

**State of Minnesota**  
**Emergency Medical Services Regulatory Board**  
**Medical Direction Standing Advisory Committee Meeting Agenda**  
**September 8, 2016, 7:00 p.m.**  
**Arrowwood Conference Center, Lake Miliona Room, Alexandria, MN**  
[Map and Directions](#)

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**1. Call to Order and Introductions – Dr. Burnett – 7:00 p.m.**

**2. Public Comment – 7:05 p.m.**

*The public comment portion of the meeting is where the public is invited to address the committee on subjects which are not part of the meeting agenda. Persons wishing to speak are asked to complete the participation form located at the meeting room door prior to the start of the meeting. Please limit remarks to three minutes.*

**3. Approve Agenda – 7:10 p.m.**

**4. Approve Minutes – 7:12 p.m.**

- Approve Minutes of March 4, 2016

**Attachments**

A1

**5. MDSAC Committee Chair Report – Dr. Burnett – 7:15 p.m.**

- Welcome New Member – Dr. Andrew Stevens
- Burnsville Fire Department EMS Pilot Project No. 2 – Presentation by Burnsville Fire
- POLST Form – Presentation by Dr. Victor Sandler
- Role of MDSAC in State EMS Crisis Standards of Care
- Physician Involvement in Rural Ambulance Assessments
- Medical Director’s Course – Dr. John Pate

C1

C2

C3

**6. Education Standards Transition – EMSRB Staff – 8:15 p.m.**

- ACLS & CPR – Current Statutory Requirements
- NCCR Recertification Requirements

E1

E2

**7. Executive Director Report – Tony Spector – 8:30 p.m.**

- Agency Update

**8. EMSC Pediatric BLS/ALS Guidelines Approval – Dr. Fink Kocken – 8:40 p.m.**

**9. U of M Cardiac Care Consortium – Lucinda Hodgson and Kim Harkins – 8:55 p.m.**

UM

**10. New Business – 9:10 p.m.**

**11. Next Meeting – 9:12 p.m. (at Long Hot Summer – March 3, 2017)**

**12. Adjourn – 9:15 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 4:00 p.m. on Tuesday, September 6, 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>*

**State of Minnesota**  
**Emergency Medical Services Regulatory Board**  
**Medical Direction Standing Advisory**  
**Committee Meeting Minutes**  
**March 4, 2016**

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**Attendance:** Aaron Burnett, M.D., Chair; Marc Conterato, M.D.; R.J. Frascone, M.D.; Kari Haley, M.D.; Jeffrey Ho, M.D.; Pat Lilja, M.D.; John Lyng, M.D.; Kevin Miller; John Pate, M.D.; Kevin Sipprell, M.D.; Tony Spector; Executive Director: Mari Thomas, M.D.; Melody Nagy, Office Coordinator; Robert Norlen, Field Services Supervisor (by phone); Michael Wilcox, M.D.; Mary Zappetillo, EMS Specialist; Greg Schaefer, Assistant Attorney General.

**1. Call to Order – 9:00 a.m.**

Dr. Burnett called the meeting to order at 9:04 a.m.

**2. Public Comment**

*The public comment portion of the Committee meeting is where the public may address the Committee on subjects which are not part of the meeting agenda. Persons wishing to speak are asked to complete a 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.*

None.

**3. Approve Agenda**

Dr. Lyng moved approval of the agenda. Dr. Wilcox seconded. Roll call vote taken. Motion carried.

**4. Approve Minutes**

Dr. Lilja moved approval of the September 10, 2015 minutes. Dr. Pate seconded. Roll call vote taken. Motion carried.

**5. MDSAC Committee Chair Report**

Burnsville Fire Department EMS Pilot Program

Chief B.J. Jungmann and Assistant Chief Brian Carlson of the Burnsville Fire Department provided an overview of the project and answered questions from committee members.

Dr. Lilja asked if it was required by statute that an “ambulance” respond. Mr. Schaefer said the statute is not specific. The EMSRB does not need to seek a change of statute for this pilot project.

Dr. Burnett said the Executive Committee also discussed this pilot project and did not think this required change in statute but wanted input from MDSAC for medical concerns. Dr. Burnett asked for a progress report from Burnsville Fire Department in six months.

Burnsville Fire Department EMS Pilot Program Phase 2

Mr. Jungmann said that Phase 2 is planned further out in the future. Burnsville Fire Department wants to triage the calls by telephone with an accredited emergency medical dispatch center.

Definition of a Health Officer “Hold”

This will be discussed in the Legislative Report.

HR 4365 Protecting Patient Access to Emergency Medications Act of 2016

Dr. Burnett said that standing orders are not legal and multiple DEA licenses are required for each location. This bill would address these issues. The ambulance service would hold the license.

Dr. Lilja moved that the EMSRB send a letter of support for this legislation. Dr. Thomas seconded. Roll call vote taken. Motion carried.

NASEMSO Patient Care Guidelines

Dr. Burnett said the guidelines are available on the website and could be used by physicians in Minnesota as model guidelines. Dr. Thomas asked that a link be placed on the EMSRB website.

Dr. Fink-Kocken said the pediatric guidelines will be updated with the new recommendations from the American Heart Association.

MNSTAR Data for MDSAC Review

Dr. Burnett asked if there are canned reports the medical directors would like to see. He asked for a NARCAN report for today’s meeting.

Dr. Burnett said MNSTAR data provides a broad overview of conditions in Minnesota. This data will provide information to identify trends in the state. Discussion occurred regarding whether MNSTAR data is or could be available to answer questions and how the information could be useful to physicians. Dr. Burnett said the EMSRB can provide reports to regions on outliers.

Dr. Lilja asked for a report on Epinephrine for food allergies.

Dr. Burnett asked the physicians to contact him if they want other reports.

Licensure vs. Certification

This will be discussed during the Legislative Report.

**6. Executive Director Report**

Agency Update

Mr. Spector said the EMSRB has a booth at the conference and will be providing customer assistance for people completing their EMT and paramedic certification renewals. March 31, 2016 is the deadline for renewal of EMTs and paramedics. Agency staff at the booth will assist with real-time password resets.

EMSRB staff have expressed concerns about unregulated EMS response. The EMSRB does regulate (non-ambulance) fire departments or first responder agencies. Some fire services are changing their model of service to respond to medical emergencies. Dr. Lyng said he is concerned that there is no physician medical control and no reporting requirements if the response is not provided by a licensed ambulance service.

Mr. Spector said he wants the EMSRB to be inclusive with public safety.

Mr. Spector said the Ambulance Standards Work Group is meeting. The goal of the work group is to provide standards that assure safety for the patient and attendant.

The Post Transition Education Work Group has been meeting and the Board approved some of its recommendations.

Ebola Preparedness Grant Funding is available for reimbursement to ambulance services that incurred extraordinary cost for their preparations. Information on applying for the award is available on the EMSRB website.

#### Legislative Changes

Mr. Spector said two small housekeeping bills were developed. One is for clarification of due dates for regional program audits. The other is to strike out “training programs” and replace it with “education programs.” Several other things the agency would like to accomplish may need to wait until next legislative session.

#### Post Transition Education Work Group Report

Ms. Zappetillo provided handouts and gave a report of the work group’s activities. These recommendations were approved by the Board. The state is moving to a new model of education. The National Registry requirements are available on the website. At the local level medical directors have control of the education provided to their staff. Ms. Zappetillo said the skill assessments must be consistent. Education programs must have medical direction.

Dr. Burnett suggested a statewide initiative from MDSAC, including one-hour of physician education statewide for all personnel. A broad educational goal. Dr. Burnett asked for a motion for one hour of time for educational topics to be determined by the MDSAC. The local medical director provides the content.

Mr. Spector said staff have been participating in rural ambulance assessments. There is a correlation between successful services and local medical director involvement.

#### Data Policy Standing Advisory Committee Report

Mr. Norlen said the Board approved the requirements for the upgrade to NEMSIS version 3.0. DPSAC is meeting next week to discuss an implementation plan.

#### Medication Expiration Dates

Mr. Miller said expiration dates for medications was not discussed by the Legislative Work Group. This involves regulation by the Board of Pharmacy. Dr. Burnett said medications are stored by manufacturer’s specification. Mr. Miller asked for a clarification in writing from the Board of Pharmacy. Dr. Thomas asked about the validity of expiration dates.

Mr. Spector said that when there is an expiration date, there must be compliance with that date for inspection standards for patient care/safety.

Dr. Frascone asked for standards in other states.

Definition of a Health Officer “Hold”

Mr. Spector said this is not an EMSRB statute. Another group could sponsor legislation for this change. Dr. Frascone said that immunity is controversial. Dr. Burnett asked for the wording “on-line medical control”.

Dr. Contrerato said he will share information on requirements in other states.

Dr. Frascone suggested asking the American College of Emergency Physicians to sponsor this legislation.

Variance to Minnesota Rule for Epinephrine

Dr. Burnett said any change to rule would be opposed by nurses. It was suggested that we seek an opinion from the Board of Pharmacy on a premeasured syringe and then take our action.

Mr. Schaefer referred to the Board of Pharmacy’s previously provided information. He indicated that training is needed. He is waiting for an answer from the Board of Pharmacy.

Dr. Conterato moved that MDSAC provide clarification and the definition of a premeasured medication and could include a premeasured commercial auto injector, unit dose vial or volume limited syringe to allow a maximum amount to treat the condition consistent with the service medical director guidelines. Dr. Thomas seconded. Motion carried.

This motion if approved by the Board should be distributed to all ambulance services.

License vs Certification

This topic was tabled and will be discussed further.

**7. Medical Director’s Role in Education Standards Transition**

This topic was discussed under the Post-Transition Education Work Group Report.

**8. Medical Director’s Course at Arrowwood**

The Medical Director’s Course was developed by Dr. Satterlee. Dr. Pate reworked the content. A Power Point presentation was provided. This will be a topic at the Medical Director’s Conference in Alexandria.

**9. New Business**

Ambulance Response to Emergency Room for 9-1-1 Calls

Dr. Lilja said the hospital has had several instances at the emergency room when a patient calls 9-1-1. Does an ambulance need to respond to the emergency room? He sought clarification of the requirements. EMSRB staff will need to research this topic to provide an answer.

Health Information Exchange

Dr. Sipprell said that they have a history of persons who are high utilizers, but information is not shared beyond PSA boundaries. This needs further discussion and a possible legal opinion. He would like to see monitoring on a statewide level. This was discussed by the committee. Dr. Sipprell said the pharmacy prescription monitoring program is a good model.

Dr. Sipprell moved that the MDSAC consider an EMS health information exchange as an important topic for further consideration. Dr. Lyng seconded. Motion carried.

**10. Next Meeting**

During the Medical Director's Conference in September in Alexandria.

**11. Adjourn**

Dr. Frascone moved to adjourn. Dr. Lilja seconded. Motion carried.

Meeting adjourned at 12:30 p.m.

## **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

# **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

# POLST: Provider Orders for Life Sustaining Treatment

# POLST

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

## PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider. This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First/Middle Initial

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Primary Care Provider/Phone

### A

Check  
One

#### CARDIOPULMONARY RESUSCITATION (CPR):

Patient has no pulse and is not breathing.

CPR/ATTEMPT RESUSCITATION

DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

When not in cardiopulmonary arrest, follow orders in B and C.

### B

Check  
One  
Goal

#### GOALS OF TREATMENT:

Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

Additional Orders (e.g. dialysis, etc.)

COMFORT CARE — Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

*Check all that apply:*

In an emergency, call \_\_\_\_\_ (e.g. hospice)

If possible, do not transport to ER (when patient can be made comfortable at residence)

If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS — Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

*Check one:*

Do not intubate

Trial of intubation (e.g. \_\_\_\_\_ days) or other instructions: \_\_\_\_\_

PROVIDE LIFE SUSTAINING TREATMENT

Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

### C

Check  
All That  
Apply

#### INTERVENTIONS AND TREATMENT

ANTIBIOTICS (*check one*):

No Antibiotics (Use other methods to relieve symptoms whenever possible.)

Oral Antibiotics Only (No IV/IM)

Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION (*check all that apply*):

Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)

Tube feeding through mouth or nose

Tube feeding directly into GI tract

IV fluid administration

Other: \_\_\_\_\_

Additional Orders:

Provider Name (MD/DO/APRN/PA when delegated, are acceptable)

Provider Signature

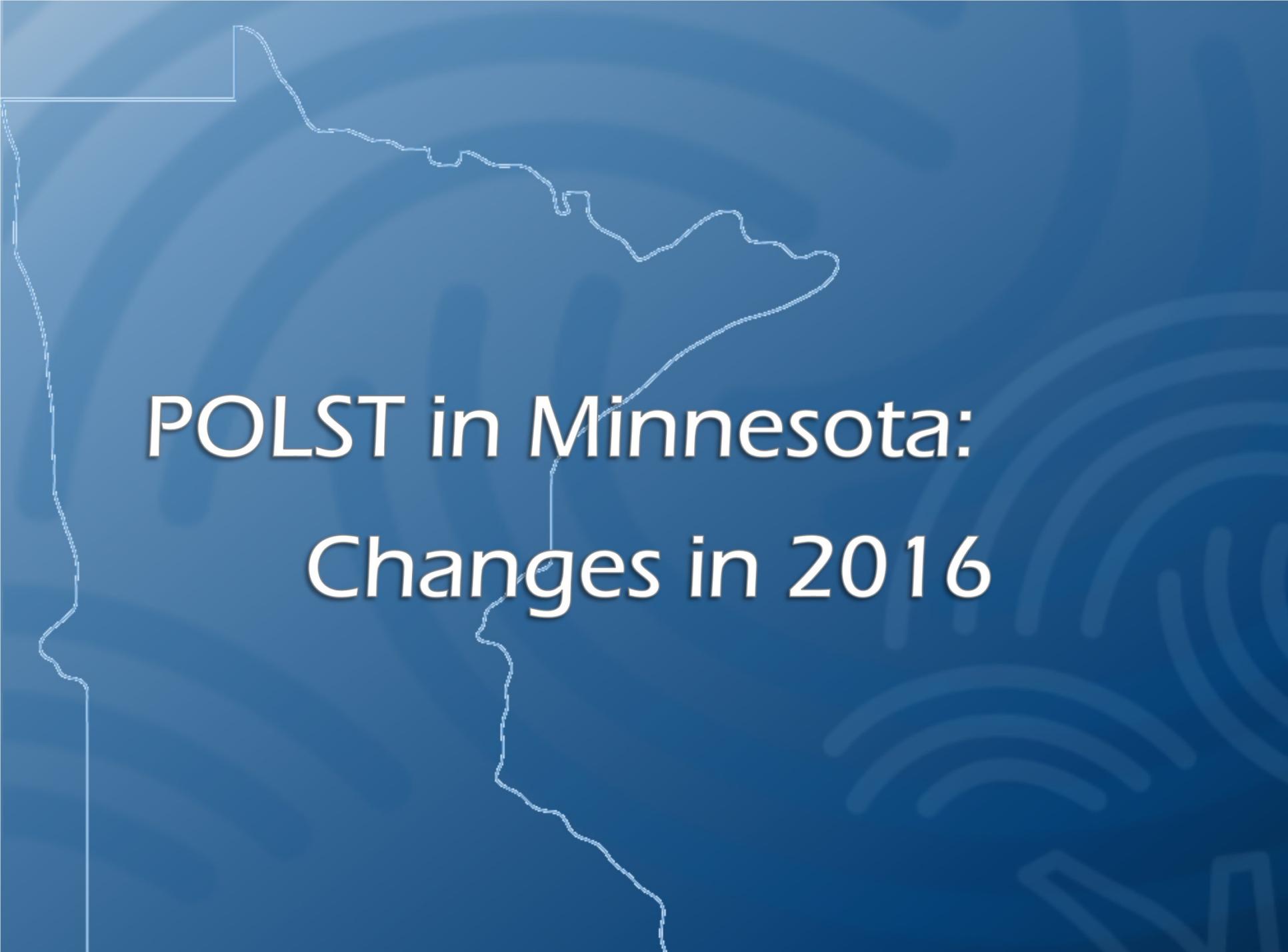
Date

FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.

TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.

# POLST





# **POLST in Minnesota: Changes in 2016**

# POLST

Provider Orders for Life Sustaining Treatment

## History:

- National



- Minnesota

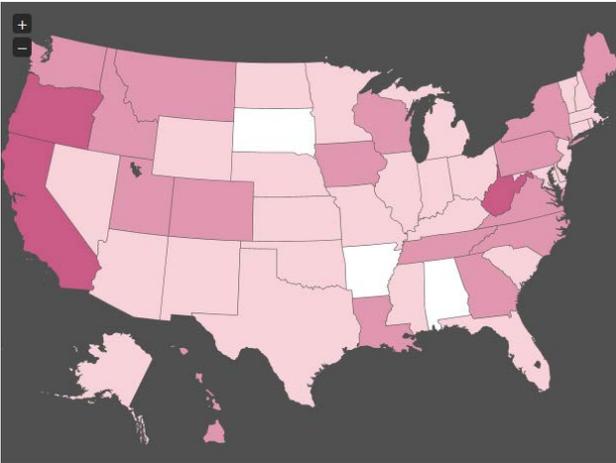


MINNESOTA  
MEDICAL  
ASSOCIATION



# Changes:

- Meet national standards
- National endorsement



## ***Currently:***

- 19 Endorsed (3 Mature)
- 25 Developing
- 3 Non-conforming
- 3 Not (yet) developing



MINNESOTA

# Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME		PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

Newly-revised Minnesota form:

## A CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

- Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).
- Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

## B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE

(NOTE REQUIREMENTS)

- Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Full treatment including life support measures in the intensive care unit.
- Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.  
**TREATMENT PLAN:** Maximize comfort through symptom management.

## C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Patient</b> ( <i>Patient has capacity</i> ) | <input type="checkbox"/> <b>Court-Appointed Guardian</b> | <input type="checkbox"/> <b>Other Surrogate</b>       |
| <input type="checkbox"/> <b>Parent of Minor</b>                         | <input type="checkbox"/> <b>Health Care Agent</b>        | <input type="checkbox"/> <b>Health Care Directive</b> |

### SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ( <b>STRONGLY RECOMMENDED</b> )	NAME ( <i>PRINT</i> )
---	-----------------------

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF")	PHONE ( <i>WITH AREA CODE</i> )
---	---------------------------------

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

## D SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME ( <i>PRINT</i> ) ( <b>REQUIRED</b> )	LICENSE TYPE ( <b>REQUIRED</b> )	PHONE ( <i>WITH AREA CODE</i> )
---	----------------------------------	---------------------------------

SIGNATURE ( <b>REQUIRED</b> )	DATE ( <b>REQUIRED</b> )
-------------------------------	--------------------------

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

Added our state name on front!



MINNESOTA

# Provider Orders for Life-Sustaining Treatment (POLST)

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LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME	PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)	

**A** **CARDIOPULMONARY RESUSCITATION (CPR)** *Patient has no pulse and is not breathing.*

CHECK ONE

**Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

**Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

*When not in cardiopulmonary arrest, follow orders in B.*

**B** **MEDICAL TREATMENTS** *Patient has pulse and/or is breathing.*

CHECK ONE  
(NOTE REQUIREMENTS)

**Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Full treatment including life support measures in the intensive care unit.

**Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Provide basic medical treatments aimed at treating new or reversible illness.

**Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.  
**TREATMENT PLAN:** Maximize comfort through symptom management.

**C** **DOCUMENTATION OF DISCUSSION**

CHECK ALL THAT APPLY

**Patient** (*Patient has capacity*)     **Court-Appointed Guardian**     **Other Surrogate**  
 **Parent of Minor**     **Health Care Agent**     **Health Care Directive**

**SIGNATURE OF PATIENT OR SURROGATE**

SIGNATURE (**STRONGLY RECOMMENDED**)    NAME (*PRINT*)

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF")    PHONE (*WITH AREA CODE*)

*Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.*

**D** **SIGNATURE OF PHYSICIAN / APRN / PA**

*My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.*

NAME (*PRINT*) (**REQUIRED**)    LICENSE TYPE (**REQUIRED**)    PHONE (*WITH AREA CODE*)

SIGNATURE (**REQUIRED**)    DATE (**REQUIRED**)

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.

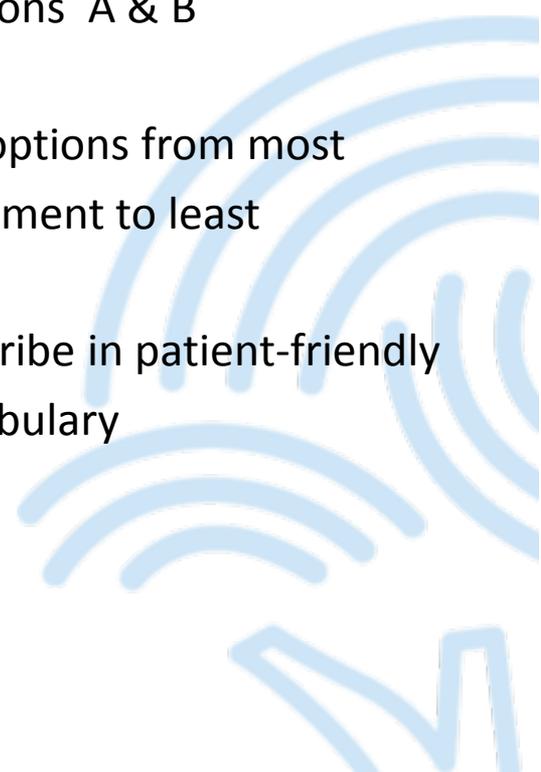
Newly-revised Minnesota form:

Sections A & B:

Indicate connection between choices made in sections A & B

List options from most treatment to least

Describe in patient-friendly vocabulary



MINNESOTA

# Provider Orders for Life-Sustaining Treatment (POLST)

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DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME	PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)	

Newly-revised Minnesota form:

## A CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

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- Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

## B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

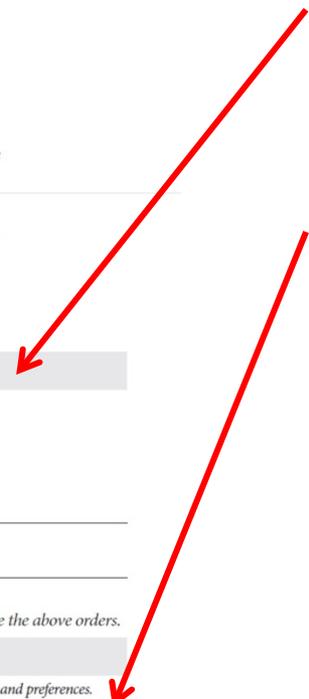
CHECK ONE  
(NOTE REQUIREMENTS)

- Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Full treatment including life support measures in the intensive care unit.
- Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.  
**TREATMENT PLAN:** Maximize comfort through symptom management.

Sections C & D:

Move to front to indicate importance

Clarify signature space



## C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Patient</b> ( <i>Patient has capacity</i> ) | <input type="checkbox"/> <b>Court-Appointed Guardian</b> | <input type="checkbox"/> <b>Other Surrogate</b>       |
| <input type="checkbox"/> <b>Parent of Minor</b>                         | <input type="checkbox"/> <b>Health Care Agent</b>        | <input type="checkbox"/> <b>Health Care Directive</b> |

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SIGNATURE ( <b>STRONGLY RECOMMENDED</b> )	NAME ( <i>PRINT</i> )
RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF")	PHONE ( <i>WITH AREA CODE</i> )

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

## D SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME ( <i>PRINT</i> ) ( <b>REQUIRED</b> )	LICENSE TYPE ( <b>REQUIRED</b> )	PHONE ( <i>WITH AREA CODE</i> )
SIGNATURE ( <b>REQUIRED</b> )	DATE ( <b>REQUIRED</b> )	



**INFORMATION FOR**

PATIENT NAMED ON THIS FORM

**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT**

**E ADDITIONAL PATIENT PREFERENCES (OPTIONAL)**

CHECK ONE FROM EACH SECTION

**ARTIFICIALLY ADMINISTERED NUTRITION** *Offer food by mouth if feasible.*

- Long-term artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- No artificial nutrition by tube.

**ANTIBIOTICS**

- Use IV/IM antibiotic treatment.
- Oral antibiotics only (no IV/IM).
- No antibiotics. Use other methods to relieve symptoms when possible.

**ADDITIONAL PATIENT PREFERENCES** *(e.g. dialysis, duration of intubation).*

\_\_\_\_\_

**HEALTH CARE PROVIDER WHO PREPARED DOCUMENT**

PREPARER NAME (REQUIRED)

PREPARER TITLE (REQUIRED)

PREPARER PHONE (WITH AREA CODE) (REQUIRED)

DATE PREPARED (REQUIRED)

**NOTE TO PATIENTS AND SURROGATES**

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form

can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a Health Care Agent to speak for you if you are unable to speak for yourself.

**DIRECTIONS FOR HEALTH CARE PROVIDERS**

**Completing POLST**

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, Health Care Agent designated in a Health Care Directive, or a person whom the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a verbally designated surrogate, spouse, registered domestic partner, parent of a minor, or closest available relative.

**Reviewing POLST**

- This POLST should be reviewed periodically, and if:
- The patient is transferred from one care setting or care level to another, or
  - There is a substantial change in the patient's health status, or
  - The patient's treatment preferences change, or
  - The patient's Primary Medical Care Provider changes.

**Voiding POLST**

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.**

Newly-revised Minnesota form:

Back (Page 2):

Add patient name on page 2

Allow space for optional treatment indicators

Clarify preparer information

Update and clarify instructions

Add URL and revision date

# POLST

Provider Orders for Life Sustaining Treatment

## What's next:

- Final approvals and endorsements
- Education development
- Roll out!



Questions?

MINNESOTA

# Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH		
PRIMARY MEDICAL CARE PROVIDER NAME	PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)	

## A

### CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

- Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).
- Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

*When not in cardiopulmonary arrest, follow orders in B.*

## B

### MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE  
(NOTE REQUIREMENTS)

- Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Full treatment including life support measures in the intensive care unit.
- Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.  
**TREATMENT PLAN:** Provide basic medical treatments aimed at treating new or reversible illness.
- Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.  
**TREATMENT PLAN:** Maximize comfort through symptom management.

## C

### DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Patient</b> ( <i>Patient has capacity</i> ) | <input type="checkbox"/> <b>Court-Appointed Guardian</b> | <input type="checkbox"/> <b>Other Surrogate</b>       |
| <input type="checkbox"/> <b>Parent of Minor</b>                         | <input type="checkbox"/> <b>Health Care Agent</b>        | <input type="checkbox"/> <b>Health Care Directive</b> |

### SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ( <b>STRONGLY RECOMMENDED</b> )	NAME ( <i>PRINT</i> )
RELATIONSHIP ( <i>IF YOU ARE THE PATIENT, WRITE "SELF"</i> )	PHONE ( <i>WITH AREA CODE</i> )

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## D

### SIGNATURE OF PHYSICIAN / APRN / PA

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SIGNATURE ( <b>REQUIRED</b> )	DATE ( <b>REQUIRED</b> )	

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# INFORMATION FOR

PATIENT NAMED ON THIS FORM

**HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT**

## **E** ADDITIONAL PATIENT PREFERENCES (OPTIONAL)

CHECK  
ONE  
FROM  
EACH  
SECTION

### **ARTIFICIALLY ADMINISTERED NUTRITION** *Offer food by mouth if feasible.*

- Long-term artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- No artificial nutrition by tube.

### **ANTIBIOTICS**

- Use IV/IM antibiotic treatment.
- Oral antibiotics only (no IV/IM).
- No antibiotics. Use other methods to relieve symptoms when possible.

### **ADDITIONAL PATIENT PREFERENCES** (e.g. dialysis, duration of intubation).

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## HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

PREPARER NAME (REQUIRED)

PREPARER TITLE (REQUIRED)

PREPARER PHONE (WITH AREA CODE) (REQUIRED)

DATE PREPARED (REQUIRED)

### NOTE TO PATIENTS AND SURROGATES

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## NATIONAL CONTINUED COMPETENCY PROGRAM (NCCP) CPR/ACLS REQUIREMENTS

- NREMT no longer requires CPR or ACLS for NCCP recertification at any level.
- Some hours from an ACLS Refresher course can be utilized toward NCCR component.
- Minnesota or a local agency can require these courses. Hours not used toward the NCCR component can be utilized toward the LCCR or ICCR components
- Should this be considered a minimum competency to ensure Stroke and STEMI protocols are met?
- Expectations of the public?

Currently required for renewal by Minnesota Statute § 144E.28:

- EMT: a course in CPR approved by the Board or medical director
- AEMT: a course in CPR approved by the Board or medical director
- Paramedic: a course in advanced cardiac life support approved by the Board or medical director
- EMR: NO CPR Required for Renewal (see Minnesota Statute § 144E.27)

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### National Registry of EMT's

#### For Initial Certification:

- Requires "Verification from the Program Director that you hold a current CPR-BLS for Healthcare Providers or equivalent credential....." at all levels EMT and above.

#### Under "Old" Recertification Model:

- EMT & AEMT - Have CPR-BLS for Healthcare Provider credential that is current on the March 31 expiration date.
- Paramedic - Have CPR-BLS for Healthcare Provider and ACLS credential that is current on the March 31 expiration date.

#### National Continued Competency Program:

- No CPR or ACLS requirement

### NCCP Components

#### National Continued Competency Requirements (50%)

- Provided by the NREMT – updated every 4 years.

#### Local Continued Competency Requirements (25%)

- Can be chosen by **State** EMS Offices, EMS Regional Directors, Medical Directors or Training Officers.
- Includes skill competency attestation by Training Officer or Medical Director.

#### Individual Continued Competency Requirements (25%)

- Individual selects any EMS related education.

## "ALPHABET" COURSE BREAKDOWN

## INITIAL COURSE APPLICATION:

Course/Category	EMT	AEMT	NRP
<b>ACLS</b>	<b>2.5 Hrs.</b>	<b>2.5 Hrs.</b>	<b>7 Hrs.</b>
Ventilation	1 Hr.	1 Hr.	1 Hr.
Capnography	0	0	1 Hr.
Advanced Airway Management (Adult)	0	0	0.5 Hr.
Post-Resuscitation Care	0.5 Hr.	0.5 Hr.	1 Hr.
Stroke	1 Hr.	1 Hr.	1.5 Hrs.
Cardiac Arrest	0	0	2 Hrs.

CPR	3 Hrs.	3 Hrs.	3.5 Hrs.
Ventilation	1 Hr.	1 Hr.	1 Hr.
Pediatric Cardiac Arrest	2 Hrs.	2 Hrs.	2.5 Hrs.

## REFRESHER COURSE APPLICATION:

Course/Category	EMT	AEMT	NRP
<b>ACLS</b>	<b>1 Hrs.</b>	<b>1 Hrs.</b>	<b>3.5 Hrs.</b>
Ventilation	1 Hr.	1 Hr.	1 Hr.
Capnography	0	0	1 Hr.
Advanced Airway Management (Adult)	0	0	0.5 Hr.
Cardiac Arrest	0	0	1 Hr.

**144E.28 CERTIFICATION OF EMT, AEMT, AND PARAMEDIC.**

Subdivision 1. **Requirements.** To be eligible for certification by the board as an EMT, AEMT, or paramedic, an individual shall:

- (1) successfully complete the United States Department of Transportation course, or its equivalent as approved by the board, specific to the EMT, AEMT, or paramedic classification;
- (2) pass the written and practical examinations approved by the board and administered by the board or its designee, specific to the EMT, AEMT, or paramedic classification; and
- (3) complete a board-approved application form.

\* \* \*

Subd. 7. **Renewal.** (a) Before the expiration date of certification, an applicant for renewal of certification as an EMT shall:

(1) successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director;

(2) take the United States Department of Transportation EMT refresher course and successfully pass the practical skills test portion of the course, or successfully complete 48 hours of continuing education in EMT programs that are consistent with the United States Department of Transportation National EMS Education Standards or its equivalent as approved by the board or as approved by the licensee's medical director and pass a practical skills test approved by the board and administered by an education program approved by the board. The cardiopulmonary resuscitation course and practical skills test may be included as part of the refresher course or continuing education renewal requirements; and

(3) complete a board-approved application form.

(b) Before the expiration date of certification, an applicant for renewal of certification as an AEMT or paramedic shall:

(1) for an AEMT, successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director and for a paramedic, successfully complete a course in advanced cardiac life support that is approved by the board or the licensee's medical director;

(2) successfully complete 48 hours of continuing education in emergency medical training programs, appropriate to the level of the applicant's AEMT or paramedic certification, that are consistent with the United States Department of Transportation National EMS Education Standards or its equivalent as approved by the board or as approved by the licensee's medical director. An applicant may take the United States Department of Transportation Emergency Medical Technician refresher course or its equivalent without the written or practical test as approved by the board, and as appropriate to the applicant's level of certification, as part of the 48 hours of continuing education. Each hour of the refresher course, the cardiopulmonary resuscitation course, and the advanced cardiac life-support course counts toward the 48-hour continuing education requirement; and

(3) complete a board-approved application form.

(c) Certification shall be renewed every two years.

(d) If the applicant does not meet the renewal requirements under this subdivision, the applicant's certification expires.

must ensure that the services provided by the community paramedic are consistent with the services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(b) A community paramedic is subject to all certification, disciplinary, complaint, renewal, and other regulatory requirements that apply to paramedics under this chapter. In addition to the renewal requirements in subdivision 7, a community paramedic must complete an additional 12 hours of continuing education in clinical topics approved by the ambulance service medical director.

\* \* \* \*

**History:** 1999 c 245 art 9 s 37; 2000 c 313 s 2,3; 2005 c 147 art 10 s 6-9; 2011 c 12 s 2; 2012 c 193 s 33-36; 2013 c 18 s 1

**144E.27 EDUCATION PROGRAMS; BOARD APPROVAL.**

Subdivision 1. **Education program instructor.** An education program instructor must be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.

Subd. 1a. **Approval required.** (a) All education programs for an emergency medical responder must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

(iii) admission criteria for students; and

(iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to Emergency Medical Responder registration education;

(3) have a program medical director and a program coordinator;

(4) have at least one instructor for every ten students at the practical skill stations;

(5) retain documentation of program approval by the board, course outline, and student information; and

(6) submit the appropriate fee as required under section 144E.29.

(c) The National EMS Education Standards by the NHTSA, United States Department of Transportation contains the minimal entry level of knowledge and skills for emergency medical responders. Medical directors of emergency medical responder groups may expand the knowledge and skill set.

Subd. 2. **Registration.** To be eligible for registration with the board as an emergency medical responder, an individual shall complete a board-approved application form and:

(1) successfully complete a board-approved initial emergency medical responder education program. Registration under this clause is valid for two years and expires on October 31; or

(2) be credentialed as an emergency medical responder by the National Registry of Emergency Medical Technicians. Registration under this clause expires the same day as the National Registry credential.

\* \* \* \*

**Subd. 3. Renewal.** (a) The board may renew the registration of an emergency medical responder who:

(1) successfully completes a board-approved refresher course; and

(2) submits a completed renewal application to the board before the registration expiration date.

(b) The board may renew the lapsed registration of an emergency medical responder who:

(1) successfully completes a board-approved refresher course; and

(2) submits a completed renewal application to the board within 12 months after the registration expiration date.

\* \* \* \*

**History:** 1997 c 199 s 13; 1999 c 245 art 9 s 35,36; 2004 c 144 s 3,4; 2005 c 147 art 10 s 5; 2012 c 193 s 27-31; 2013 c 13 s 3,4

# Minnesota EMSRB/NREMT **Emergency Medical Technician** Recertification Requirements

Minnesota EMTs must meet the following requirements in order to renew their Minnesota and/or NREMT certification.

National Content Required: 20 Hours		
	Topics:	Hours
Cardiovascular 6 Hours Required*	<b>Stroke:</b> Assessment (Stroke Scale); Oxygen administration; Time of onset (duration); Transport destination;	1
	<b>Cardiac Arrest &amp; Ventricular Assist Device (VAD)</b>	0.5
	<b>Post Resuscitation Care:</b> Recognition of ROSC; Induced hypothermia; Oxygenation	0.5
	<b>Pediatric:</b> Tachycardia, Irregular pulse, Bradycardia	1
	<b>Pedi Cardiac Arrest:</b> Optimal CPR techniques, AED use, Ventilation/compression ratio, 1 & 2 rescuer CPR	2
	<b>Chest Pain &amp; ACS:</b> Medication administration, Oxygen, Nitroglycerin, Transportation Destination, Aspirin (ASA)	1
Airway, Respiration, Ventilations 4 Hours Required*	<b>Ventilation:</b> Assisted Ventilations, Automatic Transport Ventilator, Respiratory failure vs. distress, Minute Ventilation, Adjuncts, Effect on Cardiac output, Positioning	3
	<b>Oxygenation</b>	1
Trauma 2 Hours Required*	<b>CNS Injury:</b> Concussions	0.5
	<b>Tourniquets</b>	0.5
	<b>Field Triage:</b> Model uniform core criteria (MUCC)	1
	Sort, Assess, Lifesaving interventions, Treatment /Transport (SALT) CDC Trauma Triage Decision Scheme	
Medical 6 Hours Required*	<b>Immunological Diseases:</b> Allergic reaction, Anaphylaxis	1
	<b>Communicable Diseases:</b> Hygiene (hand washing), Vaccines, Influenza, Antibiotic resistant infections, Public health—epidemics, pandemics, reporting, etc. Systematic inflammatory response syndrome (SIRS) vs. Sepsis vs. septic shock, Fluid resuscitation (Oral)	0.5
	<b>Psychiatric Emergencies:</b> Mental Health, Patient Restraints, Agitated Delirium, Depression/Suicide	1.5
	<b>Special Healthcare needs:</b> Tracheostomy care, Dialysis shunts, Feeding tubes, VP shunts, Cognitive issues	1
	<b>OB Emergency:</b> Abnormal presentations, Nuchal cord, Neonatal resuscitation, Routine suctioning of the neonate	1
	<b>Endocrine:</b> Diabetes, Metabolic syndrome, Insulin resistance, DKA/HHNS, Insulin pumps, Glucometers	1
	<b>At-Risk Populations:</b> Pediatric, Geriatric, Economically disadvantaged, Domestic violence, Human trafficking	0.5
<b>Pediatric Transport</b>	0.5	
Operations 2 Hours Required*	<b>Affective Characteristics:</b> Professionalism, Cultural competency, Changing demographics	0.5
	<b>Role of Research in EMS</b>	0.5
<b>Total National Core Content Hours</b>		<b>20</b>

Local Content Required: 10 Hours	
	Topics: Required for NCCP Renewal
Skill Competencies Required*	<b>REQUIRED</b> Patient Assessment/Management Ventilatory Management Cardiac Arrest Management Hemorrhage Control/Splinting IV/IO Therapy - Medications Spinal Immobilization OB/GYN Other: Report Documentation Radio Communication
	<b>Suggested Local Topics Below</b>
Patient Advocacy	<i>Reporting Obligations Professional Accountability End of Life Decisions Safe Havens</i>
Protocols	<i>Adult Pediatric STEMI Stroke Trauma MCI</i>
Disaster Preparedness Laws Regulation	<b>Disaster Preparedness:</b> <i>ICS, Disaster Operations Patient Tracking Local/Entity Disaster Plans Regional/Local Disaster Plans State Disaster Plans</i> <b>Laws/Regulation:</b> <i>Regulatory Requirements Mandatory Reporting Minnesota EMS Related Law Penalties Scope of Practice</i>
Local / Agency	<i>Topics designated by primary EMS affiliated EMS agency.</i>  <b>Note:</b> If not affiliated or a local agency does not specify topics refer to suggested topics.
<b>Total Local Core Content Hours</b>	
<b>10</b>	

A total of 10 Hours of specific topics are required, in any combination of hours and topics from this suggested list. \*Please Note: Skill Competency Verification is required to be completed with the local training officer.

Individual Content Required: 10 Hours	
Topics:	Hours
To satisfy these requirements, an Individual may select any EMS-related education. Please note that an agency medical director or training officer may require specific individual training courses.	
<b>Total Individual Core Content Hours</b>	<b>10</b>
<b>**CPR REFRESHER**</b> <b>Minnesota Statute § 144E.28, subd. 7, requires all EMTs to successfully complete a refresher course in CPR. Please note that CPR refresher hours may be used as local or individual content hours.</b>	
<b>Total EMT Renewal Hours</b>	
<b>Category</b>	<b>Total Hours</b>
National (NCCR)	20
Local (LCCR)	10
Individual (ICCR)	10
<b>Total</b>	<b>40</b>
<b>Guidelines on Distributive Education</b> Distributive Education (DE) is defined as education received when a live, “real time” instructor is not available. The number of DE hours allowed is limited based on the category in which they are obtained.  <b>National Content:</b> up to 7 hours of DE is allowed <b>Local Content:</b> up to 7 hours of DE is allowed <b>Individual Content:</b> up to 10 hours of DE is allowed  <i>Using DE is optional, however, please be mindful of the hour limits if you choose to use them.</i>	



\*Note: Topics listed in **Local Content Hours** are suggested topics only. EMS agencies can determine specific topics needed to meet the agencies ongoing education/training requirements. Only the skill competency verification is required.

# Minnesota EMSRB/NREMT Advanced Emergency Medical Technician Recertification Requirements

Minnesota AEMTs must meet the following requirements in order to renew their Minnesota and/or NREMT certification.

National Content Required: 25 Hours		
	Topics:	Hours
<b>Cardiovascular 6 Hours Required*</b>	<b>Stroke:</b> Assessment (Stroke Scale); Oxygen administration; Time of onset (duration); Transport destination;	1
	<b>Cardiac Arrest &amp; Ventricular Assist Device (VAD)</b>	0.5
	<b>Post Resuscitation Care:</b> Recognition of ROSC; Induced hypothermia; Oxygenation	0.5
	<b>Pediatric:</b> Tachycardia, Irregular pulse, Bradycardia	1
	<b>Pedi Cardiac Arrest:</b> Optimal CPR techniques, AED use, Ventilation/compression ratio, 1 & 2 rescuer CPR	2
	<b>Chest Pain &amp; ACS:</b> Medication administration, Oxygen, Nitroglycerin, Transportation Destination, Aspirin (ASA)	1
<b>Airway, Respiration, Ventilations 4 Hours Required*</b>	<b>Ventilation:</b> Assisted Ventilations, Automatic Transport Ventilator, Respiratory failure vs. distress, Minute Ventilation, Adjuncts, Effect on Cardiac output, Positioning	3
	<b>Oxygenation</b>	1
<b>Trauma 2 Hours Required*</b>	<b>CNS Injury:</b> Concussions	0.5
	<b>Tourniquets</b>	0.5
	<b>Field Triage:</b> Model uniform core criteria (MUCC)	1
	Sort, Assess, Lifesaving interventions, Treatment /Transport (SALT) CDC Trauma Triage Decision Scheme	
<b>Medical 6 Hours Required*</b>	<b>Immunological Diseases:</b> Allergic reaction, Anaphylaxis	1
	<b>Communicable Diseases:</b> Hygiene (hand washing), Vaccines, Influenza, Antibiotic resistant infections, Public health—epidemics, pandemics, reporting, etc. Systematic inflammatory response syndrome (SIRS) vs. Sepsis vs. septic shock, Fluid resuscitation (Oral)	0.5
	<b>Psychiatric Emergencies:</b> Mental Health, Patient Restraints, Agitated Delirium, Depression/Suicide	1.5
	<b>Special Healthcare needs:</b> Tracheostomy care, Dialysis shunts, Feeding tubes, VP shunts, Cognitive issues	1
	<b>OB Emergency:</b> Abnormal presentations, Nuchal cord, Neonatal resuscitation, Routine suctioning of the neonate	1
	<b>Endocrine:</b> Diabetes, Metabolic syndrome, Insulin resistance, DKA/HHNS, Insulin pumps, Glucometers	1
<b>Operations 2 Hours Required*</b>	<b>At-Risk Populations:</b> Pediatric, Geriatric, Economically disadvantaged, Domestic violence, Human trafficking	0.5
	<b>Pediatric Transport</b>	0.5
	<b>Affective Characteristics:</b> Professionalism, Cultural competency, Changing demographics	0.5
	<b>Role of Research in EMS</b>	0.5
<b>ALS 5 Hours</b>	<b>Required*:</b> Advanced Life Support EMS Education: AEMTs must complete additional ALS – EMS related education.	5
<b>Total National Core Content Hours</b>		<b>25</b>

Local Content Required: 12.5 Hours		
	Topics: <b>Required for NCCP Renewal</b>	
<b>Skill Competencies Required*</b>	<b>REQUIRED</b>	
	Patient Assessment/Management Ventilatory Management Cardiac Arrest Management Hemorrhage Control/Splinting IV/IO Therapy - Medications Spinal Immobilization OB/GYN Other: Report Documentation Radio Communication	
<b>Suggested Local Topics Below</b>		
<b>Patient Advocacy</b>	<i>Reporting Obligations</i> <i>Professional Accountability</i> <i>End of Life Decisions</i> <i>Safe Havens</i>	
<b>Protocols</b>	<i>Adult</i>	
	<i>Pediatric</i>	
	<i>STEMI</i>	
	<i>Stroke</i>	
	<i>Trauma</i> <i>MCI</i>	
<b>Disaster Preparedness Laws Regulation</b>	<b>Disaster Preparedness:</b> <i>ICS, Disaster Operations</i> <i>Patient Tracking</i> <i>Local/Entity Disaster Plans</i> <i>Regional/Local Disaster Plans</i> <i>State Disaster Plans</i>	
	<b>Laws/Regulation:</b> <i>Regulatory Requirements</i> <i>Mandatory Reporting</i> <i>Minnesota EMS Related Law</i> <i>Penalties</i> <i>Scope of Practice</i>	
<b>Local / Agency</b>	<i>Topics designated by primary EMS affiliated EMS agency.</i>	
	<b>Note:</b> <i>If not affiliated or a local agency does not specify topics refer to suggested topics.</i>	
<b>Total Local Core Content Hours</b>		<b>12.5</b>

A total of 12.5 Hours of specific topics are required, in any combination of hours and topics from this suggested list. \*Please Note: Skill Competency Verification is required to be completed with the local medical director.

Individual Content Required: 12.5 Hours	
Topics:	Hours
To satisfy these requirements, an Individual may select any EMS-related education. Please note that an agency medical director or training officer may require specific individual training courses.	
<b>Total Individual Core Content Hours</b>	<b>12.5</b>
<p><b>**CPR REFRESHER**</b></p> <p><b>Minnesota Statute § 144E.28, subd. 7, requires all AEMTs to successfully complete a refresher course in CPR. Please note that CPR refresher hours may be used as local or individual content hours.</b></p>	
<b>Total AEMT Renewal Hours</b>	
<b>Category</b>	<b>Total Hours</b>
National (NCCR)	25
Local (LCCR)	12.5
Individual (ICCR)	12.5
<b>Total</b>	<b>50</b>
<p><b>Guidelines on Distributive Education</b> Distributive Education (DE) is defined as education received when a live, “real time” instructor is not available. The number of DE hours allowed is limited based on the category in which they are obtained.</p> <p><b>National Content:</b> up to 8 hours of DE is allowed <b>Local Content:</b> up to 8 hours of DE is allowed <b>Individual Content:</b> up to 12.5 hours of DE is allowed</p> <p><i>Using DE is optional, however, please be mindful of the hour limits if you choose to use them.</i></p>	



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\*Note: Topics listed in **Local Content Hours** are suggested topics only. EMS agencies can determine specific topics needed to meet the agencies ongoing education/training requirements. Only the skill competency verification is required.

# Minnesota EMSRB/NREMT **Paramedic** Recertification Requirements

Minnesota Paramedics must meet the following requirements in order to renew their Minnesota and/or NREMT certification.

National Content Required: 30 Hours		
	Topics:	Hours
<b>Cardiovascular 10 Hours Required*</b>	<b>Stroke:</b> Assessment (Stroke Scale); Oxygen administration; Time of onset (duration); Transport destination; Fibrinolytics check sheet	1.5
	<b>Post Resuscitation Care:</b> Recognition of ROSC; Induced hypothermia; Oxygenation	2
	<b>Ventricular Assist Device (VAD)</b>	0.5
	<b>Cardiac Arrest:</b> Chain of Survival, Optimal chest compressions, airway issues (halting CPR to intubate, hyperventilation, supraglottic vs ETT vs BVM), termination decision criteria, ETOC2 changes during arrest and ROSC	2
	<b>Congestive Heart Failure:</b> recognition, treatments	0.5
<b>Airway, Respirations, Ventilations 4 Hours Required*</b>	<b>Pedi Cardiac Arrest:</b> Optimal CPR techniques, ALS mgmt., Ventilation/compression ratio, 1 & 2 rescuer CPR, unique causes of Pedi-Cardiac Arrest (HOCM), Comotio cordis, Long QT, AHA Channelopathy)	2.5
	<b>ACS:</b> 12-Lead review, STEMI impostures	1
	<b>Ventilations</b>	2
<b>Trauma 4 Hours Required*</b>	<b>Capnography</b>	1
	<b>Advanced Airway Management in the perfusing patient</b>	1
	<b>CNS Injury:</b> Concussions, ETOC2 monitoring	2
	<b>Tourniquets</b>	0.5
<b>Medical 7 Hours Required*</b>	<b>Field Triage:</b> Model Uniform Core Criteria (MUCC), Sort, Assess, Lifesaving interventions, Treatment /Transport (SALT) CDC Trauma Triage Decision Scheme	1
	<b>Fluid Resuscitation:</b> physiology, effects of over-loading	0.5
	<b>Special Healthcare needs:</b> Tracheostomy care, Dialysis shunts, Feeding tubes, VP shunts, Cognitive issues, CSF shunts	2
	<b>OB Emergency:</b> Abnormal presentations, Nuchal cord, Neonatal resuscitation, Routine suctioning of the neonate	1
	<b>Communicable Diseases:</b> Hygiene (hand washing), Vaccines, Influenza, Antibiotic resistant infections, Public health—epidemics, pandemics, reporting, etc.	1
<b>Operations 5 Hours Required*</b>	Systematic inflammatory response syndrome (SIRS) vs. Sepsis vs. septic shock, Fluid resuscitation (Oral)	1
	<b>Medication Delivery:</b> IM vs SC (e.g., epi), atomized/nasal	1
	<b>Pain Management:</b> NAEMSP recommendations, AAP pediatric pain management	1
	<b>Psychiatric Emergencies:</b> Mental Health, Patient Restraints, Agitated Delirium, Depression/Suicide	1
	<b>At-Risk Populations:</b> Pediatric, Geriatric, Economically disadvantaged, Domestic violence, Human trafficking	1
	<b>Pediatric Transport</b>	0.5
	<b>Culture of Safety:</b> adverse event reporting, medication safety	0.5
	<b>Affective Characteristics:</b> Professionalism, Cultural competency, Changing demographics	1
	<b>Crew Resource Management</b>	1
	<b>Role of Research in EMS</b>	1
<b>Total National Core Content Hours</b>		<b>30</b>

Local Content Required: 15 Hours		
	Topics: <b>Required for NCCP Renewal</b>	
<b>Skill Competencies Required*</b>	<b>REQUIRED</b>	
	Patient Assessment/Management Ventilatory Management Cardiac Arrest Management Hemorrhage Control/Splinting IV/IO Therapy - Medications Spinal Immobilization OB/GYN Other: Report Documentation Radio Communication	
<b>Suggested Local Topics Below</b>		
<b>Patient Advocacy</b>	<i>Reporting Obligations</i> <i>Professional Accountability</i> <i>End of Life Decisions</i> <i>Safe Havens</i>	
<b>Protocols</b>	<i>Adult</i> <i>Pediatric</i> <i>Stroke</i> <i>STEMI</i> <i>Trauma</i> <i>MCI</i>	
<b>Disaster Preparedness Laws Regulation</b>	<b>Disaster Preparedness:</b> <i>ICS, Disaster Operations</i> <i>Patient Tracking</i> <i>Local/Entity Disaster Plans</i> <i>Regional/Local Disaster Plans</i> <i>State Disaster Plans</i>  <b>Laws/Regulation:</b> <i>Regulatory Requirements</i> <i>Mandatory Reporting</i> <i>Minnesota EMS Related Law</i> <i>Penalties</i> <i>Scope of Practice</i>	
<b>Local / Agency</b>	<i>Topics designated by primary EMS affiliated EMS agency.</i>  <b>Note:</b> <i>If not affiliated/or a local agency does not specify topics, five (5) individual topic hours are required.</i>	
<b>Total Local Core Content Hours</b>		<b>15</b>

A total of 15 Hours of specific topics are required, in any combination of hours and topics from this suggested list. \*Please Note: Skill Competency Verification is required to be completed with the local medical director.

Individual Content Required: 15 Hours	
Topics:	Hours
To satisfy these requirements, an Individual may select any EMS-related education. Please note that an agency medical director or training officer may require specific individual training courses.	
<b>Total Individual Core Content Hours</b>	<b>15</b>
<b>**ACLS REFRESHER**</b>	
<b>Minnesota Statute § 144E.28, subd. 7, requires all Paramedics to successfully complete a refresher course in ACLS. Please note that ACLS refresher hours may be used as local or individual content hours.</b>	
<b>Total Paramedic Renewal Hours</b>	
<b>Category</b>	<b>Total Hours</b>
National (NCCR)	30
Local (LCCR)	15
Individual (ICCR)	15
<b>Total</b>	<b>60</b>
<b>Guidelines on Distributive Education</b>	
Distributive Education (DE) is defined as education received when a live, “real time” instructor is not available. The number of DE hours allowed is limited based on the category in which they are obtained.	
<b>National Content:</b> up to 10 hours of DE is allowed	
<b>Local Content:</b> up to 10 hours of DE is allowed	
<b>Individual Content:</b> up to 15 hours of DE is allowed.	
<i>Using DE is optional, however, please be mindful of the hour limits if you choose to use them.</i>	



07/28/2016

\*Note: Topics listed in **Local Content Hours** are suggested topics only. EMS agencies can determine specific topics needed to meet the agencies ongoing education/training requirements. Only the skill competency verification is required.

# Saving Lives in MN

## MN Resuscitation Consortium



## Implementing HeartRescue in MN

Working together to save lives.

A key task of developing the consortium was creating various teams to accomplish the goals of the grant and to develop additional goals based on recognized needs in MN communities or agencies. These teams were established to lead three focus areas: Bystander Response, Pre-hospital Response, and Hospital Response.

1

### BYSTANDER

Partnering with existing groups and programs to improve public awareness and response.

2

### PRE HOSPITAL

Working with EMS agencies and medical directors to improve care during transport.

3

### HOSPITAL

Experts in resuscitation working together to develop and initiate new, ground-breaking practice.

## GOALS



Improve bystander CPR rates by training 10% of MN. Increase access to AEDs for rapid use.



Improve quality of care by data driven solutions. Develop education and tools for all pre-hospital levels.



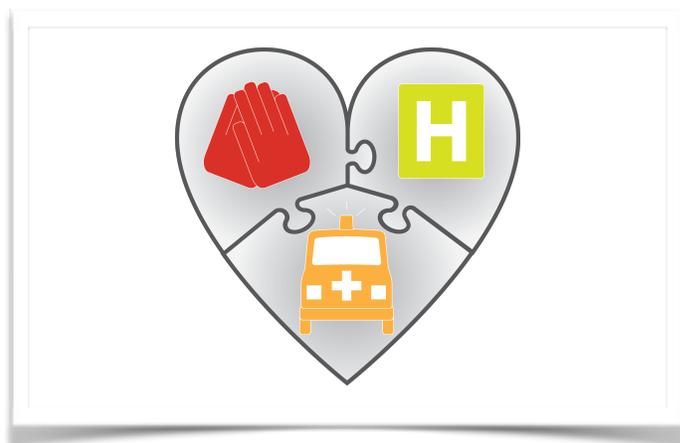
Research new solutions to expedite definitive care for CA patients. Create post cardiac arrest resources.

## Organizational goals and accomplishments

The coordinated efforts through the MRC have shown Minnesota to be a leader in resuscitation success.

The implementation of the HeartRescue Project, funded through Medtronic Philanthropy, has offered Minnesota the opportunity to develop a truly collaborative effort around the system of cardiac arrest care and the collection of out of hospital cardiac arrest (OHCA) data. The collaboration of many groups and agencies has led to changes in cardiac arrest care that could not have been accomplished if they were working alone. These efforts are leading to significant state-wide changes in protocol that are showing a measurable impact on outcomes.

The MRC has an extensive web of partners including state level agencies, police and fire departments, ambulance agencies and hospital systems that are working on improving survival. Community level agencies including schools, faith-based, and government programs are engaged in bystander response solutions and creating awareness. These partnerships have been key to the success of the MRC. They have lead to new ideas in training, opportunities for collaborative research, successful passage of policies, and most importantly - more survivors who are returning to their families, lives, jobs, and normal activities.



**“Improving cardiac arrest outcomes is like a puzzle - all the pieces need to fit together for solutions to work.”**

The MRC has prided itself on grants available to communities and agencies to improve survival. Approximately 30% of the overall grant budget has been used for grants toward equipment, data collection, community events, training, and much more. This included partial funding of a LUCAS device for Brainerd Lakes Police Department. They often arrive on scene and have a long wait for EMS due to the rural area and winding lake roads. Within a month of receiving the device, a lone officer arrived on scene with a cardiac arrest patient. He applied the LUCAS device and AED. With this new life-saving tool, he was able to provide care with uninterrupted, ongoing CPR. The patient survived! MRC dollars have meant lives saved in Minnesota!



### CARDIAC ARREST SURVIVORS - HEART OF LIFE

The annual survivors dinner, hosted by Allina Health EMS, brings together survivors from across the state. Heart Safe Dinner 2014

# Today in MN, communities are better prepared for cardiac emergencies by.....

## Learning CPR and how to use an AED

**LEARN CPR**  
www.learnCPRnow.org

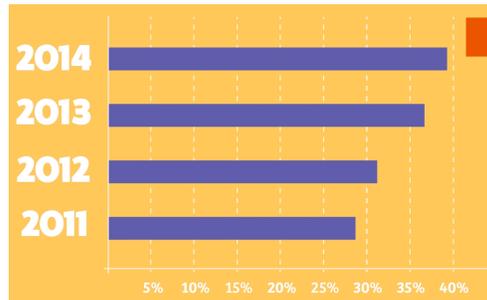
More than **50** online training resources.

More than **89,664** Minnesotans have learned CPR

**Over 12** informational videos created.



**2012** Minnesota CPR in Schools Law. Requiring CPR to be taught before graduation.



2015 Bystander CPR Rate **43%**

**2014** AED registry law. Ensuring AEDs are ready for use.



Registering **4,793** AEDs across Minnesota

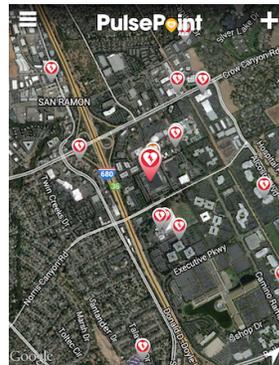
Using crowdsourcing apps to identify and map AED locations

**3,701** AEDs used on OHCA patients

**HEART SAFE**



Being designated as a Heart Safe Community, Campus, or Business. More than **100** across the state are better prepared for cardiac emergencies.



## I AM THE FACE OF BYSTANDER RESPONSE

Dale had his cardiac arrest while referring a basketball game at Fridley HS. A high school student started CPR and an AED was brought from the school hallway. Dale was resuscitated by bystander CPR and public AED use.



# Today in MN, first responders and EMS are better prepared for cardiac emergencies by.....



Dispatchers engaged in 'Fast Track' CPR instructions

Rapid EMS Response



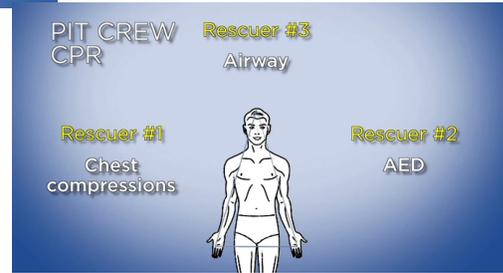
MN Resuscitation Consortium

**BLS Protocol Recommendations:**

- Continuous chest compressions whenever possible
- Early Defibrillation
- Apply ResQPod (if available)
- Asynchronous ventilations for 2+ rescuers (8-10/min)
- O2 4L/min
- OK to delay ventilations for single rescuer (3-4 min)



Using Standardized Protocols & Pit Crew CPR

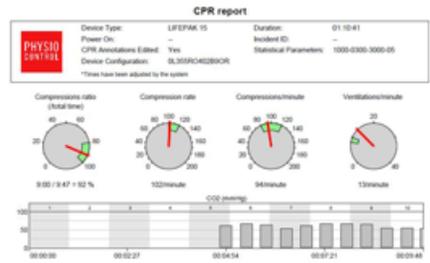


Improving skills at 8 resuscitation academies and more than 50 presentations at statewide conferences

Using new technologies in Minnesota. 5,096 Automated CPR Devices applied



Data collection covering 85% of the population and feedback tools for quality improvement and education



**ORIGINAL RESEARCH**

Minnesota Resuscitation Consortium's Advanced Perfusion and Reperfusion Cardiac Life Support Strategy for Out-of-Hospital Refractory Ventricular Fibrillation

Demetris Yannopoulos, MD; Jason A. Bartos, MD, PhD; Cindy Martin, MD; Ganesh Raveendran, MD, MPH; Emil Missov, MD, PhD

Collaborative research opportunities



**I AM THE FACE OF PRE-HOSPITAL RESPONSE**

Jamie had her cardiac arrest when she was 18 years old and working at Mall of America. None of her co-workers knew CPR. Mall security first responders and Allina EMS arrived on scene and provided CPR and AED.



## Strategies to Improve Cardiac Arrest Survival: A Time to Act

### Recommendations from the Institute of Medicine Report - how do we compare?

1. **Establish a National Cardiac Arrest Registry** - The MRC has been collecting data through CARES since 2010. Currently, CARES collection covers approximately 85% of the entire states population. The MRC works with the Minnesota Department of Health and the Emergency Medical Services Regulatory Board to evaluate data, determine feedback solutions, and find ways to capture the remaining rural areas. MN CARES is also collecting data from Wisconsin, North and South Dakota.
2. **Foster a Culture of Action through Public Awareness and Training** - The MRC has supported and implemented several training programs and provides resources for ongoing events and training. We have created public service announcements, media tools and online education for CPR and AED use. The MRC is a key partner in the Heart Safe Designation program in Minnesota. We worked with AHA to pass the CPR in Schools and AED Registry Laws in Minnesota.
3. **Enhance the Capabilities and Performance of EMS Systems** - The MRC has provided ongoing education through annual academies and speakers at rural conferences. We have assisting with resources for dispatch, police and fire first response and ambulance services including equipment and other tools.
4. **Set National Accreditation Standards Related to Cardiac Arrest for Hospitals and Health Care Systems** - The MRC is working with the development of a Time Critical Care Team to create streamlines systems for cardiac arrest, stroke, STEMI, and trauma for EMS and hospitals.
5. **Adopt CQI Programs** - The MRC provides reports to EMS and hospital systems to assist with benchmarking and education following the US HR model of 'Measure and Improve'.
6. **Accelerate Research on Pathophysiology, New Therapies, and Translation of Science for Cardiac Arrest** - The MRC, through the APIC lab and Dr. Yannopoulos is part of several NIH research grants investigating new therapies. The MRC works to help the Minnesota community better understand the science behind resuscitation care and how they can be part of the solution.
7. **Accelerate Research on Evaluation and Adoption of Cardiac Arrest Therapies** - The MRC works with local EMS and cardiologists to implement ground-breaking research to improve survival and change the standard of care for cardiac arrest patients.
8. **Create a National Cardiac Arrest Collaborative** - The MRC has created solutions for collaboration through our committee structure that has created a platform for discussion and cooperative efforts. These committees have continuously updated goals and strategies to ensure that we are on the cutting edge of solutions.



# FACT SHEET

The MN Resuscitation Consortium, at the University of Minnesota School of Medicine, Cardiovascular Division is a state-wide effort to increase survival from sudden cardiac arrest. Through partnerships and committees, the MRC strives to improve the systems based approach to cardiac arrest from bystander to pre-hospital to hospital response. The MRC began with funding through the Medtronic Philanthropy Heart Rescue project. This multi-state project serves to share best practices, expansion from centers throughout the state they serve and data collection process to determine baseline and progress in cardiac arrest care.

To enroll in CARES MN - go to [www.mrc.umn.edu/CARES](http://www.mrc.umn.edu/CARES)

## “You can’t change, what you don’t measure”.

This is the basis for the partnership between the MRC, Heart Rescue teams and CARES, the Cardiac Registry to Enhance Survival. The CARES database is a nationwide database that supports the goal of increased survival from sudden cardiac arrest. The MRC provides a Minnesota CARES coordinator to give personalized training, offer support, and customized reports for agencies participating in CARES, while maintaining confidentiality. The data captures the specific epidemiological characteristics for cardiac arrest survival outcomes and therapies. It

### CARES allows EMS administrators and community leaders to answer important questions such as:

- Who is affected in my community?
- When and where are cardiac events happening?
- What parts of the system are working well?
- What parts of the system could be better?
- How can emergency cardiac treatment be improved?

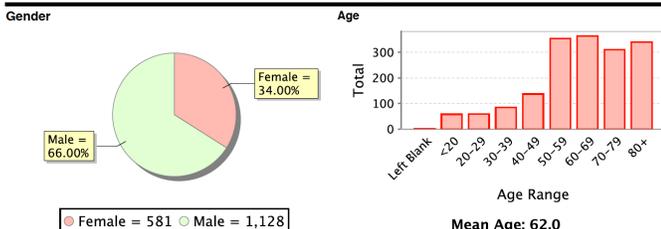
### What does CARES and the MRC offer to help you measure cardiac arrest outcomes:

- Ability to run agency specific reports
- Ability to compare to national aggregate and future plans to compare to like size agencies
- Customized reports from MRC and MDH
- Summary data reports
- Annual report from CARES
- Ability to connect CODE STAT to outcomes

#### Demographics

##### All Agencies

Presumed Cardiac Arrest Etiology: Presumed Cardiac Etiology, Respiratory, Drowning, Electrocution, Other | Service Date: From: 1/1/13 Through: 12/31/2013 | Resuscitation Attempted by 911 Responder: Yes | End of the Event: Died in Field, Pronounced Dead in ED, Ongoing Resuscitation in ED



Location Type	Count
Home/Residence	1219 - 71.3%
Street/Hwy	124 - 7.3%
Public/Commercial Building	116 - 6.8%
Nursing Home	114 - 6.7%
Healthcare Facility	79 - 4.8%
Place of Recreation	31 - 1.8%
Industrial Place	12 - 0.7%
Other	9 - 0.5%
Transport Center	5 - 0.3%

## Some interesting facts for 2015 (MN)...

- 1849 Non-Traumatic CARES cases
- 36% female
- 73% occurred at home
- 7% occurred in NH
- 41% bystander witnessed (37% national)
- 38% rec'd bystander CPR (41% national)
- 8% bystander AED (18%)
- 2% bystander shock (2%)
- 25% VF/VT/shockable (20%)
- 26% field hypo (10%)
- 43.5% died in field (30%)
- 31% admitted (29%)
- 10% dc with good cpc (8.5%)
- 36% Utstein survival (33%)