

**State of Minnesota**  
**Emergency Medical Services Regulatory Board**  
**Medical Direction Standing Advisory Committee Meeting Agenda**  
**Lake Michigan Room**  
**March 4, 2016, 9:30 a.m.**  
**7025 Northland Drive**  
**Brooklyn Park, MN 55428**  
[MAP & DIRECTIONS](#)

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**1. Call to Order – Dr. Burnett – 9:30 a.m.**

**2. Public Comment – 9:35 a.m.**

*The public comment portion of the Medical Direction Standing Advisory Committee meeting is where the public may address the Committee on subjects which are not part of the meeting agenda. Persons wishing to speak must complete the participation form provided at the meeting room door prior to the start of the meeting. Please limit remarks to 3 minutes. The Committee will listen attentively to comments but, in most instances, will not respond at the meeting. Typically, replies to issues or concerns expressed will be made via letter or phone call within a week.*

**3. Approve Agenda – 9:45 a.m.**

**4. Approve Minutes – 9:50 a.m.**

- Approve Minutes of September 10, 2015

**Attachments**

A1

**5. MDSAC Committee Chair Report – Dr. Burnett, 9:55 a.m.**

- Burnsville Pilot Program
- Definition of a Health Officer “hold”
- HR 4365 Protecting Patient Access to Emergency Medications Act of 2016
- NASEMSO Patient Care Guidelines
- MNSTAR Data for MDSAC Review
- Licensure vs. Certification

C1

C2

C3 Link

Handout

**6. Executive Director Report – Tony Spector, 11:00 a.m.**

- Agency Update
- Legislative Update

**7. Medical Director’s Role in Education Standards Transition – Mary Zappetillo 11:15 a.m.**

**8. Medical Director’s Course at Arrowwood – Dr. Pate 11:30 a.m.**

MDC 1

**9. New Business -- 11:50 a.m.**

**10. Next Meeting – 11:45 a.m.**

**11. Adjourn – 12:00 p.m.**

**Note:** Some Committee members may be attending this meeting by telephone. In accordance with Minn. Stat. § 13D.015, subd. 4, the public portion of this meeting, therefore, may be monitored by the public remotely and telephonically. If you wish to attend by telephone, please contact Melody Nagy at 651-201-2802 or by email at [melody.nagy@state.mn.us](mailto:melody.nagy@state.mn.us) for connection information. There may be a nominal fee for members of the public to participate by telephone. Please contact Ms. Nagy no later than 10:00 a.m. on Wednesday, March 2, 2016 to ensure a timely response to connect to the meeting.

*If you plan to attend the meeting and need accommodations for a disability, please contact Melody Nagy at (651) 201-2802. In accordance with the Minnesota Open Meeting Law and the Internal Operating Procedures of the Emergency Medical Services Regulatory Board, this agenda is posted at: <http://www.emsrb.state.mn.us>*

**Meeting Minutes**

A 1

**Emergency Medical Services Regulatory Board**  
**Medical Direction Standing Advisory Committee (MDSAC)**

Thursday, September 10, 2015, 7 p.m. – 10 p.m.  
Arrowwood Resort, Alexandria, MN

**Members Present:** Dr. Burnett, Dr. Conterato, Dr. Hankins, Dr. Ho, Dr. Fink Kocken, Dr. Frascone, Dr. Pate, Dr. Thomas, Dr. Wilcox

**Staff/Guests:** Pat Coyne, Dan DeSmet, J.B. Guiton, Tim Held, Kevin Miller, Melody Nagy, Robert Norlen, Rose Olson, Bill Snoke, Tony Spector

- 1. Call to Order – (7:00 p.m.) – Dr. Burnett, Committee Chair**  
Dr. Burnett welcomed everyone to the meeting.

Dr. Burnett thanked Dr. Thomas for her leadership of the MDSAC. Dr. Burnett welcomed Dr. Pate as the new representative of family practice to the Board.

- 2. Approve Agenda – Dr. Burnett**

Dr. Ho asked for a discussion of EMR renewals (to occur at the same time). Mr. Spector commented that staff have a response for this question and will provide this information to Dr. Ho.

Dr. Frascone asked for a discussion of “holds”.

- 3. Approval of Minutes – Dr. Burnett**

Dr. Wilcox moved to approve the minutes from the March 6, 2015 meeting. Dr. Ho seconded. Motion carried.

- 4. EMSRB Update – Tony Spector, Executive Director**

Mr. Spector said he was fortunate to be appointed as the Executive Director. He thanked staff for their work in making the agency run smoothly. He noted that the EMSRB is comprised of a very small staff, and he is evaluating staffing needs. He reminded everyone that the EMSRB mission is to protect the public’s health and safety and on his watch that is and will be the top priority. He explained that staff will continue to be responsive and timely to our stakeholders. To that end, staff has implemented e-cards for certification and recertification of EMS personnel. The certification is sent by email which provides a faster response to our customers.

Mr. Spector thanked Dr. Burnett for his tour of the State Fair medical control. He said that is the busiest emergency department in the state for 12 days working in conjunction with Regions Hospital.

- 5. Composition of MDSAC – Dr. Burnett**

Dr. Burnett said the number of medical directors in the state is growing and this committee should also grow. He said that we need a group of members who attend and vote on motions to give advice to the Board. He also led discussion on how to bring new members to the committee.

Dr. Thomas said the core group is the eight regional medical directors and the physicians on the Board. We need representation from each region.

Dr. Pate asked if some meetings can be by phone. He said travel can be a factor.

Dr. Ho suggested an announcement at the conference that the membership is being opened up.

Dr. Burnett suggested four additional members who have minimum knowledge of being a medical director for an ambulance service. He wants the Board to consult with MDSAC as a partner in EMS medicine.

Dr. Fink Kocken said that a focus is to be the State Medical Director. We could also have participation with NASEMSO medical direction. Dr. Burnett said we should identify the roles for the members.

Mr. Spector said that meetings can be held by phone with conditions. The Board chair will determine this participation. DPSAC is meeting by Lync.

Dr. Burnett said that he would like to encourage rural medical directors to attend this meeting.

**6. Medication Expiration Dates and Manufacturer Recommended Storage (Succinylcholine)**

Dr. Burnett said we want medication that is safe and effective. Dr. Thomas asked if we want a modification of Minnesota Rule. Dr. Thomas asked who decides what is appropriate. What happens when staff does an inspection and something is expired? What is the ruling?

Dr. Pate said the committee would cite literature and have a guideline. The responsibility would be with the medical director.

Dr. Ho suggested changing the rules to have the medical director be responsible. Similar to what is required when there is a drug shortage. This could be handled on a case by case basis. This should be the medical director's decision.

Mr. Spector said that the statute would need to be modified this year. Mr. Spector said boards are changing from rule to statute because it would be cleaner. The EMSRB is obligated to follow the statute. Dr. Thomas said we do not want to change rules based on specific medications.

Mr. Miller said that there are rules that are unenforceable. Dr. Burnett said that is a broad topic and should be discussed another day. Mr. Schaefer said the agency must follow the statute.

Dr. Pate moved that if published peer review literature in a reputable medical journal relating to the storage and maintenance of equipment and drugs conflicts with the manufactures recommendations a service medical director may choose to store and maintain the equipment or drug according to the information/data provided in the peer review journal. Dr. Thomas seconded. Motion carried.

**7. Minnesota Medical Directors Course - Dr. Pate**

Dr. Pate provided an overview of the Medical Director's Course power point presentation. Dr. Pate suggested two hours of presentation and another hour of equipment review. Dr. Pate asked for comments from the other members of the committee.

Dr. Thomas said that this provides the basics for being a medical director. This can be a good way to ask questions of the physicians on the Board.

Dr. Wilcox asked if this can be web-based education or a conference session. Dr. Hankins asked about accreditation for continuing medical education.

Dr. Pate said that this is aimed at new rural medical directors. He suggested posting this on the EMSRB website. Dr. Burnett agreed and also suggested emailing it to all ambulance services. Dr. Pate suggested this be emailed when the state is informed of a medical director change.

Dr. Thomas said that we want to impact retention of medical directors. This can be a resource for a frustrated medical director.

## **8. Spinal Precautions Algorithm**

Dr. Lyng was not able to be at the meeting today. North Memorial has implemented this guideline.

Dr. Conterato said we should seek broad-based opinion on this change. Dr. Lyng wanted this to move this forward as a statewide change with MDSAC approval. This needs to be shared at the physician, nurse and EMS level. The state trauma committee could make a statement in a joint effort. Dr. Frascone said that the national physician statement is a more powerful tool to use.

Dr. Thomas said documents were provided by email that can be shared.

Mr. Held said the regional medical advisory committees are also discussing this issue. The information can be distributed at that level.

Mr. Guiton said this is an accepted practice in the metro area.

## **9. Community Paramedic Education Program Approval – Dr. Ho**

Dr. Ho said he is looking for a recommendation to the Board. There is a request for a program but there is a Board hold on approval of Community Paramedic Education Programs. We want to recommend moving forward with approval of the curriculum.

Mr. Guiton said that Inver Hills and Hennepin currently teach this. Others are interested in teaching this. The Board should grant approval if a program is using the same curriculum.

Dr. Fink Kocken said that we are giving Board certification for Community Paramedics and approving the education programs. The issue is evaluating what should be included in a community paramedic program. The physicians on the Board are not skilled in evaluating programs. She asked Dr. Wilcox to speak on this issue.

Dr. Wilcox said the curriculum that is currently used was developed by the North Central EMS Institute. It focuses on primary care and chronic disease management. The curriculum is available to any institute that has an academic setting. The medical director for which these people are working can sign off for their certification. Dr. Wilcox said it should be acceptable to have other institutes provide this education.

We are discussing national certification.

Mr. Spector said that the approval of programs was put on hold. A workgroup was suggested but the workgroup never met. The Board's Executive Committee suggested that the topic is best discussed by MDSAC. Mr. Guiton said that we can approve this with the use of the accepted curriculum.

Dr. Ho said that we need to move this forward. We should not deny a program using the same curriculum. Dr. Wilcox said that there can be a partnership with groups that teach the program now.

Mr. Norlen said that there is legislation that took effect for Community EMT and we need to think about the curriculum for this program. Dr. Wilcox said we are discussing community EMT.

Dr. Fink Kocken moved the EMSRB allow institutions of higher learning to use the most current version of the International Roundtable on Community Paramedic Curriculum. Dr. Wilcox seconded the motion. Motion carried.

Mr. Guiton said we want to thank Dr. Wilcox for his work as a pioneer in EMS.

**10. Other Business - Dr. Burnett**

Dr. Frascone said he would like to discuss transport “holds”. The current state of the law is that this can only be signed by a peace officer or a health officer as defined by statute. Health officer does not include paramedics. The opinion at Regions is to not have a doctor sign this. This may change depending on the physician. Dr. Frascone suggested adding a definition of paramedic to a health care professional or a physician who is not present at the scene can authorize signing the “hold”, i.e., an on-line medical control physician .

Dr. Ho said that this has been discussed at west metro. We may be waiting on scene for police officer to arrive. We do not want to “kidnap” patients. We could ask for a language change suggesting with the authorization of a Medical Director. Dr. Burnett said that this could include online medical control.

Dr. Frascone said we want to make the law clear. Mr. Snoke said that this was discussed by the Minnesota Ambulance Association. We want immunity for our personnel. We want to change the appropriate statute.

Dr. Frascone asked that this be referred to the Board for discussion. Ideally a paramedic could sign. A physician not present should be able to authorize signature. Online medical control can be discussed.

Mr. Guiton suggested this be discussed by the Legislative Committee.

Dr. Frascone moved MDSAC recommends to the EMSRB that the Legislative Committee investigate changes to Minnesota Statute 253B subdivision 9 definition of health officer to include paramedics and online medical control. Dr. Hankins seconded the motion. Motion carried.

**11. Public Comment – Dr. Burnett**

None.

**12. Next Meeting Date – Dr. Burnett**

At the Long Hot Summer Conference in March – date and time to be announced.

**13. Adjourn – Dr. Burnett**

The meeting adjourned at 9:45 p.m.

## **Burnsville Fire**

### *EMS Pilot Phase #1*

Purpose: To better utilize current resources to handle increasing EMS call volume by using alternative response units to respond low acuity calls.

#### Details:

Burnsville Fire has analyzed EMS call data and determined that measurable trends and predictors can be associated with various call types, specifically low transport rates. Using that data, and ongoing monitoring, by the Burnsville staff and their Medical Director, Burnsville Fire proposes to respond to identified call types with only a non-transport unit, instead of a transport capable, ALS ambulance.

The non-transport response unit would be staffed by at least one paramedic and equipped with the standard ALS equipment in a transport unit minus the stretcher. All patients would have a MNSTAR compliant EMS report completed by the non-transport response unit.

#### Implementation:

Burnsville Fire would propose implementation starting in the 2<sup>nd</sup> half of 2016. The duration would depend on the number of calls qualifying for the pilot program and the success of the pilot (i.e. patients being served adequately and resources being used efficiently). We would like to run the pilot for three years and if the pilot is successful we would likely be looking for a long term implementation of this program.

#### Similar Programs:

There are many EMS systems and fire departments across the nation that send non-transport response vehicles staffed by EMS certified personnel to low transport rate call types. We believe this pilot program is very similar to those non-transport response programs across the nation. This pilot program may help clear some hurdles in the state of Minnesota to changing health care system and the adaptation that will be necessary in EMS.

#### Proposed Approval Path:

- EMSRB Staff January 2106
- EMSRB Legislative Committee
- MDSAC Committee
- EMSRB Executive Committee
- EMSRB Board

## **Burnsville Fire/Allina EMS**

### *EMS Pilot Phase #2*

**Purpose:** To better utilize current resources to handle increasing EMS call volume by using a credentialed communications center to provide a secondary screening of low acuity calls. The secondary screening may determine alternatives for the caller that would be more appropriate than an emergent EMS response.

**Details:**

Burnsville Fire and Allina would analyze historical data to determine call types that have a low patient acuity (using call type, transport mode, procedures/medications administered, etc.). The historical response data and ongoing monitoring of the pilot program would be analyzed by the Burnsville staff, Allina staff and their Medical Director(s).

Calls deemed to be low acuity by EMD code would be forwarded from the primary PSAP to a credentialed secondary PSAP for a secondary screening. Medically certified or licensed personnel would conduct the secondary screening and determine the best action for that specific patient based on developed guidelines. At any point the patient does not appear to meet the criteria of a low acuity patient the secondary screener may request an immediate EMS response be initiated.

The vision would be to allow alternative response or no response based on a secondary screening of a low acuity call for service. The alternative response may be a non-transport unit, community paramedic or other appropriate care provider based on a specific need (i.e. social worker).

**Implementation:**

Burnsville Fire and Allina would propose implementation starting in 2017. The duration would depend on the number of calls qualifying for the pilot program and the success of the pilot (i.e. patients being served adequately and resources being used efficiently). We would like to run the pilot for three years and if the pilot is successful we would likely be looking for a long term implementation of this program.

**Similar Programs:**

There are other EMS systems in the nation conducting or working to implement similar programs to better serve lower acuity patients that do not need an emergency ambulance. This pilot program may help clear some hurdles in the state of Minnesota to changing health care system and the adaptation that will be necessary in EMS.

**Proposed Approval Path:**

- EMSRB Staff January 2106
- EMSRB Legislative Committee
- MDSAC Committee
- EMSRB Executive Committee
- EMSRB Board

As a sample, for purposes of illustrating call types to apply alternative response:

Using Burnsville Fire Data from 2011-2014

**Dispatch Reason: Choking.**

**EMD Code "Alpha" (25)**

50% were non-emergency transports

*50% Non-Transports*

No emergency Transports

**Dispatch Reason: Assault**

**EMD Code: Alpha (144)**

38% Routine Transport (57)

*68% Non-Transports*

One Emergency Transport

**Dispatch Reason: Traffic Accident**

**EMD Code: Alpha (142)**

25% Transports

*72% Non-Transport*

No emergency Transports



## NEWS RELEASE

January 13, 2016

**FOR IMMEDIATE RELEASE**

Contact:

### **Rep. Hudson Introduces “Protecting Patient Access to Emergency Medications Act of 2016”**

#### **Bolstering Support for Our Nation’s EMS Practitioners**

San Diego, CA (January 13, 2016) — Yesterday, Representative Richard Hudson (R-NC) joined by Reps. G.K. Butterfield (D-NC), Steve Cohen (D-TN), Blake Farenthold (R-TX), Joe Heck, M.D. (R-NV), Raul Ruiz, M.D. (D-CA) and Bruce Westerman (R-AR) introduced legislation that ensures the continued ability of emergency medical services (EMS) practitioners to administer controlled substances to countless individuals who are sick or injured enough to need them.

NAEMSP® President Jane H. Brice, MD, MPH stated, *“NAEMSP® strongly supports Rep. Hudson’s legislation and applauds the Congressman’s leadership on this vital legislation. The legislation ensures that life-saving EMS professionals are able to deliver emergency medication to the patients that so desperately need them.”*

According to Congressman Hudson, *“Without this solution, we risk sacrificing quality emergency care and endangering patients simply because law and regulation have not kept up with the evolution of modern medicine. My legislation is an important clarification of law that allows our first responders to continue administering life-saving medications to patients when they need them most.”*

The unique nature of EMS is unlike other health care services governed by the Controlled Substances Act (CSA). There is a demonstrated clinical need for administering controlled substance medications, such as to treat active seizures or administer pain medicine. Updating the CSA to recognize the existing delivery model of EMS is essential to protect patients. It will provide the Drug Enforcement Administration (DEA) a firm statutory foundation from which to oversee the use of controlled substances in field EMS and prevent drug diversion while ensuring essential medicines are provided to patients in need.

NAEMSP® looks forward to working with Rep. Hudson to enact the “Protecting Patient Access to Emergency Act of 2016.”

The following organizations support passage of H.R. 4365:

American Ambulance Association (AAA)

Association of Air Medical Services (AAMS)

Association of Critical Care Transport (ACCT)

American College of Emergency Physicians (ACEP)

International Association of Fire Chiefs (IAFC)

International Association of Fire Fighters (IAFF)

National Association of Emergency Medical Technicians (NAEMT)

National Association of Emergency Medical Physicians® (NAEMSP®)

The National Association of State EMS Officials (NASEMSO)

About NAEMSP

The National Association of EMS Physicians (NAEMSP) is an organization of physicians and other professionals partnering to provide leadership and foster excellence in the subspecialty of EMS medicine.

C 3  
see link in email for  
full document

National Association of  
State EMS Officials



[Click to Open Clinical Guidelines Document](#)

[Click to Open Clinical Guidelines Document](#)

# National Model EMS Clinical Guidelines

## Abstract

These guidelines will be maintained by NASEMSO to facilitate the creation of state and local EMS system clinical guidelines, protocols or operating procedures. System medical directors and other leaders are invited to harvest content as will be useful. These guidelines are either evidence-based or consensus-based and have been formatted for use by field EMS professionals.

NASEMSO Medical Directors Council

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[www.nasemso.org](http://www.nasemso.org)

# Minnesota Medical Directors Course

2016



# Rural EMS Survival

**Q. WHAT is the KEY FACTOR TO SURVIVAL of small EMS Services in Rural Minnesota:**

- A. Sense of Duty to Community
- B. The Medical Director
- C. Want to drive with Lights & Siren
- D. Desire to know more about your neighbors personal lives

EMSRB Rural Assessment Study 2004

# Guiding Statutes and Rules for EMS Medical Directors

## Minnesota Statute 144E

<https://www.revisor.mn.gov/?id=144E.265>

Details the responsibilities and duties of the medical director

## Minnesota Rule 4690

<https://www.revisor.mn.gov/?id=4690>

Describes medication variances, primary service area rules  
and equipment standards among other things

# Medical Director Requirements

- ▶ Licensed Minnesota Physician
- ▶ Knowledge of emergency care of ill or injured patients
- ▶ Familiar with design and operation of Local, Regional, and State EMS Systems.
- ▶ Willingness to donate your time to your community.

# Medical Director Statutory Responsibilities (Minn. Statute 144E)

- ▶ Education and orientation of personnel;
- ▶ Standards for equipment and supplies;
- ▶ Standing orders for pre-hospital care;
- ▶ Triage, treatment, and transportation guidelines for adult and pediatric patients;
- ▶ Quality improvement programs including, but not limited to, case review and resolution of patient complaints;
- ▶ Procedures for the administration of drugs;
- ▶ Maintaining quality of care (All of the above ).

# Annual Assessment

- ▶ Practical Skills assessment of all EMS personnel yearly (Statutory Requirement)
- ▶ Designated personnel may do assessment
- ▶ Records become part of EMS personnel permanent file
- ▶ Signed off with Medical Director's original signature.

# EMS Medical Director's ARE:

- ▶ Educators
- ▶ Evaluators
- ▶ Innovators
- ▶ Collaborators
- ▶ Intrepid

# EMS Personnel

## Minnesota Providers:

Emergency Medical Responder	(EMR )
Emergency Medical Technician	(EMT)
Advanced EMT	(AEMT)
Paramedic	
Community Paramedic	

## Providers Certification:

Registered or Certified, not licensed  
Renew every 2 years

# Response Organizations in Mn.

- ▶ **Medical Response Unit (MRU)**
  - ▶ **Basic Life Support Ambulance (BLS)**
  - ▶ **Advanced Life Support (ALS)**
  - ▶ **Specialized Life Support**
    - Helicopter**
    - Fixed Wing Plane**
- 

# Patient Care

- ▶ Establish Standard Operating guidelines for Pre-hospital care
  
- ▶ Triage, treatment, & transportation protocols
  - Sample Standardized BLS protocols available on the EMSRB website.
  - Stroke, STEMI, and Trauma System protocols
  - Special situation protocols

# Communication Protocols

- ▶ Define method and timing of communications with on-line medical control
- ▶ Who to call
- ▶ Alternate Plan in communication failure:
  - Phone
  - Text
  - Radio (Ham)



# Transfers of Patients

Transferring Physician responsible for the legal process: (EMTALA)

- Prescribing life support equipment

- Medical treatment

- Possible change in patient condition

Medical Director is responsible :

- Qualified Personnel are required to transport

  - EMT – RN – Paramedic

- Proper Medical Equipment

- Staff handoff at departure & arrival

# Transport Protocols

- ▶ Address patient transport situations
  - Air transport – Trauma – STEMI – Stroke
  - Psychiatric/Detox – Special Needs

- ▶ Based On

Trauma/Stroke/**STROKE** protocols

Patient Needs

Facility location and designation

Staffing and vehicles

Patient condition and stability

Nearest appropriate facility if unstable.



# Be Proactive

- ▶ Define what types of patients your service can care for:
  - Transfer
  - 911
  - BLS
  - ALS
  - Air Transport
  
- ▶ Work with local hospitals to determine when outside resources will be needed

# Minnesota EMS Regulatory Board

- ▶ State regulatory agency for:
  - Ambulance Services
  - EMS Education Programs
  - EMS Personnel
- ▶ Licenses ambulance services
- ▶ Issues registrations/certifications for EMS personnel
- ▶ Approves Education Programs
- ▶ Does NOT make laws, but proposes changes in law

# EMSRB Operations

- ▶ Licensing and Inspection of Ambulance Services and Education Programs to ensure compliance
- ▶ Investigations of Licensed/Registered/Certified EMS Providers
  - May result in restrictions on ambulance service licenses, education programs or credentials of EMS personnel.
- ▶ Credentialing of EMS Personnel
- ▶ Grants Management
- ▶ Emergency Management collaboration with State, Regional, and Local partners.
- ▶ MNSTAR – Minnesota Ambulance Patient Care Reporting System

# BLS Variance Medications

- ▶ Medical Director for BLS Service may request variance to allow administration of certain medications:
  - Sublingual nitroglycerin
  - Epinephrine pen injector
  - Beta agonist (nebs and metered dose inhalation)
  - Glucagon
  
- ▶ Naloxone: does not require a variance, but does require Medical Director approval/education/protocol
  
- ▶ No variance required for non prescription medicines, but Medical Director gives order.
  
- ▶ Medical Director is responsible for annual education

# BLS Specific Procedures

- ▶ Medical Director may also allow personnel with appropriate education to:
  - Initiate/maintain IV infusion
  - Use Supraglottic Airway
  - CPAP
  - Other reasonable interventions
  
- ▶ Not part of the five variances in Rule 4690



# State EMS Medical Director

- ▶ Reviews & approves requests for ambulance service variances.
  
- ▶ Resource regarding medical protocols:
  - EMSRB staff
  - Ambulance services
  - Medical directors
  
- ▶ Cooperative position including all physicians on the EMSRB

# Medical Direction Standing Advisory Committee (MDSAC)

- ▶ Proposes changes in rules/statutes to the Board regarding medical practice on ambulances
- ▶ Provides model medical protocols for Medical Directors
- ▶ Resource to the Board and Ambulance Services regarding care issues.
- ▶ We are always interested in your point of view

## ▶ Qualifications to be on this committee?

Any EMS Medical Director who is willing to participate.

# Regional Programs



## Minnesota EMS Regions

### Northwest

Tom Vanderwal, Program Director  
2300 24th Street NW., Suite 103  
Bemidji, MN 56601-4101  
(218) 556-5137  
tom.gnwems@midconetwork.com  
www.greaternwems.com

### Northeast

Adam Shadiw, Interim Executive Director  
4219 Enterprise Cir.  
Duluth, MN 55811-5719  
(218) 726-0070  
adam.shadiw@arrowheadems.com  
www.arrowheadems.com

### West Central

Mark McCabe, Executive Director  
2308 S. Broadway, P.O. Box 516  
Alexandria, MN 56308-0516  
(320) 762-1881  
wcmnems@gctel.com

### Central

Marion Larson, Regional Coordinator  
705 Courthouse Square  
Saint Cloud, MN 56303-4701  
(320) 656-6122  
marion.larson@co.stearns.mn.us  
centralmnems.com

### Metropolitan

Ron Robinson, Regional EMS Coordinator  
201 Metropolitan Counties Government Center  
2099 University Avenue West  
Saint Paul, MN 55104-3431  
(651) 643-8378  
rrobinson@emsmn.org  
www.emsmn.org

### Southwest

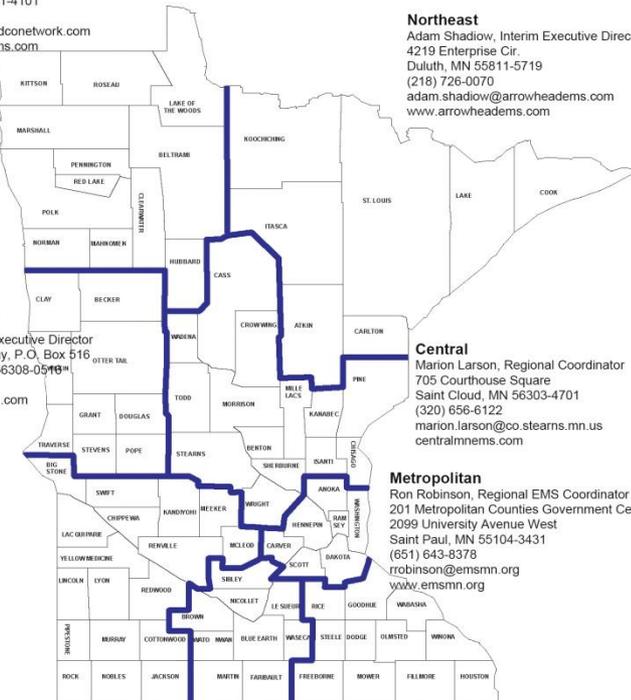
Ann Jensen, Executive Director  
689 8th Street  
Dawson, MN 56258  
(800) 253-4029  
annexecutivedirector@sw-emss.org  
www.sw-emss.org

### South Central

Mark Griffith, Executive Director  
102 Industrial Drve, PO Box 218  
Eagle Lake, MN 56024  
(507) 257-3224  
griffithm@hickorytech.net  
www.scems.org

### Southeast

Don Hauge, Executive Director  
1130 1/2 Seventh St. N.W., Suite 201  
Rochester, MN 55901  
(507) 536-9333  
hauge.donovan@mayo.edu  
www.seems.com



- ▶ 8 Regional Programs
- ▶ Provide education and other resources for EMS in region.
- ▶ <http://mn.gov/health-licensing-boards/emsrb/grantprojects/regional-programs/>

# Quality Assurance

- ▶ Most important Medical Director job.
- ▶ It's not enough to know it when you see it.
- ▶ Formal process must be established with Medical Director involvement under the Peer Review statute [145.64](#).
- ▶ The QA loop must be complete!

# Medical Director QA



# Medical Director Challenges

Difficult Situations for the Service:

May need to be Reviewed with crews through  
the QA Process

- ▶ Refusal of care
- ▶ Non-transports
- ▶ Incompetent patients
- ▶ Pediatric patients
- ▶ Terminally ill patients
- ▶ Physicians on scene

# Practical Pointers for MD's

- ▶ Team up with your Ambulance Service Manager and Education Program Coordinator.
- ▶ Know what the service/program needs are.
- ▶ Understand the economics of providing quality ambulance service and education.
- ▶ Use Adult education methods.
- ▶ Give run reviews priority.
- ▶ Take a long-term view of service/education development and changes.

# More Practical Pointers

- ▶ Develop “structure” to support the service’s “function.”
- ▶ Pay attention to “group dynamics” and help out when needed.
- ▶ Respect and nurture EMT’s - especially volunteers.
- ▶ Be careful of YOUR time & energy input: avoid personal burnout.

# Other Resources

NAEMSP EMS Medical Directors Course

[www.NAEMSP.org](http://www.NAEMSP.org)

FEMA Handbook for EMS Medical  
Directors

EMSRB Physician Members

# EMSRB Equipment Requirements

## 144E.103

<https://www.revisor.mn.gov/statutes/?id=144E.103>

- ▶ **144E.103 EQUIPMENT.**
- ▶ **Subdivision 1. General requirements.**
- ▶ Every ambulance in service for patient care shall carry, at a minimum:
  - ▶ (1) oxygen;
  - ▶ (2) airway maintenance equipment in various sizes to accommodate all age groups;
  - ▶ (3) splinting equipment in various sizes to accommodate all age groups;
  - ▶ (4) dressings, bandages, commercially manufactured tourniquets, and bandaging equipment;
  - ▶ (5) an emergency obstetric kit;
  - ▶ (6) equipment to determine vital signs in various sizes to accommodate all age groups;
  - ▶ (7) a stretcher;
  - ▶ (8) a defibrillator; and
  - ▶ (9) a fire extinguisher.

# Other Subdivision requirements

- ▶ **Subd. 2. Advanced life–support requirements.**  
ALS ambulance must carry drugs, drug administration equipment ,and supplies as approved by the licensee's medical director
- ▶ **Subd. 2a. Maintenance, sanitation, and testing of equipment, supplies, and drugs.**
- ▶ **Subd. 3. Storage**
- ▶ **Subd. 4. Safety restraints**
- ▶ **Subd. 5. Communication equipment.**

800mhz (Armer Radio)  
Active 911  
VHF Pager



# High Visibility Protective Gear



# High Visibility Lighting Systems



# High Tech Lifting Safety



# Special Safety Equipment



# Low Tech Equipment



# High Tech Electronics



# Safety First !    DRIVE CAREFULLY !

This sign has one meaning ,no matter how you look at it !



# Thank You

