able to be made at the next EMS Commission meeting. Mr. Ward stated that the EMS license plate is now available for ambulances, cars, and motorcycles. 1/3 of the money from the plates will go to the EMS memorial, 1/3 education/training, and 1/3 for public education. IEMSA is in control of the numbers for the EMS license plates. The IEMSA is developing a challenge coin the money from the coins will go for the EMS memorial (see attachment #3 for a picture of the coin). The IEMSA is launching a state wide survey to help identify why there is an EMT and Paramedic shortage in the state. They have found that less than 50% of people that are training to become EMTs and Paramedics are actually going into the profession. Mr. Ward announced that there has been an IEMSA board member resign and they are looking for a replacement.

EMS EDUCATION WORKING GROUP

Mr. Tony Pagano reported for the Education working group. The group worked on the PI proposal that was sent to the TAC for review and approval. This took most of their meeting. The group also discusses if it was time to require that a primary instructor be required to be present for the EMR courses due to issues that have been occurring with some of the courses.

PERSONNEL WAIVER REQUESTS

The following requested a waiver of 836 IAC 4-4-1 which reads (b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report. Mr. Miller is asking for more time to complete the requirement to become certified as an EMT Aaron completed EMT Class course number B79-03-14 which had an end of September 27, 2014. Due to Mr. Miller being away for work as a Cell-phone Tower Rescue Climber he could not complete the requirements. Mr. Miller passed his written on January 12, 2015 and took his initial attempt on him practical on September 27, 2014. He failed one station on his practical and has not been able to retest. Staff Recommends: Approve for a period of 90 days to meet requirements to become certified.

Aaron Miller

A motion was made by Commissioner Zartman to deny the waiver. The motion was seconded by Commissioner Hamilton. The motion passed the waiver was denied.

The following requested a waiver of Emergency Rule LSA document #12-393E Section 32 which reads (d) Certification as an emergency medical technician shall be valid for a period of two (2) years. (e) To renew a certification, a certified emergency medical technician shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report forty (40) hours of continuing education

according to the following: (1) Participate in a minimum of thirty-four (34) hours of any combination of: (A) lectures; (B) critiques; (C) skills proficiency examinations; (D) continuing education courses; or (E) teaching sessions; that review subject matter presented in the Indiana basic emergency medical technician curriculum. (2) Participate in a minimum of six (6) hours of audit and review. (3) Participate in any update course as required by the commission. (4) Successfully complete a proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum. (f) If a properly completed renewal application is submitted within one hundred twenty (120) calendar days after the expiration of the certification, together with the required documentation to show that the applicant has completed all required continuing education within the two (2) years prior to the expiration of the certification, and a fifty dollar (\$50) reapplication fee, the certification will be reinstated on the date that the commission staff determines that the required application, documentation, and reapplication fee have been properly submitted. The expiration date will be two (2) years from the expiration of the previous, expired certification. (i) An individual wanting to reacquire a certification shall: (1) complete an emergency medical technician recertification training course as approved by the commission; and (2) successfully complete the state written and practical skills examinations as set forth and approved by the commission. If the individual fails either certification examination, the person must retake an Indiana basic emergency medical technician training course. Kevin Steinbergen (2406-1305) EMT Certification expires on 12/31/2015. Kevin is requesting a waiver to allow an additional 6 months to complete his in-service hours. He has had several deaths in his family and unable to complete his in-service. Staff recommends: Approve – Based on previous Commission action.

Kevin Steinbergen

A motion was made by Commissioner Zartman to deny the requested waiver and modify it to accepting the staff recommendation to have Mr. Hensley take the Pre-Primary Instructor (EMT) written exam, the EMT practical exam, and the Primary Instructor written exam. In addition to the staff recommendation Mr. Hensley will need to also complete the internship. Mr. Hensley's NEMSE training course will be accept as his training course. The motion was seconded by Commissioner Mackey. The motion passed.

PROVIDER WAIVER REQUESTS

The following requested a waiver of 836 IAC 1-3-3 Land ambulance specifications Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 Sec. 3 which reads (a) All land ambulances shall meet or exceed the following minimum performance characteristics: (d) All land ambulances shall meet the following requirements for external identification: (1) Warning lights of red or red and white, at the discretion of the owner, and shall conform with *[sic]* to Indiana state law. Rear facing amber lights may be used. All lights on the vehicle shall be in working condition. Bristol Fire Department is requesting a waiver of the emergency lights to add a single green flashing light on the top front facing right corner. Staff recommends: Denial – We don't feel that the Commission can waive a statute that is under the motor carrier law that regulates the use of red and white lights to display the green light.

Bristol Fire Department

A motion was made by Commissioner Lockard to deny the waiver due to the EMS Commission not having the authority over the statute that is under the motor carrier law that regulates the use of red and white lights to display the green light. The motion was seconded by Commissioner Zartman. The motion was passed the waiver was denied.

The following requested a waiver of 836 IAC 2-7.2-1 which reads General requirements for Advanced/Intermediate

EMT provider organization (f) (2) The emergency medical technician-intermediate provider organization shall do the following: (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Franklin County EMS is requesting a renewal waiver of the 24 hour rule. Franklin County EMS is an Intermediate Provider. The department has sent 15 Basic EMT's through ADV EMT training and are still testing and completing requirements. Staff recommends: approval - with the stipulation of reporting to the agency the following: 6 month update e-mail to area district manager each time this occurs

Franklin County EMS

Discussion followed.

A motion was made by Commissioner Valentine to approve the waiver as staff recommended. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of 836 IAC 2-7.2-1 General requirements for Advanced/Intermediate EMT provider organization which reads (f) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Hamblen Twp Vol FD is requesting a waiver of the 24 hour rule. They currently have several EMR's and EMT's but only 2 ADV EMT's. The fire department is a non-transport and responds simultaneously with a paramedic ambulance. Staff recommends: Approve – based on they are non-transport and always responding with a paramedic ambulance. 6 month update e-mail EMS District Manager

SECTION 16. (a) This SECTION supersedes 836 IAC 2-7.2-3 which reads (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Hamblen Vol FD is requesting a waiver of the equipment and medications in the Intermediate rules. Hamblen Vol FD has ADV EMTs that are certified at the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends: Approval based on previous Commission action

Hamblen Volunteer Fire Department

A motion was made by Commissioner Valentine to pass the first waiver as staff recommended. The motion was seconded by Commissioner Zartman. The motion passed.

A motion was made by Commissioner Valentine to pass the second waiver as staff recommended. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of 836 IAC 2-7.2-1 which reads General requirements for Advanced/Intermediate EMT provider organization (f) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Moores Hill Sparta Twp is requesting a renewal waiver of the 24 hour rule. They currently have 3 EMT's and 2 ADV EMT's. In 2014 and 2015 they have missed less than one handful of runs and are still very reliant on their firefighters to drive.

SECTION 16. (a) This SECTION supersedes 836 IAC 2-7.2-3 which reads (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate (xiv) Naloxone. (xv) Nitroglycerin. Moores Hill Sparta Twp is requesting a waiver of the equipment and medications in the Intermediate rules. Moores Hill Sparta Twp has ADV EMTs that are certified at the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends: Approval

836 IAC 2-7.1 g Asking for a waiver of the second person responding with the ADV EMT be only driver.

Moores Hill Sparta Volunteer Fire Department and EMS

A motion was made by Commissioner Valentine to pass the first waiver as staff recommended. The motion was seconded by Commissioner Hoggatt. The motion passed.

A motion was made by Commissioner Valentine to pass the second waiver as staff recommended. The motion was seconded by Commissioner Hoggatt. The motion passed.

A motion was made by Commissioner Hoggatt to pass the third waiver. The motion was seconded by Commissioner Valentine. The motion passed.

The following requested a waiver of SECTION 16 which reads (a) This SECTION supersedes 836 IAC 2-7.2-3 (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb)

ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Rescue 69 is requesting a waiver of the equipment and medications in the Intermediate rules. Rescue 69 has ADV EMTs that are certified at the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level.

Southern Ripley County EMS

A motion was made by Commissioner Valentine to approve the waiver as staff recommended. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of 836 IAC 2-2-1 which reads General requirements for paramedic provider organizations (h) A paramedic ambulance service provider organization must be able to provide a paramedic level response. For the purpose of this subsection, "paramedic response" consists of the following: (1) A paramedic. (2) An emergency medical technician or higher. (3) An ambulance in compliance with the requirements of section 3(e) of this rule. (4) During transport of the patient, the following are the minimum staffing requirements: Spencer County Emergency Ambulance Services is requesting a renewal of their Staffing Waiver 836 IAC 2-2-1(h) that was approved March 1, 2007. This waiver has helped their service during many weather emergencies. It is not used for day to day staffing; it is used for emergencies within the county or weather. Staff recommends: Approval Update EMS District Manager when it happens Staff recommends: Approval – based on previous Commission action.

Spencer County EMS

A motion was made by Commissioner Mackey to approve the waiver as staff recommended. The motion was seconded by Commissioner Zartman. The motion was approved.

The following requested a waiver of 836 IAC 2-7.2-1 General requirements for Advanced/Intermediate EMT provider organization (f) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Sunman Area Life Squad is requesting a waiver of the 24 hour rule. Sunman has 2 ADV EMT's on the squad and 3 more that are working through the certification process. Staff recommends: Approve – based on previous Commission approval 6 month update, e-mail EMS District Manager

Sunman Area Life Squad

A motion was made by Commissioner Valentine to approve the waiver as staff recommended. The motion was seconded by Commissioner Lockard. The motion passed.

This waiver was added to the agenda at the meeting. The following requested a waiver of 836 IAC 2-7.2-1 General requirements for Advanced/Intermediate EMT provider organization which reads (f) The emergency medical technician-intermediate provider organization shall do the following: (1) Maintain a communications system that shall

be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission. (2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Hamblen Twp Vol FD is requesting a waiver of the 24 hour rule. They currently have several EMR's and EMT's but only 2 ADV EMT's. The fire department is a non-transport and responds simultaneously with a paramedic ambulance. Staff recommends: Approve – based on they are non-transport and always responding with a paramedic ambulance. 6 month update e-mail EMS District Manager

SECTION 16. (a) This SECTION supersedes 836 IAC 2-7.2-3 which reads (B) Endotracheal intubation devices, including the following: (i) Laryngoscope with extra batteries and bulbs. (ii) Laryngoscope blades (adult and pediatric, curved and straight). (iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter. (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Hamblen Vol FD is requesting a waiver of the equipment and medications in the Intermediate rules. Hamblen Vol FD has ADV EMTs that are certified at the ALS level. Currently our rules do not have ADV EMT so the provider needs to follow the rules at the intermediate level. Staff recommends: Approval based on previous Commission action

Bright Fire and EMS

A motion was made by Commissioner Lockard to approve the first waiver with the 6 month standard stipulation. The motion was seconded by Commissioner Hoggatt. The motion was approved. Discussion followed. The motion was amended by Commissioner Lockard to change the 6 month stipulation to the 2 year standard stipulation. The motion was seconded by Commissioner Valentine. The motion passed.

A motion was made by Commissioner Lockard to approve the second waiver. The motion was seconded by Commissioner Zartman. The motion passed.

OLD BUSINESS

1. Tables Business and/or waivers

The following waiver was tabled and is now being brought back to the Commission for action. The following requested a waiver of 836 IAC 4-5-2 Certification and recertification; general Authority: IC 16-31-2-7 Affected: IC 16-31-14 which reads: Sec. 2. (a) Application for certification will be made on forms and according to procedures prescribed by the agency. In order to be certified as an emergency medical services primary instructor, the applicant shall meet one (1) of the following requirements: (1) Successfully complete a commission-approved Indiana emergency medical services primary instructor training course and complete all of the following: (A) Successfully complete the primary instructor written examination. (B) Successfully complete the primary instructor training program. (C) Be currently

certified as an Indiana emergency medical technician. (D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor. (2) Successfully complete a training course equivalent to the material contained in the Indiana emergency medical service primary instructor course and complete all of the following: (A) successfully complete the primary instructor written examination. (B) Successfully complete the primary instructor training program. (C) Be currently certified as an Indiana emergency medical technician. (D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a Primary Instructor. Mr. Blaisuis is requesting more time to complete the requirements to become certified as a Primary Instructor. His course ended on 8/13/2014.

Christopher Blaisuis

A motion was made by Commissioner Zartman to deny the waiver. The motion was seconded by Commissioner Valentine. Discussion followed.

A motion was made by Commissioner Zartman amended his motion to deny staff recommendation but approve the waiver with 6 months to complete all testing requirements prior to doing his internship. There was no second on the amendment. The motion fails.

Commissioner Zartman's original motion to deny the waiver was brought to vote. The motion passed the waiver was denied.

2. Current ongoing studies- none at this time
3. At this meeting there was no other old business to discuss

Commissioner Jane Craigin left the meeting at 12:58pm

NEW BUSINESS

1. Rural Health Innovation Collaborative Report (see attachment # 4). Ms. Stephanie Laws and Mr. Erik Southard reviewed the report.
2. Community Paramedicine report (see attachment #5). Ms. Stephanie Laws and Mr. Erik Southard reviewed the report with the Commission.

ASSIGNMENTS

- a. Past Assignments
- b. Today's Assignments
 1. TAC to develop a proposal for the Commission at their next meeting to identify the structure content, the structure format, and the key element people and institutions that would be willing to take the pilot program on.

SUB-COMMITTEES

- a. Accreditation Sub-committee (Commissioner Zartman Chairman)- No report at this time
- b. Narcotics working group (Commissioner Zartman Chairman)- No report at this time
- c. Training Manual review work group (Tony Pagano)- Mr. Tony Pagano reported that the group has not met yet.
- d. Communications work group (Jason Smith Chairman)- No report and this group will be discontinued. Mr. Smith will report if there are any updates needed.

- e. National Registry work group (testing at all levels except EMR Lee Turpen Chairman)- Chairman Turpen stated that there has been some research completed and the group is also awaiting responses from the National Registry.
- f. Data Collections sub-committee (Commissioner Valentine Chairman)- This group will be resuscitate and Vice Chairman Valentine and Chairman Turpen will work together on this group. Discussion followed as to what needs to be done. Commission Lockard discussed the data dictionary and what data elements are needed.

A motion was made by Commissioner Valentine to add the 31 elements and move forward with the rule making process. The motion was seconded by Commissioner Lockard. The motion passed.

ADMINISTRATIVE PROCEEDINGS

- 1. Administrative Orders Issued
 - a. Personnel Orders
 - i. 1 Year Probation
Order No. 0116-2015 McMurray, Sean M.
No action required, none taken
 - ii. 2 Year Probation
Order No. 0130-2015 Baur, Jeremy R.
No action required, none taken
Order No. 0126-2015 Nordman, David D.
No action required, none taken
 - b. Provider
 - i. 2 Year Probation
Order No. 0122-2015 Switzerland County EMS
No action required, none taken
 - c. Training Institution
 - i. 2 Year Probation
Order No. 0123-2015 Switzerland County Training Institution
No action required, none taken
 - d. Non- Final Orders
 - i. Craig, Pete B.
 - ii. Soppet, Allen M.

A motion was made by Commissioner Valentine to affirm both non final orders. The motion was seconded by Commissioner Zartman. The motion passed.

STAFF REPORTS

- A. Data Report – Ms. Angie Biggs reported that 400,000 runs have been received. There are 326 that still need to be fixed. Everything is being reported to NEMISIS. Commissioner Valentine asked about

providers getting a response back from the state so that they will know that the state has received their run reports. Commission members stated that information needs to go back to the provider so that they can use the information for quality assurance.

- B. Operations Report -Ms. Robin Stump reported out. Ms. Stump introduced Mr. Jason Coffey he is new to the agency, he has been hired as a training coordinator in the EMS section for the Weapons of Mass Destruction. Ms. Stump also introduced Ms. Renee Graves who is also new to the EMS office, she is an EMS certification specialist. Ms. Stump also announced that the EMS office will be conducting interviews for a new EMS Certification specialist and a SIM Lab technician.
- C. Certifications report (see attachment #6) - no action needed, none taken.
- D. Training Report (see attachment #7) - Mr. Tony Pagano stated that the Paramedic pass rate numbers are coming up. Some discussion regarding the pass rates for EMS took place. Commissioner Zartman commented that starting December 15th all ALS accredited institutions have to have 3 years of stats on their web sites. Mr. Pagano stated that a couple of the Training Institution improvement plans have been received in the office. Mr. Pagano stated that it is a busy time for practical exams. Mr. Pagano stated that the State Rep program his going well. Director Garvey stated that there is a plan for funding to continue for the State Rep program.

STATE EMS MEDICAL DIRECTOR'S REPORT

Dr. Michael Olinger reported that there is discussion about rule promulgation regarding requirements to become an Indiana EMS Medical Director.

STATE EMS DIRECTOR'S REPORT

Director Garvey went over the Narcan report (see attachment #8) that was prepared for the Governor's task force on overdoses. Director Garvey announced that Ms. Sue Dunham is resigning from the EMS Commission as of January 1st and that IDHS is looking for a replacement. The position is for a registered Nurse Supervisor in the ER. Director Garvey let everyone know that they may be contacted by someone from IU to take a survey regarding staffing of EMS and Fire services. He asks that anyone receiving this survey to respond and to be honest. Director Garvey thanked all providers that are currently reporting their data. Director Garvey also stated that everyone needs to be aware of things that will impact EMS that is going through legislation.

State Fire Marshal James Greeson took a moment to thank the EMS section and field staff under Mike Garvey's supervision for their hard work in getting Dr. Olinger hired as the State Medical Director. Marshal Greeson also thanked Angie Biggs for her hard work with the data management.

CHAIRMAN'S REPORT AND DIRECTION

Chairman Turpen reminded everyone that the two (2) major conferences are coming up soon. The National Association of EMS Physicians in San Diego. Than shortly after EAGLES conference is in Dallas.

NEXT MEETING

City of Fishers
Fishers City Hall

One Municipal Drive
Fishers, IN 46038
February 19, 2016
10am

This meeting date will need to be changed because several Commission members will not be present. Date to be announced.

ADJOURNMENT

A motion was made by Commissioner Zartman to adjourn the meeting. The motion was seconded by Commissioner Hamilton. The motion passed. The meeting was adjourned at 2:28pm.

Approved _____

G. Lee Turpen II, Chairman

Attachment #1

Indiana State Department of Health—Narcarn Report

Report for December 2015

Indiana State Department of Health—Division of Trauma and Injury Prevention 8,084 Incidents Statewide Data from November 23, 2013—November 22, 2015

Senate Enrolled Act No. 406 became effective on April 27, 2015. This act requires certain emergency personnel to report to the state department of health the number of times an overdose intervention medication is administered.¹

This report has three charts:

- * Narcarn (naloxone) given by Emergency Medical Services by Month (11/23/2013—11/22/2015)
- * Number of Incidents where Narcarn was Given Prior to EMS Arrival (11/23/2014—11/22/2015)
- * Provider's Primary Impression when Narcarn was Given (11/23/2014—11/22/2015)

The following Emergency Medical Services reported administering Narcarn between November 23, 2013 and November 22, 2015 (126 services):

Aboite Township VFD	City of Lawrence FD
Adams County EMS	City of Mishawaka EMS
Air Methods - Kentucky	City of Nappanee EMS
Alexandria FD	City of Rushville FD
American Medical Response	Clay Township Fire Territory (South Bend)
Bargersville Community FD	Cleveland Township FD
Batesville Volunteer Fire & Rescue Department - EMS 10	Clinton County EMS (Frankfort)
Beech Grove FD	Columbus Regional Hospital Ambulance Service
Benton County Emergency Ambulance Service	Community Howard Regional Health
Boone County EMS	Crown Point Fire Rescue Department
Bright VFD	Culberson Ambulance Service
Brown Township Fire & Rescue	Culver Union Township Ambulance Service
Brownsburg Fire Territory	Danville FD / Center Township Trustee
Care Ambulance Service LLC (Indy)	Decatur County EMS
Carlisle Lions Community Ambulance Service	Decatur Township FD
Carmel FD	Delaware County / Muncie EMS
Carroll County EMS	Dublin VFD Inc
Cicero VFD	Fayette County EMS
City of Gary FD	Fire Department of Liberty Township
	Fishers FD



Indiana State
Department of Health

Indiana State Department of Health—Narcarn Report

Report for December 2015

The following Emergency Medical Services administered Narcarn between November 22, 2013 and November 23, 2015:

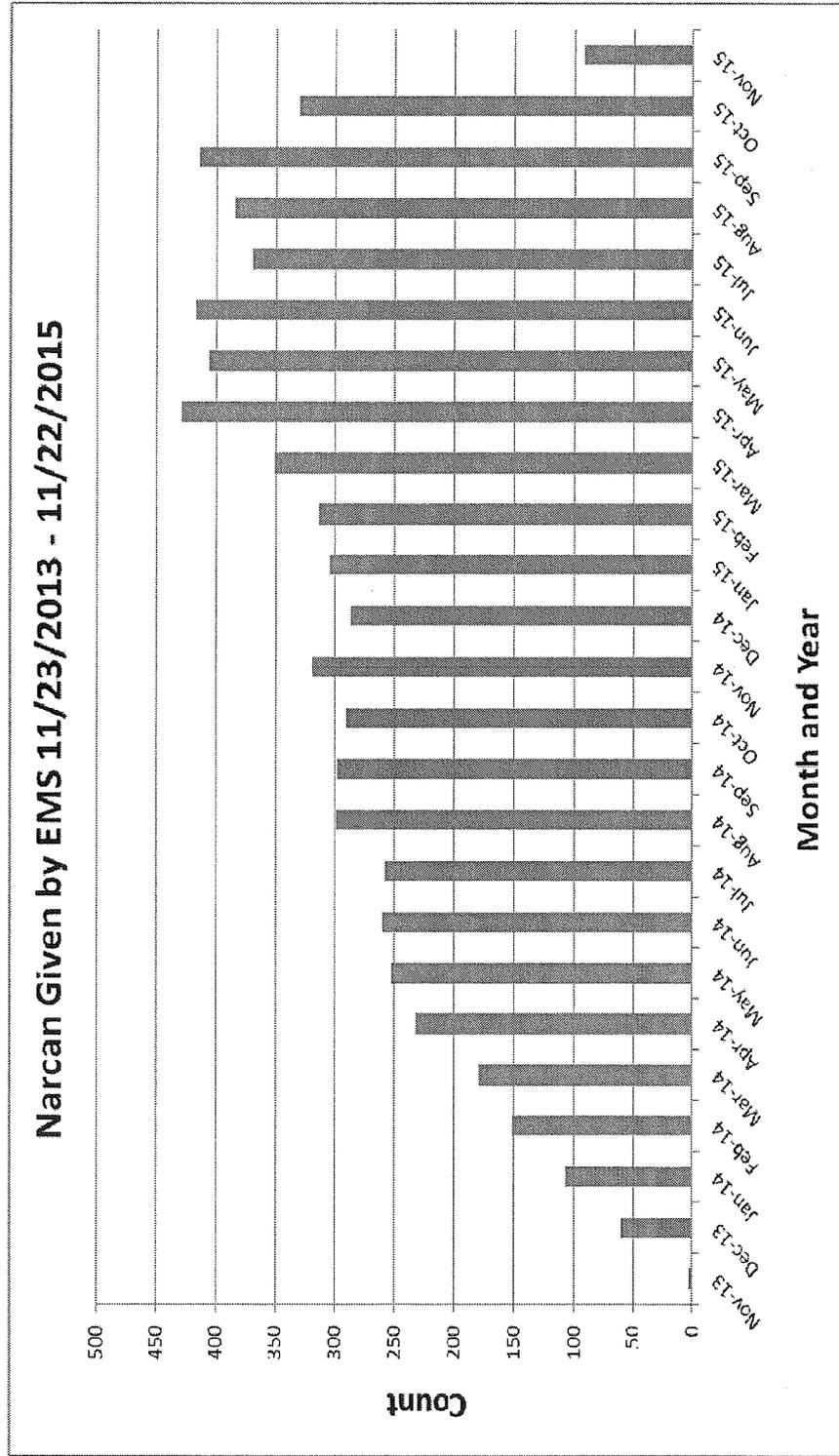
Fountain County Ambulance Service	Parkview Huntington Hospital / EMS	Stauben County EMS
Four Way Ambulance / Mentone EMS	Parkview LaGrange Hospital EMS - LaGrange County EMS	Sugar Creek Township FD
Fulton County EMS	Parkview Noble Hospital	Sullivan County Ambulance Service
Gibson County EMS	Parkview Regional Medical Center	Sullivan FD
Goshen FD	Penn Township FD	Sunman Area Life Squad Inc
Greene County Ambulance Service	Perry County Memorial Hospital	Superior Air-Ground Ambulance Service Inc
Greenfield FD	Pike County EMS	Switzerland County EMS, Inc
Henry County EMS	Pike Township FD	Terre Haute FD
Hobart FD	Pittsboro Middle Township FD, Inc	The Methodist Hospitals, Inc
Indiana University Health Paoli Hospital EMTS	Porter Memorial Hospital EMS	Three Rivers Ambulance Authority
Jackson Township FD (Arcadia)	Posey County EMS (Mount Vernon)	Tippecanoe Emergency Ambulance Service
Keener Township EMS	Prompt Ambulance Central, Inc	Town of Plainfield / Plainfield FD
King's Daughters' Health EMS	Pulaski County EMS	Turkey Creek Fire Territory
Ladoga Rescue Inc	Richmond FD	Union City FD (Indiana)
LaPorte County EMS	Riley FD	Wabash FD
Lawrenceburg Emergency Rescue	Ripley County EMS	Warren County EMS (Williamsport)
Lutheran Hospital of Indiana	Rising Sun - Ohio County Rescue	Washington County Ambulance Service
Madison Township VFD (Camby)	Rocky Mountain Holdings, LLC DBA Lutheran Air	Washington Township / Avon FD
Marion General Hospital Ambulance Service	Rush Memorial Hospital	Wayne Township FD (Indianapolis)
Memorial Hospital Ambulance	Scott County EMS (Scottsburg)	Wayne Township VFD (Noblesville)
Memorial Medflight	Scott Township VFD Inc (Evansville)	Wells County EMS, Inc
Middlebury Township FD	Seals Ambulance Service	Westfield FD
Milan Rescue 30	Shelbyville FD	White River Township FD (Greenwood)
Mooreville FD	South Bend FD	Whitley County EMS
Morocco Volunteer Fire Department	South Haven FD	Zionsville VFD Inc
Multi-Township EMS	Southern Ripley County Emergency Life Squad	
New Castle / Henry County EMS	Speedway FD	
Noblesville FD	Spencer County Emergency Ambulance Service, Inc	
North East Allen County Fire & EMS	St Clair Precision Ambulance LLC	
North Webster / Tippecanoe Township EMS	St Mary's Lifeflight	
Osolo Emergency Medical	St Marys Warrick EMS	



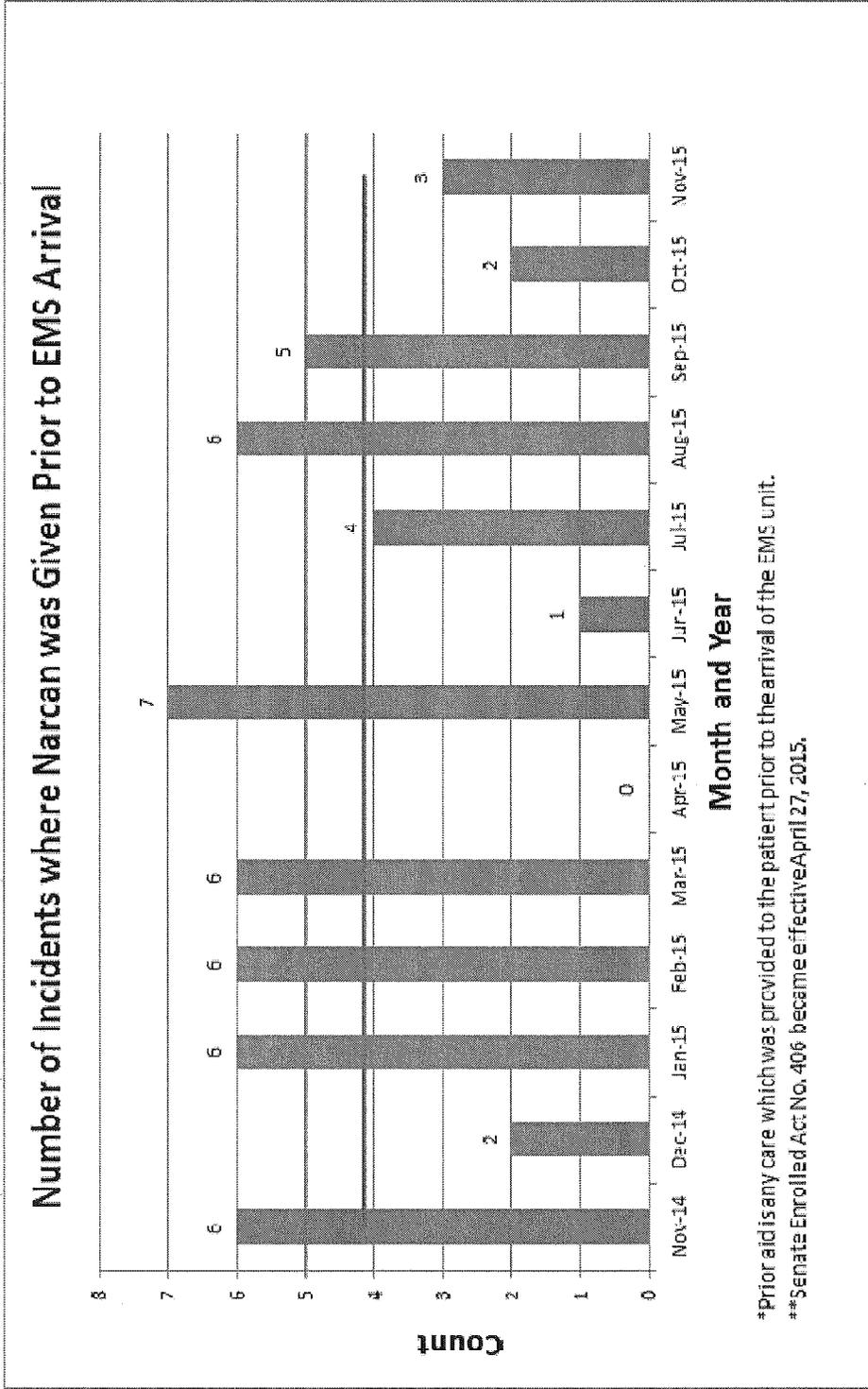
Indiana State
Department of Health

ISDH Division of Trauma and Injury Prevention
Narcan Reports

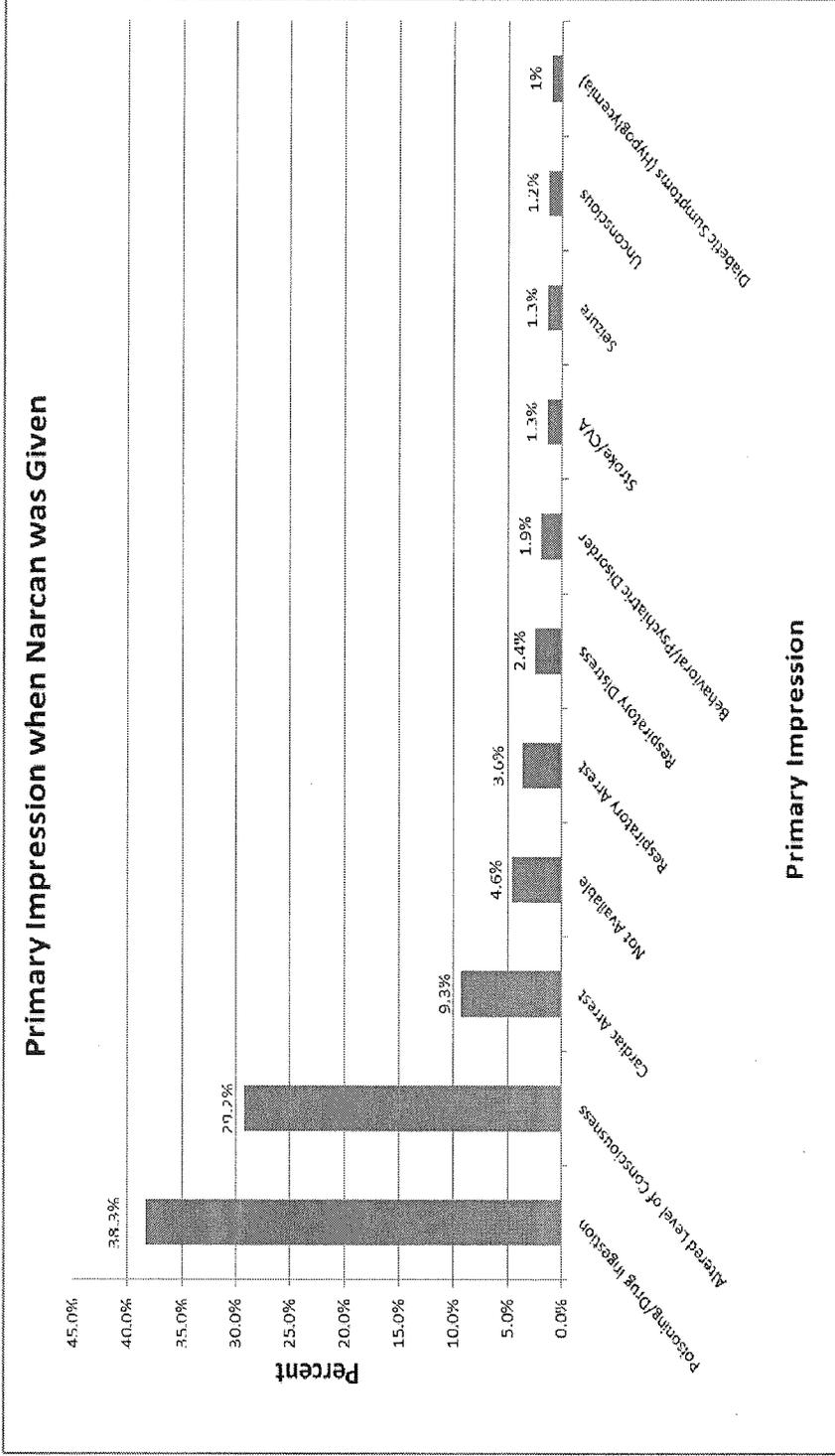
Narcan Given by EMS



Prior Aid



Provider's Primary Impression



*The following responses had <1% each: abdominal pain/problems, airway obstruction, allergic reaction, back pain (non-traumatic), cardiac rhythm disturbance, chest pain/discomfort, diarrhea, ETOH abuse, electrocution, fever, hypotension, hypothermia, hypovolemia/shock, not applicable, not known, obvious death, other, sepsis, substance/drug abuse, syncope/fainting, traumatic injury, unknown problem, weakness.

Hilton, Candice

From: Hokanson, Katie
Sent: Monday, November 23, 2015 1:16 PM
To: Hilton, Candice
Cc: Logsdon, Art
Subject: FW: Narcan report for EMS Commission
Attachments: ISDH Narcan Report.pdf

Candice,

Attached is the Narcan report we will be presenting at the December EMS Commission meeting. We also have 3 "In the Process of ACS Verification" applications that the State Health Commissioner will be recommending to the EMS Commission:

- Reid Health – Level III trauma center
- Franciscan St. Anthony – Crown Point – Level III trauma center
- Terre Haute Regional – Level II trauma center

Thanks,
~Katie

From: Hess, Camry
Sent: Monday, November 23, 2015 1:03 PM
To: Hokanson, Katie <KHokanson@isdh.IN.gov>
Subject: Narcan report for EMS Commission

Hi,

Please see the attached narcan report for the December EMS Commission meeting.

Camry Hess

CAMRY HESS, MPH
Database Analyst Epidemiologist

Trauma and Injury Prevention
Indiana State Department of Health
317.234.3265 office
317.233.8199 fax
Chess1@isdh.in.gov
www.StateHealth.in.gov



Attachment #2



MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

**EMERGENCY MEDICAL SERVICES COMMISSION
TECHNICAL ADVISORY COMMITTEE MEETING SUMMARY**

DATE: November 10, 2015 10:00 a.m.

LOCATION: Noblesville Fire Department, Station 77
15251 Olio Road
Noblesville, IN 46060

PRESENT: Leon Bell, Chairman, ALS Training Institute
Sherry Fetters, Vice Chairman, EMS Chief Executive Officer
Jessica Lawley, ALS Training Program Director
Michael McNutt, BLS Training Program Director
Faril Ward, EMS Chief of Operating Officer
Charles Ford, EMS Chief Executive Officer
Michael Cole, First Responder Training Director
Edwin Eppler, EMS Medical Director

NOT PRESENT: Elizabeth Weinstein, EMS for Children
Jaren Kilian, ALS Training Program Director
Michael Gamble, Emergency Department Director

OTHERS PRESENT: John Zartman, EMS Commissioner, EMS State Director Michael Garvey, other IDHS Staff, Kraig Kinney, and Dr. Michael Olinger



- A) Meeting called to order at 10:15 a.m. by Chairman Leon Bell.
- B) Quorum present
- C) Adoption of minutes:
 - a. September 01, 2015 minutes

A motion was made by Mr. Faril Ward to approve the minutes from the September 1, 2015 meeting as written. The motion was seconded by Mr. Michael Cole. The motion passed, minutes were approved.

New Technical Advisory Committee member Michael Cole was introduced to the group. Mr. Cole is the chief paramedic with Jennings County EMS. Mr. Cole stated in the volunteer fire service in 1994. He started with his career at Sugar Creek FD for three years prior to starting work with Jennings County EMS.

- D) Public Comment: None
- E) Announcements:
 - a. Proposed TAC meeting dates for 2016:
 1. January 5, 2016
 2. March 1, 2016
 3. May 10, 2016
 4. July 12, 2016
 5. September 13, 2016
 6. November 1, 2016

All above dates were approved by the TAC members that were present. Ms. Candice Hilton will send out calendar invites to all the members for the 2016 meetings.

- b. Commission Staff Report:

Ms. Robin Stump, Ms. Candice Hilton, and Mr. Tony Pagano reported regarding the last EMS Commission meeting. Ms. Hilton stated that there were no new assignments from the Commission to the TAC. All three staff members reported that the Commission meeting was short and that there was nothing major to report. The Primary Instructor process was discussed at the Commission meeting but nothing was decided.

Ms. Stump reported that the Governor's office has put together three different task forces in regards to Narcan use. The IDHS EMS staff has been asked to compile a report for the Governor's office.

- F) Old Business
 - a. Review the Primary Instructor Written exam
 - i. Mr. Tony Pagano opened discussion on the PI written exam. Mr. Pagano stated that the group that was assigned to look at the exam has met and reviewed the exam. Students are doing well on the new exam. Extensive discussion followed regarding the passing grade, if it needs to be raised back to 80% or left at 75%. Included in the discussion was how the Primary Instructor course should be taught. Mr. Michael McNutt stated that the Primary Instructor curriculum needs to be taught not the text book.

An extensive discussion also took place in regards of the possibility of a central course and not letting just anyone teach the PI course.

A sub-group was appointed to look at the criteria for teaching a Primary Instructor course. This sub-group will consist of Mrs. Jessica Lawley - chair, Mr. Michael McNutt and people from the Education working group. This group was asked to have recommendations for the next TAC meeting.

A motion was made by Vice Chairman Sherry Fetters to raise the PI written exam passing score back to 80% in 2016. The motion was seconded by Mr. Faril Ward. The motion passed unanimously.

A motion was made by Mr. Charles Ford to let Primary Instructor classes take place in 2016 but also have one central group class sponsored by the State. At the end of 2016 compare the test results of all other PI courses to the one central group class. The motion was seconded by Mr. McNutt. The motion passed unanimously.

Chairman Bell called for a short break at 11:35 am

Chairman Bell reconvened the meeting at 11:45am

- b. P.I. Pass procedures/ Initial certification process (see attachment #1) Mr. Kraig Kinney presented a power point to the TAC to outline a recommended PI initial certification process. An extensive discussion followed and adjustments to the power point were made.

A motion was made by Mr. McNutt to make the passing grade for the Pre-primary instructor written exam (EMT written exam) and the Primary Instructor written exam both 80% for any courses that are started after January 1, 2016. The motion was seconded by Vice chairman Fetters. The motion passed unanimously.

- c. Develop tool for reporting of waivers by provider organizations (see attachment #2) - Vice Chairman Fetters presented the waiver tool.

A motion was made by Mr. McNutt to send the waiver tool to the Commission for approval and that field staff send out and test the waiver tool until the next TAC meeting. At the next TAC meeting if changes need to be made those changes will be recommended at that time. The motion was seconded by Mr. Ward. The motion passed unanimously.

- d. PI Manual updated – two TAC members were assigned to help with the manual review.
- e. Glucometer monitoring for BLS levels (see attachment #3) - Dr. Sara Brown briefly discussed the Connecticut power point and skill sheets. Mr. Pagano stated that Connecticut gave their permission to use the power point and skill sheets as long as they were given credit. The TAC voted to accept the power point and

skill sheets pending getting permission from Connecticut to use their material at the last meeting.

G) New Business – no new business to discuss at this meeting.

With no further business needing to be discussed a motion was made by Mr. Michael Cole to adjourn the meeting. The motion was seconded by Mr. Faril Ward. The motion passed. The meeting was adjourned at 1:03 pm.

Approved _____

Leon Bell, Chairman

RF

Service Name:

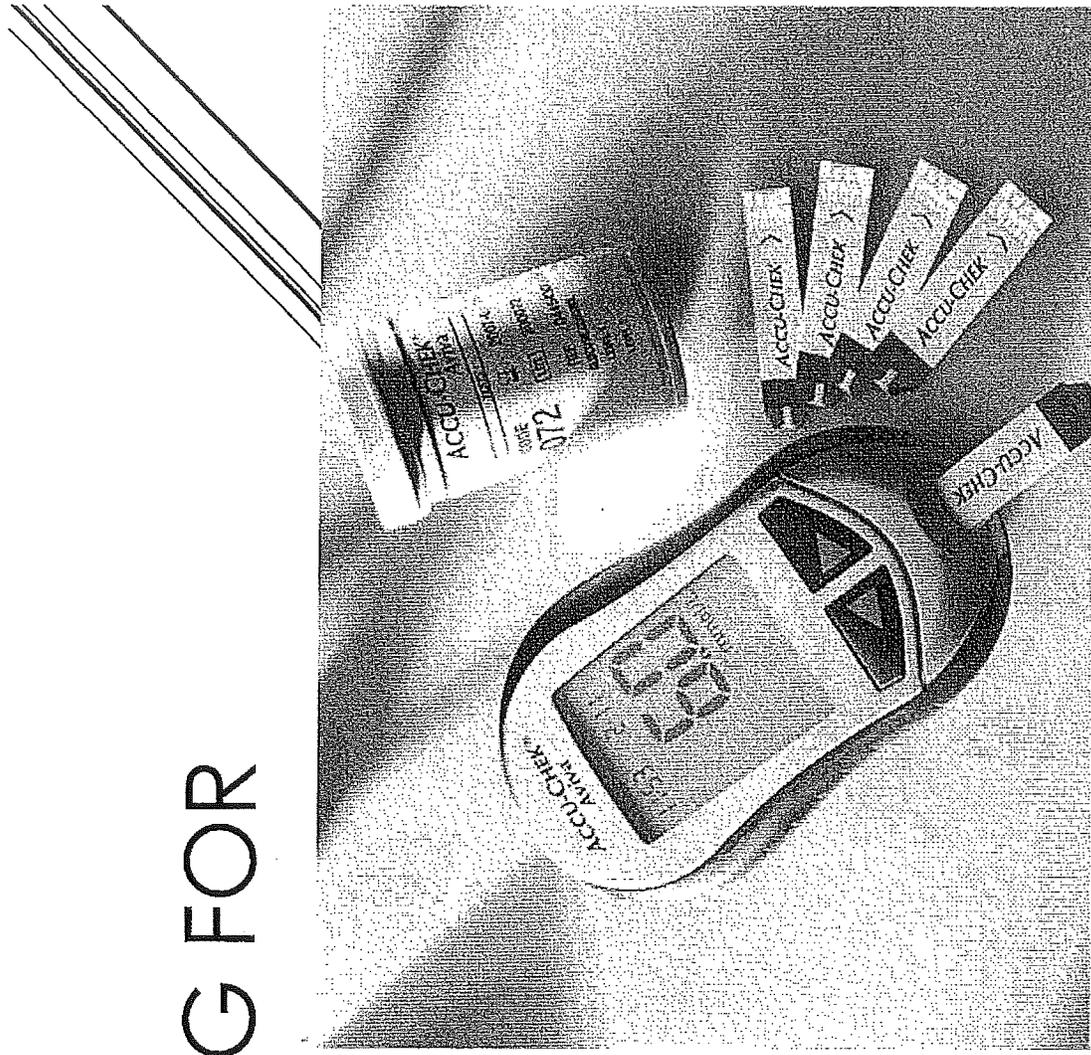
Provider Number:

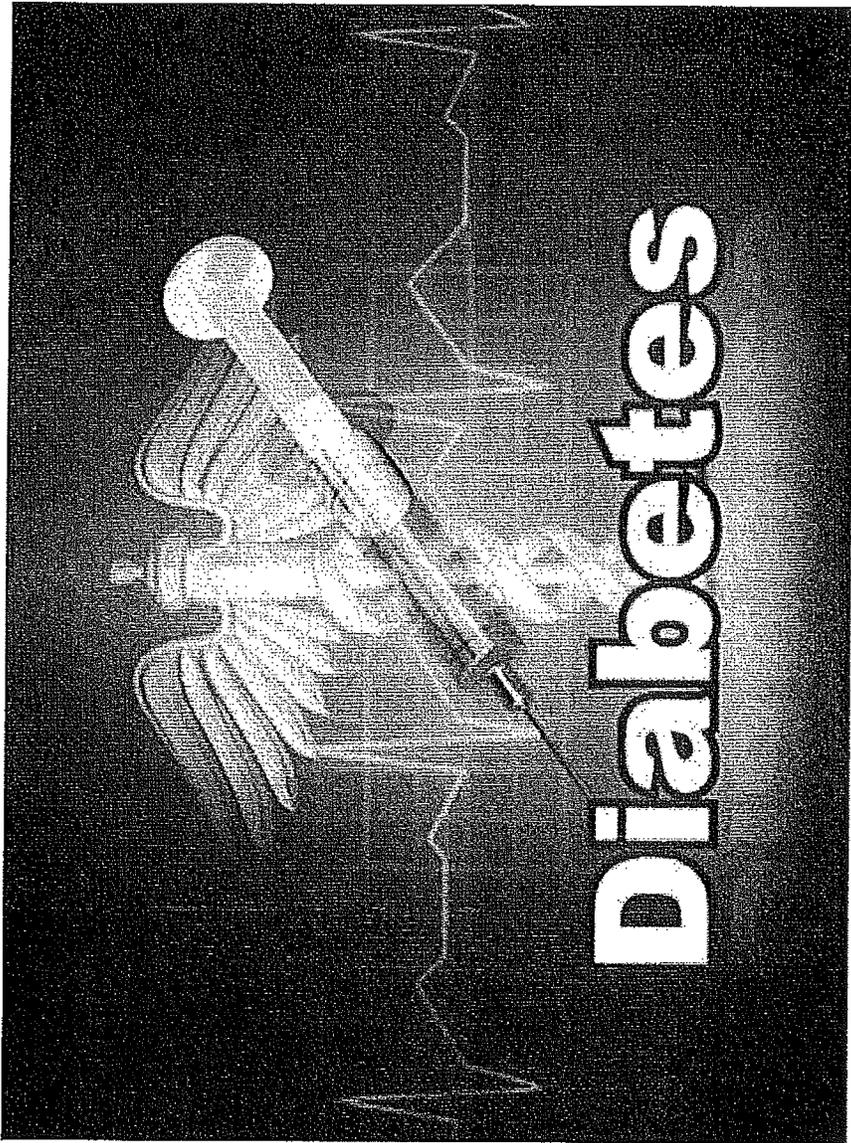
Rule waived:

Date	Time	Amount of time	Steps implemented to avoid implementing waivers
1/1/2015			
1/2/2015			
1/3/2015			
1/4/2015			
1/5/2015			
1/6/2015			
1/7/2015			
1/8/2015			
1/9/2015			
1/10/2015			
1/11/2015			
1/12/2015			
1/13/2015			
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GLUCOSE TESTING FOR EMT AND EMR

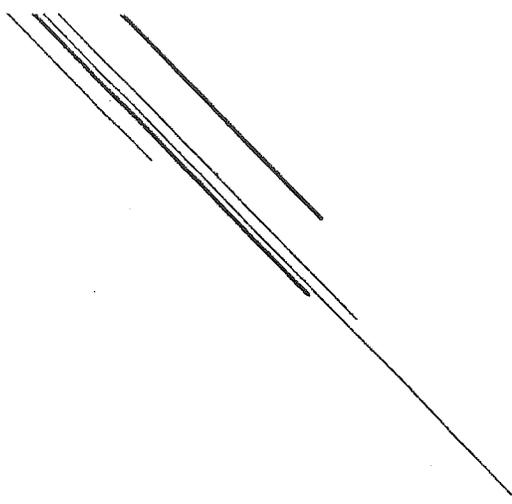




UNDERSTANDING THE DISEASE

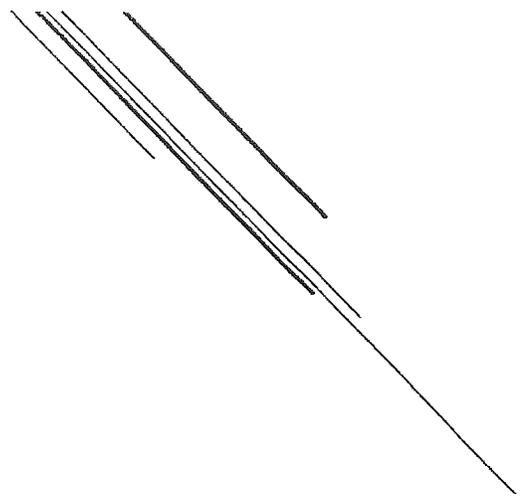
- ▶ Glucose is the fuel for all cellular basic energy needs.
- ▶ Some cells can use fats, too, for energy
- ▶ In order for MOST cells to utilize glucose, there needs to be insulin present.

CELLULAR METABOLISM



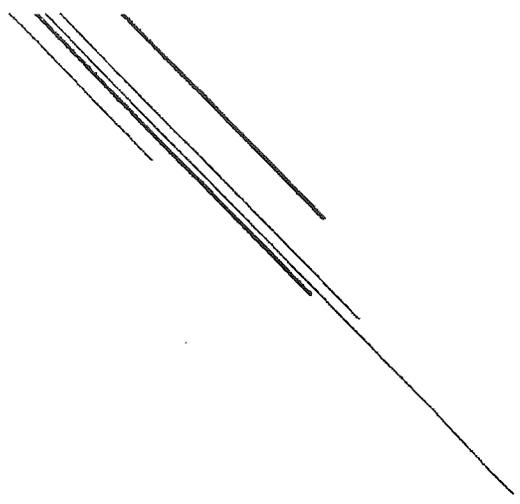
- ▶ Infant 40 – 90
- ▶ Child < 2 Years 60 – 100
- ▶ Child > 2 Years 70 – 105
- ▶ Adult 70 – 105

NORMAL BLOOD GLUCOSE FINDINGS



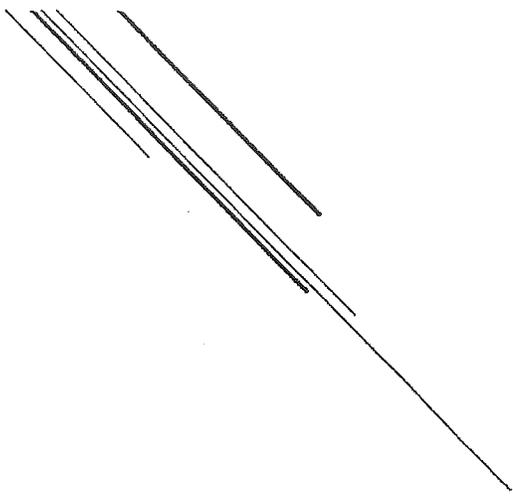
- ▶ Diabetes mellitus
- ▶ Acute stress response
- ▶ Steroid therapy
- ▶ Other

CAUSES OF ELEVATED BLOOD GLUCOSE



- ▶ Insulin overdose
- ▶ Lack of calorie intake
- ▶ Insulin tumor
- ▶ other

CAUSES OF LOW BLOOD GLUCOSE



Low blood glucose

- ▶ Normal or rapid respirations
- ▶ Pale, moist skin
- ▶ Sweating
- ▶ Dizziness, headache
- ▶ Rapid pulse
- ▶ Normal to low blood pressure
- ▶ Altered mental status, aggressive, confused, lethargic, or unusual behavior
- ▶ Anxious or combative behavior
- ▶ Seizure, fainting, coma
- ▶ Weakness on one side of the body (may mimic stroke)

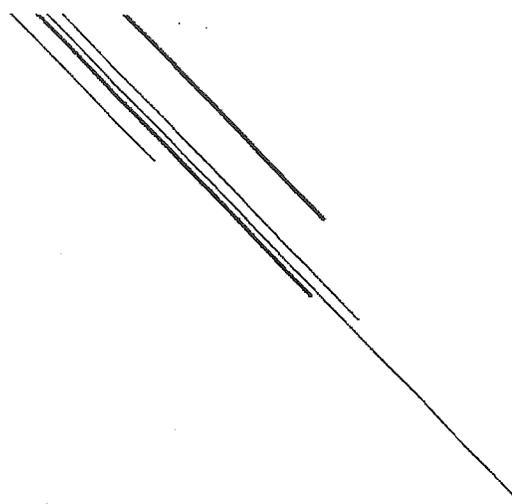
High blood glucose

- ▶ Deep, rapid respirations
 - ▶ Kussmaul
- ▶ Dry skin, sunken eyes
- ▶ Sweet or fruity odor on breath
- ▶ Rapid, weak pulse
- ▶ Normal or slightly low blood pressure
- ▶ Varying degrees of unresponsiveness

CLINICAL PRESENTATION

- ▶ Insulin and oral medication use
- ▶ Last meal
- ▶ Vomiting
- ▶ Other symptoms

ASSESSMENT



- ▶ Scene size up and body substance isolation
- ▶ Initial assessment
- ▶ Determine need for rapid transport
- ▶ Focused history and physical assessment with vitals
- ▶ Blood glucose check
- ▶ If glucose < 80 with symptoms of low blood glucose and responsive (in control of own airway) administer oral glucose or glucose containing food
- ▶ If glucose < 80 with symptoms of low blood glucose and **UN**responsive (**NOT** in control of own airway) , supportive care and get the patient to ALS care or hospital.
- ▶ Monitor level of consciousness and blood glucose level
- ▶ Supportive care in transport

TREATMENT OF LOW BLOOD GLUCOSE

- ▶ Scene size up and body substance isolation
- ▶ Initial assessment
- ▶ Determine need for rapid transport
- ▶ Focused history and physical assessment with vitals
- ▶ Blood glucose check
- ▶ If glucose > 200 transport to emergency department
- ▶ Consider ALS if vital signs are abnormal
- ▶ Monitor level of consciousness and blood glucose level
- ▶ Supportive care in transport

TREATMENT OF **HIGH** BLOOD GLUCOSE

Altered level of consciousness in any patient

Shakiness, weakness

Rapid pulse and respiratory rate

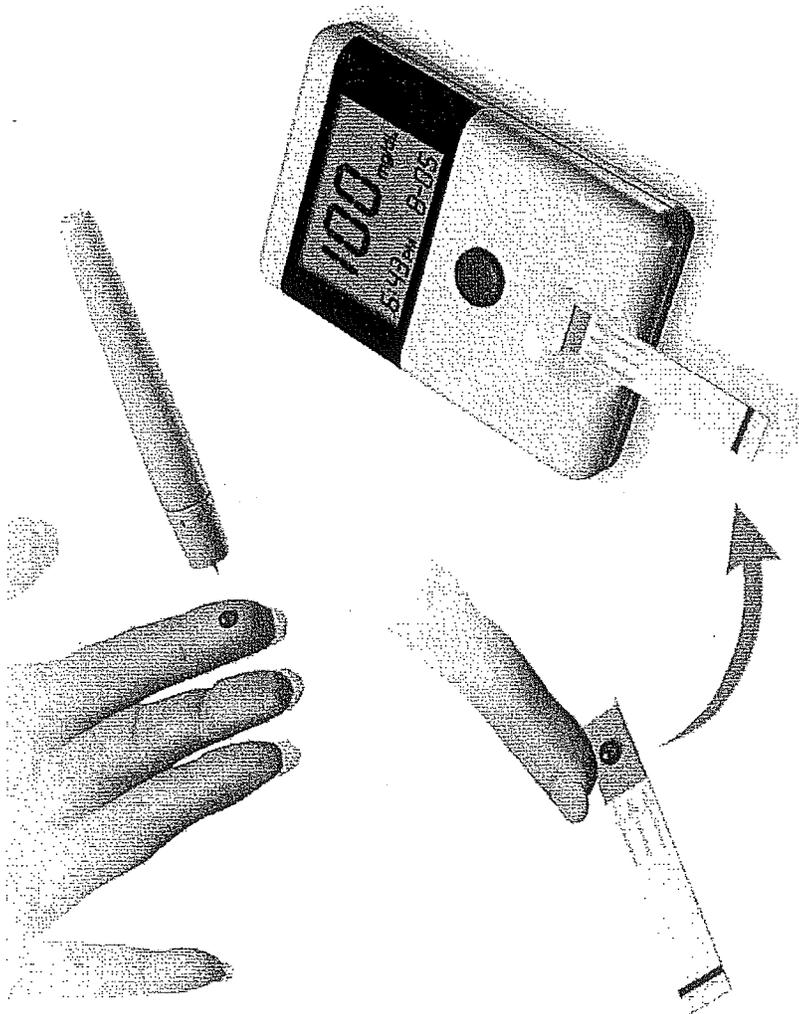
Neurologic deficit (Stroke symptoms)

Seizures

Known diabetic

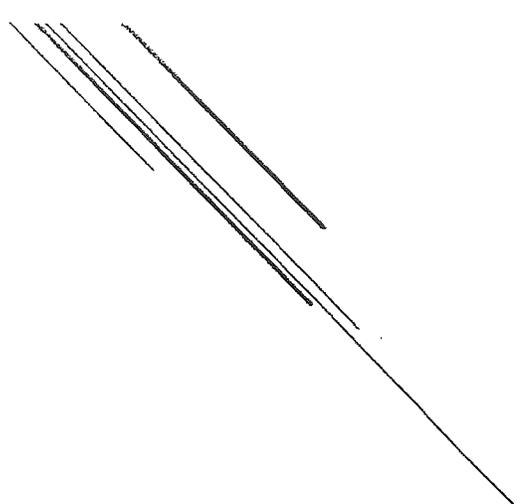
INDICATION FOR BLOOD GLUCOSE
MONITORING

PROCEDURE



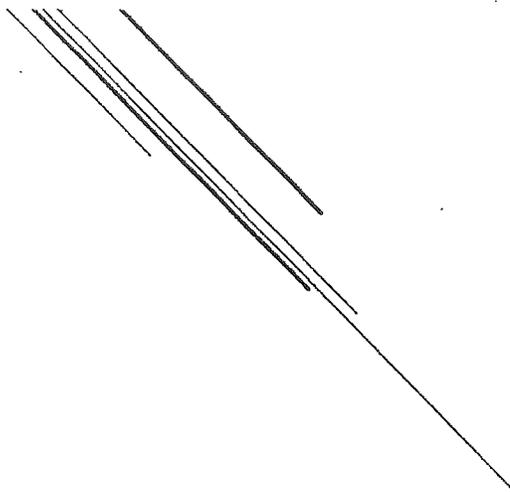
- ▶ Refer to department infection control plan
- ▶ Generally should wear exam gloves

BODY SUBSTANCE ISOLATION PROCEDURES



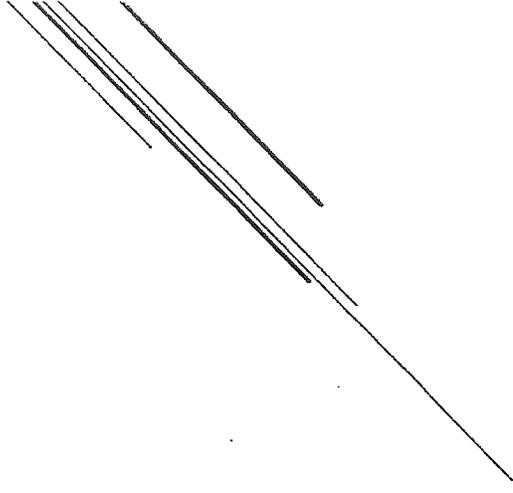
- ▶ Exam gloves
- ▶ Alcohol prep pads
- ▶ Glucometer
- ▶ Test strips
- ▶ Cotton balls / gauze / Band-Aid
- ▶ Lancets
- ▶ Sharps container

EQUIPMENT NEEDED



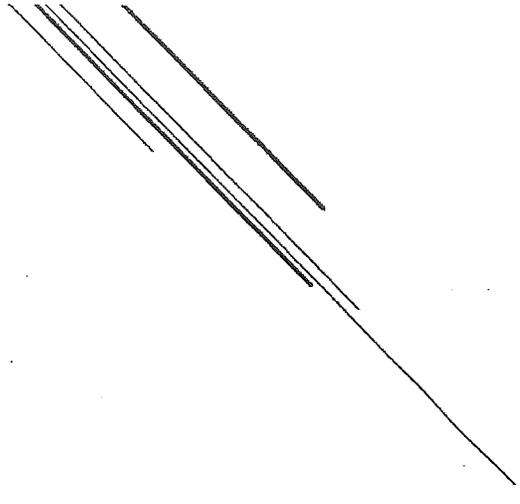
- ▶ Adult and children over 1 year
 - ▶ Fingers, 3rd or 4th on the palmar side
 - ▶ Central fleshy areas

IDENTIFY APPROPRIATE PUNCTURE SITE



- ▶ Cleanse with 70% isopropyl alcohol, using a scrubbing / circular motion
 - ▶ Do NOT use iodine
 - ▶ Allow alcohol to dry

PREPARATION OF THE SITE

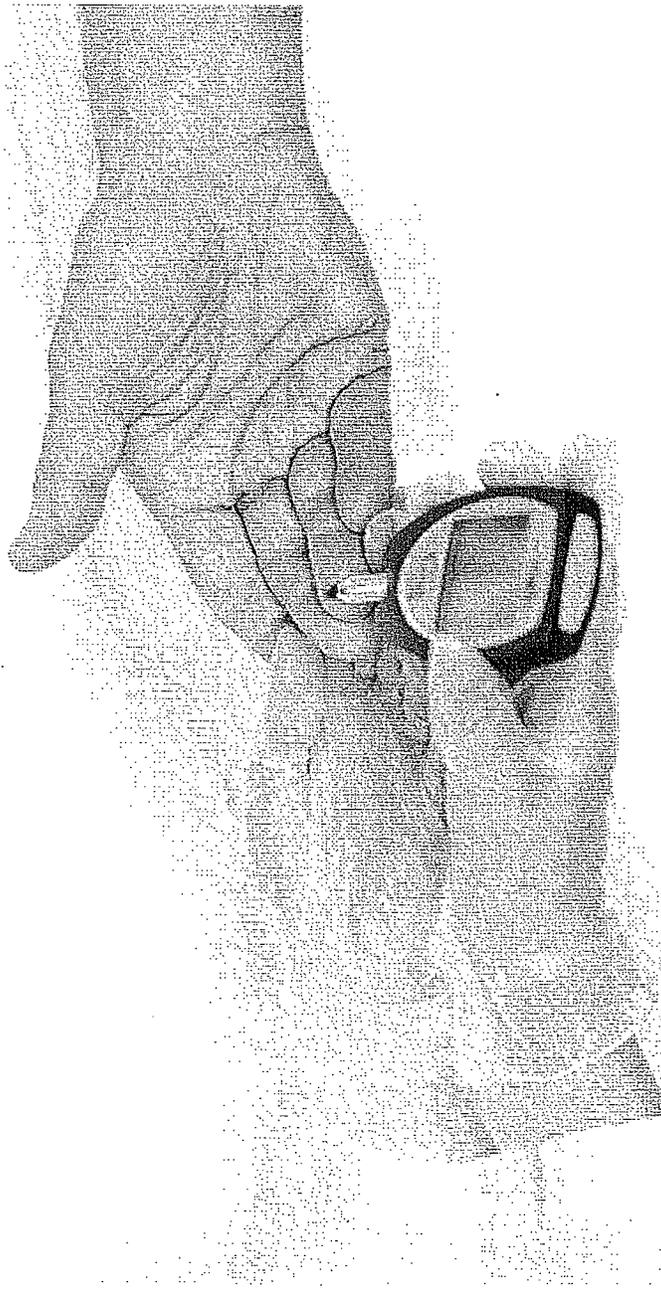


**You must read manufacturer's instructions for
your *particular* glucometer**

- ▶ Load test strip into meter
- ▶ Glucometer must be set for the test strip code to ensure an accurate test

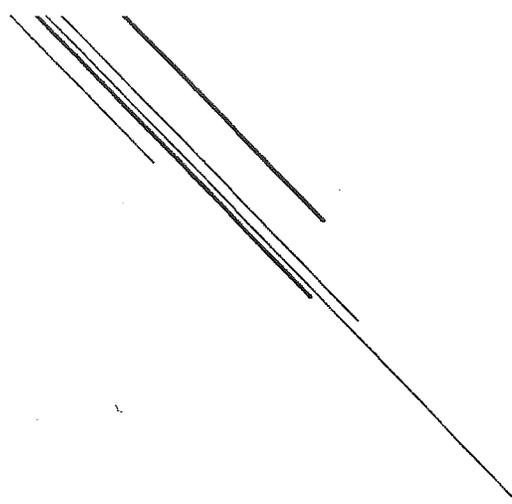


PREPARE GLUCOMETER



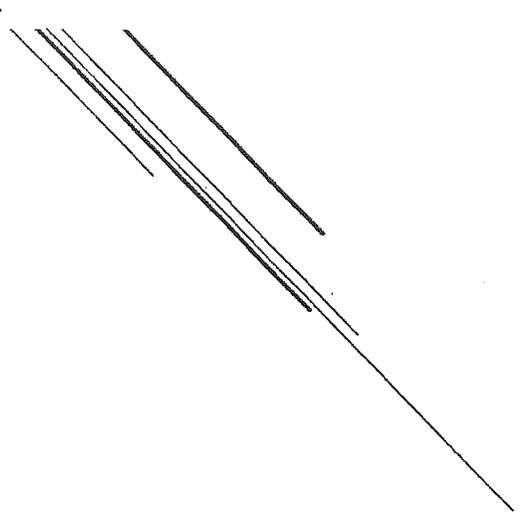
- ▶ Use lancet to stick the site prepared and form a small drop of blood
- ▶ Apply blood drop to the test strip

ACQUIRE BLOOD SPECIMEN



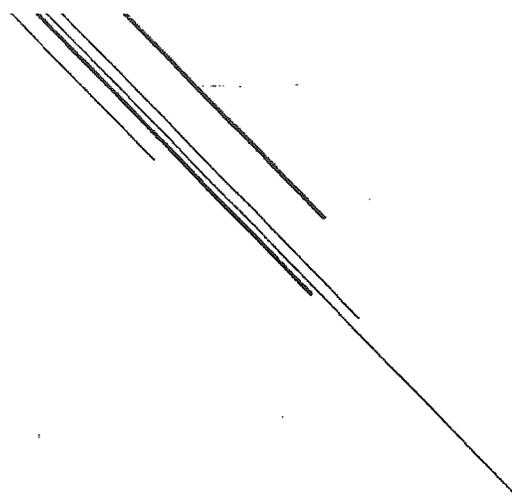
- ▶ Hold pressure to the side with cotton ball or gauze and secure
- ▶ Record blood glucometer reading

AFTER TEST CARE AND PROCEDURE



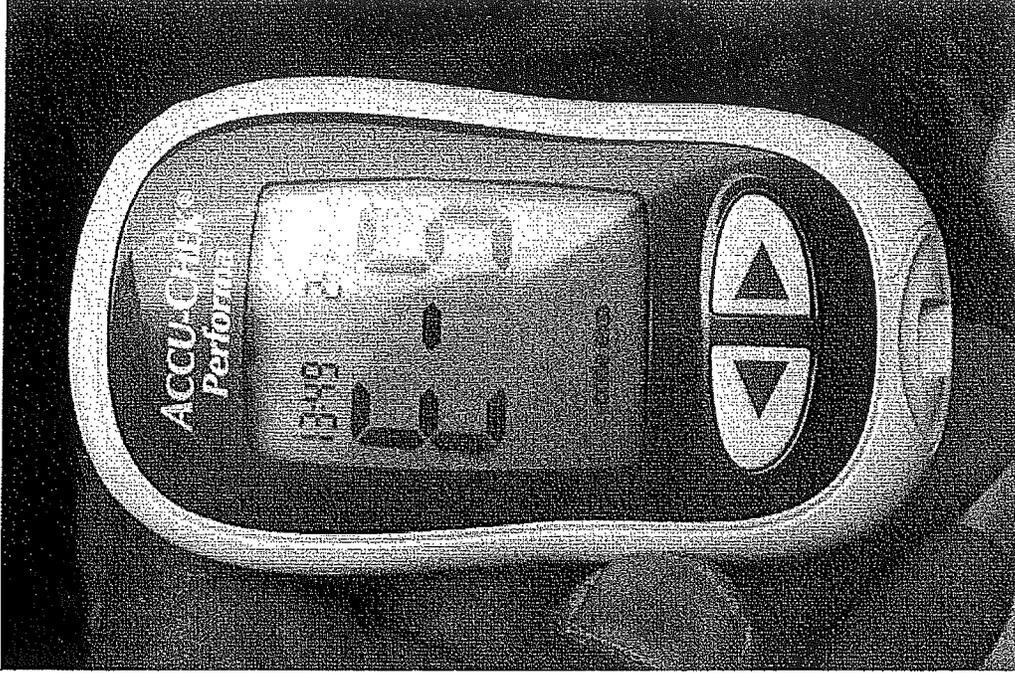
- ▶ Test strip batch number
 - ▶ See manufacturer's instructions
- ▶ Expiration date
- ▶ Meter calibration

METER SET UP

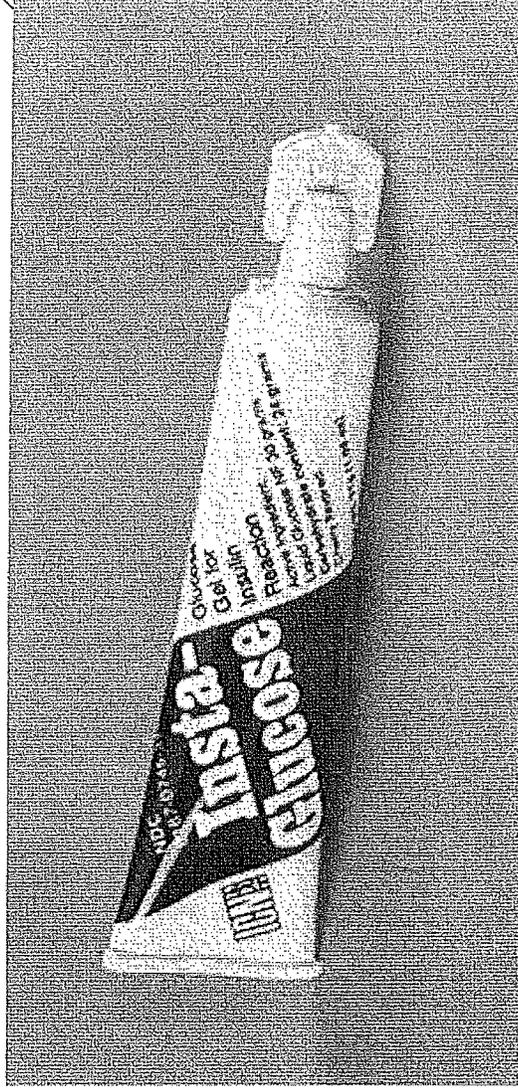


- ▶ Display codes indicate malfunction
 - ▶ See manufacturer instructions
- ▶ Battery failure
- ▶ Test strip batch number
- ▶ "Out of Range"
 - ▶ Consider repeating test
 - ▶ May be extremely high or extremely low blood glucose
- ▶ "Lo"
 - ▶ Less than 20
- ▶ "Hi"
 - ▶ Greater than 500 - 600

METER AND TESTS STRIP PROBLEMS

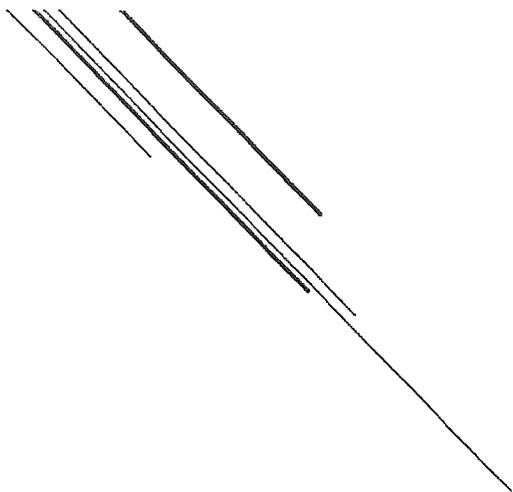


- ▶ Oral glucose
- ▶ Indications
 - ▶ Altered mental status
 - ▶ Blood glucose reading below normal
- ▶ Contraindications
 - ▶ Unresponsive patient
 - ▶ Patients who cannot swallow or maintain their airway
- ▶ Dosage
 - ▶ One tube
 - ▶ May need to be repeated
- ▶ Route
 - ▶ Between cheek and gum



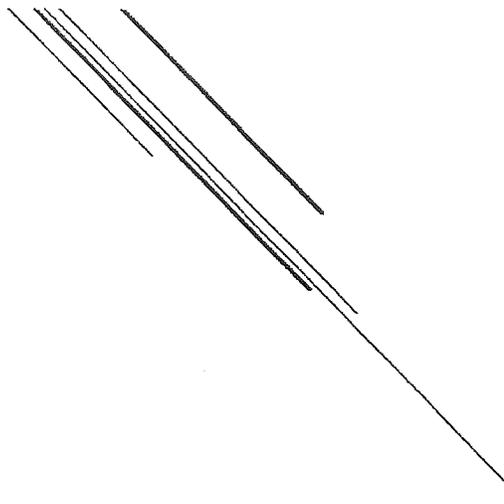
GLUCOSE ADMINISTRATION

CASE # 1



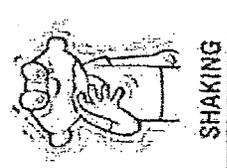
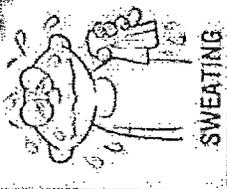
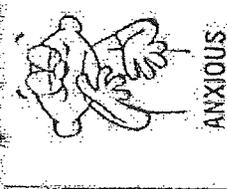
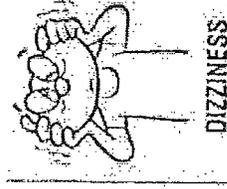
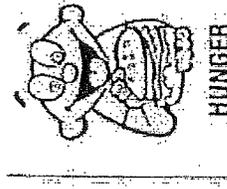
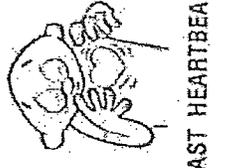
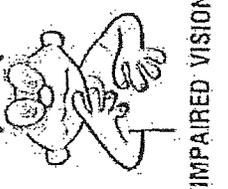
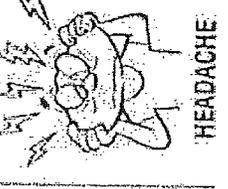
- ▶ Call for insulin reaction
- ▶ 44 year old female
- ▶ Giddy and nervous
- ▶ Insulin dependent diabetic
- ▶ Family reports she had her insulin today but has not eaten

CASE #1

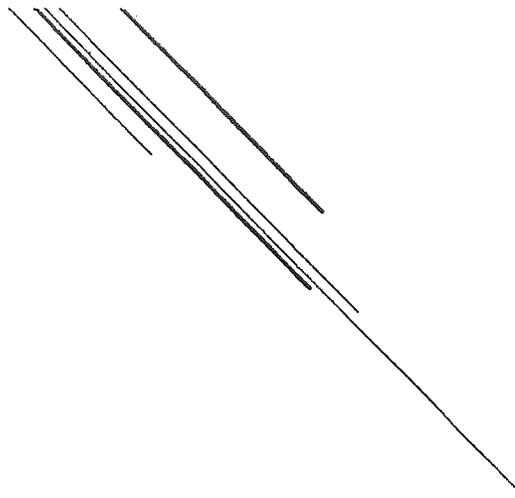


▶ Blood glucose reading shows 40 mg/dl

CASE #1 TREATMENT

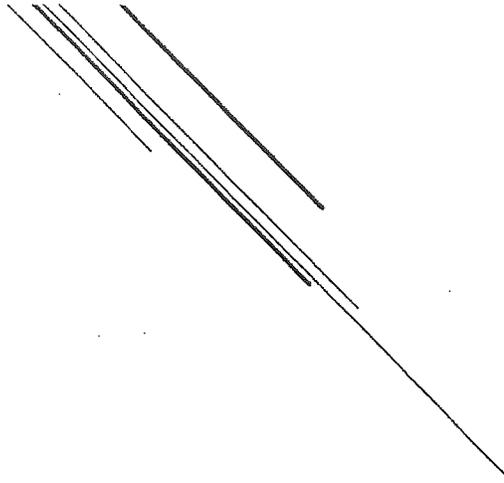
 SHAKING	 SWEATING	 ANXIOUS	 DIZZINESS	 HUNGER
 FAST HEARTBEAT IMPAIRED VISION	 WEAKNESS FATIGUE	 HEADACHE	 IRRITABLE	

CASE #2



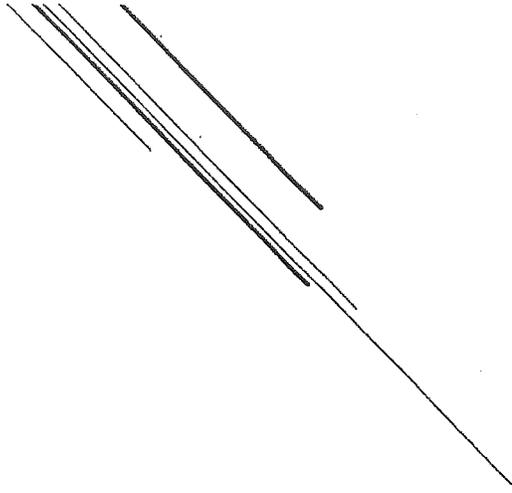
- ▶ Call for unconscious subject at a business
- ▶ 22 year old male
- ▶ Supine on floor unresponsive
- ▶ Vomitus on floor beside him and around his mouth
- ▶ Breathing on his own with strong pulse
- ▶ No medic alert tag

CASE #2

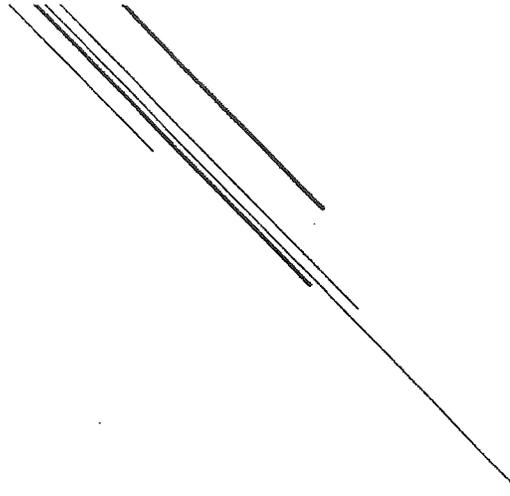


▶ Blood glucose reading of "Lo"

CASE #2 TREATMENT

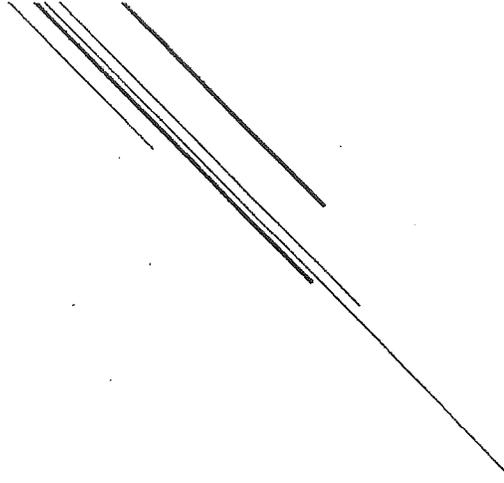


CASE #3



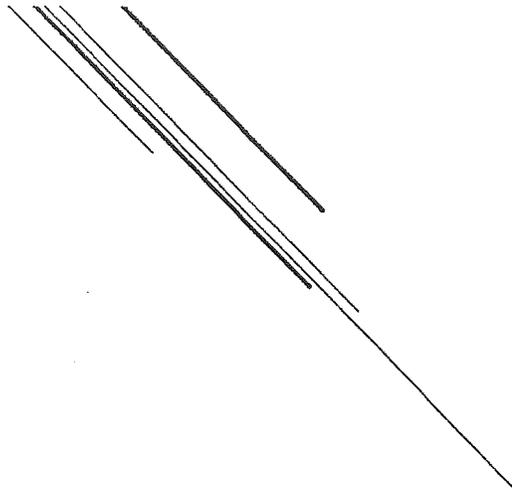
- ▶ MVC
- ▶ Elderly patient driver
- ▶ Single vehicle off the road against a tree
- ▶ Unresponsive but no signs of injury to patient
- ▶ Vitals stable

CASE #3

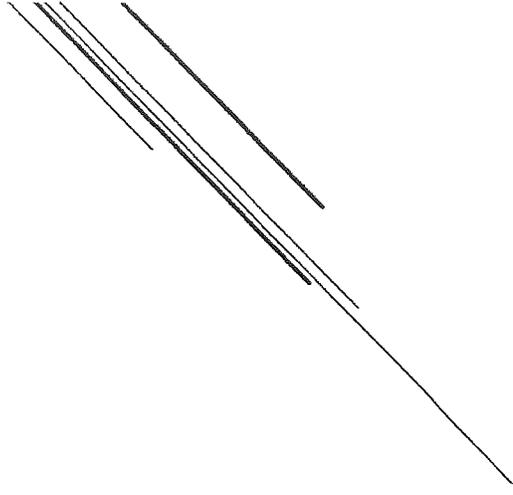


▶ Blood glucose reading of 22

CASE #3 TREATMENT

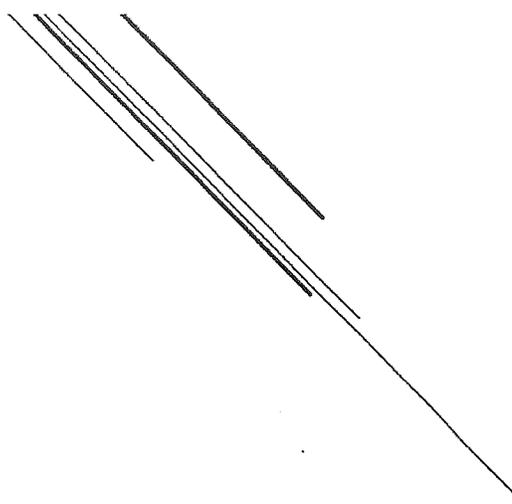


CASE #4



- ▶ Unresponsive diabetic at home
- ▶ 77 year old female
- ▶ Breathing shallow
- ▶ Skin warm and dry
- ▶ Vitals normal
- ▶ Ate today but unknown if she took insulin

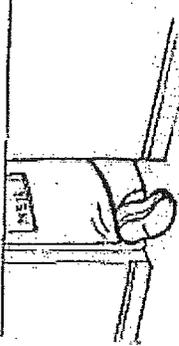
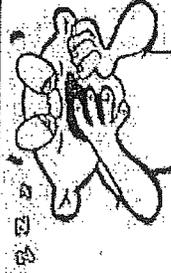
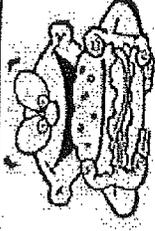
CASE #4



- ▶ Blood glucose "Hi"

CASE #4 TREATMENT

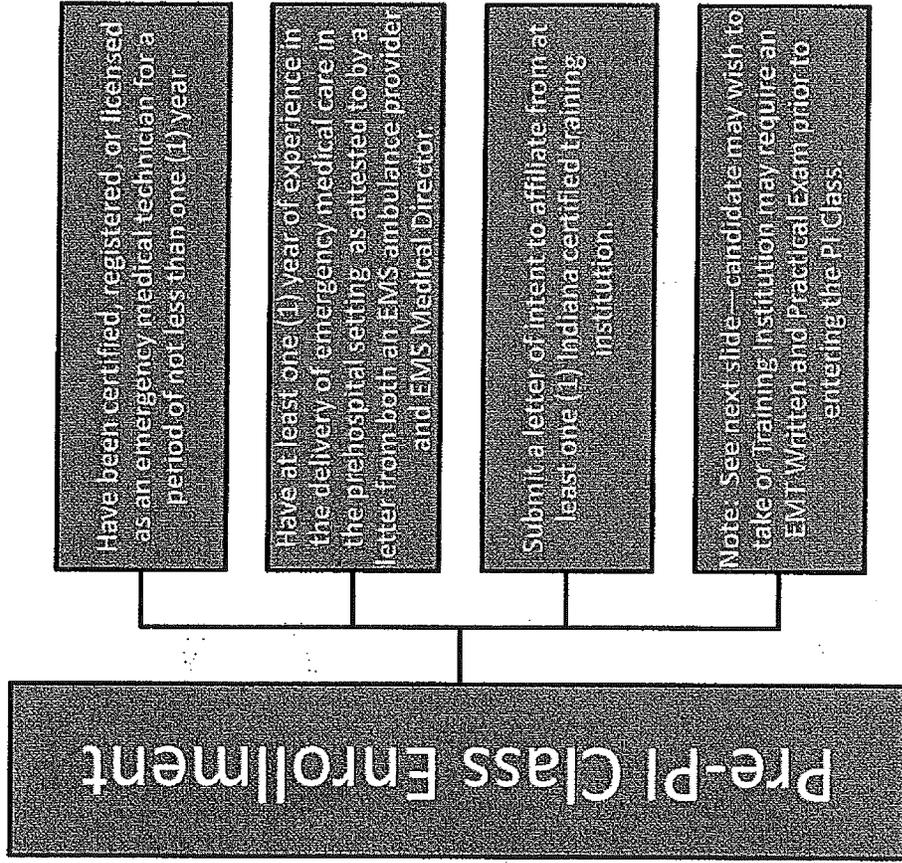
Symptoms

 FREQUENT URINATION	 DRY SKIN	 EXTREME THIRST
 BLURRED VISION	 DROWSINESS	 HUNGER
		 NAUSEA

Indiana Primary Instructor Certification Process

Developed by the Indiana EMS
Education Workgroup and TAC as
approved by the TAC & EMS
Commission on _____

Indiana EMS Primary Instructor Certification – Class Trained

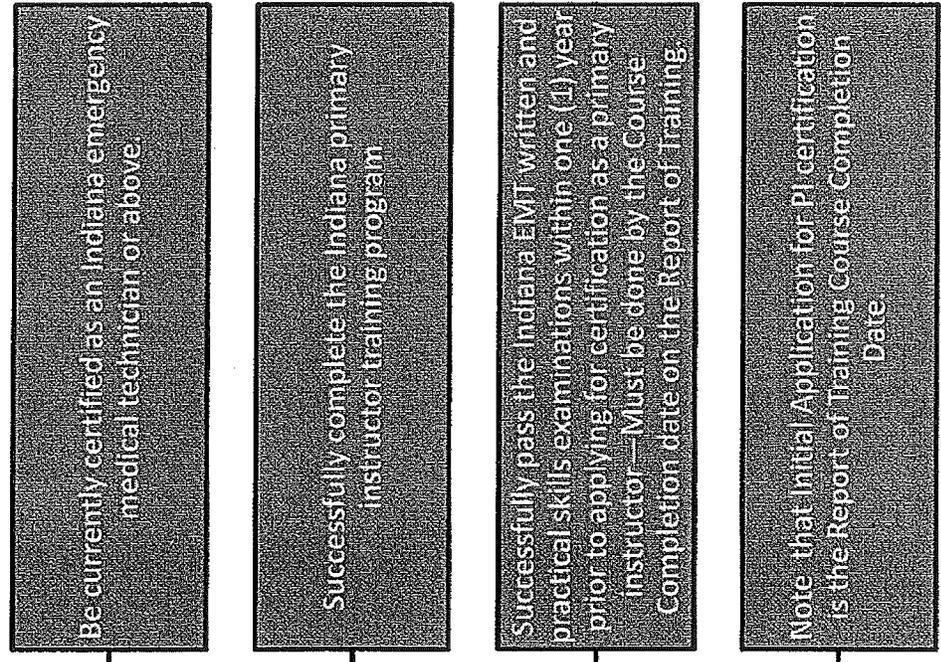


Source: 836 IAC 4-5-1

Step 1

Indiana EMS Primary Instructor Certification – Class Trained

PI Class Completion Requirements



EMT Written:
Two (2) attempts before (not to exceed a year in advance) the Course Completion Date.

EMT Practical:
One single (1) Attempt cycle before (not to exceed a year in advance) the Course Completion Date.

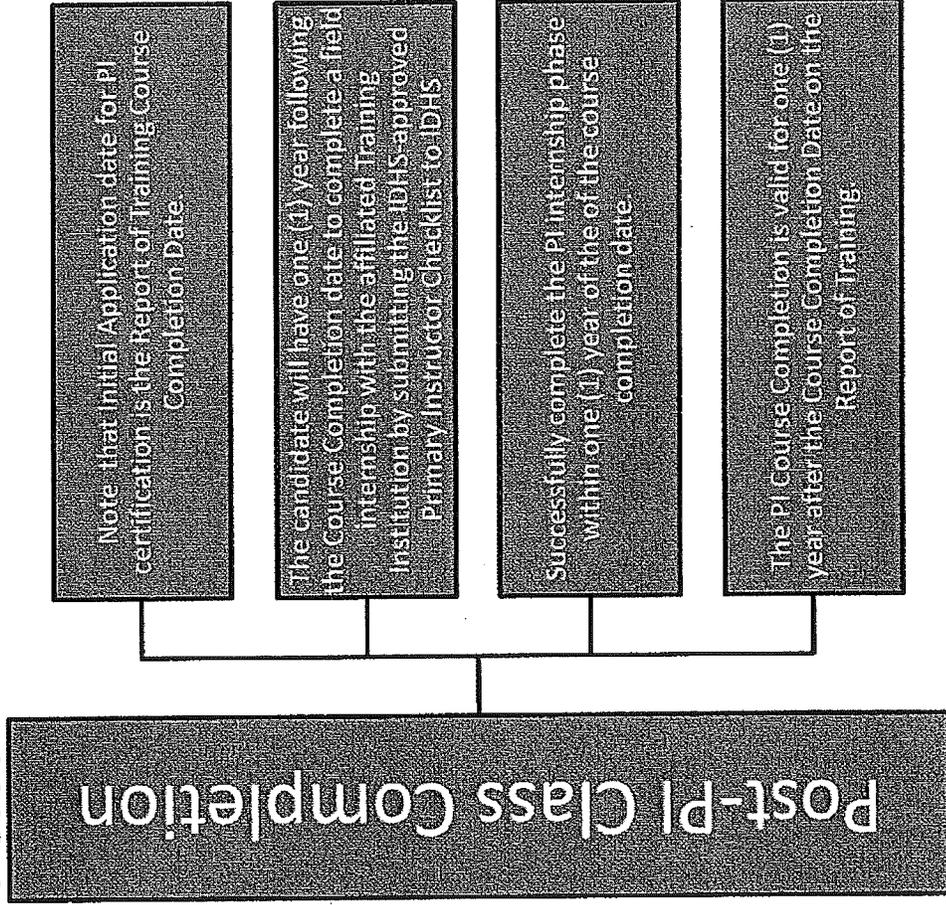
Step 2

Source: 836 IAC 4-5-2 and EMS Commission policy

Notes—Successful PI Class Process

- The Primary Instructor (PI) Course must be approved by IDHS and be based on the national curriculum for EMS Educators.
 - The Course Completion Date on the Report of Training is always the candidate's "Application Date" for purposes of certification.
 - EMT Written: Two (2) attempts before (not to exceed a year in advance) the Course Completion Date.
 - The PI Candidate must have an 80% pass rate on the current Indiana EMT written examination.
 - Candidates can either be issued a testing ID by IDHS with the submission of the PI Class Roster or contact IDHS for a "Challenge" ID.
 - EMT Practical: One single (1) Attempt before (not to exceed a year in advance) the Course Completion Date.
 - Note that a single "Attempt" means one process which could include re-tests so long as four of the EMT stations are passed on the initial attempt and no single station may be attempted more than three (3) times total.
 - There is only one attempt per PI Course attempt/enrollment.
-

Indiana EMS Primary Instructor Certification – Class Trained



Source: 836 IAC 4-5-1 and EMS Commission Policy

Step 3

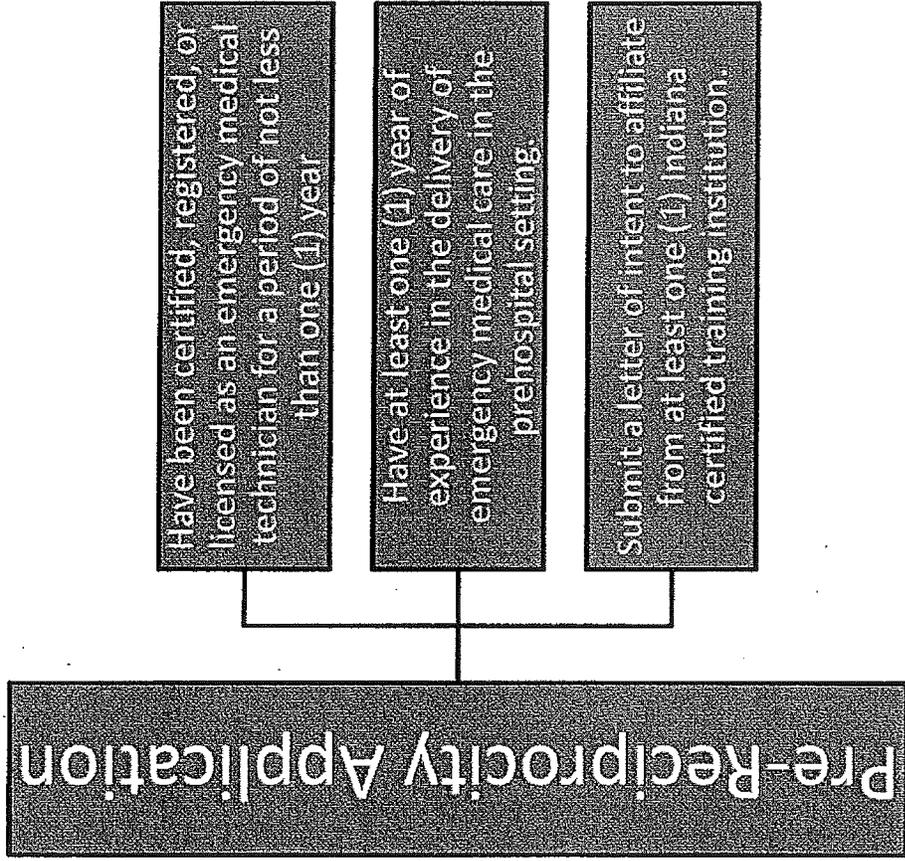
Notes– Post-PI Class Completion

- The Indiana PI Exam must be passed with a 80% passage rate within one (1) year of the PI Course Completion Date on the Report of Training.
 - The PI Candidate is allowed two attempts following a successful course completion as designated on a Report of Training submitted to IDHS.
 - A third and final attempt will be allowed if the candidate submits a letter of remediation by a certified Indiana PI through their affiliating Training Institution and can be completed within the one (1) year of the Course Completion Date on the Report of Training.
 - If not successful on the third attempt, the PI candidate would have to complete all pre-requisites and the PI class again with retesting not less than a year after completion of the current course.

Notes– Post-PI Class Completion

- The Indiana PI Internship must be completed through the affiliated Training Institution and the IDHS-approved checklist submitted to IDHS within one (1) year of the PI Course Completion Date on the Report of Training.
 - PI Candidates may teach at any EMS provider level (EMR, EMT, AEMT, Paramedic) so long as the Internship Checklist Requirements are met, the candidate is directly monitored and evaluated by an active PI from the affiliated Training Institution and the PI candidate is teaching at his/her certification level or lower.
 - Note that for an EMR course, a PI is not required to be present for class sessions. However, if it is included as part of the internship, both the PI candidate and supervising affiliated Training Institution PI must be present.

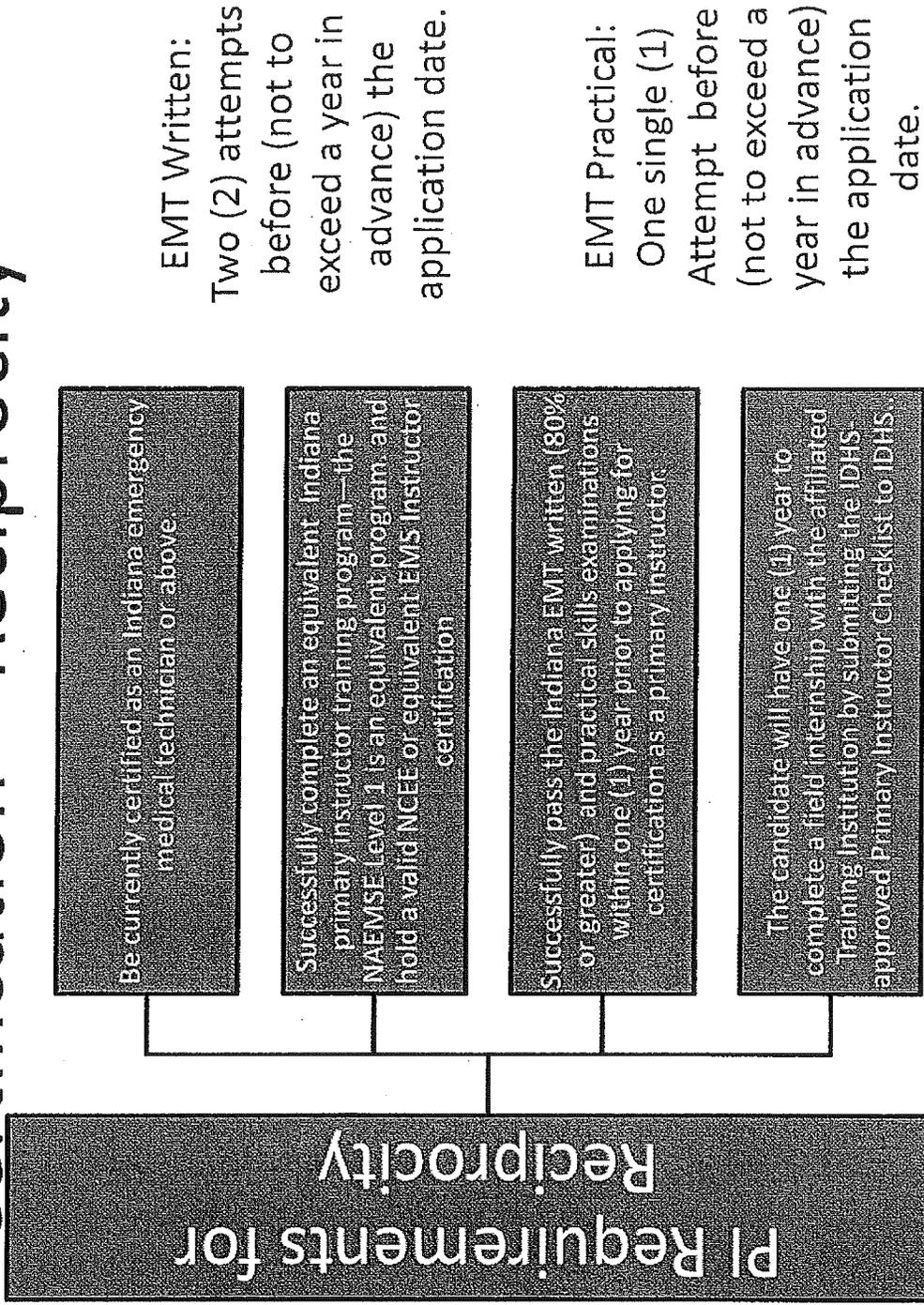
Indiana EMS Primary Instructor Certification – Reciprocity



Source: 836 IAC 4-5-1

Step 1

Indiana EMS Primary Instructor Certification – Reciprocity



EMT Written:
Two (2) attempts before (not to exceed a year in advance) the application date.

EMT Practical:
One single (1) Attempt before (not to exceed a year in advance) the application date.

Step 2

Source: 836 IAC 4-5-2 and EMS Commission policy

PI Certification Process

Indiana EMS Training Manual Section 5

December 2015

PI Certification Process—Indiana Primary Instructor Course

836 IAC 4-5-2 Certification and recertification; general

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-14

Sec. 2. (a) Application for certification will be made on forms and according to procedures prescribed by the agency. In order to be certified as an emergency medical services primary instructor, the applicant shall meet one (1) of the following requirements:

(1) Successfully complete a commission-approved Indiana emergency medical services primary instructor training course and complete all of the following:

(A) Successfully complete the primary instructor written examination.

(B) Successfully complete the primary instructor training program.

(C) Be currently certified as an Indiana emergency medical technician.

(D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor.

1. The Primary Instructor candidate will secure and provide to both the host Primary Instructor class coordinator and keep on file with their Training Institution:
 - a. Evidence of certification as an EMS provider for at least one (1) year.
 - b. The agreement with the Training Institution to affiliate on appropriate forms
 - c. A letter from an EMS ambulance provider (operations level manager or chief or above) attesting to exposure and competency in pre-hospital EMS for a period of not less than one (1) year.
 - * Note while this determination is left to the EMS provider, it should include direct patient contact on 911 responses (not just pre-scheduled transports) with transport to an emergency department and should be verifiable.
 - ** While each region may determine the volume and type of responses, it should be noted that for paramedic class enrollment, a candidate must document 20 verifiable patient contacts.
 - d. A letter from an EMS Medical Director attesting to the competency in provision of EMS as well as recommendation for certification as an EMS Instructor.
2. For testing the EMT written and practical examinations, the following guidelines shall apply:
 - a. EMT Written: Two (2) attempts before (not to exceed a year in advance) the Course Completion Date.
 - i. The PI Candidate must have an 80% pass rate on the current Indiana EMT written examination.
 - ii. Candidates can either be issued a testing ID by IDHS with the submission of the PI Class Roster or contact IDHS for a "Challenge" ID.
 - b. EMT Practical: One single (1) Attempt cycle before (not to exceed a year in advance) the Course Completion Date.

PI Certification Process

Indiana EMS Training Manual Section 5

December 2015

- b. The PI candidate must successfully pass the Indiana Primary Instructor Exam with an 80% passage rate within one (1) year of the Course Completion Date as noted on the Report of Training for the PI Course.
 - i. The PI Candidate is allowed two attempts following a successful course completion as designated on a Report of Training submitted to IDHS.
 - ii. A third and final attempt will be allowed if the candidate submits a letter of remediation by a certified Indiana PI through their affiliating Training Institution. *Note that all three attempts and the remediation must be completed within one (1) year of the Course Completion Date on the Report of Training.
 - iii. If not successful on the third attempt, the PI candidate would have to complete all pre-requisites and the PI class again with retesting of the pre-requisite EMT written and practical exams.
 - iv. A second PI Class for any individual candidate is not permitted within a one year period after completion of the initial course.
 - c. Upon successful completion of all of the above, the PI candidate will remit all required documentation to the State of Indiana EMS office within one year of the PI application date.
6. Upon EMS staff review and compliance with the above outlined process, the PI candidate will be issued Primary Instructor Certification.

PI Certification Process

Indiana EMS Training Manual Section 5

December 2015

PI Certification Process—Reciprocity

836 IAC 4-5-2 Certification and recertification; general

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-14

Sec. 2. (a) Application for certification will be made on forms and according to procedures prescribed by the agency. In order to be certified as an emergency medical services primary instructor, the applicant shall meet one (1) of the following requirements:

(2) Successfully complete a training course equivalent to the material contained in the Indiana emergency medical service primary instructor course and complete all of the following:

- (A) Successfully complete the primary instructor written examination.
- (B) Successfully complete the primary instructor training program.
- (C) Be currently certified as an Indiana emergency medical technician.
- (D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor.

1. Same process as the Indiana Primary Instructor Course candidate as noted in the previous section with the following modifications.
 - a. The NAEMSE Level I Instructor Course completion will suffice for the Primary Instructor Course so long as the provider has valid documentation of Course Completion as well as holds a current NCEE certification.
 - b. Candidate would then have to complete the following within one year of the initial application:
 - i. EMT Written: Two (2) attempts before (not to exceed a year in advance) the Course Completion Date.
 - 1) The PI Candidate must have an 80% pass rate on the current Indiana EMT-written examination.
 - 2) Candidates can either be issued a testing ID by IDHS with the submission of the PI Class Roster or contact IDHS for a "Challenge" ID.
 - ii. EMT Practical: One single (1) Attempt cycle before (not to exceed a year in advance) the Course Completion Date.
 - 1) Note that a single "Attempt" cycle means one process which could include re-tests so long as four of the EMT stations are passed on the initial attempt and no single station may be attempted more than three (3) times total.

PI Certification Process

Indiana EMS Training Manual Section 5

December 2015

- 2) There is only one EMT practical attempt cycle per PI Reciprocity application.
 - c. The PI candidate will successfully complete the Indiana Primary Instructor Internship Requirements within one year of the Course Completion Date as noted on the Report of Training for the PI Course. This must be verified by the Training Institution on the approved PI Internship checklist submitted to the Office of EMS with all other paperwork.
 - d. Upon successful completion of all of the above, the PI candidate will remit all required documentation to the State of Indiana EMS office within one year of the PI application date.
2. Upon EMS staff review and compliance with the above outlined process, the PI candidate will be issued Primary Instructor Certification.
3. Reciprocity within Indiana for Firefighter II and II instructors for acceptance as an EMS Primary Instructor.
 - a. Currently, the curriculum of the FF II and III is being reviewed to determine if the same course objectives and standards are met.

Attachment #3

Attachment #4

The State of Mobile Integrated Health Care and Community Paramedicine in Indiana

Project Activity Report

Indiana State Department of Health

State Office of Rural Health

Rural Hospital Flexibility Grant Program

Erik Southard DNP, FNP-BC

Cody Mullen, PhD(c)

Stephanie Laws, RN, MS

Robert Eberhardt, NRP, AAS, PI

October 6, 2015



Introduction

Community paramedicine (CP) is an evolving practice of promise that broadens the scope of activities for paramedics beyond the realm of emergency care, allowing these professionals to operate in expanded capacity to pursue the vital and noble role of population health management. CP is commonly used interchangeably with mobile integrated health care or (MIH). According to the National Association of Emergency Medical Technicians, MIH is defined as the provision of health care using patient-centered, mobile resources in the out-of-hospital environment that are integrated with the entire spectrum of health care and social service resources available in the local community.¹

After significant study of MIH and CP in Indiana and across the nation, it has become apparent that the activities taking place within Indiana are in fact congruent with the overarching definition of MIH listed above however the overwhelming majority of programs (MIH or CP) are self-termed community paramedicine programs. While this may be an oversimplification of sorts, perhaps for the sake of brevity, national experts hold that activities under the umbrella of CP are narrower than those of MIH.

Examples of CP activities are: protocols for treatment and release on scene, alternate destination transport, or redirection of emergency room overutilizers. Examples of MIH are: telephone triage and guidance, chronic disease management support and teaching, post-discharge follow-up, and referral to a broad range of community resources over and above provider offices, emergency rooms, or hospitals. Despite this understandable dichotomy between the two terms (CP and MIH), further discussion within the context of Indiana is moot.

The beauty of community paramedicine programs is that if you have seen one CP program you have seen one CP program. These programs are uniquely designed to meet the predominant health needs and concerns of the local communities and therefore have the ability to fill the gaps, contribute to the underlying safety net, and elevate EMS providers in an innovative and important way.

While emergency medical technicians (EMTs) and paramedics have operated beyond the realm of emergency medicine abroad for years (New Zealand, Australia, Europe, Canada) the practice first surfaced in 2004 in the United States (US). A 2004 report from the National Rural Health Association (NRHA) titled Rural and Frontier Emergency Medical Services: An agenda for the

future, is the first known concerted effort to advance a MIH agenda in the US.² While it is likely that pockets of activity were taking place prior to this document in the US, it is unclear whether post 2004 programs evolved out of sheer necessity or as a product of a shifting national EMS health care agenda.

CP programs are typically designed to address specific local problems and to take advantage of locally developed linkages and collaborations between and among emergency medical services (EMS) and other health care and social service providers and, thus, are varied in nature. Interest in community paramedicine has grown substantially in recent years based on the belief that it may improve access to and quality of care while also reducing costs.

The work that follows is the result of a collaboration to determine the efficacy of community paramedicine programs as it pertains to facilitating the improvement of health outcomes across the continuum of care in rural, urban, suburban and medically underserved regions of Indiana. In the fall of 2014 the Rural Health Innovation Collaborative submitted a grant request to the Indiana State Department of Health, State Office of Rural Health for Indiana Medicare Rural Hospital Flexibility Grant Program dollars. The grant request was funded with the following objectives:

1. Utilize Health Resources and Services Administration (HRSA) Office of Rural Health Policy evaluation tool to evaluate CP program in Indiana.
2. Develop and distribute a survey to collect information regarding CP programs – perceptions, activities, roles, scope of practice, legal implications, medical oversight and direction.
3. Complete a comprehensive analysis to determine current status of Community Paramedicine program research to key stakeholders, constituency groups, and others.
4. Report findings to Indiana State Department of Health, Office of Rural Health.

Surveying State Paramedics

In the Spring of 2015, an interprofessional care team convened to discuss strategies for advancing community paramedicine (CP) in the state of Indiana. In January and February of 2015 the Rural Health Innovation Collaborative (RHIC) created and distributed a survey to all licensed paramedics in the state of Indiana surrounding their views on community paramedicine. The survey instrument was created through a collaboration between the RHIC, Terre Haute Fire Department, Indiana Department of Homeland Security, Ivy Tech Community College, Indiana State University, and the Indiana Rural Health Association. This group heretofore known as the Rural Health Innovation Collaborative Community Paramedicine Working Group (RHIC CPWG) had broad based representation from multiple health care disciplines.

Team members present were nurses, paramedics, educators, nurse practitioners, physicians and administrators. The team discussed various mechanisms for assessing the current status of CP in

the state of Indiana and for quantifying the level of interest that paramedics and their individual agencies have in the concept. The team developed a survey to examine these and other factors and worked with state EMS leaders to email out the link to the survey to 4,200 paramedics across the state using the state EMS registry system. The study received a designation of exempt IRB approval from the Indiana State University Review Board.

Responses from across Indiana were gathered via utilization of a commercially available, internet survey platform. In total, 1,343/4200 (32% return rate) survey responses were collected. The demographics of those returned are represented below in table 1. The survey also looked at the current Indiana Paramedic workforce. The survey was sent to all paramedics in the state and those who responded may not necessarily represent the Indiana paramedic workforce as a whole.

Variable	Count (% of Reported)
Age	
20-29 Years Old	179 (13.3%)
30-39 Years Old	396 (29.5%)
40-49 Years Old	397 (29.6%)
50-59 Years Old	280 (20.8%)
60-70 Years Old	71 (5.3%)
Unreported	20 (1.5%)
Education	
Some High School	2 (0.1%)
High School Degree	168 (12.5%)
Some College	515 (38.3%)
Associate Degree	342 (25.5%)
Bachelor Degree	238 (17.7%)
Master Degree	55 (4.1%)
Doctorate Degree	3 (0.2%)
Unreported	20 (1.5%)
Rurality	
Rural	276 (20.6%)
Suburban	496 (36.9%)
Urban	512 (38.1%)
Unreported	59 (4.4%)
Race	
Caucasian/White	1,275 (94.9%)
Other	49 (3.6%)
Unreported	19 (1.4%)
Gender	
Male	1,033 (76.9%)
Female	289 (21.5%)
Unreported	21 (1.5%)

Table 1: Demographic Data Information of Survey Respondents

Of those who responded, it was found that Indiana paramedics have worked an average of 13.27 years, 35.85% of paramedics work at least two positions, and 13.88% work at least three positions as a paramedic.

The average paramedic who completed the survey works on average 53.21 hours a week. Table 2 shows the breakdown based on each demographic variable. Of interest, it was found that the paramedics 40-49 tend to work the most hours a week, 56.10 hours, and those in a suburban area have the longest workweek, 55.78 hours.

Variable	How Many Years Have you Been a Paramedic?	Do you work a Second Position (as a paramedic)? (% Answered Yes)	Do you work a Third Position (as a paramedic)? (% Answered Yes)	Average Hour's Worked per Week (all positions)
Overall Average	13.27	35.85%	13.88%	53.21
Age				
20-29 Years Old	3.74	45.03%	7.79%	53.35
30-39 Years Old	7.99	38.70%	16.33%	53.69
40-49 Years Old	14.50	36.29%	14.08%	56.10
50-59 Years Old	22.09	26.47%	15.07%	49.95
60-70 Years Old	24.82	31.43%	13.64%	43.24
Education				
High School Degree	12.78	35.98%	15.25%	56.71
Some College	14.14	37.55%	12.63%	55.18
Associate Degree	10.99	38.44%	16.67%	53.22
Bachelor Degree	13.56	28.45%	10.61%	49.29
Master Degree	19.41	33.96%	11.11%	36.58
Rurality				
Rural	11.89	36.96%	12.75%	52.45
Suburban	13.29	40.73%	12.38%	55.78
Urban	13.97	30.53%	16.56%	54.03
Race				
Caucasian/White	13.34	35.58%	13.80%	52.90
Other	11.55	41.67%	15.79%	55.39
Gender				
Male	13.62	37.45%	13.49%	55.93
Female	12.02	30.36%	15.48%	42.79

Table 2: Current Indiana Paramedicine Workforce

Three areas of community paramedicine were investigated through this survey. First, the survey asked questions around the concept of community paramedicine, what did the paramedic know about community paramedicine, do they have interest in working as a community paramedic, and what percentage of calls do they currently respond to that would be better responded to by a community paramedic. Secondly, it was looked at the training needs requested by paramedics

before beginning as a community paramedic. Finally, the survey looked at some of the financial mechanisms to cover the cost of the program and some of the barriers perceived by paramedics.

Looking at the concept of community paramedicine it was found that, on a 5 point Likert scale, most paramedics agreed/strongly agreed, mean score of 3.86, that they were familiar with the term community paramedicine. The term tended to be more familiar to those 20-29 years old and those living in a suburban and urban area. After a definition of community paramedicine was shared with the respondents, it was found that 75.0% had interest in working as a community paramedic. A higher rate of those 20-29 years old and those living in a rural setting tended to agree with this statement. Women also tended, 11% more compared to men, to have an interest in working as a community paramedic.

Finally, it was asked of paramedics, what percentage of calls that you participate in do you believe could be managed without EMS transport. Paramedics reported 51.90% of their calls could be treated without transport. This was highest among those 60-70 years old and female paramedics.

Variable	Familiar with Community Paramedicine (5 point Scale)	Do you have interest in working in Community Paramedicine (% answered Yes)	Percentage of Calls felt Believe be Managed without Transport Currently
Overall Average	3.86	75.0%	51.90%
Age			
20-29 Years Old	3.91	78.18%	54.18%
30-39 Years Old	3.83	73.71%	54.25%
40-49 Years Old	3.89	75.07%	51.32%
50-59 Years Old	3.83	75.49%	48.89%
60-70 Years Old	3.87	71.01%	58.06%
Education			
High School Degree	3.69	71.79%	48.14%
Some College	3.79	75.05%	51.64%
Associate Degree	3.93	80.25%	54.29%
Bachelor Degree	3.95	69.51%	50.83%
Master Degree	4.19	78.43%	54.16%
Rurality			
Rural	3.81	80.22%	52.03%
Suburban	3.88	71.97%	47.19%
Urban	3.87	75.51%	56.53%
Race			
Caucasian/White	3.86	74.66%	51.63%
Other	3.83	82.61%	59.87%
Gender			
Male	3.84	72.69%	50.54%
Female	3.93	83.65%	57.16%

Table 3: Paramedic View on Community Paramedicine

The survey also looked at the areas paramedics felt a community paramedicine could service their area or community. The results are listed in table 4 in decreasing preference order. Paramedics were asked to respond on a 5-point Likert scale. It should be noted that none of the averages for any condition presented to a paramedic received a response of disagree or strongly disagree.

Variable	Community Paramedic Could Care For: (5 Point Scale)
Minor wounds and lacerations	4.34
Insect bite	4.28
Dressings	4.27
Sting	4.25
Minor Allergic Reactions	4.24
Minor soft-tissue injuries and burns	4.22
Resolved hypoglycemia in known IDDM	4.20
Epistaxis	4.07
Cold	4.03
Diabetes	4.02
Sore throat	3.97
Flu	3.94
Seizure in known epileptics	3.90
Chronic disease process	3.89
Back pain	3.83
Hypertension	3.79
Diarrhea	3.78
Postoperative wound problems	3.78
Boils and abscesses	3.76
Foreign body ear	3.69
Fainting	3.69
Constipations	3.66
Emotional or hysterical reactions	3.66
Foreign body nose	3.62
Blocked urinary catheter	3.57
Alcohol intoxications	3.54
Toothache	3.54
Foreign body throat	3.44
Social problems	3.44
Foreign body eye	3.29

Table 4: List of conditions a Paramedic felt community paramedicine could support on a 5-point Likert scale.

Next, it was looked at the training that a paramedic would need to feel comfortable to be a community paramedic. These results are presented in table 5 and 6. On a 5-point Likert scale it was found that paramedics strongly agree, score of 3.93, that they would take a training or certificate course if one would be offered. They also reported that the training should be on

average 88.49 hours. The younger the paramedic, generally, the more receptive they were to additional training. There was an inverse correlation between age and hours of training needed to feel comfortable operating as a community paramedic; younger paramedics felt a greater number of hours of additional training would be necessary. In addition, those living in rural communities felt additional training hours were necessary before delivering services as a community paramedic. The higher level of education a paramedic had the more training they desired.

Paramedics felt that it would be necessary to have their own malpractice/liability coverage, reporting a 3.71 on a 5-point Likert scale. This was highest for those who were 30-39 and 60-70 years old. Also, the higher level of education you have received the more likely you were to report the necessity of carrying personal malpractice/liability insurance.

Variable	If there were a Community Paramedic Training/certificate would you consider it? (5 Point Scale)	How many additional hours of training do you think you would need?	Would you find it necessary to have your own malpractice/liability coverage? (5 point scale)
Overall Average	3.93	88.49	3.71
Age			
20-29 Years Old	4.09	110.19	3.55
30-39 Years Old	3.92	93.71	3.82
40-49 Years Old	3.88	91.30	3.68
50-59 Years Old	3.94	88.59	3.68
60-70 Years Old	3.71	88.39	3.84
Education			
High School Degree	3.74	75.70	3.48
Some College	3.95	92.78	3.68
Associate Degree	4.05	83.66	3.79
Bachelor Degree	3.83	107.51	3.78
Master Degree	4.06	147.07	3.84
Rurality			
Rural	4.05	100.87	3.75
Suburban	3.81	90.22	3.77
Urban	3.98	87.00	3.64
Race			
Caucasian/White	3.93	88.55	3.70
Other	3.89	125.69	3.91
Gender			
Male	3.86	90.67	3.72
Female	4.17	86.43	3.66

Table 5: Paramedic View on Community Paramedicine Training and Liability Insurance

Paramedics were very open to having additional training and when presented with a list of training topics, all were selected with the neutral and above level of inclusion in training. The list of training topics is shared in table 6. The variation between the highest desired and the least desired was also minimal, spread of 0.58.

Variable	Community Paramedicine Training should include: (5 Point Scale)
Pharmacology and vaccines	4.41
Chronic wounds	4.24
Diabetes mellitus	4.23
Infectious Disease	4.21
Renal Failure	4.20
Hypertension	4.19
Congestive heart failure	4.16
Wellness Principles	4.13
Home hazard assessment and survey	4.11
Disease transmission	4.08
Community mental health	4.08
Quality Improvement	4.06
Interviewing Techniques	4.05
Death and Dying	4.01
Tort and Criminal Action	4.00
Stress Management	4.00
Principles of Documentation	4.00
Self-defense tactics	3.98
Anatomy and physiology	3.92
Confidentiality	3.88
Family and psychosocial counseling	3.83

Table 6: Training topics paramedics would like covered in community paramedicine courses

When we asked paramedics which of the various payer sources should cover the cost of community paramedicine services the majority stated that public payers (Medicare and Medicaid) should cover the cost. The least popular option was through an additional tax on their community or based on the donation of private donors.

Variable	Community Paramedicine efforts should be financed by: (5 Point Scale)
Medicare reimbursement	4.28
Medicaid reimbursement	4.26
30-day hospital readmission savings	4.07
Private payers	3.76
Private donors	3.41
Tax dollars	3.20

Table 7: Who should finance community paramedicine activity

Additionally, we looked at the perceived barriers paramedics face in conducting community paramedicine activity. The primary barrier was centered on funding and reimbursement. In addition, paramedics were concerned with their potential liability when delivering community paramedicine services. The least of their concerns was medical direction and interest among the paramedic community.

Variable	Community Paramedic potential barriers are: (5 Point Scale)
Funding	4.40
Reimbursement	4.22
Liability	4.03
State statutes	3.67
Scope of Practice	3.58
Training	3.46
Medical Direction	3.29
Paramedic Interest	3.24

Table 8: Paramedic perceived barriers in delivery community paramedicine

Survey respondents were also asked a question about CP certification; more specifically, the question was if a certification were available, should it be applied to the individual service provider (ISP), the individual paramedic, or to both. Out of 1184 paramedics that responded, 134 (11%) stated the ISP, 764 (65%) stated the paramedic, and 286 (24%) stated that it should apply to both.

The survey also collected information about CP programs currently operating in Indiana. Despite the National Association of Emergency Medical Technicians 2014 survey³ touting Indiana as the leader in CP programs with a total of 19 programs, only five programs were reported by respondents. CP programs are currently operating in Fishers, Indianapolis, Fort Wayne (Parview), Carmel, and at Indiana University's Ball Memorial. All programs reported small numbers of patients being served. Respondents stated that they were generally recording outcomes through an electronic platform. Platforms being utilized were EPIC, ESO, and HealthCall. Additional information on Indiana CP activity can be found in the State Programs section of this document.

Discussion

The survey completed in the early part of 2015 was very insightful to the Indiana Paramedic community's mindset around community paramedicine. It was found, of those who participated in the survey, that the average workweek was 53 hours. This range was as high as 100 hours a week. Thirty-six percent of paramedics also reported that they work more than one job as a paramedic. This could indicate a fragile and overworked paramedic workforce and create possible shortages in the near future for traditional EMS and community paramedicine services. This may also speak to a wage disparity among this profession resulting in a need to work multiple venues in order to make ends meet.

When introduced to the concept of community paramedicine a majority of paramedics were interested in the concept but it was found that the younger generation and those living in rural communities were both more receptive to serving as a community paramedic. This could indicate a changing in perception of the profession among paramedics and the younger generation being trained early on the continuum of care and prevalence of chronic diseases among patients. It could also indicate that the younger generation sees a different role for paramedic and EMS services in the future.

Those wanting community paramedicine programs in their rural communities could highlight a shortage of providers or barriers that prevent patients reaching a provider for a traditional face-to-face appointment causing more chronic conditions to go untreated, transitioning to being emergent and/or acute care concerns. Overall, paramedics felt 50% of their current calls could be treated without traditional EMS services, indicating a potential alteration in EMS run volume if the chronic conditions were treated in a traditional outpatient setting via CP programs or linkages to primary care and not through the emergency department.

It was found that the younger paramedics and those living in rural settings were more receptive to the needs of training. Overall, those who completed the survey generally agreed that training was necessary and highlighted all proposed areas of training to be provided are needed. It was also found that those with a higher level of education desired the greatest amount of community paramedicine training. This was a surprising finding but may indicate those with more training in chronic condition treatment already understand the complexity of these disease processes. This complexity could require additional training than those unfamiliar may recognize.

Finally, the greatest barrier was the determination of how to pay for community paramedicine services. Paramedics identified that public payer (Medicare and Medicaid) sources may be the ideal payer for these services. This indicates that paramedics see that community paramedicine should be an added health service and not something that is done under the traditional EMS trauma system that is funded directly through their municipality. Other barriers were also identified but the current payment structure was the primary barrier.

Overall, paramedics are interested in the concept of community paramedicine and willing to receive additional training to ensure they are ready for this role. Outreach for training should be targeted to the younger generation of paramedics and those living in rural communities. In addition, the state must devise a plan to ensure proper compensation for community paramedicine is in place to help struggling EMS agencies diversify revenue streams and broaden the types of activities that they are reimbursed for. If a payment model was in place that incentivized activities outside of the traditional treat and transfer paradigm that exists, emergency room utilization could be altered dramatically resulting in a significant impact on health care costs.

State Programs

According to the NAEMT National Survey on CP and MIHC programs, Indiana leads the country in the number of CP/MIHC programs with 19 programs.³ The RHIC CPWG was able to identify five actively operating programs within the state of Indiana from the statewide survey.

Three programs volunteered to undergo a thorough programmatic evaluation utilizing the Health Resources and Services Administration's Community Paramedicine Evaluation tool that can be found in Appendix A.

The RHIC CPWG would like to thank these programs for undergoing this review. It should be noted that the HRSA tool used to assess these program is lengthy and very comprehensive. The tool was developed to help programs reach an extremely high level of performance that is not currently supported through regulatory or financial structures both nationally and certainly in the state of Indiana.

All programs reviewed are considered to be in early development stages and are providing a great service for their communities. These programs are leading the charge for CP efforts in the state of Indiana and should be commended for their efforts. Language included below is based on phrasing within the tool and is meant to facilitate a formative improvement process for all programs. All programs scored very high on the tool and are striving to improve identified areas of deficiency with limited resources. Nothing in the report is meant to be critical of these community paramedicine programs that have been assembled to meet the individualized needs of the communities despite multiple barriers that exist in Indiana.

Fishers We-Care Program

The Fishers We-Care Program (WCP) was started in October of 2014. The WCP is housed at the Fishers Municipal Fire Department located at 2 Municipal Drive in Fishers, Indiana 46038. This municipal service provides emergency care to a population of 87,500. The WCP focuses on fall prevention, CHF Management, COPD, Asthma, AMI discharges, and is currently looking into strategies to address mental health concerns within the community. The WCP operates with two community paramedics and currently has 17 patients enrolled in their target programs. The program is supported by agency funds, third party payers, and through tax revenue. The WCP program, directed by Dr. Sal Miglieori, and is operated under the local authority of an ordinance of the town of Fishers. The program has an existing memorandum of understanding with Community Hospital Network. They currently do not have any contracts with other health care entities, provider practices or medical homes.

Assessment

Multiple population-based and clinical data sources (e.g., ED data, hospital discharge data and others) are electronically linked and used to describe illness and injury within the jurisdiction. Public health officials, along with health care and community paramedicine participants, assist with the design of illness/injury risk assessments. The community paramedicine electronic information system is used for both surveillance and performance improvement activities. There is electronic medical record documentation of each patient/client contact that can be accessed by primary care physicians and case managers. Special reports can be generated as needed and used by the program director to assist in scheduling or other administrative issues. The WCP has

completed a comprehensive inventory that identifies the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community. The community-wide resource assessment has identified several clinical condition groups/individuals that can be addressed with resources from within the community.

The WCP program has not completed a gap analysis to identify areas where the program could facilitate improvements in population health and does not have established resource standards. There is, however, ongoing assessment of multiple program outcomes over time as the outcomes relate to changes within the program for specific program interventions. The WCP had not undergone any formal external examination of the program overall or individual components until the compilation of this report. Additional sources of data in terms of other economic and quality of life measures, (e.g. reduction in return hospital visits/readmissions, fewer 911 calls, shorter return to work interval, etc.) are available but were not provided for this report.

Dramatic improvements in wellness and functional outcome returns are documented sporadically or within various components of WCP, but specifics were not provided for this report. In addition to routine public official contact, WCP strives to have public officials involved in various oversight activities such as the community paramedicine advisory council. At this time, WCP does not have routine or planned contact with health insurers/payers. The broad medical community has been formally asked about what types of information would be helpful in reporting on community paramedicine events and issues.

WCP activities are allowable/supportable within EMS regulations, licensure, certification and scope of practice, however the level of involvement, as well as conflicts with other licensing agencies or authorities, including: nursing, physician assistants, home health care, primary care or others are unknown to WCP. At the time of the survey, it was unknown to WCP if the program leaders have developed and implemented a multidisciplinary, multi-agency advisory committee to provide overall guidance to the community paramedicine planning and implementation strategies. The local administrative level has an articulated decision-making process within the WCP plan, although it has not been fully implemented. Policies are not written. WCP leaders have adopted goals and time-specific, quantifiable, and measurable objectives that guide program performance, while WCP personnel operate under the protocols for general emergency care response as approved by the agency's medical director.

There is informal, two-way transmission of health care information between WCP and other health care providers and entities, but no formal written policy on data sharing has been developed.

The WCP conducts peer reviews and performance improvement under the rules and regulations pertaining to such protection for traditional EMS activities. There is no formal engagement with other health care providers in these activities. A community paramedicine program plan has been adopted, developed with a multidisciplinary, multi-agency advisory committee, and has

been endorsed by the respective agencies, however, it is not known if the WCP plan clearly described the system design (including the components necessary to have an integrated program) and if it is used to guide system implementation and management. The plan does address the resource needs and identifies gaps in the resources within the community health system, but no mechanism for correcting resource deficiencies has been identified. As of now, there is no funding to support the WCP planning, implementation, or ongoing management and operations for either program administration or community paramedicine clinical care. There may be operational budgets that may be sufficient to cover most program costs, but they are without regard to the WCP plan or priorities.

WCP does have an electronic information system (EIS) that routinely reports (written, on-line or electronic) on system-wide management performance and compliance. Linkage between management reports, resource utilization, and performance measures has begun, yet there is limited use of WCP EIS reports to target educational opportunities such as continuing education for community paramedicine providers using local data. There is a WCP community-wide multidisciplinary, multi-agency advisory committee, but it does not routinely review program data reports. WCP, along with public health/community health officials, EMS, and primary care providers assist with the design of the community risk assessments, but not the analysis.

WCP also collects patient care data electronically, but the data is not used to assess system performance or quality of care. WCP providers have a patient care record for each episode of care, but it is not yet automated or integrated with the community paramedicine EIS.

The financial aspects of the WCP are integrated into the overall performance improvement system to ensure ongoing "fine-tuning" and cost effectiveness. At this time, no cost data are collected, no outside financial data are captured, and no non-financial burden of disease costs and outcome measures are collected or modeled in regard to WCP.

An EMS agency medical director serves as medical director for the WCP, but no job description or expectations have been formally developed beyond those required of an EMS agency medical director. It is not known to WCP if there is a clear-cut legal authority and responsibility for the program medical director, including the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of WCP providers, and generally ensure medical appropriateness of the program based on regulatory agency scope of practice and accepted standards of medical care.

One of the benchmarks for community paramedicine is to ensure a competent and safe workforce, yet there are no formalized WCP training guidelines for prehospital personnel as part of initial or ongoing certification of licensure, and no credentialing process for WCP personnel. No multidisciplinary community paramedicine conferences are conducted within geographic boundaries of the community.

WCP leadership and other stakeholders, including hospitals and the lead agency, monitor and correct personnel deficiencies as identified through quality assurance and performance improvement processes. WCP does not have a mechanism in place to identify personnel deficiencies within the program.

There is a well-defined process to assess care provided by the practitioners within the WCP. The quality assurance and performance improvement processes identify deficiencies, and corrective action plans are instituted. Ideally, programs would work in conjunction with the prehospital and other regulatory agencies to ensure that WCP care provided by licensed individuals is in compliance with any rules, regulation, or protocols specific to community paramedicine delivery.

WCP's sponsoring agency and the prehospital regulatory agency work together to resolve complaints involving prehospital personnel performance. Complaints about individual personnel noncompliance with laws, rules, and regulations go directly to appropriate boards or licensure authorities. This program has not had any identified issues with performance or compliance.

Carmel Fire Department MIH Program

The Carmel Fire Department Mobile Integrated Health care Program (MIHP) was started in July of 2014. The MIHP is housed at the Carmel Municipal Fire Department located at 2 Civic Square in Carmel, Indiana 46032. This municipal service provides emergency care to a population of 85,927 (2013 Census Data). The MIHP focuses on fall prevention and health education, medication reconciliation, and health care system guidance. Currently they are in the process of developing an emergency room follow-up program with St. Vincent Hospital. The MIHP operates with five community paramedics. The program is supported by agency funds, tax revenue, a grant through St. Vincent Carmel Grant Foundation and a grant from Ascension Health through St. Vincent. The MIHP program is directed by Dr. Michael Kaufmann. MIHP is working on a contract with St. Vincent and Ascension Health, but currently does not have any health care affiliations.

Assessment

Carmel MIHP has one or more population-based data sources and one or more clinical data sources used to describe illness and injury within the jurisdiction. Public health officials, along with health care and MIHP participants assist with the design of illness /injury risk assessments. A MIHP electronic information system (EIS) exists as an extension of other databases, e.g. EMS or hospital, but is not routinely used for targeted surveillance and system performance. There is a simple log (electronic or paper based) that identifies demographic information about the patient/client contact, e.g. patient and provider identifier, date, time, etc. A community paramedicine EIS data base exists but is not used to generate reports to guide either daily operations or future planning.

A community-wide resource assessment has been completed that documents the frequency and distribution of resources for at least two of the following categories: community paramedicine, prehospital and hospital personnel, education programs, facilities, and prehospital equipment. The MIHP advisory committee has begun to develop resource standards so that a gap analysis can be completed. There has not been an assessment of the effectiveness of the MIH program. No external examination of the MIHP overall or individual component has occurred. There are no cost data from the EIS database, or other sources, available to calculate the program's benefits. Dramatic improvements in wellness and functional outcome returns are documented sporadically or within various components of the program. Public officials have been formally asked about what types of information would be helpful in reporting on community paramedicine and community health issues. At this time, there is not routine or planned contact with health insurers/payers. The broad medical community has been formally asked about what types of information would be helpful in reporting on community paramedicine events and issues.

Currently, MIHP is operating under current EMS rules for paramedics, but it is unknown if the activities are allowable/supportable within EMS regulations, licensure, certifications, and scope of practice. No effort has been made to inform the state regulatory agencies governing nursing, advanced practice nurses, physician assistants, home health care providers, primary care, or others concerning MIHP activities to determine if such activities are allowable within the state's regulations.

The decision-making process is articulated within the MIHP plan, although it has not been fully implemented. Policies are not written. MIHP leaders are beginning the process of identifying measureable program goals and outcome-based, time-specific, quantifiable, and measurable objectives. MIHP personnel operate under the protocols for general emergency care response as approved by the agency's medical director.

There is an informal, one-way transmission of health care information from the MIHP providers and other health care providers and entities. The program conducts peer review and performance improvement under the rules and regulations pertaining to such protection from traditional EMS activities. There is no formal engagement with other health care providers in these activities.

A program plan has been adopted, developed with a multidisciplinary, multi-agency advisory committee, and has been endorsed by the respective agencies. The MIHP addresses resource needs and identifies gaps in resources within the community health system, but no mechanism for correcting resource deficiencies has been identified.

Some funding for the program has been identified (two grants) but ongoing support for administration and clinical care outside of the grant structure is not available. The community paramedicine EIS routinely reports (written, on-line, or electronic) on system-wide management performance and compliance. Linkage between management reports, resource utilization, and

performance measures has begun. There are operational budgets that may be sufficient to cover most program costs, but they are without regard to the MIHP plan or priorities. There is a MIHP community-wide multidisciplinary, multi-agency advisory committee, but it does not routinely review program data. Public health/community health officials along with EMS, primary care providers, and MIHP participants assist with the design of community risk assessments.

Patient care data are collected electronically but are not used to assess system performance of quality of care. MIHP providers have a patient care record for each episode of care, but it is not yet automated or integrated with the programs EIS. The survey revealed that no cost data are collected, no outside financial data are captured, and no nonfinancial burden of disease costs and outcome measures are collected or modeled for the MIHP.

There is an EMS agency medical director that serves as medical director for the MIHP, but no job description or expectations have been formally developed beyond those required of an EMS agency medical director. It is unknown to MIHP is if there is a clear-cut legal authority and responsibility for the MIHP medical director including the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of MIHP providers, and generally ensure medical appropriateness of the program based on regulatory agency scope of practice and accepted standards of medical care.

There are no formalized MIHP training guidelines for prehospital personnel as part of initial or ongoing certification or licensure. There is no credentialing process for MIHP personnel. There are no multidisciplinary MIHP conferences conducted within geographical boundaries of the community. There is no mechanism to identify through performance improvement processes systemic personnel deficiencies within the MIHP. The program has begun a process to evaluate deficiencies in the practice patterns of individual practitioners. The MIHP sponsoring agency and the prehospital regulatory agency work together to monitor compliance of prehospital providers with any rules, regulation, or protocols specific to prehospital practice. Complaints about individual personnel noncompliance with laws, rules, and regulations go directly to the appropriate boards or licensure authorities. This program has not had any identified issues with performance or compliance.

Ball Memorial Program

The IU Health Ball Memorial Hospital and EMS Affiliates Program (Ball CP) was started in October of 2014. The program is housed at 2401 W. University Avenue, Muncie, IN 47303. Ball CP program currently provides services to 25-35 candidates per month. The initial CP program protocols will be directed to Heart Failure (HF), COPD, Post Myocardial Infarction, and Diabetes patient care. Services will include: Regular in-home visits to patients with feedback to referring provider as requested; scheduling will begin at 24-48 hours post-discharge with more scheduled as necessary by HF Coach and initial medic assessment. Twelve lead EKGs with interpretation and transmission are completed (as needed). Reinforcement of discharge

instructions and the treatment plan in the patient's home: Provide diet, exercise, rest, safety, and healthy living information in a way that is appropriate to the patient's health literacy level. Medics work to facilitate patient attendance to follow up appointments. Medication reconciliation is completed in the home.

The program works to avoid exacerbations of chronic illness through close observation and early reporting of symptoms. Medics also monitor and trend vital signs, weight, medications, and appointments. Medics assist patients with locating appropriate community resources. Medics facilitate timely communication of abnormal findings to the referring provider or assigned clinic. The program plans to offer assistance coordinating urgent (same or next day) physician or clinic appointments as appropriate. The program will also be integrated with case management to transition patients to other levels of service as needed such as homecare via nursing or assisted living.

The CP program operates with 6 community paramedics. The program is supported by agency and documents cost savings to the parent facility. The CP program is directed by Dr. Jan Kornilow. The program has an extensive, formalized training curriculum for medics consisting of two weeks (80 hours) of rotations. Medics rotate through physician offices, dietary services, cardiac rehab, pharmacy and the heart failure clinic.

Assessment

Ball CP has one or more population-based data sources but bi-directional transmission within the health system's clinical data sources is currently not utilized. Illness/injury risk assessments are conducted. Ball Memorial EIS exists as an extension of other databases (Cerner) but it is not routinely used for targeted surveillance and system performance. The CP program utilizes ImageTrend to document patient encounters and data. An EIS database exists but at this time reports are not generated from the EIS to help guide performance improvement activities and to document the effectiveness and/or efficiency of the program.

Ball CP has not completed a formalized community-wide resource assessment, therefore, no comprehensive inventory exists to identify the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community.

This however is being completed. There are no resource standards on which to base a gap analysis. There has not been an assessment of the effectiveness of the Ball CP program nor has any external examination of the Ball CP program overall or individual components occurred.

Ball CP costs are included in the EIS that can serve as the basis for calculations for cost savings, decreased EMS transports, decreased hospital visits, improved health/wellness as well as other metrics

Dramatic improvements in wellness and functional outcome returns are documented sporadically or within various components of the program. Plans are in place to feed information to public officials. There is no routine or planned contact with health insurers/payers. The broad medical community has been formally asked about what types of information would be helpful in reporting on Ball CP events and issues and the program is well integrated with local physician offices.

The state EMS agency has been made aware of the Ball CP program but has not confirmed that the program is operating within state regulations. No effort has been made to inform the state regulatory agencies governing nursing, advanced practice nurses, physician assistants, home health care providers, primary care, or others concerning Ball CP activities to determine if such activities are allowable within the state's regulations.

There is no community-wide multidisciplinary, multi-agency advisory committee providing guidance to the Ball CP leadership in planning and developing the program. The decision-making process is contained within the IU/Ball plan, and there are current policies and procedures in place to guide decision making. Ball CP leaders are beginning the process of identifying measureable program goals and outcomes-based, time-specific, quantifiable, and measurable objectives. Specific protocols for Ball CP activities that are outside of the general emergency care response activities of the agency are being drafted.

No formal data exchange of patient/client information occurs between Ball CP and other health care providers. The Ball CP program does not engage in any peer review but does engage in performance improvement activities. There is a Ball CP program plan, and some individuals or groups have begun meeting to discuss further development/expansion of the plan. The plan provides general information about all the program activities including hazard preparedness, EMS, and public health/community health integration. The plan addresses resource needs and identifies gaps in resources within the community health system, but no mechanism for correcting resource deficiencies has been identified.

Some funding for the Ball CP program has been identified, but ongoing support for administration and clinical care outside of the current operation savings structure is not available. There are no operational budgets. There is a limited Ball CP EIS consisting of a patient registry, but no data extraction is used to identify resource needs, to establish performance standards, or to routinely assess and evaluate program effectiveness.

There is evidence that some providers are using Ball EIS reports to identify educational needs and to incorporate them into training programs. There is no specific multidisciplinary, multi-agency advisory committee, and there are no regular reports of system performance.

Administrative and program cost data are collected and included in an annual program report. Outside financial data are collected from one or more sources (Medicaid or private insurers). Estimated savings using various burdens of disease costs or outcome measure models are

calculated for the program. There is an EMS agency medical director that serves as medical director for the Ball CP program. The program medical director has a written job description; however, the individual has no specific legal authority or time allocated for those tasks.

All Ball CP personnel that provide medical services to patients/clients have completed initial training using a local community paramedicine curriculum, an 80 hour course with disease specific training. There is no credentialing process for personnel outside of the standard practices for EMS. There are sporadic multidisciplinary community paramedicine conferences conducted pre-existing with hospital outreach programs. The Ball CP program has begun to identify systemic personnel deficiencies. The Ball CP program has begun a process to evaluate deficiencies in practice patterns of individual practitioners. The Ball sponsoring agency and the prehospital regulatory agency work together to resolve complaints involving prehospital personnel performance. BALL sponsoring agency personnel collaborate actively with licensure authorities to resolve complaints involving individual personnel noncompliance with laws, rules, and regulations governing BALL personnel. This program has not had any identified issues with performance or compliance.

Nationally Renowned Programs

In the fall of 2014 NAEMT conducted a comprehensive survey on nationally operating mobile intergrated health care and community paramedicine programs (MIH-CP). This survey identified over 100 EMS agencies across that nation that had undergone extensive efforts to determine their communities' population health needs and to respond with targeted programs to address the identified needs.³ The survey was the first of its kind to begin to identify and catalog the high levels of community paramedicine activity that are taking place across the country.

The RHIC CPWG utilized information from the NAEMT survey and published literature to identify three premiere programs engaged in MIHC-CP activities and who were collecting outcomes data. A brief summary of the findings follows.

Medstar Mobile Health care (Fort Worth, TX)

Medstar has initiated a program to address the issue of ambulance and emergency room super-users. The effort began in the summer of 2012 with a nurse triage system to help screen low risk or low priority 911 calls to determine if treatment and transport by an ambulance, a \$1600 charge, was necessary. It was estimated some 4,000 ambulance calls could be traced to just 160 patients. For every patient not transported to the hospital, an estimated base charge of \$2,000 is prevented. MedStar has hosted visitors from 40 states and five countries to showcase their program. When patients were surveyed about the care they receive from the program, almost 90% of them say they would prefer avoiding an ambulance ride and accessing needed care through more appropriate means.⁴ The nurse triage system has saved an estimated \$1.2 million dollars in prevented health care expenditures. Another extension of this program known as the "EMS Loyalty Program" has saved an estimated \$808,000.

The program has facilitated an 83.7% reduction in 30-day readmission rates. This program is also working to establish a measureable outcomes data set as the national standard for CP program reporting.

North Memorial Clinic (Minneapolis, MN)

This community paramedic program was initiated in October of 2012. Programmatic literature states that the program was over a decade in the making and took an additional year to obtain operating funds. This is the first program of its kind in the nation and arguably the most legislatively active as the only state in the nation receiving reimbursement from Medicaid. Minnesota was the first to have “certified” paramedics trained specifically for the purpose of community paramedicine. The program consists of scheduled home visits to the homes of patients who face barriers to accessing care, the frail, the elderly and patients with chronic conditions. It is important to note that the vast majority of these patients are not homebound and therefore do not qualify for home health services.

Typical patients are those with frequent emergency room visits and transports by medics. This program’s successes can be attributed to the fact that they are integrated with the primary care providers and hospitals in the area. As a result, this integrated system of care can be more proactive about preventing exacerbations of illnesses instead of reactive. Community paramedics in this program take referral from emergency rooms and primary care providers and follow-up by completing in home assessments, vital signs, laboratory testing among other services.

Multiple health care disciplines collaborated to bring forth legislation that ensured that high quality patient care would be rendered in a way that was not duplicative of existing services. Legislation was brought forth in the 2011 session. The community paramedic training curriculum includes a 300 hours of specialized training and focuses on assessment of health care needs.

In 2012 additional legislation was brought forth and passed to provide a set fee schedule for the reimbursement of a finite set of services. The program provided service to 1200 patients in the first year of operation and has been well received by the patients that it serves.

Western Eagle County Ambulance District (Vail, CO)

This community paramedic program was launched in 2010, then after a lack of funding the program was put on hold and then restarted again in 2012. This program was one of the first in the nation to utilize and pilot the Community Paramedic curriculum that was designed and developed by the Community Health care and Emergency Cooperative, of which Western Eagle County is a contributing member. The program has been grant funded through organizations and foundations such as the Colorado Department of Public Health Emergency Medical and Trauma Services, the Colorado Health Foundation, Eagle County, and local community grants.

The program was designed after determining that the rural populations in Eagle County are medically underserved. 30% of the residents lacked health insurance and 38% of the households there reported having a lack of access to health care. The services are rendered and provided in areas where medical clinics, hospitals, and primary care providers are scarce or simply do not exist. Patients are also referred to the program through their own primary care provider and are afforded the services which include, medicine reconciliation, hospital discharge follow-up, home safety checks, social and nutritional assessments, and illness and medication education and compliance. For those patients without a primary care provider, the community paramedic will connect the patient with one and the physician orders and directs each visit.

Patients were profiled from July 2012 to December 2013 as part of a pilot study to gauge the effectiveness of the program. Of this study, 55 patients were served and visited a total of 216 times cumulatively, the median age of the patient was 60 years of age, 36% of patients were less than 10 years of age, and 47% were over the age of 65. The program was able to prevent 120 doctor visits, 28 ambulance transports, 26 emergency room visits, 3 hospital readmissions and one patient was kept out of a skilled nursing facility for 562 days as a result of the paramedic services. Savings to the health care system were determined based on these statistics, and an average savings of \$5,237 per patient were found. Overall a total health care cost savings of \$288,028 were reported.

State of the Evidence

The RHIC working group conducted a systematic review of the literature to find empiric evidence to support an expanded scope for paramedics. Cochrane, Medline, CINAHL, and Embase databases were searched from January 1, 2000 to July 1, 2015 for all relevant articles. A complex set of search strategies was utilized including the following key terms: community paramedicine, mobile integrated health care, paramedics, community health, population health management, and emergency medical services. The string of search terms was developed by consensus of the RHIC CP working group and by hand searching various key terms and medical subject headings from articles and bibliographies found on the topics of community paramedicine and mobile integrated health care.

The main foci of the systematic review were to find evidence of improved patient outcomes and evidence of increased overall system efficiencies. The search strategy yielded 4011 articles. A total of 3915 articles were reviewed and excluded based upon titles, and 96 citation abstracts were reviewed. Only 13 articles were selected for full review, and of those 13 only 7 of them were considered worthy of inclusion in a full review of the literature. Findings from this literature review will be published in a white paper at a later date.

For the purposes of this brief report, the review of literature section will be abbreviated to include only one systematic review that sums up the state of the CP literature. Our systematic review failed to generate any new well conducted, peer reviewed research investigations that go

above and beyond the findings of this one systematic review conducted by Bigham, Kennedy, Drennan and Morrison. This systematic review found 11 well conducted research studies in the United Kingdom, Australia and the United States indicating that the utilization of community paramedics in an expanded role is safe, effective and feasible; CP was also associated with improved patient and practitioner satisfaction and health care costs were minimized. This systematic review which looked at over 3,000 citations generated only one well conducted randomized controlled trial from the United Kingdom.⁵

Perhaps the largest hurdle that the concept of MIH-CP needs to overcome is the lack of empirical data to support the practice. Systematic programmatic evaluations are few and far between. To date, there is a paucity of studies validating this as an effective model of care. Despite this shortcoming, there are volumes of promising anecdotal reports about the early successes of CP programs across the nation.

Our review of literature suggests that this is a practice of promise which needs further systematic validation and study. Indiana has a great opportunity to make significant contributions to the literature by implementing high-quality CP programs with rigorous evaluation methodologies.

Recommendations

The RHIC working group has spent a significant amount of time and effort researching CP programs both in the state and nation. The working group has the following recommendations for the state of Indiana and the Indiana State Department of Health to make CP a viable part of Indiana's population health management strategy.

1. Medicaid language should be promulgated to provide for the reimbursement of CP services by certified community paramedics.
2. A floor education and certification need to be established for the billing of CP activity. The education and certification should not be endorsed to limit current CP activities but simply to ensure that a minimum standard for training has been established for billing Medicaid. This will in turn drive future CP certifications, potentiate quality, and could ultimately result in a higher wage for one of our most underpaid and underappreciated sectors of health care professionals.

It is important that programs currently operating with paramedics who do not have a specific CP certification are not prohibited from engaging in such activities provided they are able to document that they have targeted training in place that is congruent with the types of services that the specific CP program is providing. Ball Memorial's program is a great example of this. Many Indiana CP programs are operating in the best interest of the communities that they serve and are making contributions to the general medical community and the public. While paramedics without CP certification should be encouraged to pursue certification to engage in these activities, this should not be established as the standard initially.

3. Paramedics need to have criminal background checks completed as do other licensed health care professionals in the state of Indiana. This should also apply to CPs and other EMS personnel. These professionals are entering the homes of neighbors, friends, family, and loved ones and we need to ensure that the state has rules and regulations in place to protect patients that are served. Background checks should not be optional, however there should be a small and finite set of criminal charges that would prevent paramedics and EMS personnel from maintaining or pursuing careers in the EMS field. Charges such as fraud, elder abuse, child abuse, theft, aggravated battery, assault, and substance abuse or drug diversion should top the list of concerning criminal activity.

A formal review process should be developed for EMS personnel to be able to speak to previous criminal activity. Some of the best health care professionals have been involved in criminal activity at some point in their lives and should be given due process in terms of addressing their past behaviors.

4. Services provided by community paramedics should be complimentary of those provided by nursing and home health professionals. The relationship between nursing, community paramedicine, and other members of the multidisciplinary care team should be a symbiotic one that works to coordinate care for the greater good. The essential health services provided by these health care professionals can co-exist and each can serve to improve the care delivered by others. It is only through professional interaction, improved communication, and care coordination that we will truly realize the full potential of all members of the health care team.

5. A standard set of reporting metrics should be established and required for all community paramedicine activity to help Indiana continue to be the leaders in CP across the nation. A comprehensive set of metrics must be established for Indiana to track health outcomes, to monitor cost, to make the business case for CP, and to make contributions to the generalizable knowledge regarding the state of CP in the nation.

6. Community paramedicine activity is a medical management and population health management issue and not an emergency medicine activity. Community paramedicine activity has the ability to make significant contributions to the broader public health environment in the state of Indiana, to greatly reduce cost and to improve health outcomes for all. As such, community paramedicine activity should be governed under the auspices of the Indiana State Department of Health.

While this is not congruent with current EMS activities, this strategy would allow the state to leverage the strengths of ISDH's current infrastructure and personnel to ensure that health outcomes are collected, analyzed, and reports disseminated to multiple community stakeholders. ISDH has epidemiologists, data analysts, and a larger network of health professionals that can help guide CP activity toward its full potential.

While many will deem this recommendation to be controversial, it is our belief that this finite delineation of population health management versus emergency medical services will eventually result in increased collaboration among the two distinct branches and improve monitoring of the multitude of complex medical issues facing the state. Health care is making tremendous progress toward tearing down the silos that prevent communication and collaboration. This needs to be mirrored at the state government level.

7. The recertification and education process for paramedics and EMS personnel needs to be scrutinized and revamped. This is a broad recommendation that can be more narrowly tied to CP for the purposes of this document. Paramedics serving in the role of community paramedics should have educational activities from many broad categories however they should have primers and refresher courses on CP centric topics and activities. The recertification process should be one that ensures ongoing and continued competence in the specified role.

8. Consistent with the findings from the state paramedic survey, it is the recommendation of the RHIC working group that the CP certification should apply to the individual paramedic. This model is congruent with other health care professionals who bill Indiana Medicaid for approved services. This would allow individual providers to generate revenue for their individual affiliate service to help them maintain financial solvency. It allows for more accurate tracking of community paramedicine activity on an individual level and may help to curb the unlikely but plausible practice of fraudulent billing. Applying the certification to the individual medic also has the potential to create a market and demand for paramedics who have sought additional training and certification to serve in this expanded scope.

9. The Indiana State Department of Health and the Emergency Medical Services Commission should engage EMS services, local health departments, general practitioners, public service agencies, the Indiana State Nurses Association, and others to discuss the role of CP in the state. Clear objectives for community paramedicine activity within the state of Indiana need to be established. Achieving consensus on a standard set of CP objectives will contribute to a safe and effective set of CP activities that will contribute to the improvement of health outcomes and reduction of health care costs in the state of Indiana.

10. The Indiana State Department of Health, State Office of Rural Health needs to identify funding and provide a formal request for proposals from a small cadre of invited CP programs from around the state. A set of 3-5 regional pilots should be established with funding to support CP certifications, formalized community needs assessments using a standardized tool, development of a standard set of performance measures to be collected by the programs, and a data warehouse to collect the outcomes to systematically evaluate CP in the state of Indiana using sound scientific principles. Partnerships could be identified and endorsed by the Indiana State Department of Health for targeted Federal grant opportunities to build upon the groundwork from the initial contribution of a limited amount of state dollars.

11. Governor Pence should strongly consider announcing a state community paramedicine task force, appointing members from around the state from all health care disciplines, to work in concert with ISDH, the EMS Commission, and other stakeholders to advance CP in the state of Indiana. Political push back could be minimized by getting broad support from bipartisan legislators and identifying this as a non-political issue but a social issue. The CP task force should be charged with looking at CP as a mechanism to simultaneously improve the health of Hoosiers, enhance the experience and outcomes for patients while reducing the per capita cost of health care for the state of Indiana.

Conclusion

Developing a formalized nontraditional role for CPs in the state of Indiana will be a challenging endeavor. It is imperative that the state agencies that play a role in the health and well-being of Hoosiers come together to seriously consider how to formalize this role and to systematically evaluate the outcomes. Advancing CP in the state of Indiana will take an unprecedented amount of collaboration and coordination among state agencies, Indiana Medicaid, and state legislators.

The RHIC CP working group has multiple reasons to believe that elevating the practice of nonphysician health care providers such as community paramedics will contribute to increased interprofessional collaboration and improved health outcomes. Perhaps the easiest way to build support around this important role is to look at the simple targets of ambulance use and ED utilization to begin to put a dollar figure to the potential of this intervention.

It should be noted that a review of the top 50 utilizers of a regional medical center and one ambulance service found that this small cadre of patients was responsible for nearly seven million dollars in gross healthcare charges and nearly \$400,000 in bad debt. These results are from one hospital ED and one ambulance service. Payer sources for this small subset of patients were mainly comprised of Indiana Medicaid.

Indiana is not alone in the fight against increasing healthcare costs, poor health outcomes, staggering morbidity and mortality and poor quality-of-life indicators. We are however uniquely poised to take decisive and deliberate action to clearly take the national stage as the leader in community paramedicine for the betterment of the health and well-being of Hoosiers.

References

1. National Association of Emergency Medical Technicians. Mobile integrated health care and community paramedicine. Available at: <http://www.naemt.org/MIC-CP/MIH-CP.aspx>. Accessed July 23, 2015.
- 2 Rural and Frontier EMS Agenda for the Future:
<http://www.ruralcenter.org/sites/default/files/rfemsagenda.pdf>
3. NAEMT Survey
4. Internet Video http://www.medstar911.org/Websites/medstar911/images/CBS_11_MIH_07-29-2015_16.29.45.mp4
5. Bigham BL, Kennedy SM, Drennan I, Morrison LJ: **Expanding paramedic scope of practice in the community: a systematic review of the literature.** *Prehosp Emerg Care* 2013, 17(3):361-372.

Attachment #5



EMS COMMISSION CERTIFICATION REPORT

Compiled: December 10, 2015



CERTIFICATIONS (12/10/2015)	Total # of Certs	Highest Lvl. Cert
EMS - PARAMEDIC	4273	4273
EMS - ADVANCED EMT	498	461
EMS - EMT	19463	14726
EMS - EMR	5237	4935
EMT - PI	512	N/A
TOTAL:	29983	24395

Q1 - 2015	Count
EMS - PARAMEDIC	78
EMS - ADVANCED EMT	37
EMS - EMT	430
EMS - EMR	124
EMT - PI	5
TOTAL:	674

Q2 - 2015	Count
EMS - PARAMEDIC	69
EMS - ADVANCED EMT	19
EMS - EMT	559
EMS - EMR	168
EMT - PI	10
TOTAL:	825

Q3 - 2015	Count
EMS - PARAMEDIC	80
EMS - ADVANCED EMT	24
EMS - EMT	412
EMS - EMR	91
EMT - PI	8
TOTAL:	615

Q4 - 2015	Count
EMS - PARAMEDIC	80
EMS - ADVANCED EMT	24
EMS - EMT	412
EMS - EMR	91
EMT - PI	8
TOTAL:	615

Q1 - 2014	Count
EMS - PARAMEDIC	68
EMT - INTERMEDIATE	0
EMS - ADVANCED EMT (new)	44
EMT - BASIC ADVANCED	0
EMS - EMT	171
EMS - EMR	88
EMT - PI	7
TOTAL:	378

Q2 - 2014	Count
EMS - PARAMEDIC	127
EMT - INTERMEDIATE	0
EMS - ADVANCED EMT (new)	80
EMT - BASIC ADVANCED	0
EMS - EMT	475
EMS - EMR	197
EMT - PI	2
TOTAL:	881

Q3 - 2014	Count
EMS - PARAMEDIC	97
EMS - ADVANCED EMT	232
EMS - EMT	468
EMS - EMR	66
EMT - PI	11
TOTAL:	874

Q4 - 2014	Count
EMS - PARAMEDIC	78
EMS - ADVANCED EMT	47
EMS - EMT	225
EMS - EMR	156
EMT - PI	9
TOTAL:	515

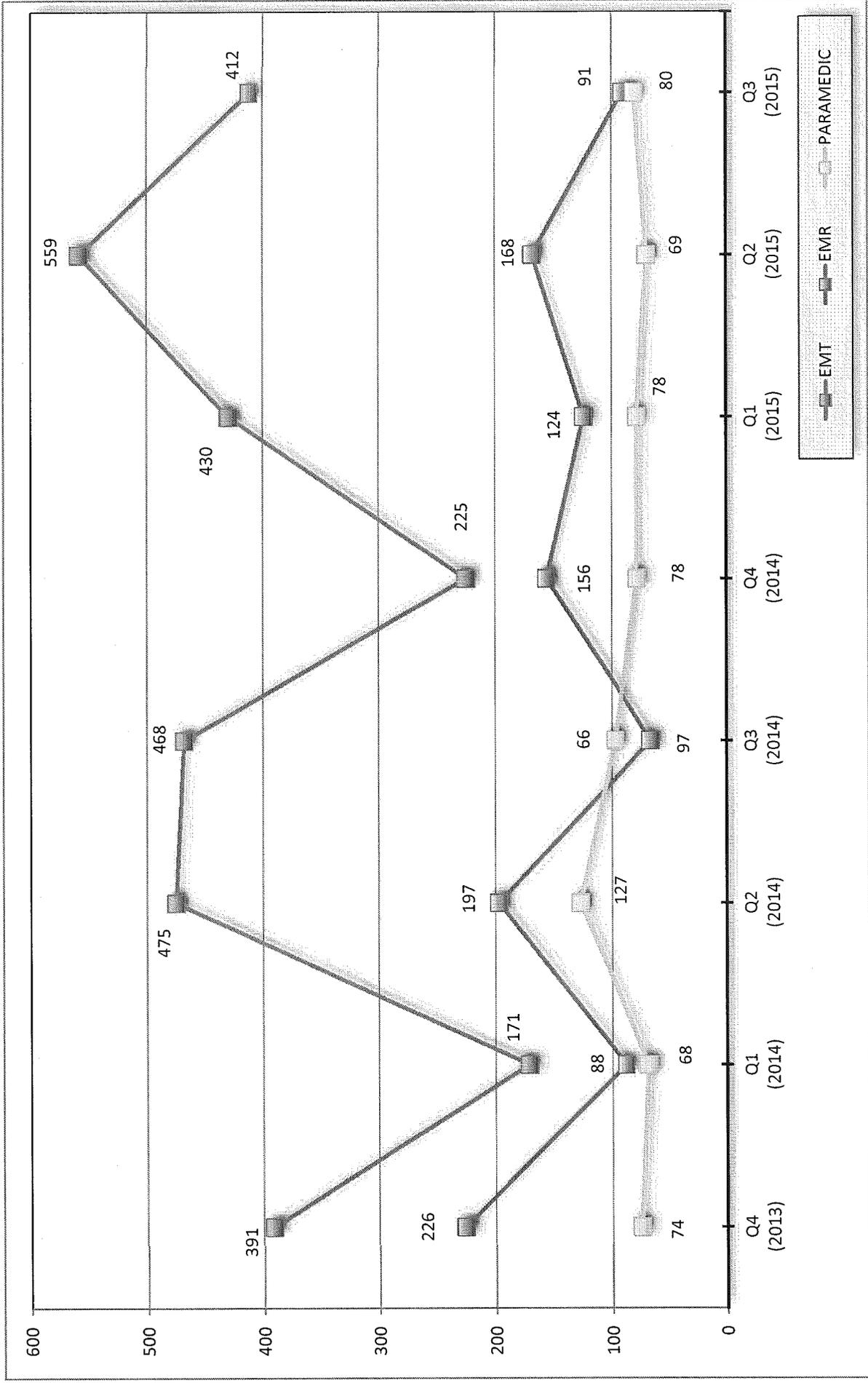
Q1 - 2013	Count
EMS - PARAMEDIC	97
EMT - INTERMEDIATE	2
EMS - ADVANCED EMT (new)	0
EMT - BASIC ADVANCED	18
EMS - EMT	372
EMS - EMR	198
EMT - PI	8
TOTAL:	695

Q2 - 2013	Count
EMS - PARAMEDIC	24
EMT - INTERMEDIATE	2
EMS - ADVANCED EMT (new)	2
EMT - BASIC ADVANCED	14
EMS - EMT	525
EMS - EMR	209
EMT - PI	3
TOTAL:	779

Q3 - 2013	Count
EMS - PARAMEDIC	76
EMT - INTERMEDIATE	1
EMS - ADVANCED EMT (new)	11
EMT - BASIC ADVANCED	1
EMS - EMT	464
EMS - EMR	93
EMT - PI	15
TOTAL:	661

Q4 - 2013	Count
EMS - PARAMEDIC	74
EMT - INTERMEDIATE	0
EMS - ADVANCED EMT (new)	15
EMT - BASIC ADVANCED	0
EMS - EMT	391
EMS - EMR	226
EMT - PI	6
TOTAL:	712

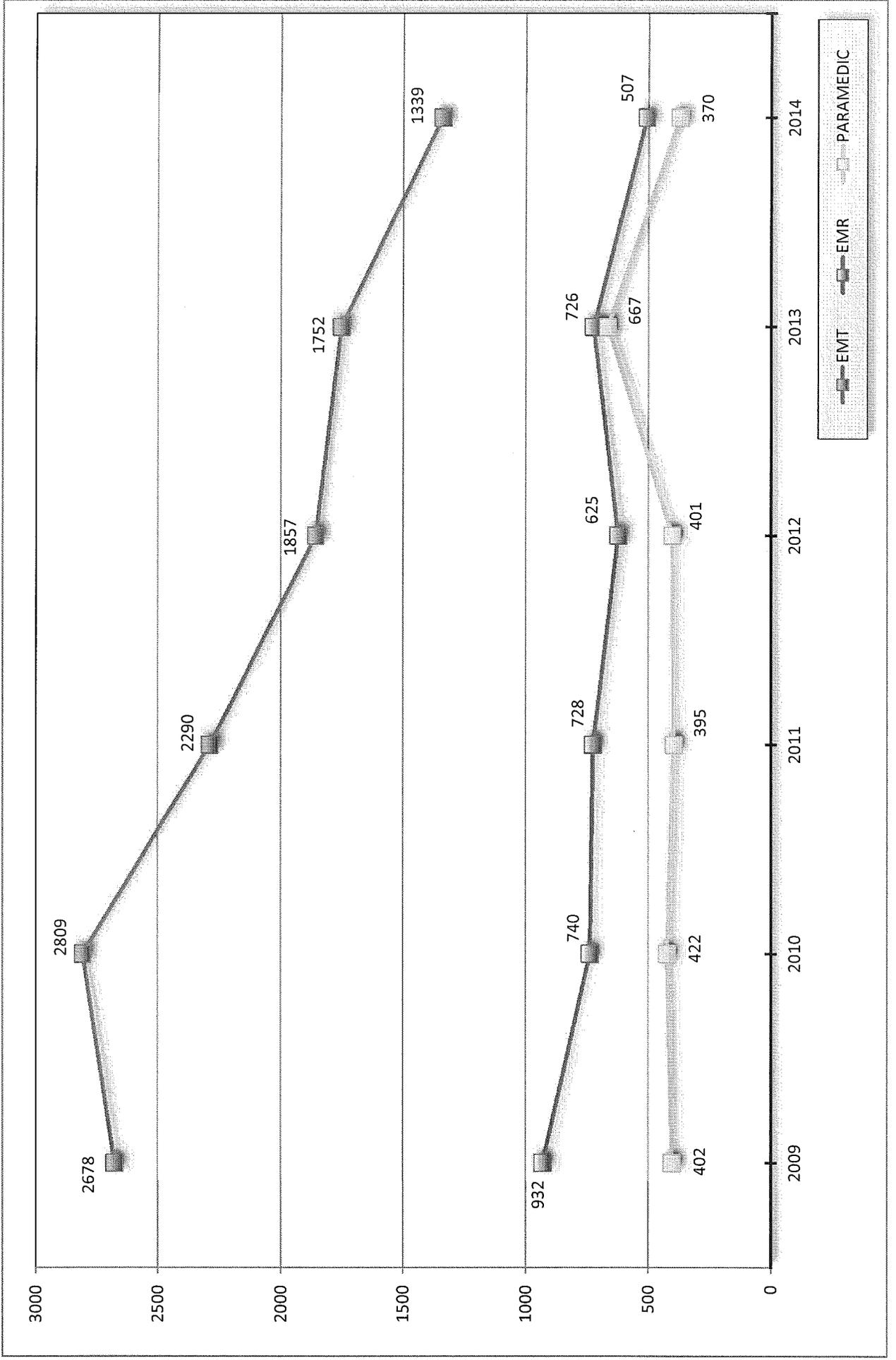
QUARTERLY	Q4 (2013)	Q1 (2014)	Q2 (2014)	Q3 (2014)	Q4 (2014)	Q1 (2015)	Q2 (2015)	Q3 (2015)
EMT	391	171	475	468	225	430	559	412
EMR	226	88	197	66	156	124	168	91
PARAMEDIC	74	68	127	97	78	78	69	80



Q4 (2015)	Q1 (2016)	Q2 (2016)	Q3 (2016)	Q4 (2016)	Q1 (2017)	Q2 (2017)
-	-	-	-	-	-	-
-	-	-	-	-	-	-
-	-	-	-	-	-	-

YEARLY	2009	2010	2011	2012	2013	2014	2015
EMT	2678	2809	2290	1857	1752	1339	
EMR	932	740	728	625	726	507	
PARAMEDIC	402	422	395	401	667	370	

YEARLY CHANGE	'09-'10	'10-'11	'11-'12	'12-'13	'13-'14	'14-'15
EMT	131	(519)	(433)	(105)	(413)	
EMR	(192)	(12)	(103)	101	(219)	
PARAMEDIC	20	(27)	6	266	(297)	



Hilton, Candice

From: Straumins, Alexander
Sent: Thursday, December 10, 2015 1:35 PM
To: Hilton, Candice
Subject: COMMISSION DATA (12.10.2015)
Attachments: COMMISSION REPORT(12.10.2015).xlsx; POST DATA - Do NOT have POST (12.10.2015).xlsx

Candice,

Here is the data for the commission meeting.

- Commission Report Attached

- **POST DATA - Detailed file attached with person information, Org., email, and highest level cert they hold within EMS.**
 - TOTAL PERSONS WHO HAVE **ACTIVE (ACTIVE)** EMS CERT, BUT NOT POST – **2163**
 - TOTAL PERSONS WHO HAVE **PROBATION (ACTIVE)** EMS CERT, BUT NOT POST – **13**
 - TOTAL PERSONS WHO HAVE **INACTIVE (INACTIVE)** EMS CERT, BUT NOT POST – **8**
 - TOTAL PERSONS WHO HAVE **SUSPENDED (INACTIVE)** EMS CERT, BUT NOT POST – **4**
 - **GRAND TOTAL -> 2188**

NOTE: **115** of the **2188** persons do NOT have an email addresses in Acadis.

BREAKDOWN OF DATA BY CERT TYPE (**ACTIVE CERTS ONLY**) (*Based on their highest level active cert*)

- EMS – PAREMEDIC: **223**
- EMS – AEMT: **20**
- EMS – EMT: **1255**
- EMS – EMR: **678**

BREAKDOWN OF PRIMARY ORGS OF THESE PERSONS (**ACTIVE CERTS ONLY**)

- PERSONS WITH NO PRIMARY ORG ON THEIR RECORD – **816**
- # of individual organizations set as primary employment for these persons – **600+**
 - **~410** Fire department
 - **~60** Police or Sheriff departments
 - **~80** ambulance or EMS services

Alex

Emergency Medical Services Provider Certification Report

Date : December 11, 2015

December 18, 2015

In compliance with the Rules and Regulations for the operation and administration of Emergency Medical Services, this report is respectfully submit to the Commission at the **December 18, 2015** Commission meeting, the following report of agencies who have meet the requirements for certification as Emergency Medical Service Providers and their vehicles.

<u>Provider Level</u>	<u>Counts</u>
Rescue Squad Organization	3
Basic Life Support Non-Transport	447
Ambulance Service Provider	95
EMT Basic-Advanced Organization	14
EMT Basic-Advanced Organization non-transport	11
EMT Intermediate Organization	18
EMT Intermediate Organization non-transport	0
Paramedic Organization	192
Paramedic Organization non-transport	12
Rotorcraft Air Ambulance	13
Fixed Wing Air Ambulance	3
Total Count:	808

New Providers Since 07-OCT-15

Red Line Emergency Medical Services	Paramedic Certification: 12/03/2015
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Military Reciprocity since the last Commission meeting (information gathered 12/11/2015)

11 new individuals since the last Commission meeting for EMT for a total of 56 individuals for 2015

7 individual just needs to complete POST to receive his/her full two year certification

1 individual needs to turn in additional paperwork along with completing the POST

Total we have issued 48 full two year certification for military personnel since the beginning of 2015.

Attachment #6

Pass/Fail Report

Report Date: 11/20/2015 11:10:44 AM
Report Type: National Report
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
9660	76% (7340 / 9660)	86% (8286 / 9660)	86% (8355 / 9660)	0% (5 / 9660)	13% (1300 / 9660)	0% (0 / 9660)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:12:58 AM
Report Type: State Report (IN)
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
198	75% (148 / 198)	84% (167 / 198)	85% (168 / 198)	0% (0 / 198)	15% (30 / 198)	0% (0 / 198)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:16:38 AM
 Report Type: Program Report (IN)
 Registration Level: EMT-Paramedic / Paramedic
 Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
 Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	7	100% (7 / 7)	100% (7 / 7)	100% (7 / 7)	0% (0 / 7)	0% (0 / 7)	0% (0 / 7)
Community Health Network EMS	IN-4063	19	89% (17 / 19)	95% (18 / 19)	95% (18 / 19)	0% (0 / 19)	5% (1 / 19)	0% (0 / 19)
Elkhart General Hospital	IN-4067	8	75% (6 / 8)	75% (6 / 8)	75% (6 / 8)	0% (0 / 8)	25% (2 / 8)	0% (0 / 8)
Franciscan Saint Anthony Health Crown Point	IN-4079	7	71% (5 / 7)	71% (5 / 7)	86% (6 / 7)	0% (0 / 7)	14% (1 / 7)	0% (0 / 7)
Franciscan St Elizabeth Health	IN-4068	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Hendricks Regional Health	IN-4380	15	93% (14 / 15)	100% (15 / 15)	100% (15 / 15)	0% (0 / 15)	0% (0 / 15)	0% (0 / 15)
Ivy Tech Bloomington	IN-4071	5	100% (5 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Ivy Tech Community College Columbus	IN-4073	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)

Ivy Tech Community College Northeast	IN-4169	15	60% (9 / 15)	93% (14 / 15)	93% (14 / 15)	0% (0 / 15)	7% (1 / 15)	0% (0 / 15)
Ivy Tech Community College Richmond	IN-4501	5	20% (1 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Ivy Tech Community College Terre Haute	IN-4612	13	38% (5 / 13)	54% (7 / 13)	54% (7 / 13)	0% (0 / 13)	46% (6 / 13)	0% (0 / 13)
Ivy Tech Community College- Evansville	IN-4141	8	75% (6 / 8)	75% (6 / 8)	75% (6 / 8)	0% (0 / 8)	25% (2 / 8)	0% (0 / 8)
Ivy Tech Community College- Kokomo	IN-4362	8	63% (5 / 8)	63% (5 / 8)	63% (5 / 8)	0% (0 / 8)	38% (3 / 8)	0% (0 / 8)
Ivy Tech South Bend	IN-4070	4	75% (3 / 4)	75% (3 / 4)	75% (3 / 4)	0% (0 / 4)	25% (1 / 4)	0% (0 / 4)
Methodist Hospitals	IN-4072	8	50% (4 / 8)	50% (4 / 8)	50% (4 / 8)	0% (0 / 8)	50% (4 / 8)	0% (0 / 8)
Pelham Training	IN-4668	24	83% (20 / 24)	92% (22 / 24)	92% (22 / 24)	0% (0 / 24)	8% (2 / 24)	0% (0 / 24)
St Francis Hospital	IN-4080	5	100% (5 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
St Mary Medical Center/Hbrt	IN-4943	10	50% (5 / 10)	80% (8 / 10)	80% (8 / 10)	0% (0 / 10)	20% (2 / 10)	0% (0 / 10)
St Vincent Hospital	IN-4081	9	100% (9 / 9)	100% (9 / 9)	100% (9 / 9)	0% (0 / 9)	0% (0 / 9)	0% (0 / 9)
Vincennes University	IN-4153	8	38% (3 / 8)	50% (4 / 8)	50% (4 / 8)	0% (0 / 8)	50% (4 / 8)	0% (0 / 8)
Wishard Health Services	IN-4083	17	100% (17 / 17)	100% (17 / 17)	100% (17 / 17)	0% (0 / 17)	0% (0 / 17)	0% (0 / 17)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:22:22 AM
Report Type: National Report
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
4499	59% (2667 / 4499)	71% (3202 / 4499)	72% (3224 / 4499)	0% (2 / 4499)	28% (1273 / 4499)	0% (0 / 4499)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:23:26 AM
Report Type: State Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
78	54% (42 / 78)	63% (49 / 78)	63% (49 / 78)	0% (0 / 78)	37% (29 / 78)	0% (0 / 78)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:24:14 AM
Report Type: Program Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2014 to 4th Quarter 2015
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Ball Memorial Hospital	IN-4369	12	42% (5 / 12)	67% (8 / 12)	67% (8 / 12)	0% (0 / 12)	33% (4 / 12)	0% (0 / 12)
Dearborn County Hospital	IN-4065	11	55% (6 / 11)	55% (6 / 11)	55% (6 / 11)	0% (0 / 11)	45% (5 / 11)	0% (0 / 11)
Ivy Tech Bloomin	IN-4071	3	100% (3 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Ivy Tech College Richmnd	IN-4501	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech South Bend	IN-4070	7	71% (5 / 7)	71% (5 / 7)	71% (5 / 7)	0% (0 / 7)	29% (2 / 7)	0% (0 / 7)
Jennings County Training Institutin	IN-5281	6	50% (3 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	33% (2 / 6)	0% (0 / 6)
Memori Hospital	IN-4157	19	53% (10 / 19)	53% (10 / 19)	53% (10 / 19)	0% (0 / 19)	47% (9 / 19)	0% (0 / 19)
New Haven EMS Training Institute	IN-5653	3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)

North Webster Tippecone Township EMS Ed	IN- 5311	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Parkview Whitley Hospital	IN- 5023	8	38% (3 / 8)	75% (6 / 8)	75% (6 / 8)	0% (0 / 8)	25% (2 / 8)	0% (0 / 8)
Scott County EMS	IN- 4078	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
St Vincent Hospital	IN- 4081	4	50% (2 / 4)	50% (2 / 4)	50% (2 / 4)	0% (0 / 4)	50% (2 / 4)	0% (0 / 4)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:34:02 AM
 Report Type: National Report
 Registration Level: EMT-Basic / EMT
 Course Completion Date: 4th Quarter 2015
 Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
1766	78% (1369 / 1766)	82% (1456 / 1766)	82% (1456 / 1766)	0% (0 / 1766)	18% (310 / 1766)	0% (0 / 1766)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Report Date: 11/20/2015 11:35:02 AM
Report Type: State Report (IN)
Registration Level: EMT-Basic / EMT
Course Completion Date: 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
7	71% (5 / 7)	71% (5 / 7)	71% (5 / 7)	0% (0 / 7)	29% (2 / 7)	0% (0 / 7)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Report Date: 11/20/2015 11:35:58 AM
Report Type: Program Report (IN)
Registration Level: EMT-Basic / EMT
Course Completion Date: 4th Quarter 2015
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Indiana University Health Goshen Hospital	IN-4162	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Pelham Training	IN-4668	6	67% (4 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	33% (2 / 6)	0% (0 / 6)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:37:45 AM
Report Type: National Report
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
31572	74% (23355 / 31572)	87% (27312 / 31572)	88% (27849 / 31572)	0% (154 / 31572)	7% (2257 / 31572)	4% (1327 / 31572)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 12:15:39 PM
Report Type: State Report (IN)
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
848	67% (572 / 848)	82% (695 / 848)	85% (721 / 848)	1% (10 / 848)	9% (80 / 848)	5% (42 / 848)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:38:54 AM
Report Type: Program Report (IN)
Registration Level: EMT-Paramedic / Paramedic
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	31	68% (21 / 31)	90% (28 / 31)	97% (30 / 31)	0% (0 / 31)	3% (1 / 31)	0% (0 / 31)
Community Health Network EMS	IN-4063	56	77% (43 / 56)	89% (50 / 56)	89% (50 / 56)	0% (0 / 56)	4% (2 / 56)	7% (4 / 56)
Elkhart General Hospital	IN-4067	62	58% (36 / 62)	77% (48 / 62)	85% (53 / 62)	3% (2 / 62)	11% (7 / 62)	3% (2 / 62)
Franciscan Saint Anthony Health	IN-4079	32	41% (13 / 32)	75% (24 / 32)	81% (26 / 32)	3% (1 / 32)	9% (3 / 32)	6% (2 / 32)
Crown Point Franciscan St Elizabeth Health	IN-4068	6	67% (4 / 6)	100% (6 / 6)	100% (6 / 6)	0% (0 / 6)	0% (0 / 6)	0% (0 / 6)
Hendricks Regional Health	IN-4380	28	93% (26 / 28)	100% (28 / 28)	100% (28 / 28)	0% (0 / 28)	0% (0 / 28)	0% (0 / 28)
Indiana University Health	IN-4062	16	88% (14 / 16)	94% (15 / 16)	100% (16 / 16)	0% (0 / 16)	0% (0 / 16)	0% (0 / 16)
Indiana University Health Goshen Hospital	IN-4162	5	40% (2 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)

Ivy Tech Bloomington	IN-4071	20	60%	70%	75%	0%	10%	15%
			(12 / 20)	(14 / 20)	(15 / 20)	(0 / 20)	(2 / 20)	(3 / 20)
Ivy Tech Community College - Madison	IN-4542	11	82%	91%	91%	0%	9%	0%
			(9 / 11)	(10 / 11)	(10 / 11)	(0 / 11)	(1 / 11)	(0 / 11)
Ivy Tech Community College Columbus	IN-4073	28	79%	93%	93%	0%	7%	0%
			(22 / 28)	(26 / 28)	(26 / 28)	(0 / 28)	(2 / 28)	(0 / 28)
Ivy Tech Community College Northeast	IN-4169	43	44%	65%	70%	0%	9%	21%
			(19 / 43)	(28 / 43)	(30 / 43)	(0 / 43)	(4 / 43)	(9 / 43)
Ivy Tech Community College Richmond	IN-4501	9	33%	89%	89%	0%	11%	0%
			(3 / 9)	(8 / 9)	(8 / 9)	(0 / 9)	(1 / 9)	(0 / 9)
Ivy Tech Community College Terre Haute	IN-4612	44	34%	45%	52%	5%	34%	9%
			(15 / 44)	(20 / 44)	(23 / 44)	(2 / 44)	(15 / 44)	(4 / 44)
Ivy Tech Community College- Evansville	IN-4141	33	55%	73%	79%	3%	12%	6%
			(18 / 33)	(24 / 33)	(26 / 33)	(1 / 33)	(4 / 33)	(2 / 33)
Ivy Tech Community College- Kokomo	IN-4362	27	63%	74%	78%	0%	19%	4%
			(17 / 27)	(20 / 27)	(21 / 27)	(0 / 27)	(5 / 27)	(1 / 27)
Ivy Tech South Bend	IN-4070	44	57%	64%	66%	0%	16%	18%
			(25 / 44)	(28 / 44)	(29 / 44)	(0 / 44)	(7 / 44)	(8 / 44)
Methodist Hospitals	IN-4072	27	56%	74%	74%	0%	22%	4%
			(15 / 27)	(20 / 27)	(20 / 27)	(0 / 27)	(6 / 27)	(1 / 27)
Pelham Training	IN-4668	150	79%	89%	91%	2%	6%	2%
			(119 / 150)	(134 / 150)	(137 / 150)	(3 / 150)	(9 / 150)	(3 / 150)
St Francis Hospital	IN-4080	16	94%	100%	100%	0%	0%	0%
			(15 / 16)	(16 / 16)	(16 / 16)	(0 / 16)	(0 / 16)	(0 / 16)
St Mary Medical Center/Hoba rt	IN-4943	27	56%	81%	81%	0%	15%	4%
			(15 / 27)	(22 / 27)	(22 / 27)	(0 / 27)	(4 / 27)	(1 / 27)

St Vincent Hospital	IN-4081 34	100% (34 / 34)	100% (34 / 34)	100% (34 / 34)	0% (0 / 34)	0% (0 / 34)	0% (0 / 34)
Vincennes University	IN-4153 34	50% (17 / 34)	71% (24 / 34)	79% (27 / 34)	3% (1 / 34)	18% (6 / 34)	3% (1 / 34)
Wishard Health Services	IN-4083 65	89% (58 / 65)	97% (63 / 65)	97% (63 / 65)	0% (0 / 65)	2% (1 / 65)	2% (1 / 65)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:48:34 AM
Report Type: National Report
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
12172	57% (6994 / 12172)	73% (8855 / 12172)	74% (9046 / 12172)	0% (44 / 12172)	18% (2176 / 12172)	8% (920 / 12172)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:49:53 AM
Report Type: State Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
568	50% (285 / 568)	67% (381 / 568)	69% (393 / 568)	1% (7 / 568)	19% (106 / 568)	11% (62 / 568)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:51:03 AM
Report Type: Program Report (IN)
Registration Level: Advanced EMT (AEMT)
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Adams Memorial Hospital	IN-4201	10	90% (9 / 10)	90% (9 / 10)	90% (9 / 10)	0% (0 / 10)	0% (0 / 10)	10% (1 / 10)
Alliance EMS	IN-5293	14	71% (10 / 14)	79% (11 / 14)	79% (11 / 14)	0% (0 / 14)	7% (1 / 14)	14% (2 / 14)
Ball Memorial Hospital	IN-4369	37	46% (17 / 37)	65% (24 / 37)	65% (24 / 37)	0% (0 / 37)	19% (7 / 37)	16% (6 / 37)
Columbus Regional Hospital	IN-4355	8	50% (4 / 8)	50% (4 / 8)	63% (5 / 8)	0% (0 / 8)	38% (3 / 8)	0% (0 / 8)
Deaconess Hospital	IN-4516	15	60% (9 / 15)	87% (13 / 15)	87% (13 / 15)	0% (0 / 15)	7% (1 / 15)	7% (1 / 15)
Dearborn County Hospital	IN-4065	24	50% (12 / 24)	58% (14 / 24)	58% (14 / 24)	0% (0 / 24)	42% (10 / 24)	0% (0 / 24)
Harrison County Hospital EMS	IN-4336	10	80% (8 / 10)	90% (9 / 10)	90% (9 / 10)	0% (0 / 10)	0% (0 / 10)	10% (1 / 10)
Indiana University Health Goshen Hospital	IN-4162	10	40% (4 / 10)	50% (5 / 10)	50% (5 / 10)	0% (0 / 10)	0% (0 / 10)	50% (5 / 10)
Ivy Tech	IN-4071	3	100%	100%	100%	0%	0%	0%

Bloomington		(3 / 3)	(3 / 3)	(3 / 3)	(0 / 3)	(0 / 3)	(0 / 3)
Ivy Tech Community College	IN-4864 1	0% (0 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech Community College Northeast	IN-4169 5	100% (5 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Ivy Tech Community College Richmond	IN-4501 2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	0% (0 / 2)	50% (1 / 2)
Ivy Tech Community College- Evansville	IN-4141 1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech South Bend	IN-4070 52	46% (24 / 52)	77% (40 / 52)	83% (43 / 52)	4% (2 / 52)	8% (4 / 52)	6% (3 / 52)
Jennings County Training Institution	IN-5281 24	42% (10 / 24)	50% (12 / 24)	50% (12 / 24)	0% (0 / 24)	50% (12 / 24)	0% (0 / 24)
Kings Daughters Hospital EMS	IN-5473 7	43% (3 / 7)	57% (4 / 7)	57% (4 / 7)	0% (0 / 7)	43% (3 / 7)	0% (0 / 7)
Margaret Mary Community Hospital	IN-4084 2	50% (1 / 2)	100% (2 / 2)	100% (2 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)
Memorial Hospital	IN-4157 79	49% (39 / 79)	62% (49 / 79)	66% (52 / 79)	1% (1 / 79)	25% (20 / 79)	8% (6 / 79)
Memorial Hospital/Jasp er	IN-5271 6	33% (2 / 6)	50% (3 / 6)	50% (3 / 6)	0% (0 / 6)	0% (0 / 6)	50% (3 / 6)
Methodist Hospitals	IN-4072 4	75% (3 / 4)	75% (3 / 4)	75% (3 / 4)	0% (0 / 4)	25% (1 / 4)	0% (0 / 4)
New Haven EMS Training Institute	IN-5653 3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)

North Webster Tippecanoe Township EMS Ed	IN-5311 38	53% (20 / 38)	71% (27 / 38)	76% (29 / 38)	3% (1 / 38)	21% (8 / 38)	0% (0 / 38)
Parkview Huntington Hospital EMS	IN-5269 62	58% (36 / 62)	81% (50 / 62)	82% (51 / 62)	2% (1 / 62)	5% (3 / 62)	11% (7 / 62)
Parkview Regional Medical Center	IN-5296 16	63% (10 / 16)	88% (14 / 16)	88% (14 / 16)	0% (0 / 16)	0% (0 / 16)	13% (2 / 16)
Parkview Whitley Hospital	IN-5023 8	38% (3 / 8)	75% (6 / 8)	75% (6 / 8)	0% (0 / 8)	25% (2 / 8)	0% (0 / 8)
Pelham Training	IN-4668 15	20% (3 / 15)	53% (8 / 15)	53% (8 / 15)	0% (0 / 15)	47% (7 / 15)	0% (0 / 15)
Prompt Ambulance Central	IN-5138 15	87% (13 / 15)	87% (13 / 15)	87% (13 / 15)	0% (0 / 15)	13% (2 / 15)	0% (0 / 15)
Pulaski County EMS Training Institute	IN-5027 3	33% (1 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)
Scott County EMS	IN-4078 15	40% (6 / 15)	53% (8 / 15)	53% (8 / 15)	0% (0 / 15)	33% (5 / 15)	13% (2 / 15)
St Joseph's Regional Med Ctr- Plymouth	IN-5001 5	20% (1 / 5)	80% (4 / 5)	80% (4 / 5)	0% (0 / 5)	20% (1 / 5)	0% (0 / 5)
St Mary Medical Center/Hobar t	IN-4943 14	36% (5 / 14)	36% (5 / 14)	43% (6 / 14)	0% (0 / 14)	0% (0 / 14)	57% (8 / 14)
St Vincent Hospital	IN-4081 4	50% (2 / 4)	50% (2 / 4)	50% (2 / 4)	0% (0 / 4)	50% (2 / 4)	0% (0 / 4)
Sullivan County Community Hospital	IN-5193 4	25% (1 / 4)	25% (1 / 4)	25% (1 / 4)	0% (0 / 4)	0% (0 / 4)	75% (3 / 4)
Switzerland County EMS Inc.	IN-4145 8	25% (2 / 8)	50% (4 / 8)	50% (4 / 8)	0% (0 / 8)	0% (0 / 8)	50% (4 / 8)

Terre Haute Regional Hospital	IN-4152 9	33% (3 / 9)	56% (5 / 9)	56% (5 / 9)	22% (2 / 9)	0% (0 / 9)	22% (2 / 9)
Tri County Ambulance	IN-4644 27	37% (10 / 27)	48% (13 / 27)	52% (14 / 27)	0% (0 / 27)	30% (8 / 27)	19% (5 / 27)
Union Hosp Health Group	IN-4431 2	0% (0 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Vincennes University	IN-4153 1	0% (0 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Yellow Ambulance Training Bureau	IN-4085 5	40% (2 / 5)	40% (2 / 5)	40% (2 / 5)	0% (0 / 5)	60% (3 / 5)	0% (0 / 5)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:53:08 AM
Report Type: National Report
Registration Level: EMT-Basic / EMT
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempt ed The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
208337	68% (142182 / 208 337)	79% (164629 / 208 337)	80% (165835 / 208 337)	0% (166 / 2083 37)	14% (28653 / 208 337)	7% (13784 / 208 337)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:54:37 AM
Report Type: State Report (IN)
Registration Level: EMT-Basic / EMT
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
701	68% (477 / 701)	77% (538 / 701)	77% (541 / 701)	0% (0 / 701)	17% (116 / 701)	6% (44 / 701)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Pass/Fail Report

Report Date: 11/20/2015 11:56:28 AM
Report Type: Program Report (IN)
Registration Level: EMT-Basic / EMT
Course Completion Date: 4th Quarter 2012 to 4th Quarter 2015
Training Program: All

Program Name	Program Code	Attempted The Exam	First Attempt Pass	Cumulative Pass Within 3 Attempts	Cumulative Pass Within 6 Attempts	Failed All 6 Attempts	Eligible For Retest	Did Not Complete Within 2 Years
Area 30 Career Center	IN-5147	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ball Memorial Hospital	IN-4369	3	100% (3 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Bloomington Hospital of Orange County	IN-4761	1	0% (0 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Cameron Memorial Hospital	IN-4534	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Central Nine Career Center	IN-5026	3	33% (1 / 3)	33% (1 / 3)	33% (1 / 3)	0% (0 / 3)	67% (2 / 3)	0% (0 / 3)
Community Health Network EMS	IN-4063	6	67% (4 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	17% (1 / 6)	17% (1 / 6)
Deaconess Hospital	IN-4516	22	73% (16 / 22)	86% (19 / 22)	86% (19 / 22)	0% (0 / 22)	14% (3 / 22)	0% (0 / 22)
DePauw University	IN-4580	8	38% (3 / 8)	50% (4 / 8)	50% (4 / 8)	0% (0 / 8)	38% (3 / 8)	13% (1 / 8)

Elkhart General Hospital	IN- 4067	23	52% (12 / 23)	57% (13 / 23)	65% (15 / 23)	0% (0 / 23)	26% (6 / 23)	9% (2 / 23)
Emergency Services Education Center	IN- 4960	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Franciscan Saint Anthony Health	IN- 4079	3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	0% (0 / 3)	33% (1 / 3)
Crown Point Franciscan St Elizabeth Health	IN- 4068	5	100% (5 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
Franciscan St. Margaret Health EMS Acade	IN- 5267	3	100% (3 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Grant County EMS	IN- 4732	1	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	100% (1 / 1)	0% (0 / 1)
Indiana University	IN- 4495	16	38% (6 / 16)	50% (8 / 16)	50% (8 / 16)	0% (0 / 16)	25% (4 / 16)	25% (4 / 16)
Indiana University Health	IN- 4062	3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	0% (0 / 3)	33% (1 / 3)
Indiana University Health Goshen Hospital	IN- 4162	5	80% (4 / 5)	100% (5 / 5)	100% (5 / 5)	0% (0 / 5)	0% (0 / 5)	0% (0 / 5)
IU Health Blackford Hospital	IN- 5302	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech Bloomington	IN- 4071	3	33% (1 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)
Ivy Tech Community College	IN- 4864	7	57% (4 / 7)	71% (5 / 7)	71% (5 / 7)	0% (0 / 7)	29% (2 / 7)	0% (0 / 7)

Ivy Tech Community College - Northwest	IN- 4979	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Ivy Tech Community College Columbus	IN- 4073	3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)
Ivy Tech Community College Northeast	IN- 4169	17	82% (14 / 17)	82% (14 / 17)	82% (14 / 17)	0% (0 / 17)	12% (2 / 17)	6% (1 / 17)
Ivy Tech Community College Richmond	IN- 4501	6	50% (3 / 6)	67% (4 / 6)	67% (4 / 6)	0% (0 / 6)	17% (1 / 6)	17% (1 / 6)
Ivy Tech Community College Southeast	IN- 4687	2	100% (2 / 2)	100% (2 / 2)	100% (2 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)
Ivy Tech Community College Terre Haute	IN- 4612	1	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	100% (1 / 1)	0% (0 / 1)
Ivy Tech Community College- Evansville	IN- 4141	44	66% (29 / 44)	73% (32 / 44)	73% (32 / 44)	0% (0 / 44)	20% (9 / 44)	7% (3 / 44)
Ivy Tech Community College- Kokomo	IN- 4362	4	50% (2 / 4)	100% (4 / 4)	100% (4 / 4)	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)
Ivy Tech South Bend	IN- 4070	20	60% (12 / 20)	75% (15 / 20)	75% (15 / 20)	0% (0 / 20)	20% (4 / 20)	5% (1 / 20)
Margaret Mary Community Hospital	IN- 4084	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Memorial Hospital	IN- 4157	2	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)	100% (2 / 2)
Memorial Hospital/Jas per	IN- 5271	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
New Chapel	IN-	1	0%	100%	100%	0%	0%	0%

Fire & EMS	4934		(0 / 1)	(1 / 1)	(1 / 1)	(0 / 1)	(0 / 1)	(0 / 1)
Paramedic Science	IN-5082	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Parkview Huntington Hospital	IN-5269	1	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	100% (1 / 1)	0% (0 / 1)
Parkview Memorial Hospital	IN-4074	3	67% (2 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Parkview Regional Medical Center	IN-5296	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Pelham Training	IN-4668	196	74% (145 / 196)	82% (160 / 196)	82% (160 / 196)	0% (0 / 196)	13% (26 / 196)	5% (10 / 196)
Porter Health System	IN-4075	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Prompt Ambulance Central	IN-5138	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Riverview Hospital	IN-4077	4	75% (3 / 4)	100% (4 / 4)	100% (4 / 4)	0% (0 / 4)	0% (0 / 4)	0% (0 / 4)
Saint John's Health System	IN-4588	1	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	100% (1 / 1)	0% (0 / 1)
St Francis Hospital	IN-4080	4	75% (3 / 4)	75% (3 / 4)	75% (3 / 4)	0% (0 / 4)	25% (1 / 4)	0% (0 / 4)
St Mary Medical Center/Hobart	IN-4943	3	67% (2 / 3)	67% (2 / 3)	67% (2 / 3)	0% (0 / 3)	33% (1 / 3)	0% (0 / 3)
St Vincent Hospital	IN-4081	92	65% (60 / 92)	74% (68 / 92)	74% (68 / 92)	0% (0 / 92)	18% (17 / 92)	8% (7 / 92)
Switzerland County EMS Inc.	IN-4145	1	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)	100% (1 / 1)
Terre Haute Regional Hospital	IN-4152	2	50% (1 / 2)	100% (2 / 2)	100% (2 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)

Tri County Ambulance	IN- 4644	1	100% (1 / 1)	100% (1 / 1)	100% (1 / 1)	0% (0 / 1)	0% (0 / 1)	0% (0 / 1)
Vincennes University	IN- 4153	3	67% (2 / 3)	100% (3 / 3)	100% (3 / 3)	0% (0 / 3)	0% (0 / 3)	0% (0 / 3)
Vincennes University Jasper Center	IN- 4478	2	50% (1 / 2)	50% (1 / 2)	50% (1 / 2)	0% (0 / 2)	50% (1 / 2)	0% (0 / 2)
Westfield Fire Department	IN- 5028	2	50% (1 / 2)	100% (2 / 2)	100% (2 / 2)	0% (0 / 2)	0% (0 / 2)	0% (0 / 2)
Wishard Health Services	IN- 4083	55	85% (47 / 55)	91% (50 / 55)	91% (50 / 55)	0% (0 / 55)	9% (5 / 55)	0% (0 / 55)
Yellow Ambulance Training Bureau	IN- 4085	107	64% (68 / 107)	72% (77 / 107)	73% (78 / 107)	0% (0 / 107)	20% (21 / 107)	7% (8 / 107)

Attempted the exam: Number of graduates that make at least one attempt at the exam.

First attempt pass: Number and percent of those who attempt the exam that pass on the first attempt.

Cumulative pass within 3 attempts: Number and percent of those who attempt the exam who pass on the first, second, or third attempt.

Cumulative pass within 6 attempts: Number and percent of those who attempt the exam who pass on the first, second, third, fourth, fifth, or sixth attempt.

Failed all 6 attempts: Number and percent of those who fail the exam six times.

Eligible for retest: Number and percent of those who failed their last attempt, but remain eligible for retest (less than six attempts, less than two years from course completion.)

Did not complete within 2 years: Number and percent of those who fail their last attempt and are no longer eligible for retest (more than two years from course completion.)

Attachment #7



INDIANA DEPARTMENT
OF HOMELAND SECURITY
NALOXONE
(NARCAN) UPDATE

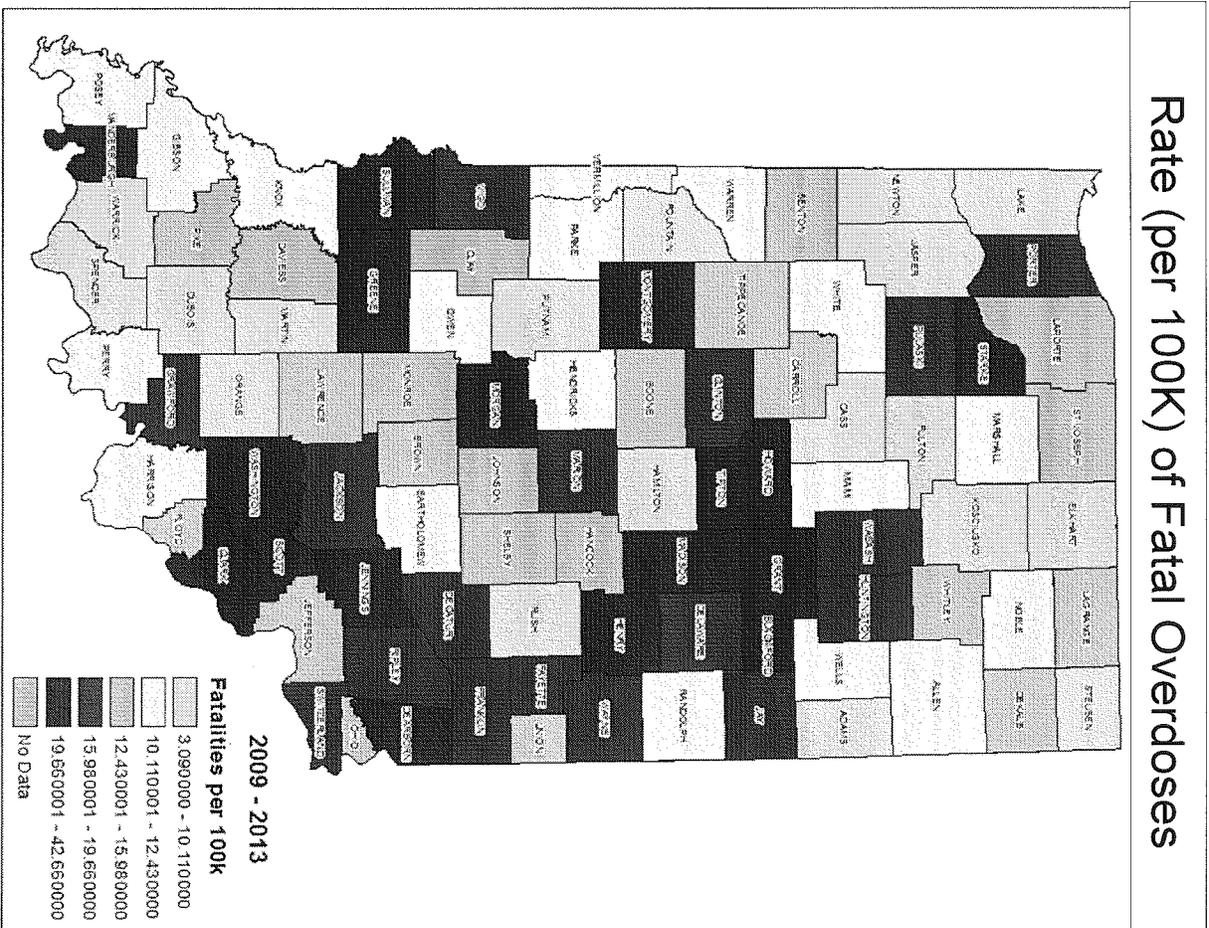




Rate (per 100K) of Fatal Overdoses

Rate (per 100K) of Fatal Overdoses,

- a. The overdose fatality data from 2009-2013 is based on the death certificates and is dependent on the coroner or the signing physician listing cause of death as narcotic overdose
- b. The inclusive dates are January 2009 thru December 2013.
- c. Data was obtained from the Indiana State Department of Health.

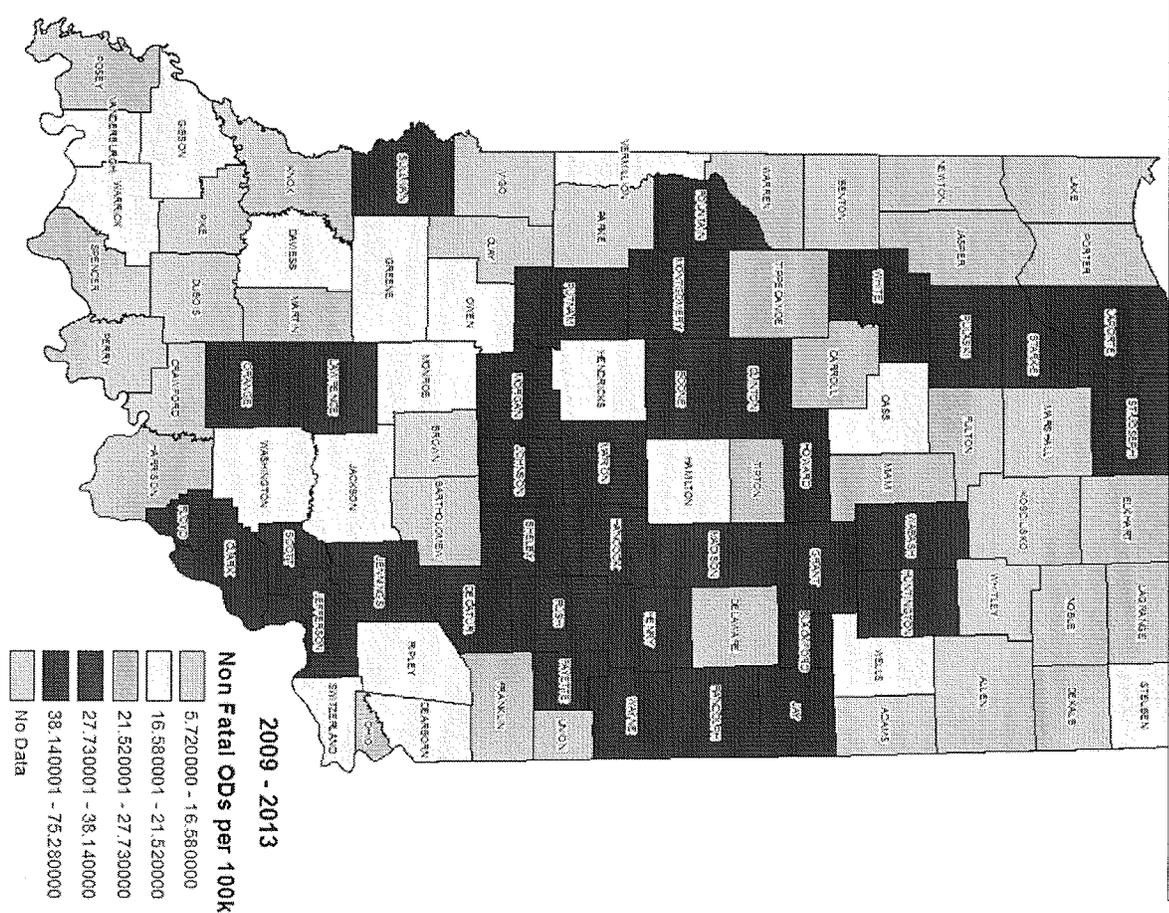




Rate (per 100K) of Non-Fatal Overdoses

Rate (per 100K) of Non-fatal Overdoses

- a. The non-fatal overdose data from 2009-2013 is based upon emergency department discharge diagnosis as documented by the treating physician.
- b. The inclusive dates are January 2009 thru December 2013.
- c. Data was obtained from the Indiana State Department of Health.

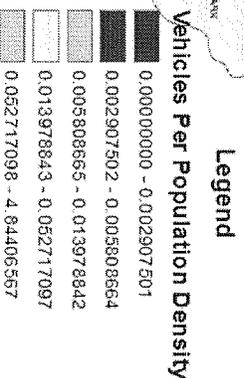
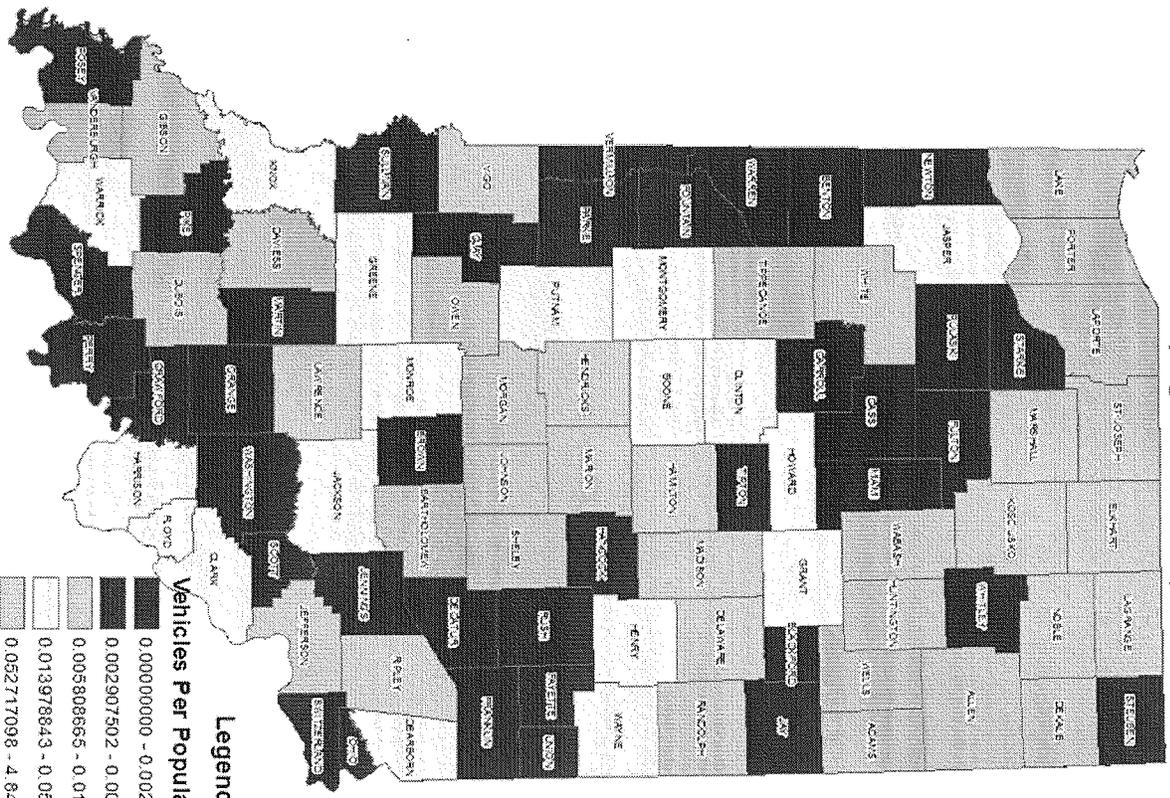




Vehicles carrying per person per sq mile (High is Better)

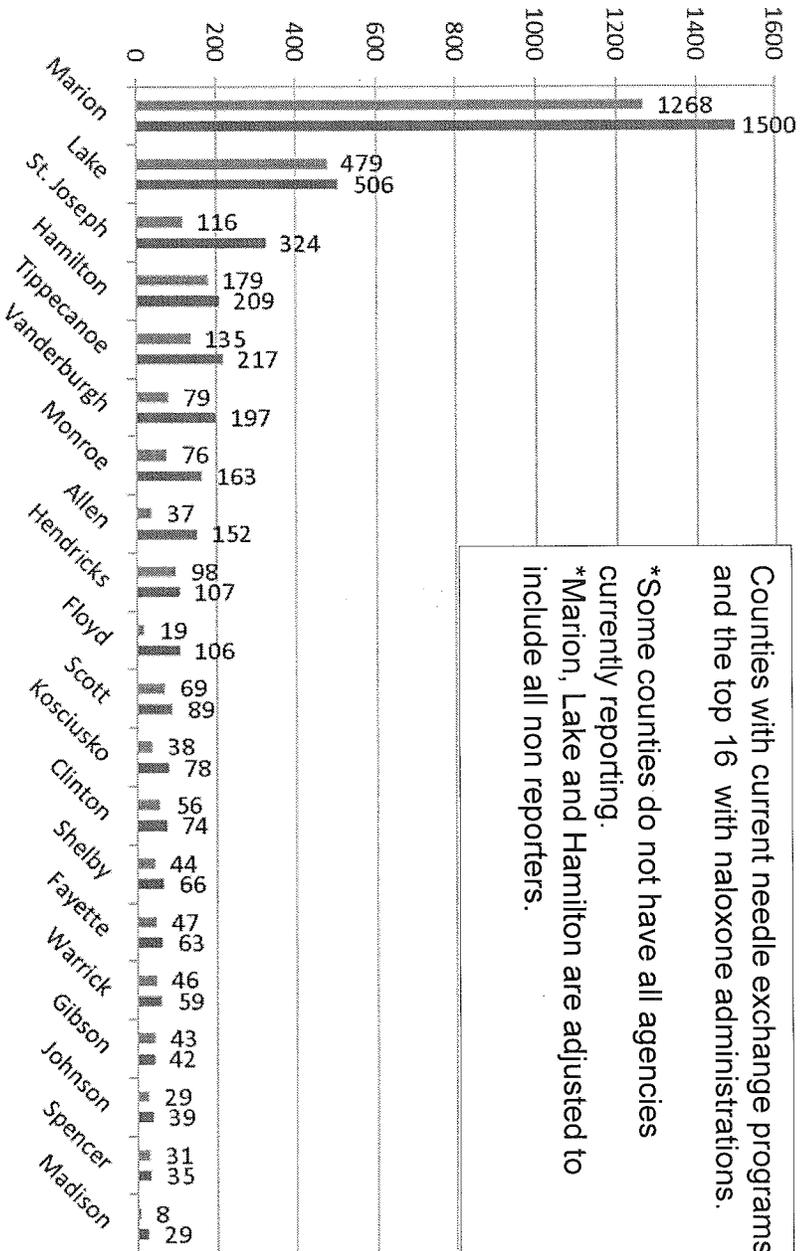
Emergency Vehicles Carrying Naloxone (Population Density)

- a. Vehicle data is from IDHS/EMS on the EMS agencies carrying and number of vehicle certified by those agencies.
- b. Paramedic providers which are Advanced Life Support (ALS) have always carried Naloxone. (Currently 221 certified ALS providers)
- c. This data also includes the Basic Life Support vehicles that are now carrying naloxone.





Incidents where Naloxone was Administered by Transporting EMS Agencies



Countries with current needle exchange programs and the top 16 with naloxone administrations.

*Some countries do not have all agencies currently reporting.

*Marion, Lake and Hamilton are adjusted to include all non reporters.

■ Naloxone Administrations 10-1-13 thru 9-30-14
 ■ Naloxone Administrations 10-1-14 thru 9-30-15

Statewide administrations
 10-1-13 thru 9-30-14 = 3,321
 10-2-14 thru 9-30-15 = 5,049
 Total 8,370

Incidents where naloxone was administered by Transporting EMS Agencies.

- a. This data is based upon agencies reporting to the Indiana Department of Homeland Security EMS Branch.
- b. Currently not all EMS agencies are reporting to IDHS.
 - i. This is due to the EMS Branch's change in software version or due to financial limitation of EMS agencies.

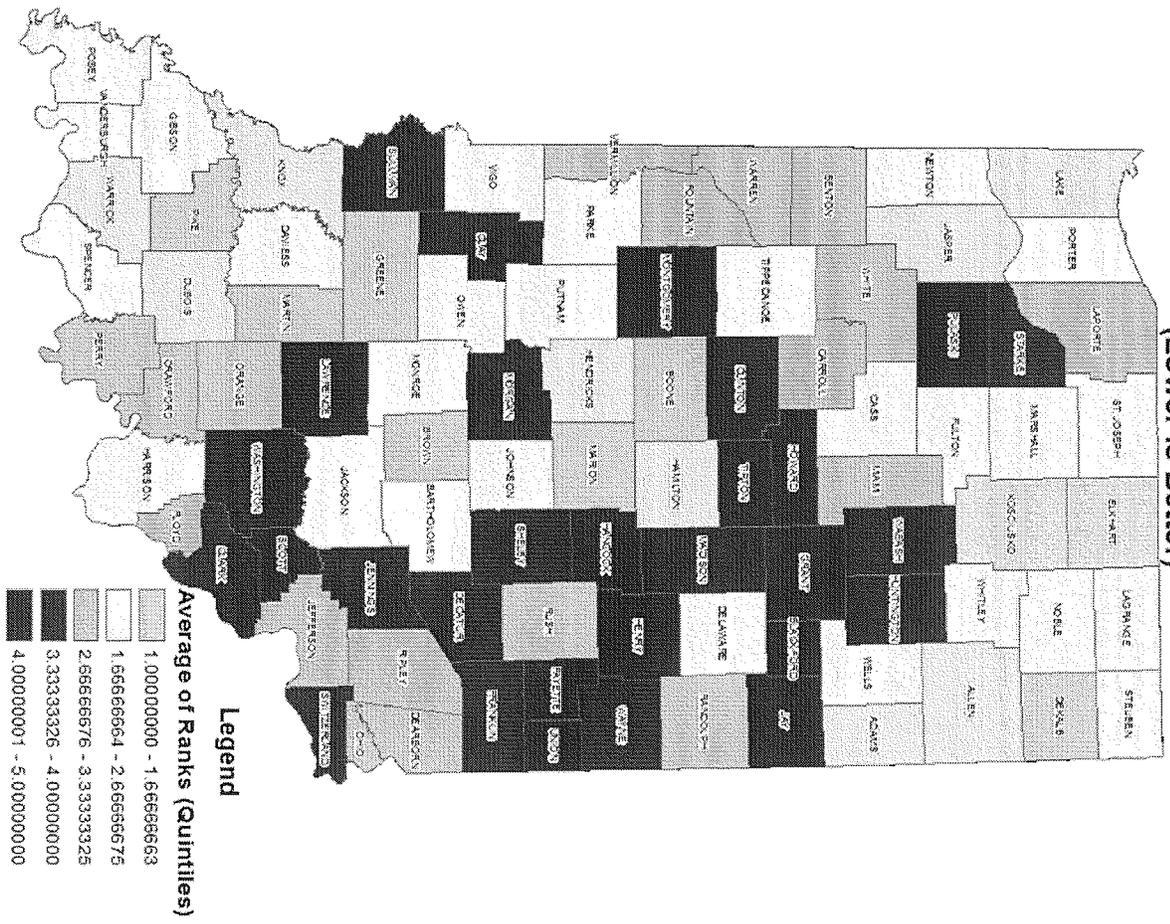


Rate per population density Non-Fatal Overdoes, Fatal Overdoes(Rate per 100K) and Emergency Vehicles Carrying(Pop Density)

- a. The overdose fatality data from 2009-2013 is based on the death certificates and is dependent on the coroner or the signing physician listing cause of death as narcotic overdose. *
- b. The non-fatal overdose data from 2009-2013 is based upon emergency departments discharge diagnosis as document by the treating physician. *
- c. Vehicle data is from IDHS/EMS on the EMS agencies carrying and number of vehicle certified by those agencies.

*Data was obtained from the Indiana State Department of Health.

Average of Ranks for rates of ODs, Deaths, Vehicles | Pop Density
(Lower is Better)





Limitations

- Currently no one keeps a comprehensive lists of the number of law enforcement agencies carrying naloxone or trained in it's administration nor the number of police vehicles on duty at any given time.
- Currently no one keeps a comprehensive lists of the number of EMS response vehicles on duty at any given time.
- The overdose fatality data from 2009-2013 is based on the death certificates and is dependent on the coroner or the signing physician listing cause of death as narcotic overdose.
- The non-fatal overdose data from 2009-2013 is based upon emergency departments discharge diagnosis as document by the treating physician.
- The EMS data base (ImageTrend) is currently missing data on numerous EMS responses.
- IDHS data reflecting the usage of naloxone by EMS organizations does not necessarily correlate with heroin overdoses.