

State of Minnesota
Emergency Medical Services Regulatory Board
Executive Committee Meeting Agenda**

January 22, 2016 – 1:00 p.m.

2nd Floor Board Room

Duluth Entertainment and Convention Center

350 Harbor Drive, Duluth, MN 55802

[Map & Directions](#)

1. Call to Order – 1:00 p.m.

2. Public Comment – 1:05 p.m.

The public comment portion of the Executive Committee meeting is where the public may address the Executive 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 Executive 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 – 1:25 p.m.

4. Approve Minutes – 1:30 p.m.

- Approval Executive Committee Meeting Minutes from December 17, 2015

Attachments

A 1

5. Board Chair Report – 1:35 p.m.

- Burnsville Fire EMS Pilot Project
- Premeasured Epinephrine and Naloxone
- Recommendation to Fill Vacancy on DPSAC

BC 1

BC 2

6. Executive Director Report – 2:00 p.m. – Tony Spector

- MDH EMS Ebola Preparedness Survey Update
- MDH EMS Ebola Grant Update
- MDH Sustainability Survey
- MNSTAR Version 3 Update
- Budget Process Update

ED 1

Report

Report

Report

Report

7. Committee Reports – 2:25 p.m. – Committee Chairs/Staff

- MDSAC Report – Aaron Burnett, M.D.
 - o NAEMSP News Release
- DPSAC Committee Report – Megan Hartigan/Robert Norlen
- Post Transition Education Standards Workgroup/Lisa Consie
- Legislative Ad-Hoc Committee Report – Kevin Miller
- Complaint Review Panel Report – Matt Simpson

MDSAC 1

Report

Report

Report

Report

8. New Business – 2:55 p.m.

9. Adjourn – 3:00 p.m.

Note: Some Board members will 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 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, January 20, 2016 to ensure a timely response to connect to the meeting.

Next Executive Committee Meeting: April 21, 2016 -- Minneapolis

Attachment Key:

A = Agenda Attachment

BC = Board Chair

ED = Executive Director

MDSAC = Medical Direction Standing Advisory Committee

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
Executive Committee Meeting Minutes
December 17, 2015

Attendance: J.B. Guiton, Board Chair; Aaron Burnett, M.D.; Lisa Consie, (by phone); Megan Hartigan; Kevin Miller, (by phone); Tony Spector; Executive Director, Melody Nagy, Office Coordinator; Robert Norlen, Field Services Supervisor; Chris Popp, Compliance Supervisor; Greg Schaefer, Assistant Attorney General.

Absent: Jeffrey Ho, M.D.; Matt Simpson

1. Call to Order – 10:00 a.m.

Mr. Guiton called the meeting to order at 10:13 a.m.

Mr. Popp provided a report on the Toys for Tots Drive. Mr. Popp had organized a Toys for Tots campaign involving the health licensing boards and also had orchestrated an appearance on KARE-11 television. On December 4, 2015, Mr. Popp and others from the EMSRB appeared on the 5:00 p.m. newscast, delivering 162 toys and \$260.00.

2. Public Comment – 10:05 a.m.

The public comment portion of the Executive Committee meeting is where the public may address the Executive 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 Executive 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.

Mark Griffith, attending as a member of the public, said he and the other EMS regions appreciate their relationship with the EMSRB.

3. Approve Agenda – 10:10 a.m.

Dr. Burnett asked to add a Medical Direction Standing Advisory Committee report.

Motion: Dr. Burnett moved to approve the agenda with the addition. Ms. Hartigan seconded. Roll call vote taken. Motion carried.

4. Approve Minutes – 10:15 a.m.

- Approval Executive Committee Meeting Minutes from October 29, 2015
- Approval of Board Meeting Minutes to consent agenda from November 19, 2015

Motion: Dr. Burnett moved to approve the minutes from the October 29, 2015 Executive Committee meeting and to move the November 19, 2015 draft Board minutes to the consent agenda for the February 18, 2016 Board meeting. Ms. Hartigan seconded. Roll call vote was taken. Motion carried.

5. Board Chair Report – 10:20 a.m.

Mr. Guiton said one of the topics for Board discussion is education transition. The transition concludes on March 31, 2016. At the November Board meeting, Lisa Consie provided a presentation of the efforts of the Post-Transition Education Workgroup as well as the group's recommendations to the Board.

Mr. Guiton said the January Board meeting date conflicts with the Arrowhead EMS Conference. His suggestion is to "flip-flop" the January Board meeting and the February Executive Committee meeting. The Executive Committee therefore would meet in Duluth on January 22, 2016, and the Board would meet on February 18, 2016. The Legislative Ad-Hoc Workgroup already is meeting in Duluth at 10 a.m. on Friday, January 22.

Mr. Guiton said that one of his goals is to have two outstate meetings per year within the budget allowance. Mr. Guiton also expresses his desire that EMSRB staff have a presence at the Arrowhead EMS Conference with a booth in the exhibitor's area.

Motion: Ms. Hartigan moved to change the meeting dates to have the Executive Committee meet on January 22 at 1 p.m. at the Arrowhead EMS Conference at the Duluth Entertainment and Convention Center in the 2nd floor Board Room. The regular Board meeting will be February 18, 2016 at 10 a.m. Mr. Miller seconded. Roll call vote taken. Motion carried.

Pat Lee, Executive Director of the Arrowhead EMS Region, was in attendance at the meeting and said that the EMSRB may have a booth at the conference for no charge (consistent with the language in the EMS regional grant contract).

Staff Update

Mr. Spector thanked Mr. Guiton, other members of the Board, and EMSRB staff and for their support and well-wishes during his absence.

6. Executive Director Report – 10:25 a.m. – Tony Spector

Plainview Rural Assessment Report

Mr. Norlen said the report was provided to the Plainview City Council and Plainview Ambulance Service at the December 1st city council meeting by EMS Specialist Holly Hammann-Jacobs and Board Member Matt Simpson. The report was well received. Staff continues to follow up with Plainview Ambulance Service and provide assistance as requested. Dr. Burnett said that this is a very detailed review of the ambulance service. It is very time and labor intensive.

Mr. Spector said the EMSRB is a regulatory agency and its responsibility includes the critical component of education and support. We should continue to assist EMS agencies to maintain compliance. Mr. Spector further said that the EMSRB does not have a conflict of interest regarding regulation and education/support. Our goal is to protect the public's health and safety.

Ambulance Standards Ad-Hoc Workgroup

Mr. Norlen said the committee has not met yet. The Board appointed Board Member Pat Coyne as chair of this workgroup that intends on meeting after the first of the year.

Mr. Spector said at the October meeting of the National Association of EMS Officials ("NASEMSO"), he attended a breakout session on the topic for ambulance standards. He said that the workgroup might benefit from discussing the topic with national experts via conference call. The goal of changes to ambulance standards is to focus on occupant and crew safety, specifically adopting standards that aim to reduce occupant injuries and deaths. Mr. Guiton said that current ambulances would have a "grandfather" process for implementation of these changes.

STAC Meeting Update

Mr. Popp said he attended the STAC meeting at the Minnesota Department of Health on December 8. He shared information about the change for the MNSTAR data set approved by the Board. Dr. Burnett said there was a presentation about recognition of child abuse for doctors. He will share this information and suggested that it be posted on the EMSRB website.

MDH Hospital Evacuation Exercise

Mr. Norlen said this exercise was attended by staff on December 10 in partnership with Minnesota Department of Health.

Mr. Norlen said the Emergency Preparedness State Agency Response Guide (part of Minnesota Emergency Operations Plan) is being shared with Board members. This is a non-public document. This document is reviewed annually by the EMSRB and Minnesota Homeland Security and Emergency Management.

Regional System Grants

Mr. Guiton said administering regional EMS system grants is a large part of the EMSRB. He wants to support the regional programs, and our relationships have improved drastically. One of the EMS regions purchased three drones costing over \$20,000.00. This region is seeking post-purchase reimbursement with grant funding. This is concerning when grant funding arguably should be used for training or other EMS expenditures. Mr. Guiton wants the Executive Committee to be aware of this purchase. The EMSRB may receive questions on this purchase. The region seeking grant reimbursement stated the purpose of the three-drone purchase is for search and rescue. Mr. Miller asked if this is an allowable purchase under the current RFP.

In answering Mr. Miller's question, Mr. Spector said he discussed this invoice with staff and looked at statutory language and the contract with the region. EMS is a profession that is in its infancy compared to fire/police. Times change and technology changes. We are stewards of taxpayer money. We do not want to limit the regions in doing their business, but we nevertheless have the responsibility to ensure that grant dollars are used in accordance with contract and statutory language.

Mr. Popp said when the EMSRB wrote the contract we did leave the language broad to allow the regions flexibility. This region has a lot of seat belt money to spend. Dr. Burnett asked for a report on usage for EMS purposes.

Mr. Guiton suggested a workgroup meet before the next RFP to discuss the appropriate use of the regional program funds.

Mr. Spector said at the NASEMSO conference there was a question as to who serves as the state medical director in Minnesota. Mr. Spector will communicate that Dr. Burnett is the state medical director. (Dr. Ho serves as the alternate.)

7. Committee Reports – 11:00 a.m. – Committee Chairs/Staff

DPSAC Committee Report – Megan Hartigan/Robert Norlen

Ms. Hartigan said that DPSAC is working on finding another meeting date to discuss other committee tasks. Mr. Norlen said they are preparing the MNSTAR Version 3 data dictionary and working on implementation of the NEMESIS Version 3 software. Mr. Norlen is meeting weekly with ImageTrend to get the platform ready for implementation and pilot testing. It is expected by the February Board meeting the platform will be ready and pilot testing will be underway with services ready to transition to the MNSTAR version 3 dataset and file formats. The committee will be scheduling additional meetings to discuss an overall transition date for movement to the MNSTAR version 3 database and file formatting. Currently, ImageTrend is building our platform on their servers. They will do this until we determine how MNSTAR version 3 will be hosted on final implementation.

Post Transition Education Standards Workgroup – Mary Zappetillo and Lisa Consie, Workgroup Chair, on the phone

Ms. Consie said the recommendations were presented at the November Board meeting. The Board asked for additional public comment. The workgroup developed a video that was played at the Executive Committee meeting and it received overall very favorable comment from the group. The video will need to be edited at the end due to the change in the date of the Board meeting to February 2016. The video will be posted on the EMSRB website. The workgroup minutes are posted on the website. The workgroup will develop a FAQ sheet. There currently is not another meeting date set but it will be scheduled after the holidays. This information was presented at the Wright County EMS Meeting.

Ms. Consie said that she and Mr. Wright will be presenting this information at the Arrowhead EMS Conference.

A survey was conducted and there were 3,000 responses received. Mr. Guiton said continuation of practical testing for EMTs has been received as a positive comment. A more detailed report will be provided when it is available.

Mr. Guiton said he appreciates the efforts of the workgroup to communicate this information throughout the state. Mr. Spector said we wanted to include as many stakeholders as possible. The workgroup's meetings are public, and the EMSRB wants to hear of any public concern.

Legislative Ad-Hoc Workgroup Report – Kevin Miller

Mr. Miller said they discussed statute and rule changes and a supplementary budget request for staffing. Mr. Guiton said the supplementary budget requested named staff positions, and the Executive Director has the ability to determine staffing. Also discussed was funding for MNSTAR (software) updates and the costs of a fingerprinting effort. Mr. Guiton said that fingerprinting is a push nationally 10 to 16 % of applicants fail to disclose information.

Mr. Miller, through EMSRB staff, presented a summary document highlighting contemplated changes to relevant statute and rule. This document was presented to those in attendance.

Bill Snoke, attending as a member of the public, asked that information be shared with MAA. Mr. Spector said that he would have a discussion with Mr. Snoke.

Mr. Miller asked for a one-page summary document of the supplemental budget request.

Mr. Miller said they identified clean-up language for regional audit requirements and will be developing this proposal in conjunction with the regional programs.

Mr. Miller said the legislative proposals that deal with education may generate enough questions that perhaps this should be separate legislation.

Mr. Miller said there are simple repeals of rules that are not enforceable. Staff will need to do further work on the process to repeal rules.

Mr. Miller said the other items will take further discussion and may require legislative action in two or three years.

Dr. Burnett said MDSAC passed a motion referring an item to the Legislative Ad-Hoc Committee for "hold" language. Mr. Miller said this will be discussed at the next meeting. Mr. Miller commented on the importance of prioritizing legislative efforts.

MDSAC Report

Dr. Burnett said that Wisconsin released a memo regarding out-of-state ambulances responding into Wisconsin.

8. New Business – 11:30 a.m.

None

9. Adjourn – 11:35 a.m.

Dr. Burnett moved to adjourn. Ms. Hartigan seconded. Roll call vote was taken. Motion carried. Meeting adjourned.

Next Executive Committee Meeting: Friday, January 22, 2016, at 1:00 p.m., in Duluth.

Duluth Convention Center – Second Floor Boardroom

Note: Specific Meeting Location to be Posted on EMSRB Website

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 a 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 2nd 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

BC 2

Date: May 27, 2014

To: Ambulance Service Medical Directors & Managers

From: EMSRB State Medical Director

Re: Clarification on Use of Premeasured Epinephrine – BLS Medication Variances

This memo is a follow up to the information the EMSRB provided in December 2013 to medical directors and ambulance services regarding Premeasured Epinephrine used under Basic Life Support (BLS) medication variances issued by the EMSRB.

For further clarification on the previous information provided, EMT's are allowed to give a "premeasured" dose of epinephrine per the Minnesota Rules 4690.8300 subp. 7. This law does not allow EMT's to draw up a medication dose. They could draw up epinephrine into a syringe and give the medication if it were a single dose vial of medication. That would be similar to the glucagon kit where they draw up the saline, inject it into a vial of medication and then give that "premeasured" dose. The purpose of the premeasured dose is to eliminate a higher or lower dose of a medication being given in error. A single dose vial or a glucagon kit or EpiPen® has only one possible dose to give. No overdose potential.

It should be noted that use of pharmacy pre-filled syringes is allowable as long as the syringes are obtained through a licensed pharmacy and have appropriate labeling with drug name, dose, expiration date and proper storage of the medication filled syringes is maintained.

Thank you for your attention to this important ambulance service licensing matter.

Attachment: December 2013 Premeasured Epinephrine Letter

Dear Medical Director,

At the September 13, 2013 Emergency Medical Services Regulatory Board (EMSRB) meeting one of the Medical Directors of a BLS service asked a question of the EMSRB regarding drug variances for ambulance services. Chairman Kelly Spratt sent the matter to the Physicians of the Board and Greg Schaefer from the Minnesota Attorney General's Office for evaluation. Minnesota Rule 4690.8300, subp. 7, in part, allow variances for carrying and administering certain drugs to basic ambulance service licensees which includes "...premeasured subcutaneous epinephrine". The requestor's concern was that the state variance limits the BLS services to "manufactured" Epi-Pens and noted difficulty with supply.

The results of our research conclude that the law does not limit our BLS services to the auto- injected Epi-Pens. The rules require a "pre-measured" dose of the epinephrine, not a specific manufactured auto injector.

There are other State statutes that pertain to the use of medications that also apply to this question. These are in the Board of pharmacy's jurisdiction. Specifically, MN stats 151.01 subd.14 and 151.252 which indicate that "repacking" (drawing up of medication from it's original container and using it at a later date on an unnamed patient) constitutes "manufacturing". This can only be done by a Pharmacy that is licensed as a drug wholesaler.

If the ambulance Service were to arrange this, the repackaged medication would need to follow the requirements of Minnesota Statute 144E and Minnesota Rules Chapter 4690; part of the Medical Director responsibilities include requesting and gaining approval for the variance, from the EMSRB, verifying appropriate labeling with the drug name, the dose, expiration date, storage of the prefilled syringes, developing the policy for administration of the medication, the training of the EMT's to administer the medication. There would need to be documentation of the policy for administration of the alternatively packaged medication and the completed training of each of the EMT's authorized to give the medication. It is recommended that the medication administration policy mirror those already developed for the other variance medications, such as, glucagon, albuterol and nitroglycerin. This makes the training more consistent. The EMSRB Regional Specialists would then be able to check this documentation during inspection like any of the other variances.

The question related to drug variance requests in this letter are specific to the EMSRB laws and requirements and do not preclude any other federal or state laws or requirements. This information has been presented to the EMSRB Executive Committee and approved by the EMSRB urging Medical Directors to follow the EMSRB Minnesota Statute 144E, Minnesota Rule 4690, and other federal or state laws and requirements. If you have any questions you can contact Dr. Thomas through the EMSRB Board Chair e-mail address at EMSRB.board.chair@state.mn.us. Or contact the Minnesota State Board of Pharmacy.

Sincerely,

Kelly Spratt, Board and Executive Committee Chair
Dr. Mari Thomas, MD, Board Member and Medical Director Standing Advisory Committee Chair
Dr. Paula Kocken, MD, Board and Executive Committee Member

Attachment: Variance BLS Meds Inspection Procedures

<u>On-Site Inspection for Required BLS Medication Variance Documentation / Drug & Supplies Requirements.</u>	Beta Agonist by Metered Dosed Inhalation	Beta Agonist by Nebulization	Premeasured Subcutaneous Epinephrine Manufacture Premeasured Epi-Pen®	Premeasured Subcutaneous Epinephrine Ambulance Service Premeasured	Sublingual Nitroglycerin	Premeasured Intramuscular or Subcutaneous Glucagon
MR 4690.8300, Subpart 7- Variance for Certain Drugs						
MR 4690.8300 A - each attendant who will administer the drug has satisfactorily completed training in the administration of the drug and the training has been approved by the licensee's medical director – <u>Verify Documentation</u>	X	X	X	X	X	X
MR 4690.8300 B - the administration of the drug has been authorized by the licensee's medical director – <u>Verify Documentation</u>	X	X	X	X	X	X
MR 4690.8300 C - the licensee's medical director has developed or approved standing orders for the use of the drug – <u>Verify Approved Standing Orders – MD Approved</u>	X	X	X	X	X	X
MR 4690.8300 D - continuing education or clinical training in the administration of the drug shall be provided at least annually to the licensee's attendants who are trained to administer the drug – <u>Verify Documentation</u>	X	X	X	X	X	X
MR 4690.8300 E - at all times, at least one attendant on duty is trained in accordance with item A to administer the drug for which the ambulance service has been granted a variance – <u>Verify on-call schedules</u>	X	X	X	X	X	X
MR 4690.8300, Subpart 8- Variance Maintenance -The Licensee's Medical Director Shall, Annually:						
MR 4690.8300 A & B - provide a list of the licensee's attendants; certify in writing that each attendant has satisfactorily completed the required training and retained skill proficiency - <u>Verify Documentation</u>	X	X	X	X	X	X
MR 4690.8300 C - certify in writing that, prior to allowing an attendant who was hired after the variance was granted to administer a drug specified in subpart 7, the attendant satisfactorily completed the required training under subpart 7, item A - <u>Verify Documentation</u>	X	X	X	X	X	X
MS 144E.103, Subd. 2a - Patient care equipment, supplies, and drugs must be stored and maintained within manufacturer's recommendations – <u>Verify for each drug Ambulance</u>	X	X	X	X	X	X
MS 144E.125 - A licensee shall establish and implement written procedures for... procuring and storing drugs... - <u>Verify Documentation</u>	X	X	X	X	X	X

Key: X = Documentation / Requirement verified during on-site inspection for each variance medication the ambulance service has EMSRB approval.

Note: Documentation of Items A-E in MR 4690.8300 subpart 7, Items A-C in MR 4690.8300 Subpart 8 and MS 144E.125 must be retained in the Licensee's files.

 Denotes proposed use of **Ambulance Service** Premeasured Subcutaneous Epinephrine; No difference with inspection requirements. Disclaimer: Does not nullify other federal or state requirements.

EMS Ebola Readiness - ALL

Type: Statewide Ebola Report 12-18

Date: 12/18/2015

Total number of responses collected: 104

ED 1

The following EMS services participated in the Ebola Preparedness and Response Survey
Allina Health EMS
Altru ambulance Services
Ambulance Service, Inc.
Barnesville Ambulance
Bertha
Blooming Prairie Ambulance
Bois Forte Ambulance, Bois Forte Band of Chippewa
Browns Valley EMS
Buffalo Lake Ambulance
Burnsville
Cannon Falls Ambulance
CentraCare Health Monticello
Centracare Health-Paynesville
Chatfield Ambulance Service
Chisholm Ambulance Services

The following EMS services participated in the Ebola Preparedness and Response Survey

Clifton EMS

Cokato Ambulance Service

Cook County Ambulance

Cottonwood Ambulance Service

Dawson Ambulance

Dodge Center Ambulance

Edgerton Volunteer Ambulance Association

Edina Fire and EMS

Elgin Ambulance

Ely Area Ambulance Service

Essentia EMS-Fosston

Eyota Volunteer Ambulance

F-M Ambulance

Freeborn Fire Dept. & Ambulance

Glacial Ridge Ambulance

Gold Cross Ambulance

Grand Lake Ambulance

Grand Meadow Area Ambulance

Grove City Rescue Squad

Hastings Fire and EMS

The following EMS services participated in the Ebola Preparedness and Response Survey

Hayfield Community Ambulance

HealthEast Medical Transportation

Hector Ambulance Service

Hennepin EMS

Henning Ambulance Service

Hoffman Ambulance service

International Falls Ambulance Service

Jackson Ambulance Service

Lake City Ambulance

Lake County Ambulance Service

Lake Crystal Area Ambulance

Lakes Region EMS

Lakeview EMS

Lamberton Ambulance

Lanesboro Ambulance

Le Sueur Ambulance

Leech Lake Ambulance Service, Leech Lake Band of Ojibwe

LeRoy Area Ambulance Service

Lewiston Volunteer Ambulance

Mahnomen Health Center Ambulance

The following EMS services participated in the Ebola Preparedness and Response Survey

Mahtomedi Ambulance

Mahtowa Ambulance

Maplewood Fire and EMS

Melrose Area Ambulance

Mille Lacs Health System Ambulance

Minnesota Lake Ambulance Service

New London Ambulance

North Memorial Ambulance Service

North Memorial Princeton

North Valley Health Center Emergency Medical Services

Northfield Ambulance

Olivia Ambulance

Parkers Prairie Community Ambulance

Perham Area EMS

Pipestone Ambulance

Plainview EMS

Preston Emergency Services

Red Wing Fire Department

Remer Area Ambulance Service

Ridgeview Ambulance Service

The following EMS services participated in the Ebola Preparedness and Response Survey

River's Edge EMS

Roseau EMS

Rushford Ambulance

Saint Paul Fire and Ambulance

Sanford Bagley Ambulance Service

Sanford Wheaton Ambulance Service

Sauk Centre Ambulance Service

SMSC Emergency Services, Shakopee Mdewakanton Sioux Community

South Metro Fire Department

Spring Valley Area Ambulance

St. Charles Ambulance

St. James Ambulance

Staples Ambulance

Stevens County Ambulance Service

Tri-County Health Care EMS

Wabasha Ambulance Service

Wabasso Ambulance Association

Warroad Rescue Unit

Watkins Ambulance

Wells Community Ambulance Service

The following EMS services participated in the Ebola Preparedness and Response Survey

West Concord Ambulance

White Earth Reservation Ambulance Service, White Earth Nation

Willmar Ambulance

Winnebago Area Ambulance

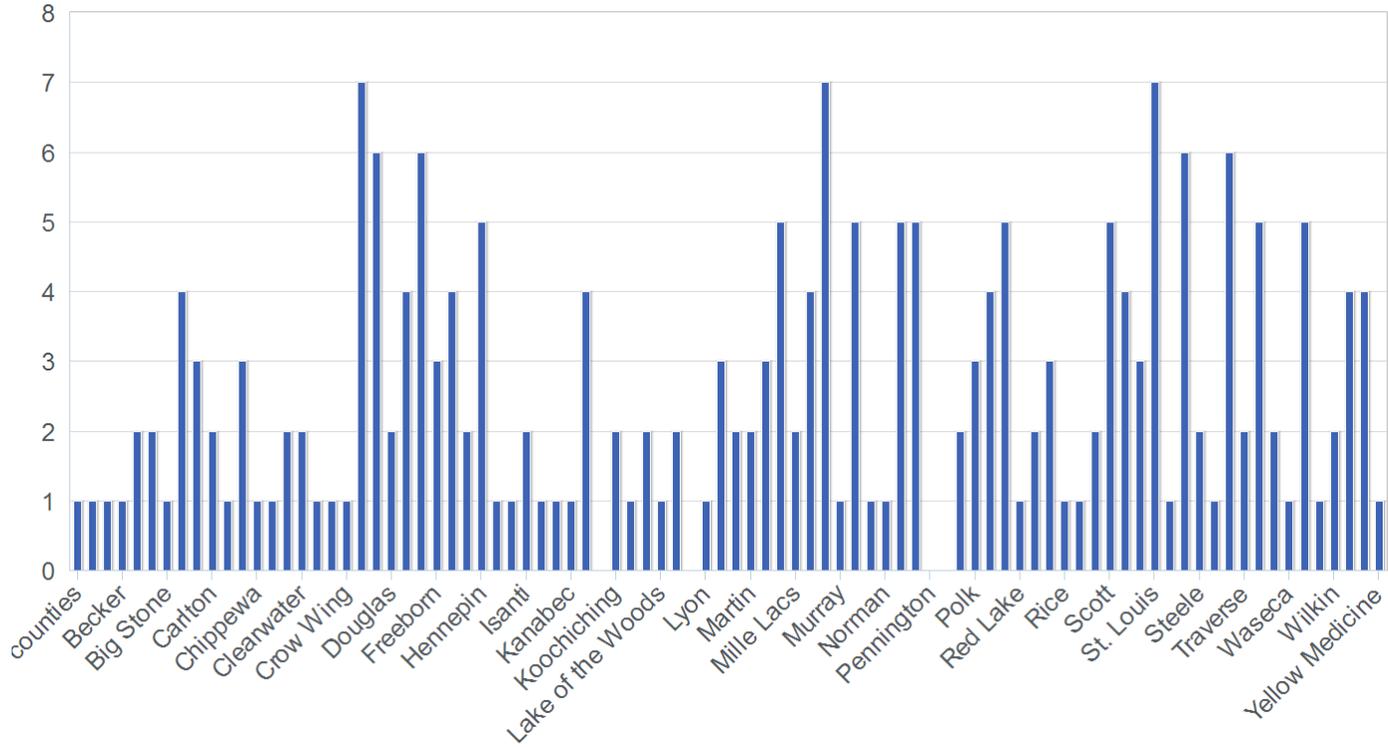
Winona Area Ambulance Service

Woodbury Ambulance

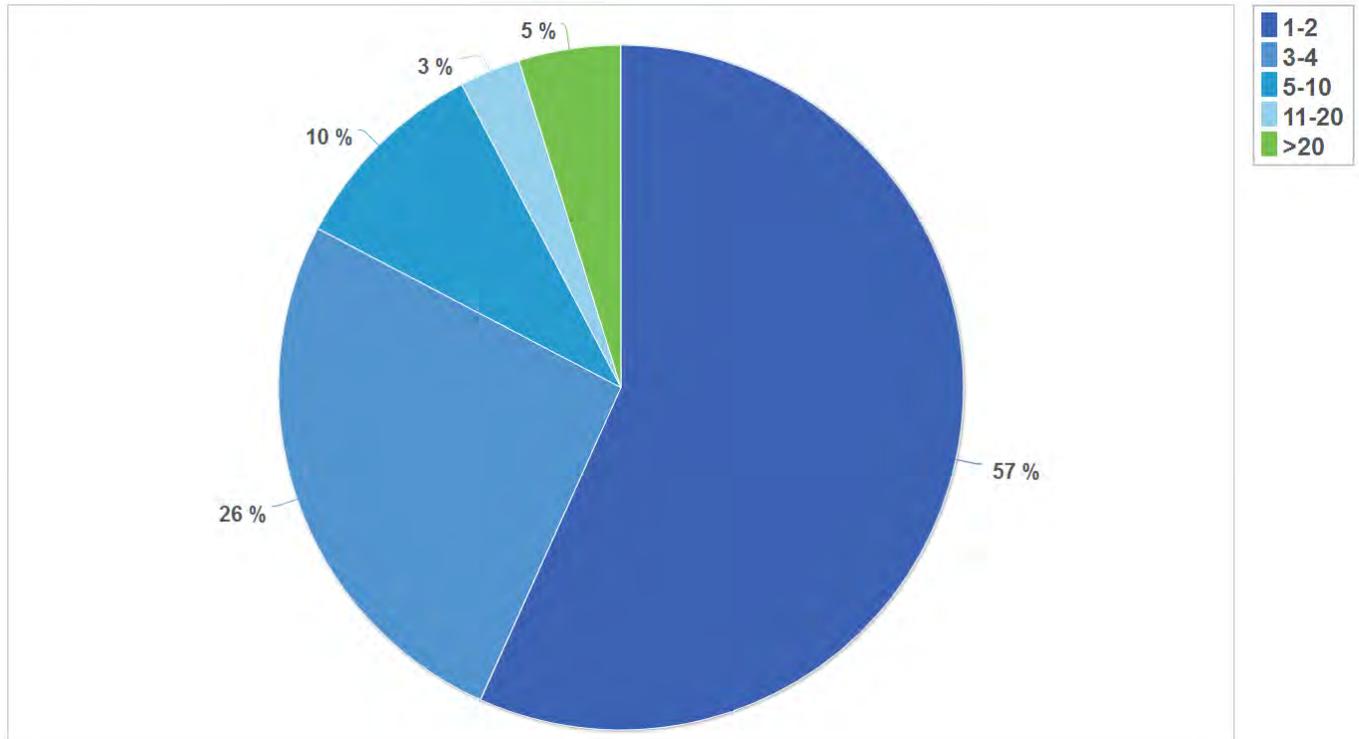
Total Responses

104

Counties and the number of ambulance services which operate in them and responded to the survey (alphabetical beginning with “All Counties”):



How many ambulances do you license for emergency response and transport?



Approximately how many **Full time** paramedics and EMTs do you have in your ambulance service?

60 Responses – Number of Full Time EMT-P or EMT	Number of Ambulance Services Reporting
0	5
1	7
2	5
3	1
4	5
5	1
6	3
7	1
8	3
9	1
11	1
12	2
15	2
16	1
17	1
18	1
20	1
21	2
24	1
25	4
27	1
31	1

60 Responses – Number of Full Time EMT-P or EMT	Number of Ambulance Services Reporting
37	1
39	1
45	1
52	1
78	1
94	1
160	1
250	1
345	1
450	1
	60

Approximately how many **Part Time** paramedics and EMTs do you have in your ambulance service?

46 Responses – Number of Part Time EMT-P or EMT	Number of Ambulance Services Reporting
0	6
1	1
2	1
3	2
4	1
5	5
6	2
7	1
8	1
9	1
10	3
11	1
12	1
13	1
14	1
15	5
20	1
22	2

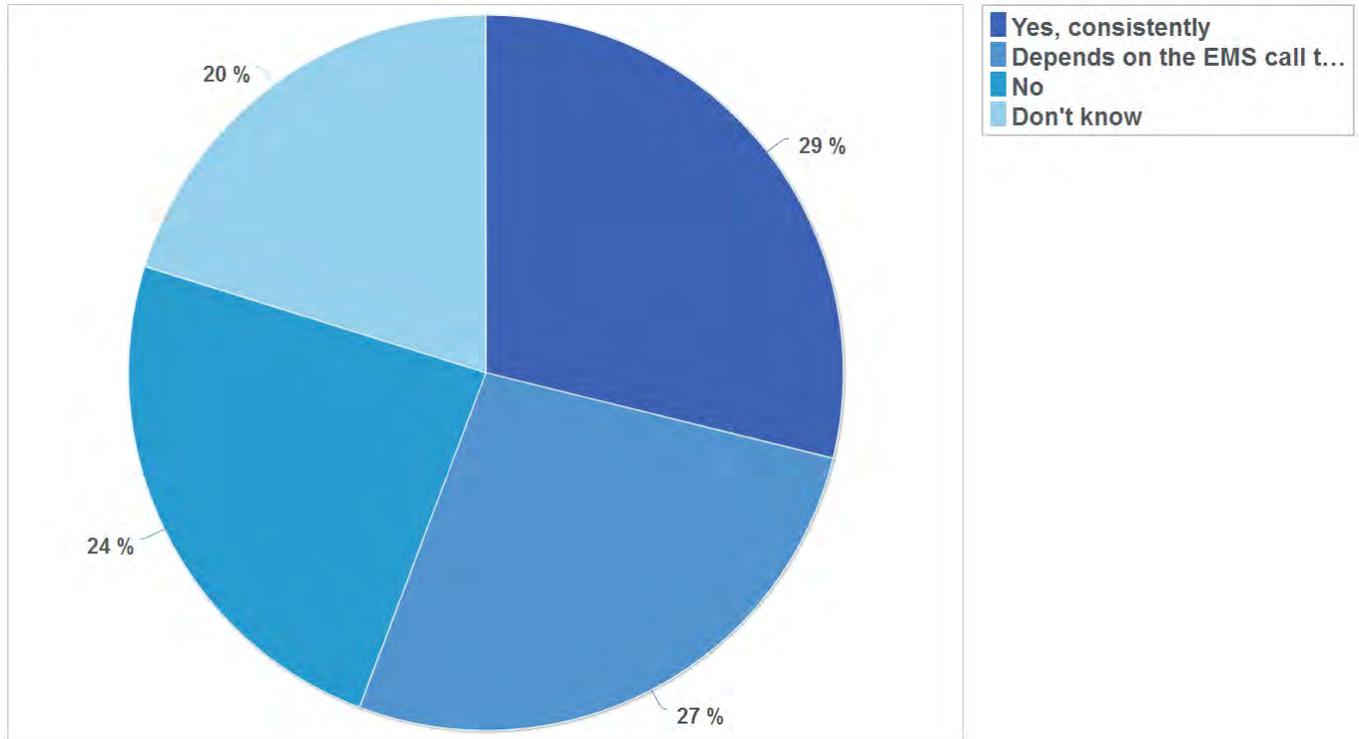
46 Responses – Number of Part Time EMT-P or EMT	Number of Ambulance Services Reporting
23	1
25	2
29	1
32	1
34	1
40	1
50	1
150	1
405	1
	46

Approximately how many paramedics and EMTs do you have in your ambulance service: (**Volunteers**)

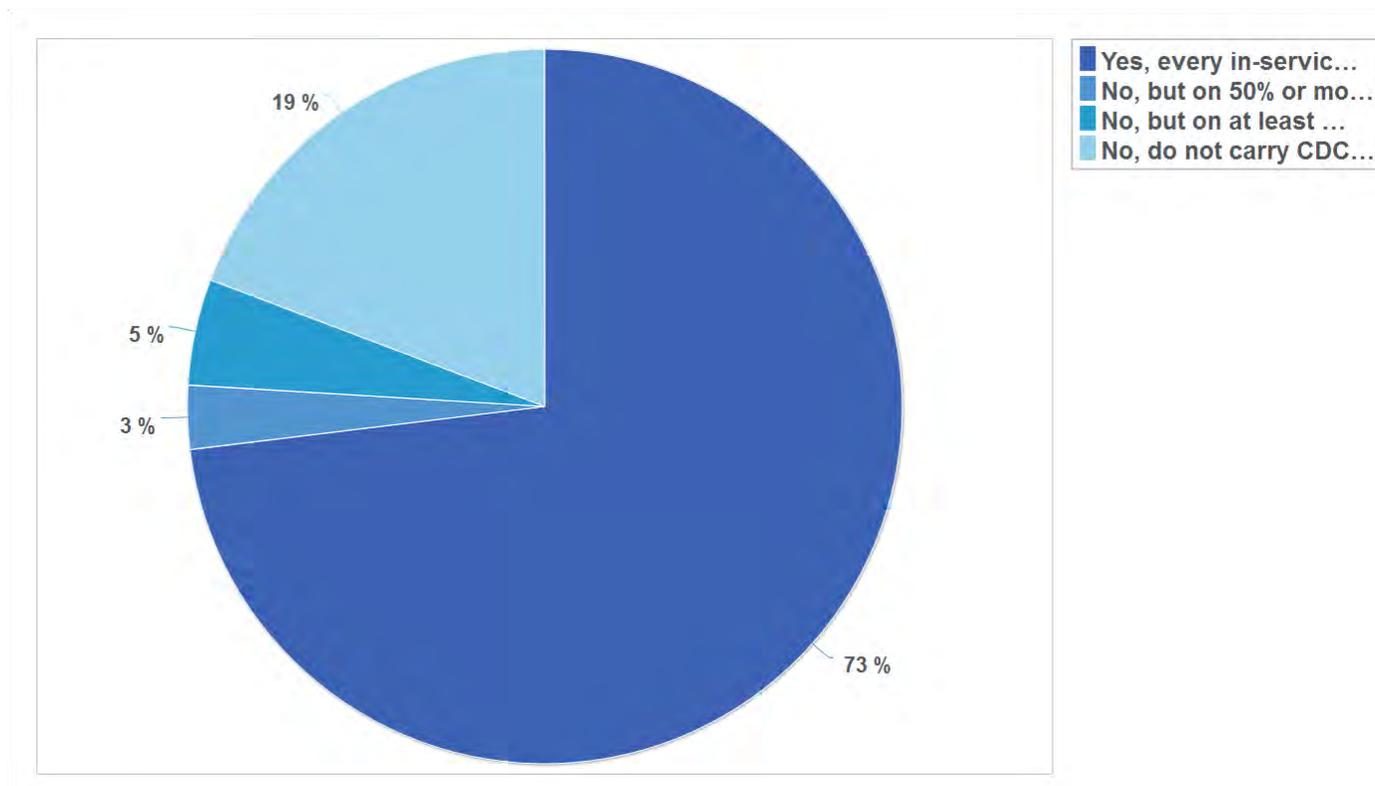
78 Responses – Number of Volunteers	Number of Ambulance Services Reporting
0	7
3	1
7	2
9	3
10	5
11	8
12	4
13	3
14	2
15	6
16	1
17	2
18	3
19	1
20	8
21	4
22	3
24	4

78 Responses – Number of Volunteers	Number of Ambulance Services Reporting
25	4
30	2
32	2
33	1
35	1
74	1
	78

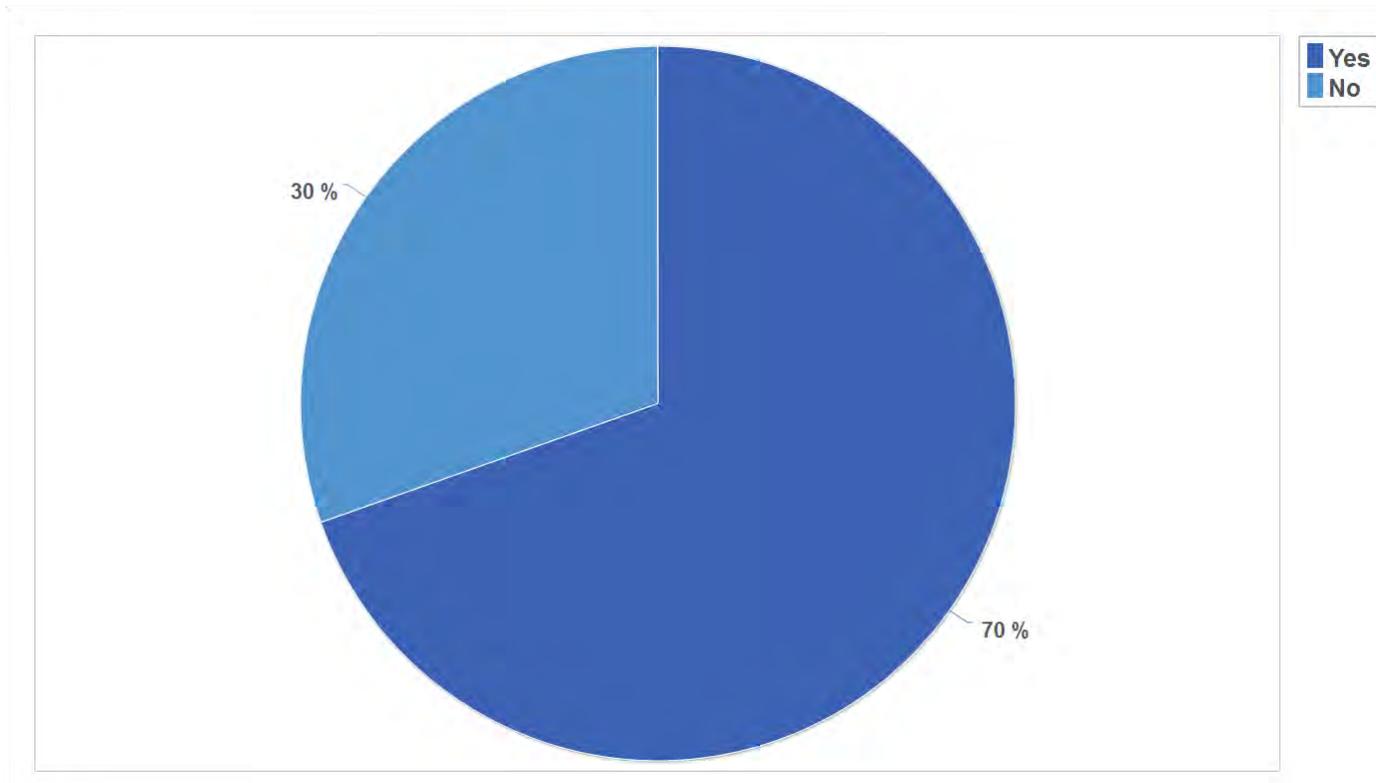
Does your ambulance dispatch (in-house, hospital or secondary public safety answering point) interview the caller on the nature of the medical emergency, symptoms and, if appropriate, about travel and direct exposure history within the past 21 days?



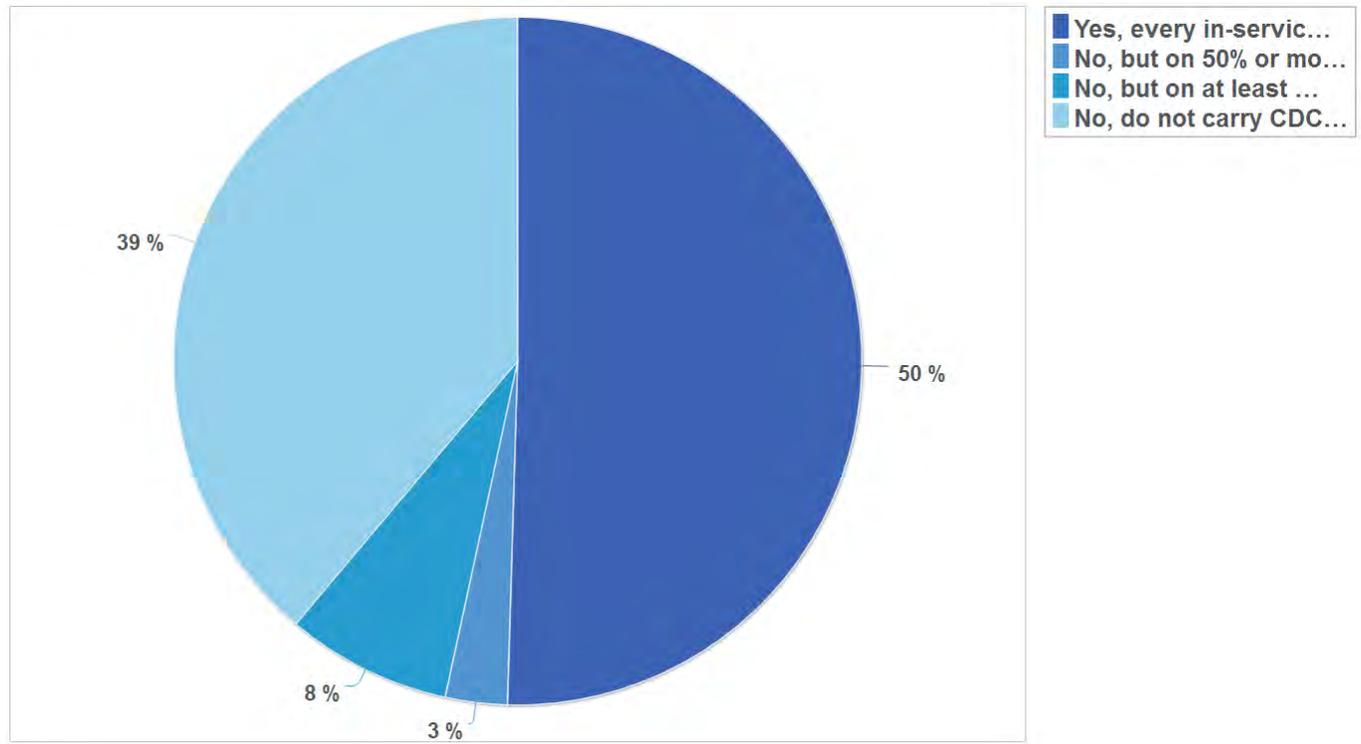
Does your ambulance service maintain the CDC recommended personal protective equipment (PPE) consisting of a face shield and surgical face mask, impermeable gown and two pairs of gloves, with extended cuffs on the outer pair on every ambulance for a suspect Ebola patient who is NOT exhibiting vomiting, bleeding, diarrhea or clinical condition that warrants invasive or aerosol-generating personal protective procedures? (Source: CDC For U.S. Healthcare Settings: Donning and Doffing Personal Protective Equipment (PPE) for Evaluating Persons Under Investigation (PUIs) for Ebola Who Are Clinically Stable and Do Not Have Bleeding, Vomiting, or Diarrhea)



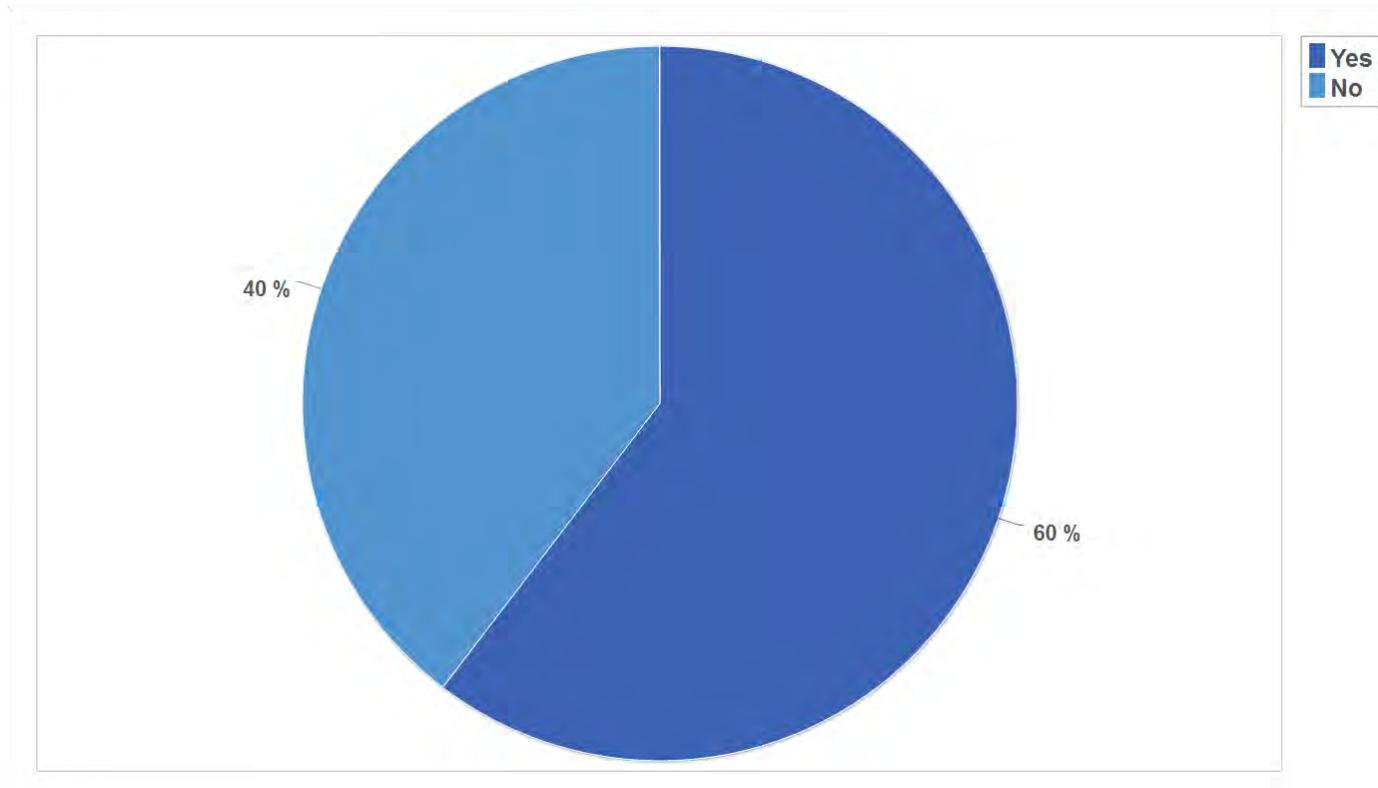
Do you have a readily available and accessible re-supply or re-placement source for these PPE items if used during a response and patient transport?



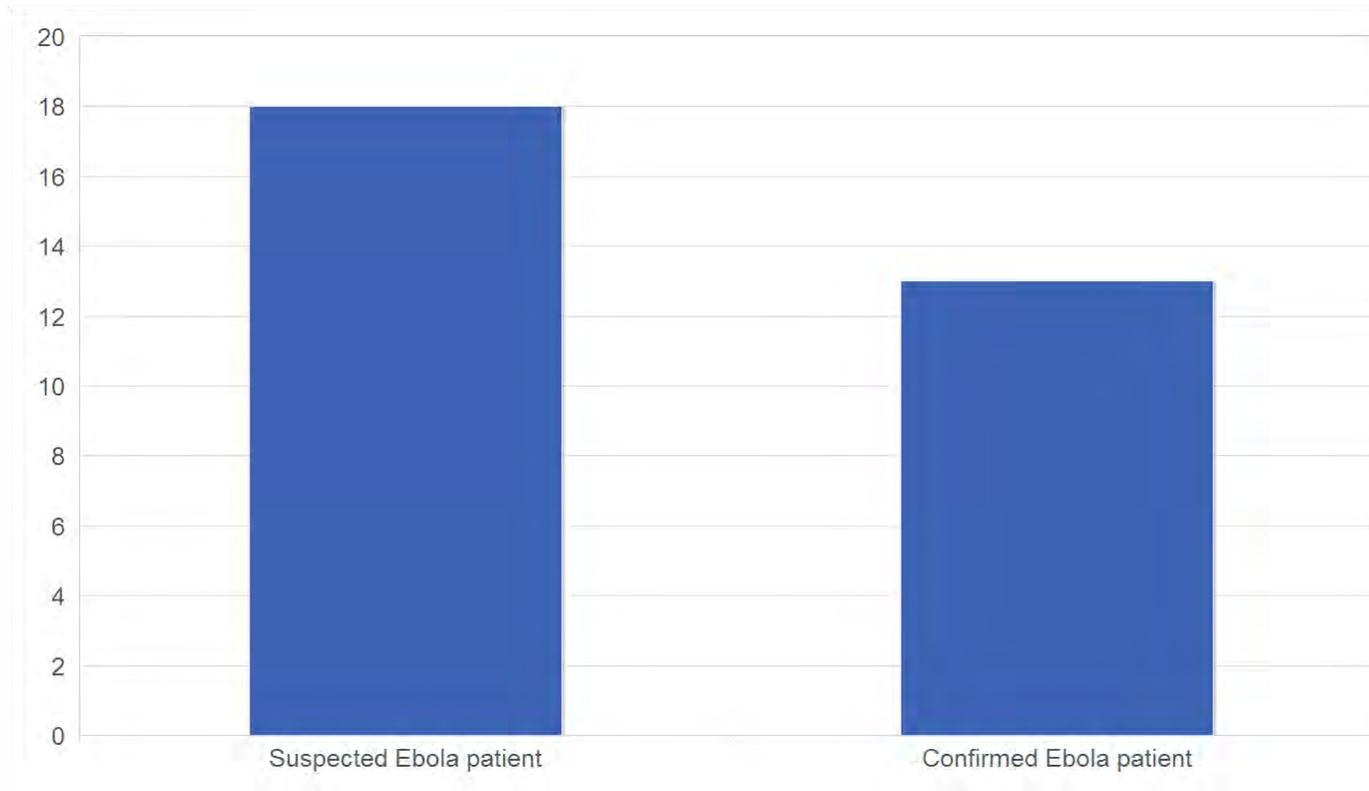
Does your ambulance service maintain or have readily accessible recommended CDC PPE designated for the care of hospitalized patients (<http://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>) if the patient exhibits obvious bleeding, vomiting, copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (such as intubation, suctioning, active resuscitation)?



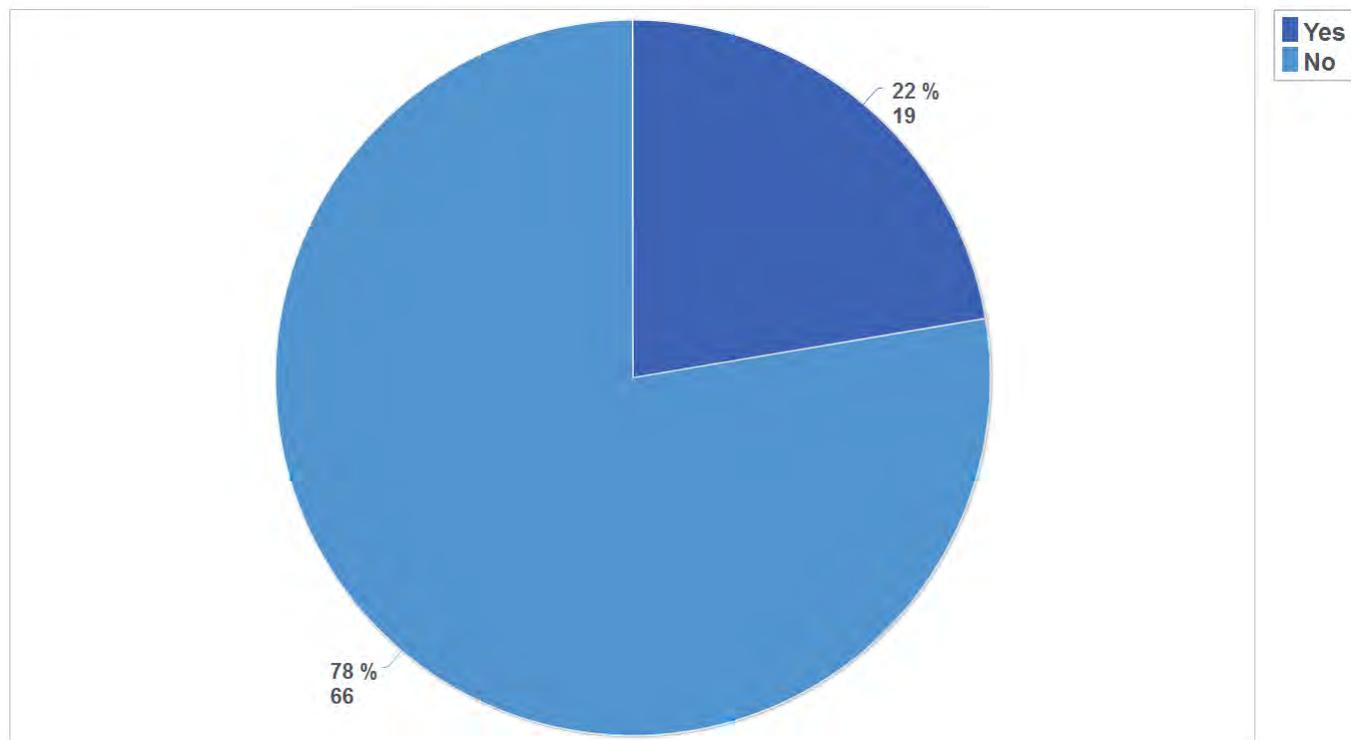
Do you have a readily available and accessible re-supply or re-placement source for these PPE items if used during a response and patient transport?



The number of ambulance services with designated or dedicated ambulance(s) and personnel/crews to respond to suspected or confirmed Ebola patient:



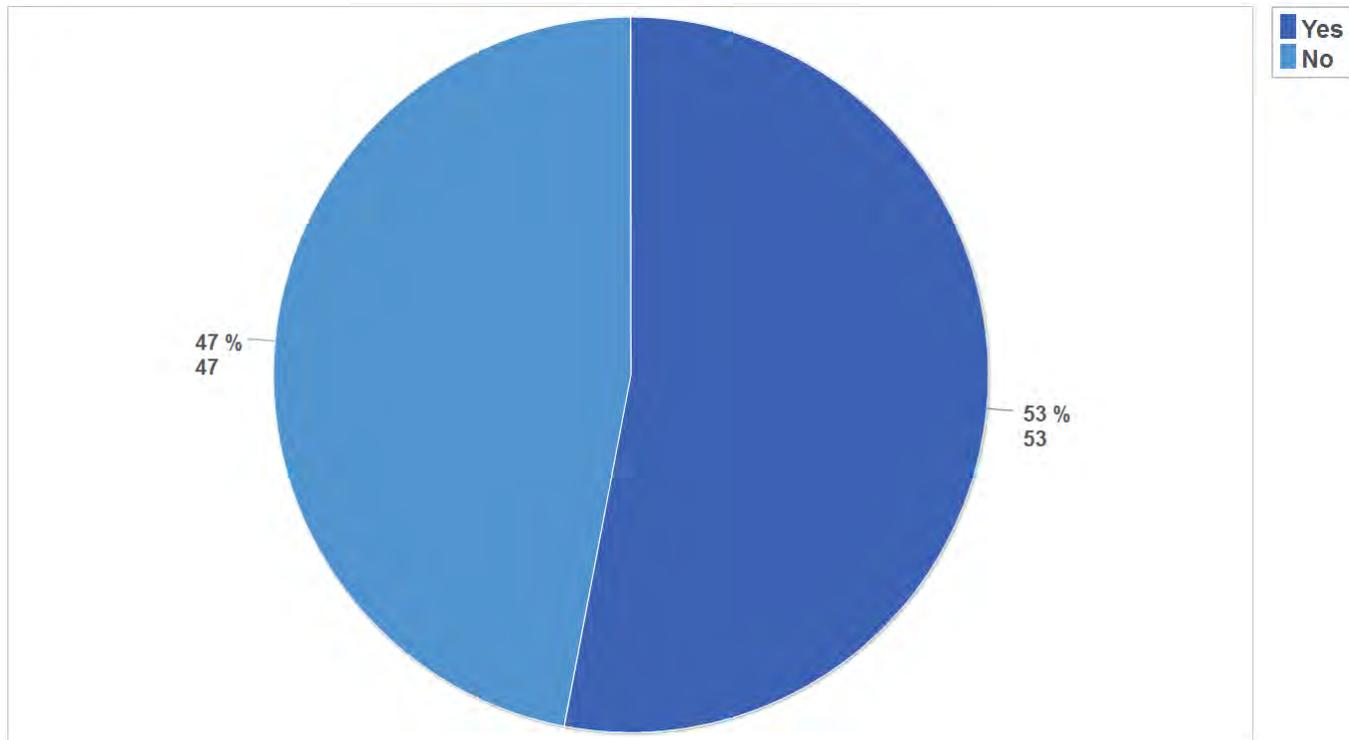
If you do not have the CDC recommended PPE in your ambulance or an ambulance available to respond to and transport a suspected Ebola or confirmed Ebola patient, is a formal arrangement or agreement in place with another EMS provider to respond?



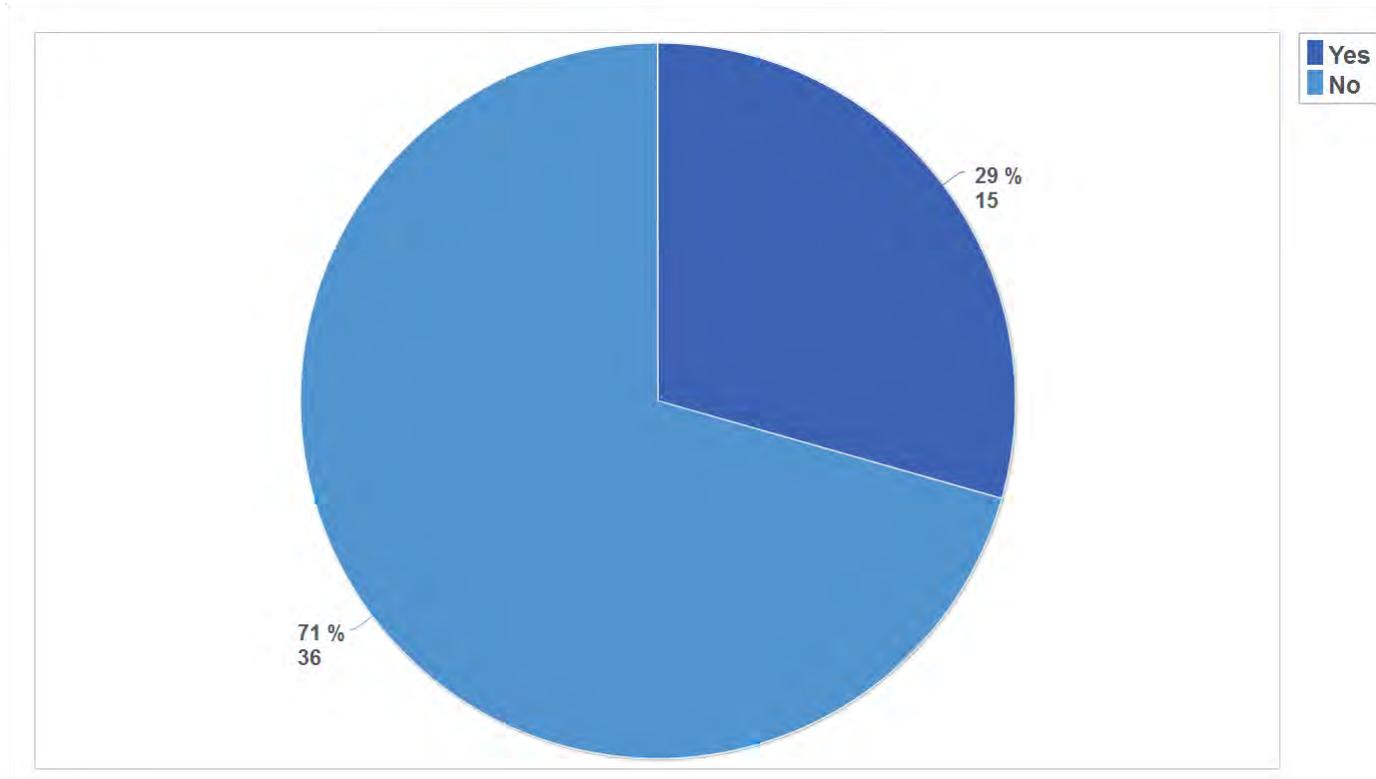
If you have an agreement or arrangement with another ambulance provider, what is the name of the ambulance service you have an agreement or formal arrangement with?

Response Comments		
We do not have a designated ambulance. All of our ambulances could be used and it would be staffed by the on call crew.		
Gold Cross Ambulance – 10 respondents would contact Gold Cross, 3 specifically reference "Rochester", 1 "Mankato"		
Altru – 2 respondents would contact Altru, 1 specifically references "Grand Forks"		
HealthEast Transportation – 2 respondents would contact HealthEast Transportation		
North Memorial Ambulance Service		
Willmar Ambulance Service		
Rice Hospital, North Memorial, Marshall		
F-M Ambulance		
		Total Responses
		19

Will your ambulance service transport or transfer a suspected Ebola or confirmed Ebola patient to one of Minnesota's four Ebola assessment and treatment facilities (Fairview University Medical Center, Mpls.; Mayo Clinic, St. Mary's, Rochester; Unity Hospital, Fridley; Children's Hospital, St. Paul)?



If “No” you will not transfer a patient to an Ebola assessment/treatment facility in Minnesota, is there a formal agreement in place with another EMS provider licensed in the State of Minnesota that will respond to and transport the patient to an Ebola assessment/treatment facility?



If you do not have a formal agreement to transport a patient to a Minnesota Ebola assessment or treatment facility, what would you do? (Response Comments)

Call the receiving hospital for advice on who could transport for us,

Contact St. Mary's ECC in Rochester for assistance in locating a service.

Call Gold Cross intercept They are mutual aid

Call Medical Direction for advice

Probably see if we can get the PPE from the hospital.

Mutual aid agreement w/ Gold Cross Duluth. Not specific to Ebola.

Call MDH and let them figure it out.

Don't believe we would need a formal agreement to have a specialized transport team transfer from our hospital. We **don't** have specialized agreements for neonate teams, mayo one etc. Hopefully we could get some training and supplies so we can do these.

Currently we have no written agreement with anyone in Minnesota. We service a small portion of POLK county for 911, but we do travel and transport throughout the NW Minnesota and we do transport patients from our ND hospital to Minneapolis and Rochester and other hospitals/nursing homes throughout Minnesota.

Transport to nearest facility. They arrange transport to one of the above hospitals.

We would contact MN MDH to find a service that transfer the patient. If it was a 911 call we would respond and transport patient to our local hospital.

Set up precautions at receiving facility and request acceptance at appropriate hospital.

I guess we would have to transport if no one else was available and the patient was in our PSA.

?

Gold Cross

Call another agency that has the equipment to do so.

Call a more trained ambulance service as we do not work full time.

If you do not have a formal agreement to transport a patient to a Minnesota Ebola assessment or treatment facility, what would you do? (Response Comments)

Contact the EMSRB and see who is designated to transfer Ebola patients.

Depending on the circumstances, we would/could transport if needed, but may attempt to contact a service that is more adequately equipped for this type of transport.

We don't do hospital to hospital transfers. If we were called to a non-hospital scene to transport a suspected/confirmed Ebola patient, we would call our MD to see if his ALS service that has an extra rig would be available.

Contact medical direction.

Would work with MDH.

Transport patient to closest local hospital.

Contact our medical director. We are not hospital based.

Take the patient to a local hospital who has a service that could transport the patient to an Ebola treatment facility.

Transport to closest facility for transfer of care. We do have a formal agreement with Gold Cross Ambulance and Mayo One air transport but not specifically regarding Ebola

We usually are not the ambulance service that transfers a patient after they arrive at the primary care hospital.

Refuse to transport.

We don't have a formal agreement, we have however had conversations with two of the bigger services in our region about transporting for us.

Altru Hospital Grand Forks.

Have a verbal agreement with local ALS service for transporting patient with Ebola.

We have an informal agreement with FM Ambulance.

Have dispatch call North Memorial for Mutual Aid.

We have a Mutual Aid agreement with Gold Cross. This would qualify as an appropriate request for additional resources.

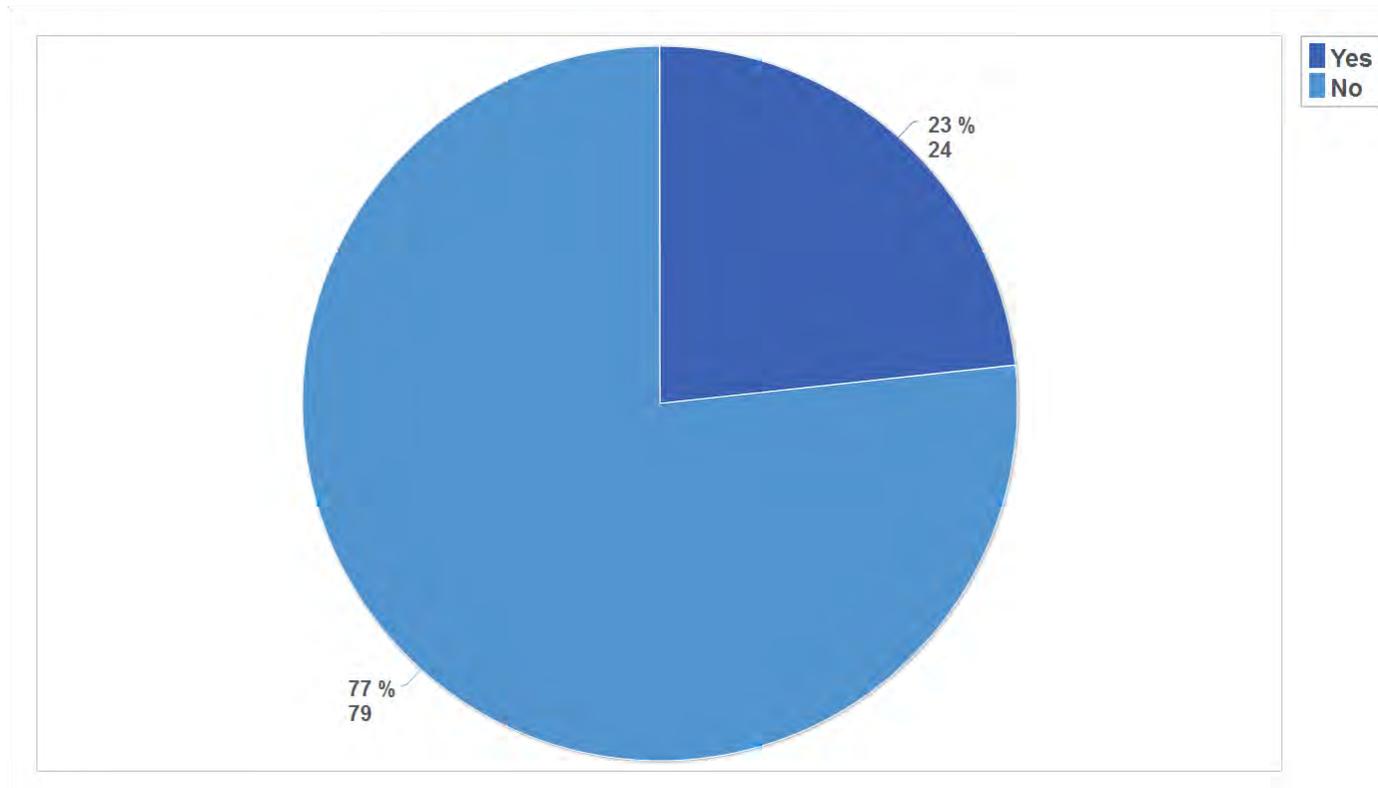
Check with Gold Cross in Rochester.

If you do not have a formal agreement to transport a patient to a Minnesota Ebola assessment or treatment facility, what would you do? (Response Comments)

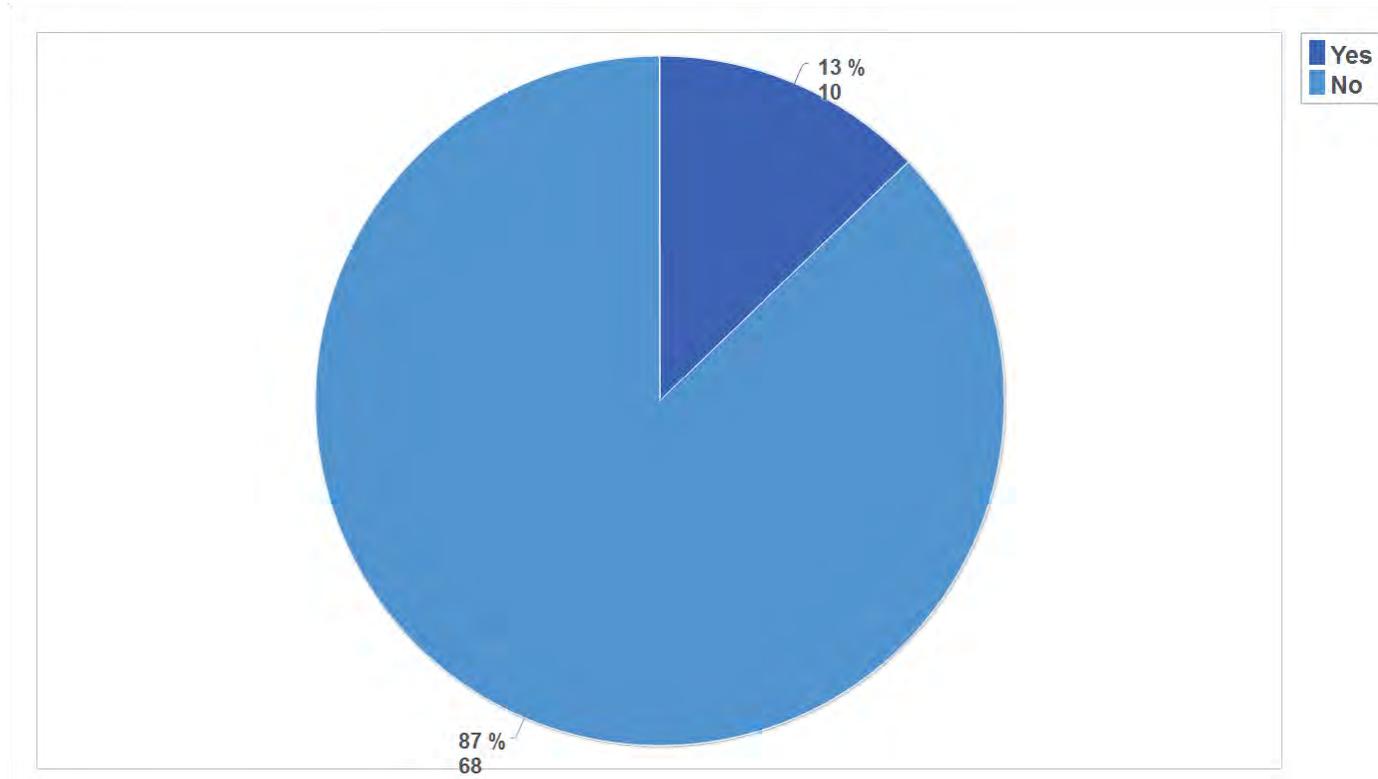
If yes to any of the symptoms, PPE and transport to the nearest facility. If they answered "yes " to any of the questions on EBOLA check list. Call ahead to notify.

Total Responses	37
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Will your ambulance service transport or transfer a suspected Ebola or confirmed Ebola patient to Ebola assessment and treatment facility in another state?



If will not transfer the patient out of state, do you have a formal arrangement with another regional EMS provider that will transport a suspected Ebola or confirmed Ebola patient to a Ebola assessment and treatment facility in another state?



What would you do if you do not have a formal arrangement with another regional EMS provider to transport a suspected Ebola or confirmed Ebola patient to a Ebola assessment and treatment facility in another state? (Response Comments)

Call the receiving hospital for advice on who can transport.

Depends on what the recommendations of MDH are.

Contact St. Mary's ECC for assistance in finding suitable transport.

Contact Gold Cross.

We are in Central Minnesota and do not usually get too close to the state line. If we were directed to do so we could make arrangements and transport ourselves.

Transport to the nearest hospital and rely on another agency to transport elsewhere.

We don't do inter facility transfers and do not transport to any hospitals out of state.

Mutual aid agreement with Gold Cross Duluth. Not specific to Ebola.

Call MDH.

Same as above, if we had supplies and training we could, if we had back up coverage for the long transport. I believe the hospitals should have a list of services available?

Work with medical control and MDH to find a solution.

Transfer to Albert Lea Gold Cross.

Call MDH and take direction from them.

Transport to a local hospital.

We would have to transport.

?

Contact Mayo Clinic Medical Transport/ECC for further advice

Call Duluth Gold Cross

What would you do if you do not have a formal arrangement with another regional EMS provider to transport a suspected Ebola or confirmed Ebola patient to a Ebola assessment and treatment facility in another state? (Response Comments)

Call another agency that has the equipment to do so.

Why would we transport to another state.

Have another service dispatched that is able to leave the state.

Call St. Mary's ECC and ask if they have a resource.

Contact the EMSRB and see who is designated to transfer Ebola patients.

Same as above.

Go to Rochester.

Call the MDH.

Contact medical direction

At this time we only transport in state

Transport to Mayo Clinic and they can arrange transport if needed to go any out lying State hospital if needed.

Contact medical director.

Have a service qualified to handle Ebola patients do the transport

Transport to the closest facility for transfer of care.

Discuss with MN Dept. of Health / admitting hospital

Transport to one of the 4 Minnesota hospitals.

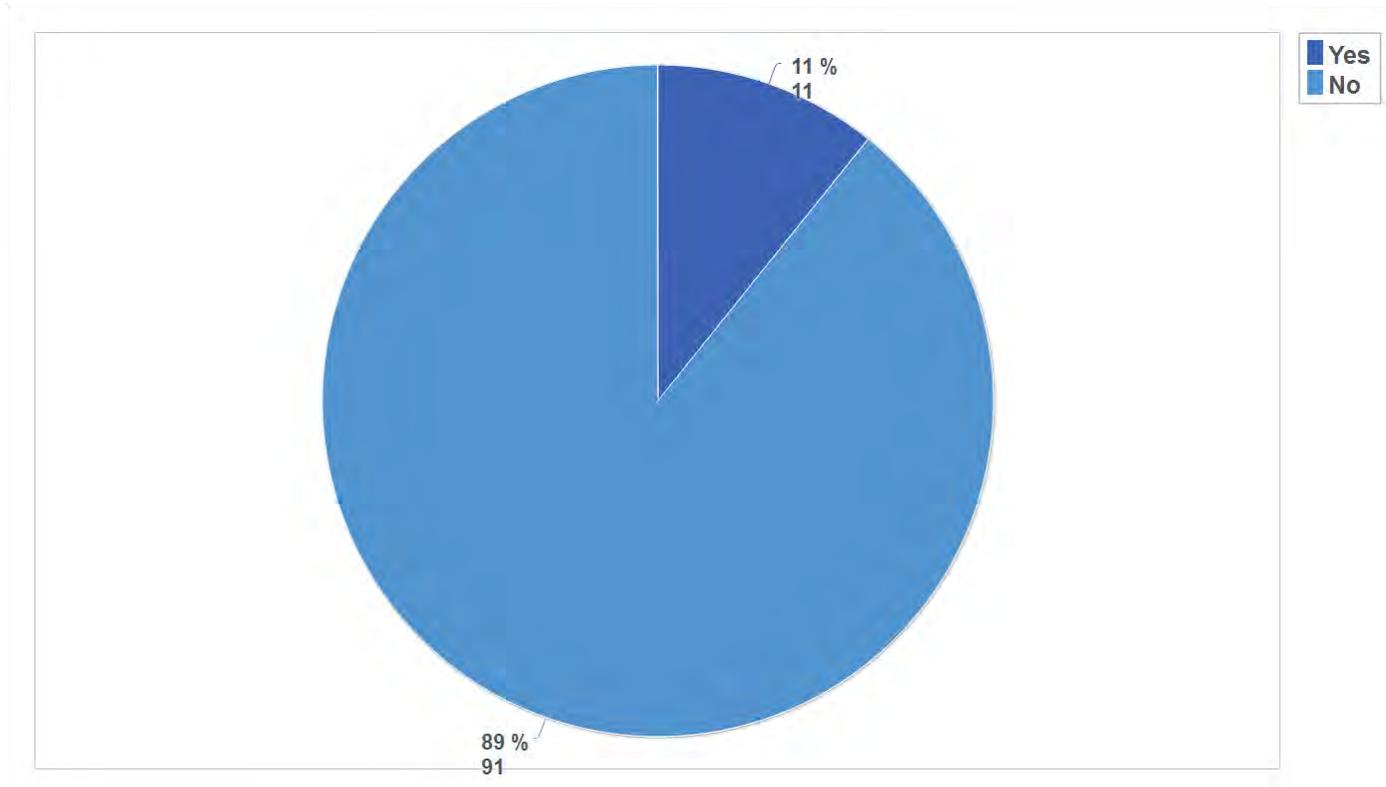
We would not be put in that position.

Transfer to designated local hospital.

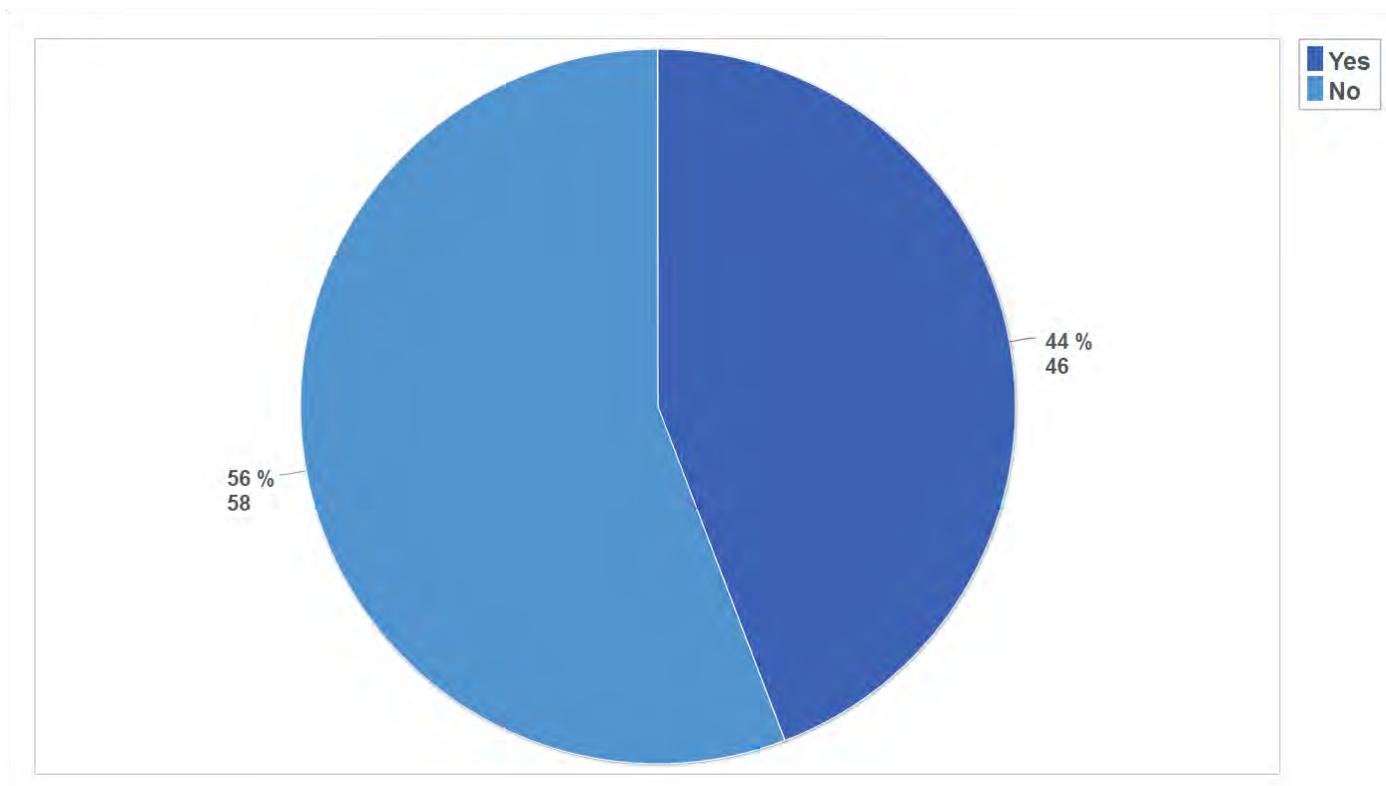
What would you do if you do not have a formal arrangement with another regional EMS provider to transport a suspected Ebola or confirmed Ebola patient to a Ebola assessment and treatment facility in another state? (Response Comments)

Same as above		
Refuse to transport.		
We do not have a formal agreement, we have talked about using North Memorial, Marshall. We have talked to them about this.		
Call local ALS service.		
We have an informal agreement with FM Ambulance.		
Call dispatch and ask for North Memorial for Mutual Aid.		
Mankato Mayo.		
Our ambulance service is only licensed to transfer to nearest ER.		
Refer to Gold Cross.		
Call Gold Cross Ambulance for assistance.		
Notify Dept. of Health and local health care facility.		
Total Responses		48

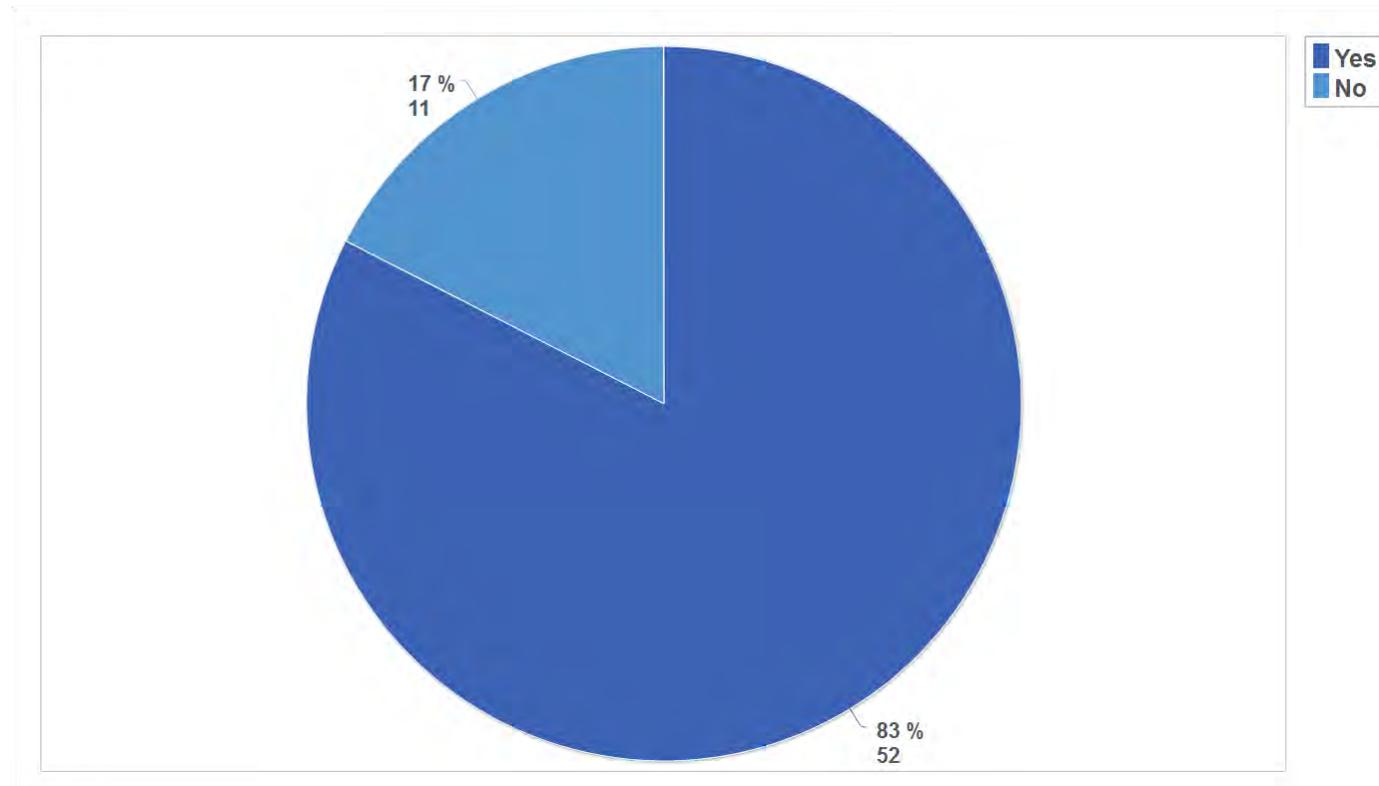
Does your ambulance service have a formal arrangement, agreement or have the ability for the transfer of a suspected Ebola or confirmed Ebola patient to an Ebola assessment and treatment facility by fixed wing medical aircraft?



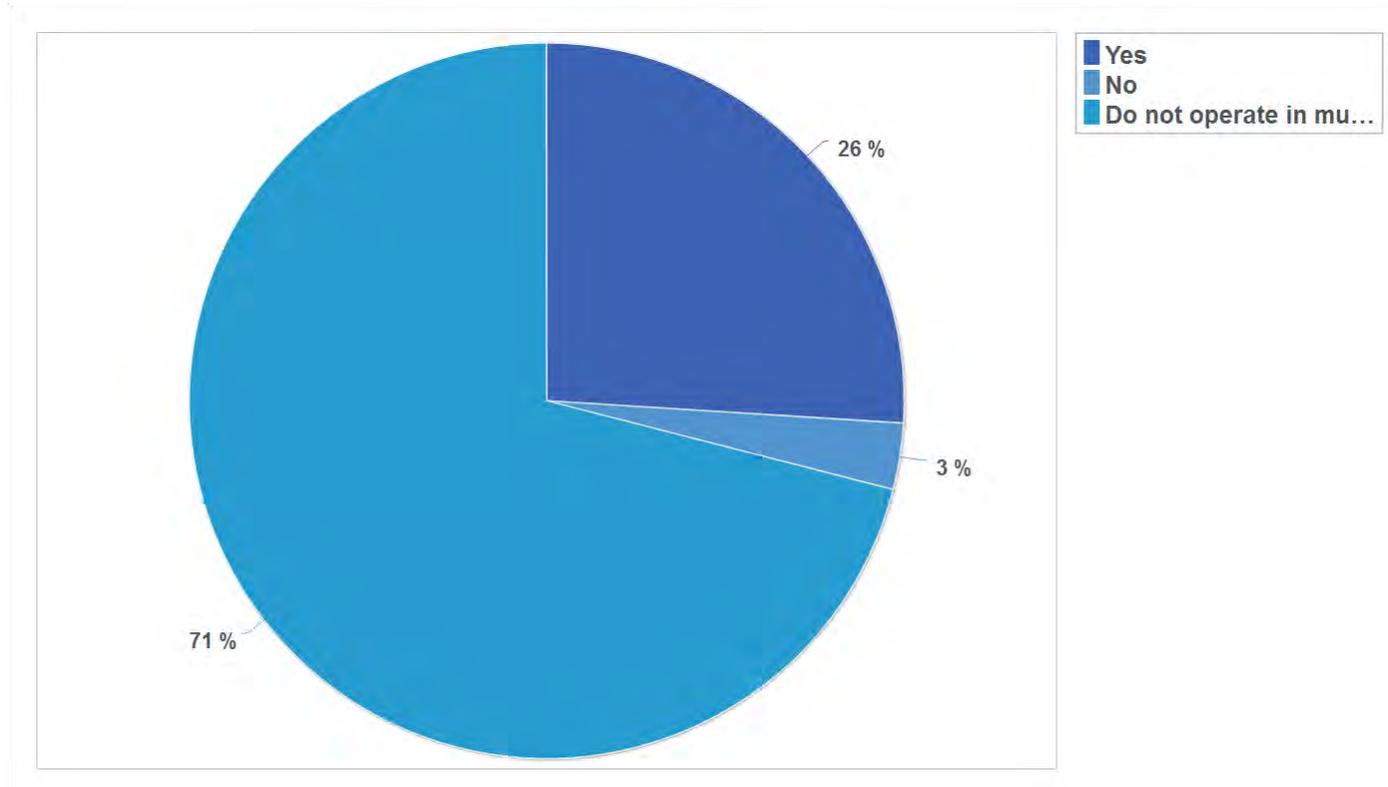
Does your ambulance service have standard operating procedures for response to and preparation for transport of a suspected Ebola or confirmed Ebola patient?



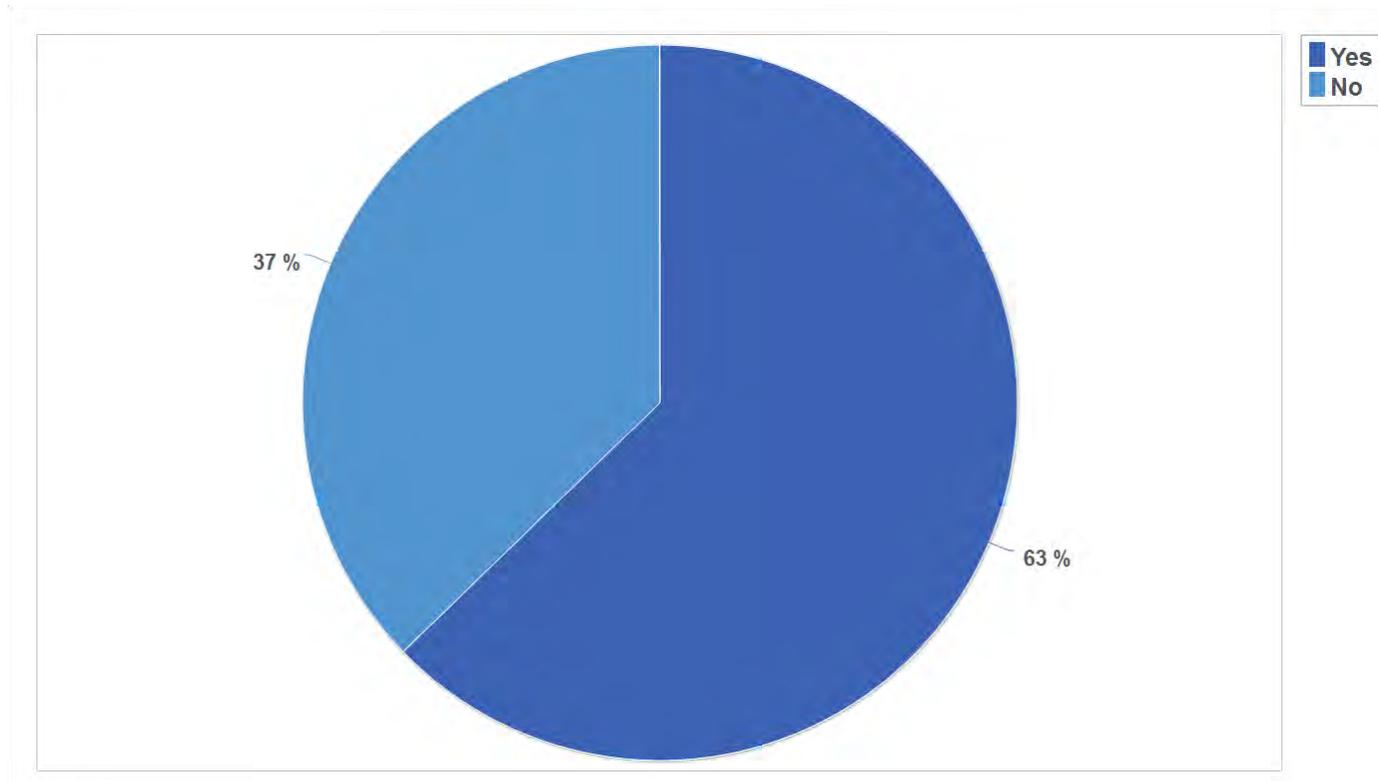
If “No”, do you have an infectious disease guideline/protocol not Ebola specific?



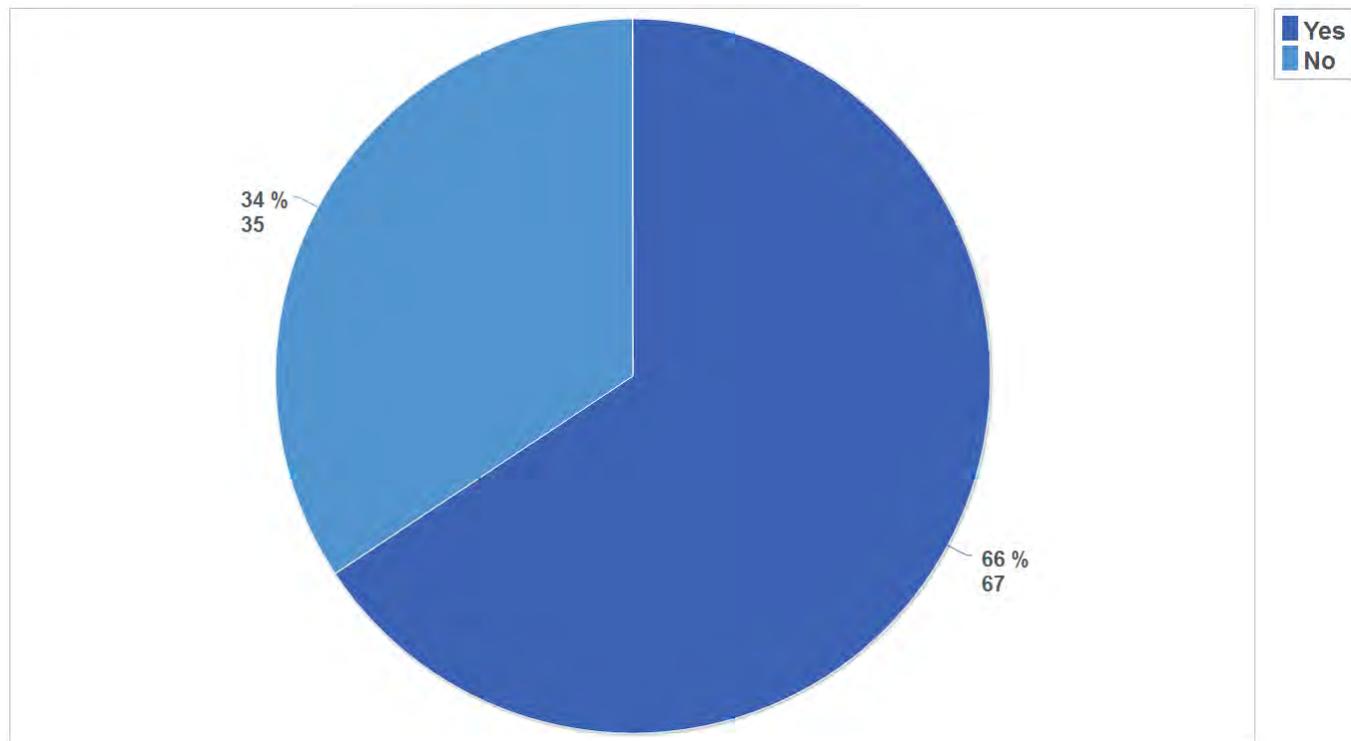
If your ambulance service operates in multiple EMS regions or maintains ambulance base stations in multiple counties do all your EMS personnel operate under the same guidelines/protocols or standard operating procedures to protect them from Ebola Viral Disease?



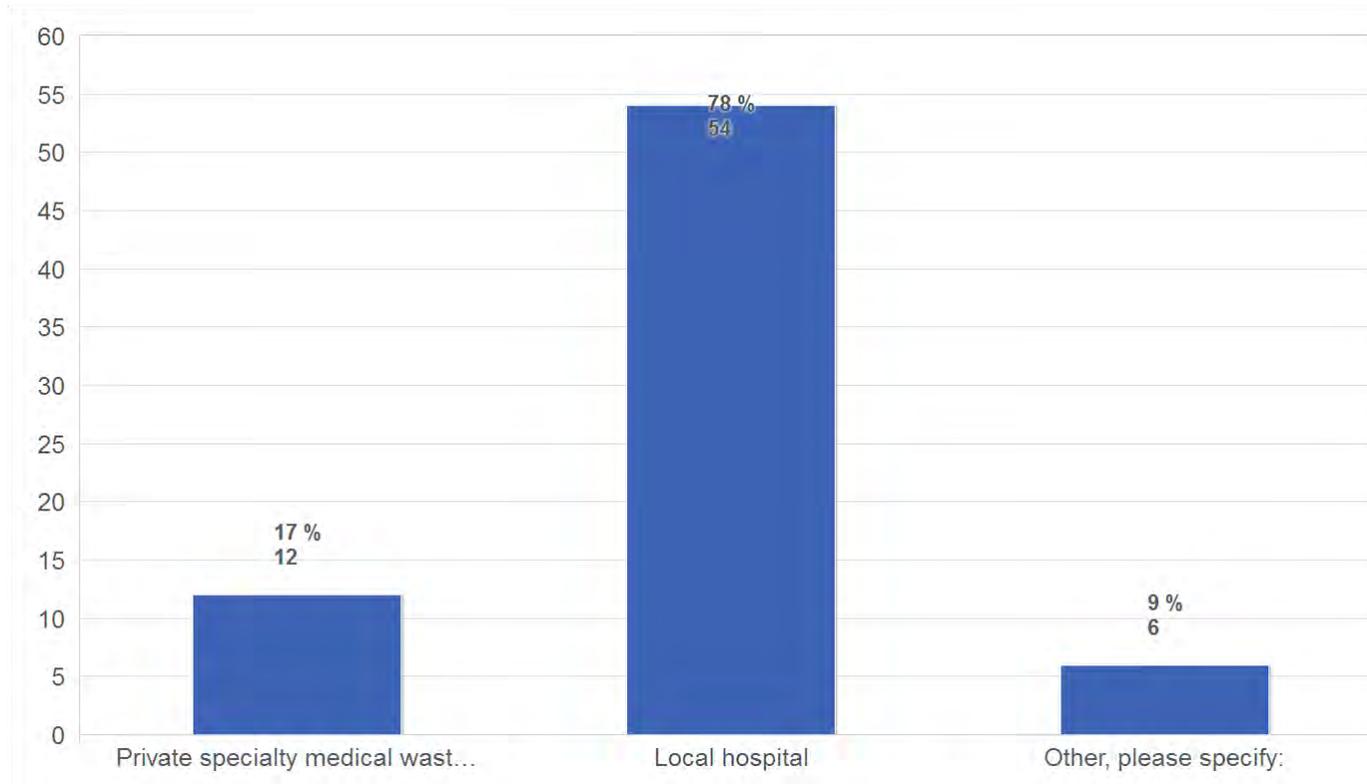
Does your ambulance service have written guidelines/protocols or standard operating procedures for protecting, cleaning and disinfecting an ambulance and equipment involved with the transport of a suspected or confirmed Ebola patient?



Does your ambulance service have guidelines/protocols and procedures for the handling, storage and disposal of Category A infectious substances (regulated as a hazardous material under the U.S. Department of Transportation (DOT) Hazardous Materials Regulations (HMR; 49 CFR, Parts 171-180) Department of Transportation Guidance for Transporting Ebola Contaminated Items, a Category A Infectious Substance?



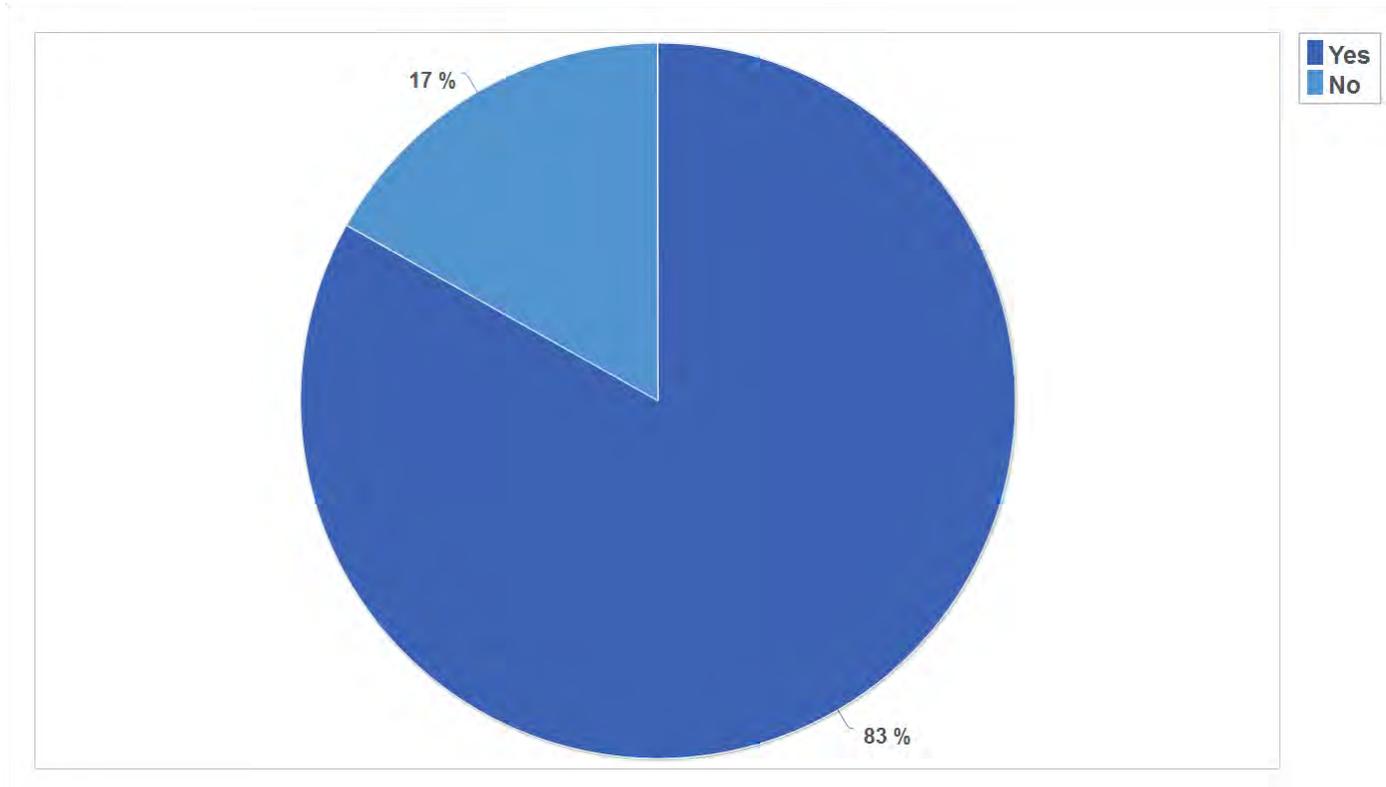
If you do have a formal arrangement for the disposal and handling who is it with?



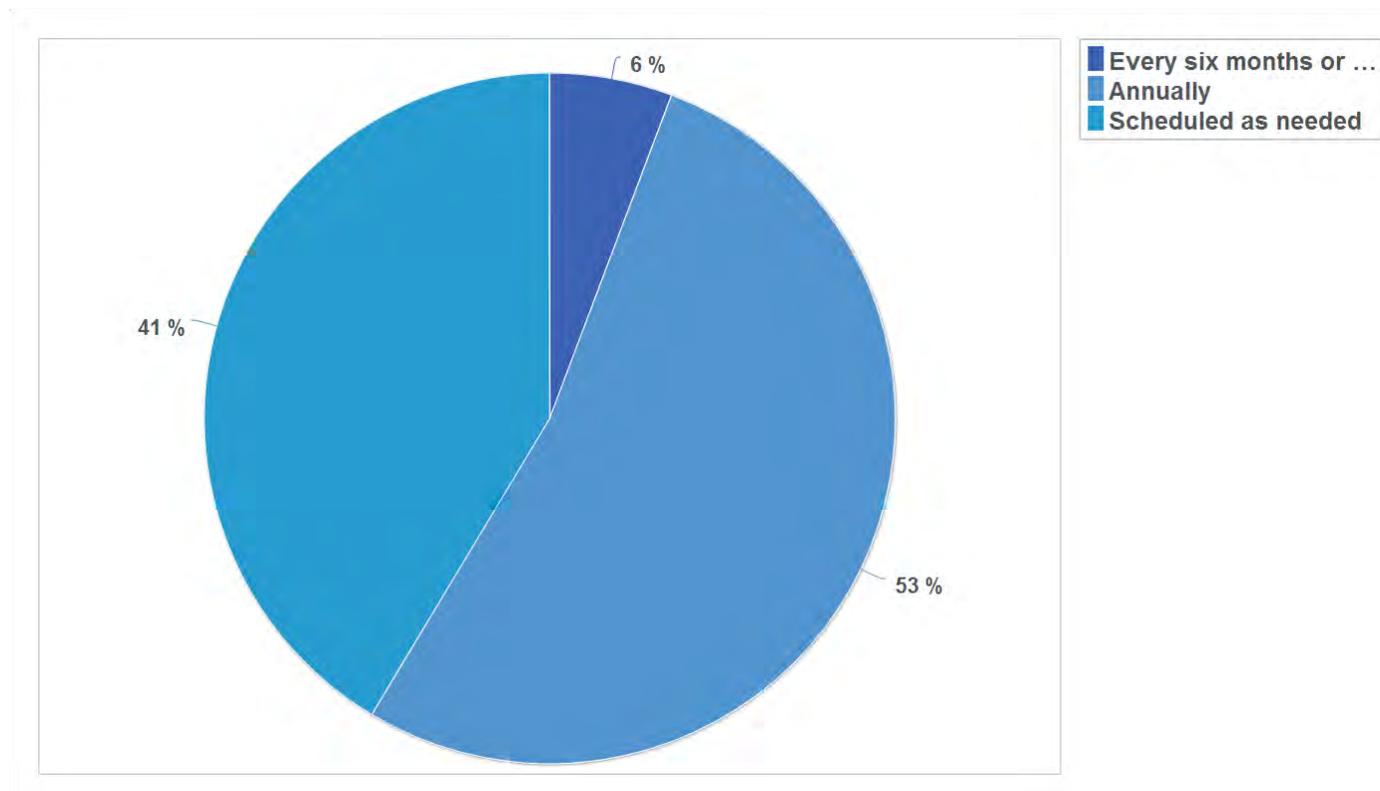
Do you have a formal arrangement for the disposal and handling with whom?

Response Comments
Waste will be left at the receiving facility with the patient.
Our own hospital, we are hospital based.
Nothing formal for Ebola, we drop all infected waste at the hospital.
Waste goes with the patient.

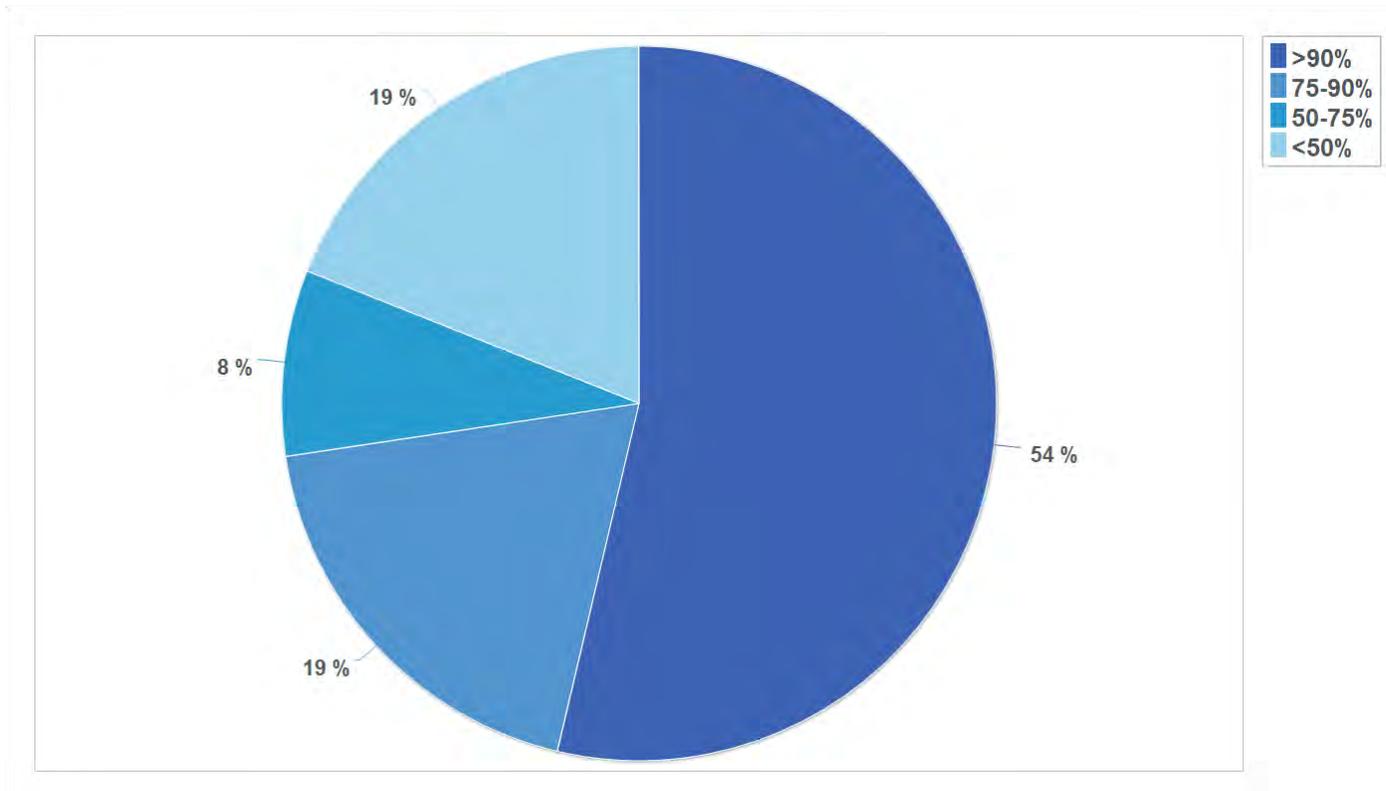
Does your ambulance service provide standard infectious disease precautions training with the minimum personal protective equipment PPE (face shield and surgical face mask, impermeable gown and two pairs of gloves)?



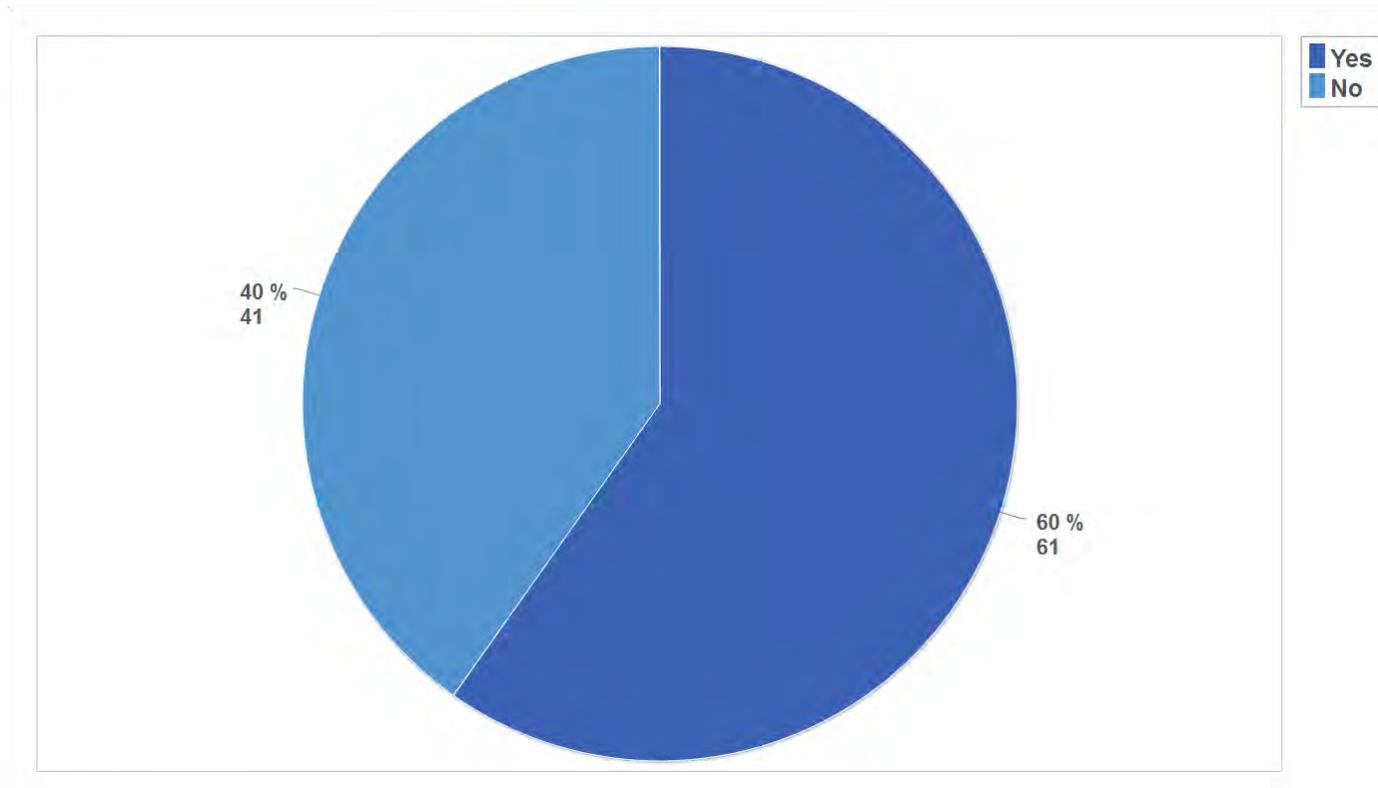
If "Yes" you receive training with the minimum protective equipment, how often does training with personal protective equipment/supplies occur?



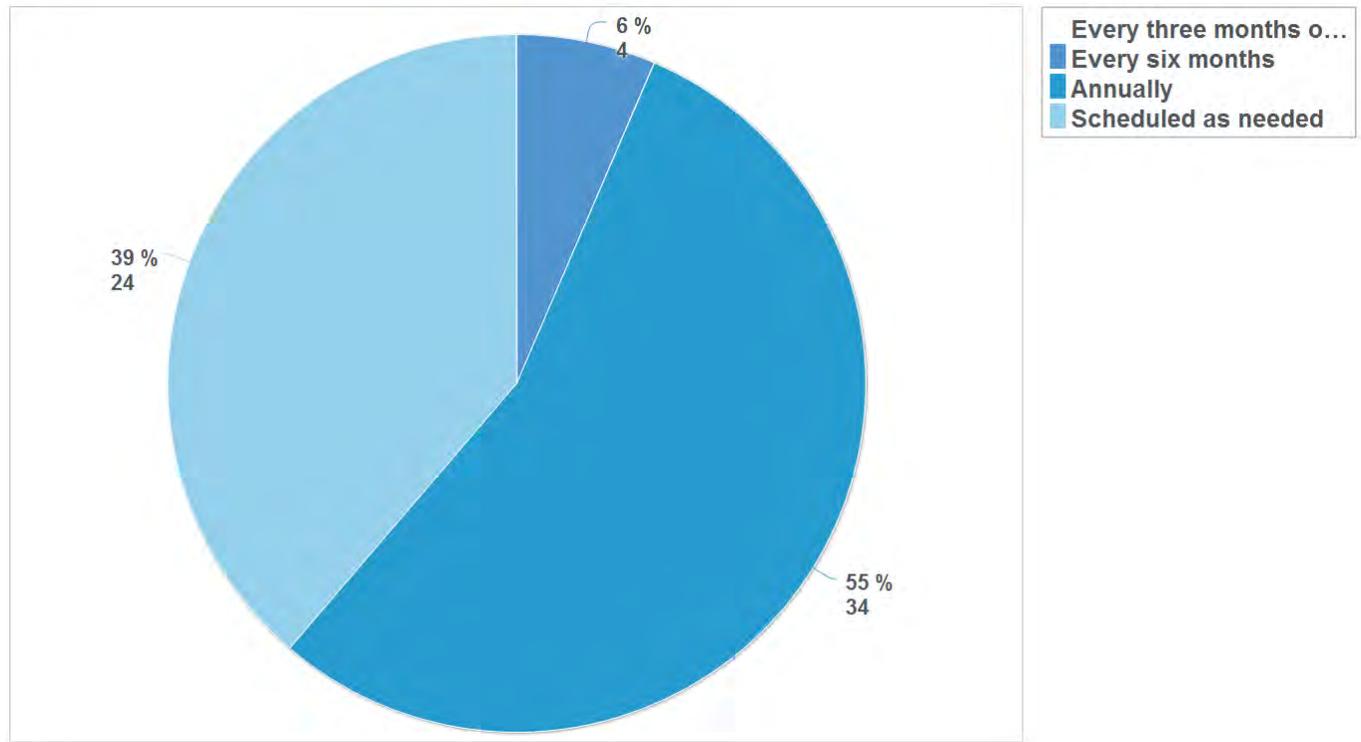
What percentage of your staff have completed and documented training related to standard contact and droplet precautions in the past twelve (12) months?



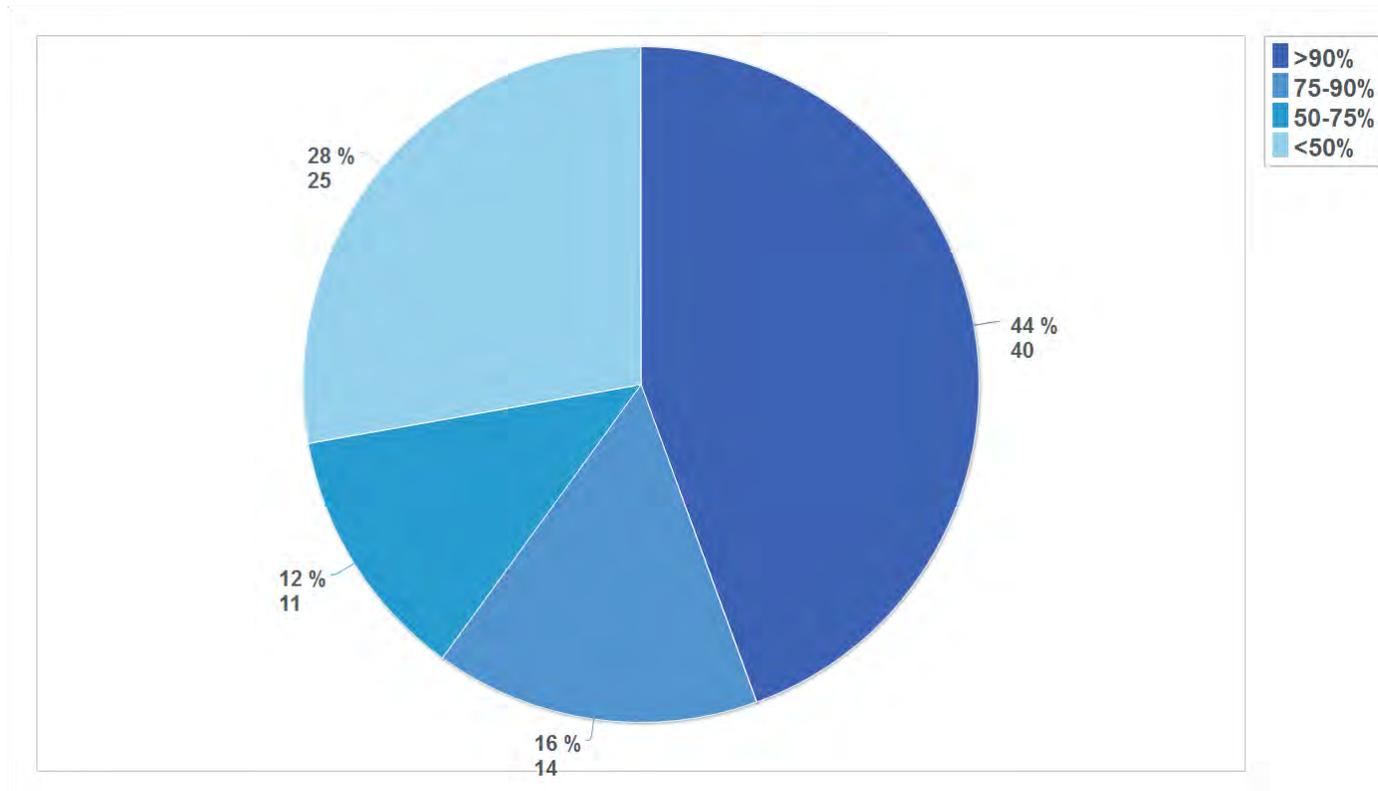
Does your service provide PPE training inclusive of procedures for the “Donning” and “Doffing” of equipment?



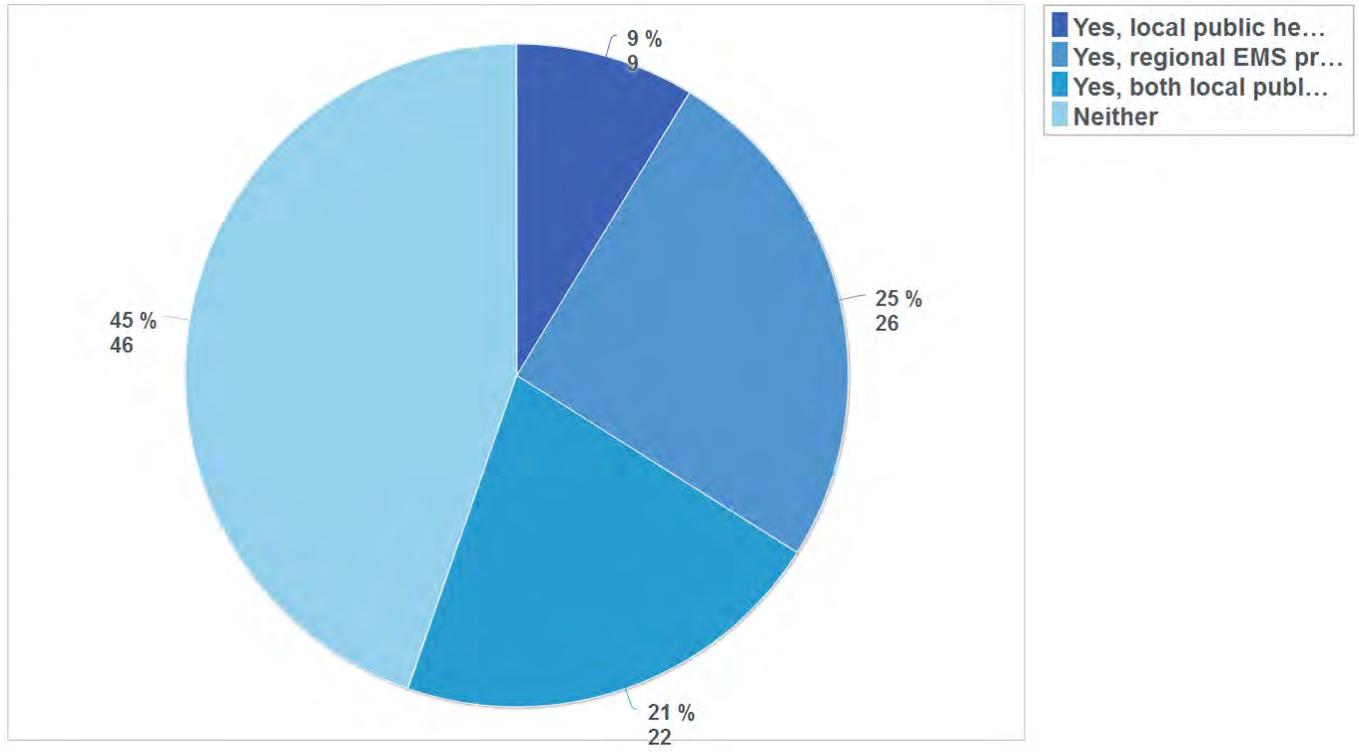
If you answered "Yes" to Donning/Doffing training, how often do you practice and document the "Donning and Doffing" of PPE?



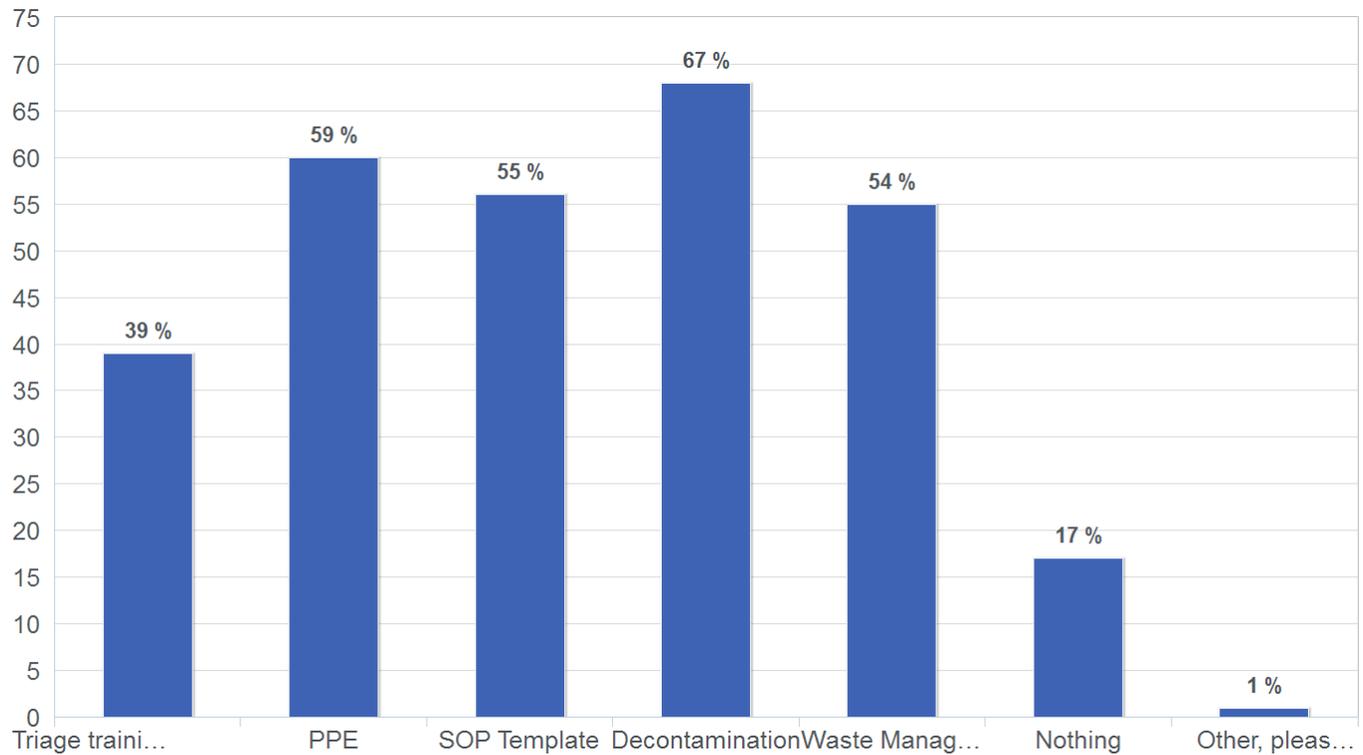
What percentage of your staff have completed and documented the full PPE training in the past twelve (12) months?



Has your ambulance service worked with your local public health department or regional EMS program regarding protection from Ebola or other highly infectious diseases?



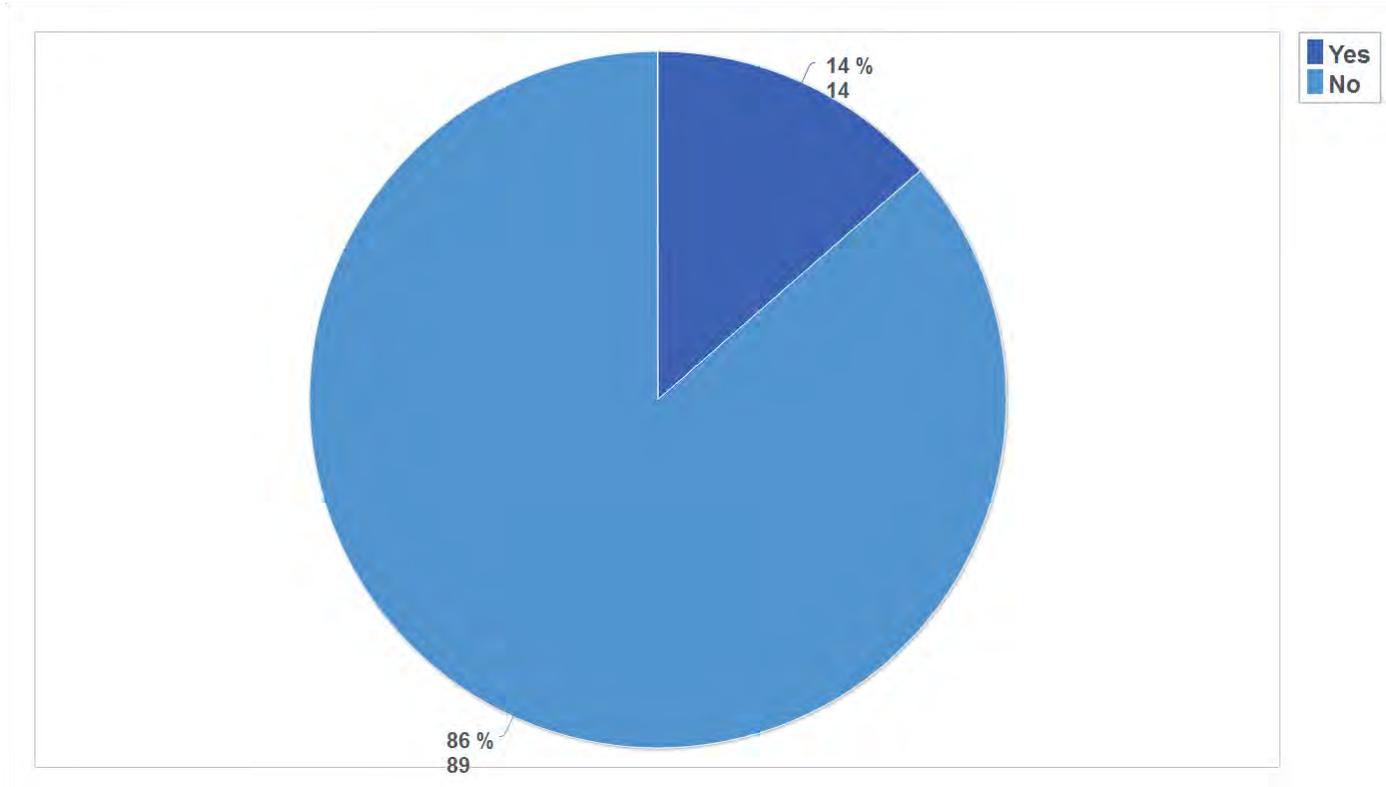
With an emerging infectious disease threat, are there other areas of information or infectious disease training your ambulance service personnel need from local public health, regional EMS program, EMSRB or MDH? Check all that apply.



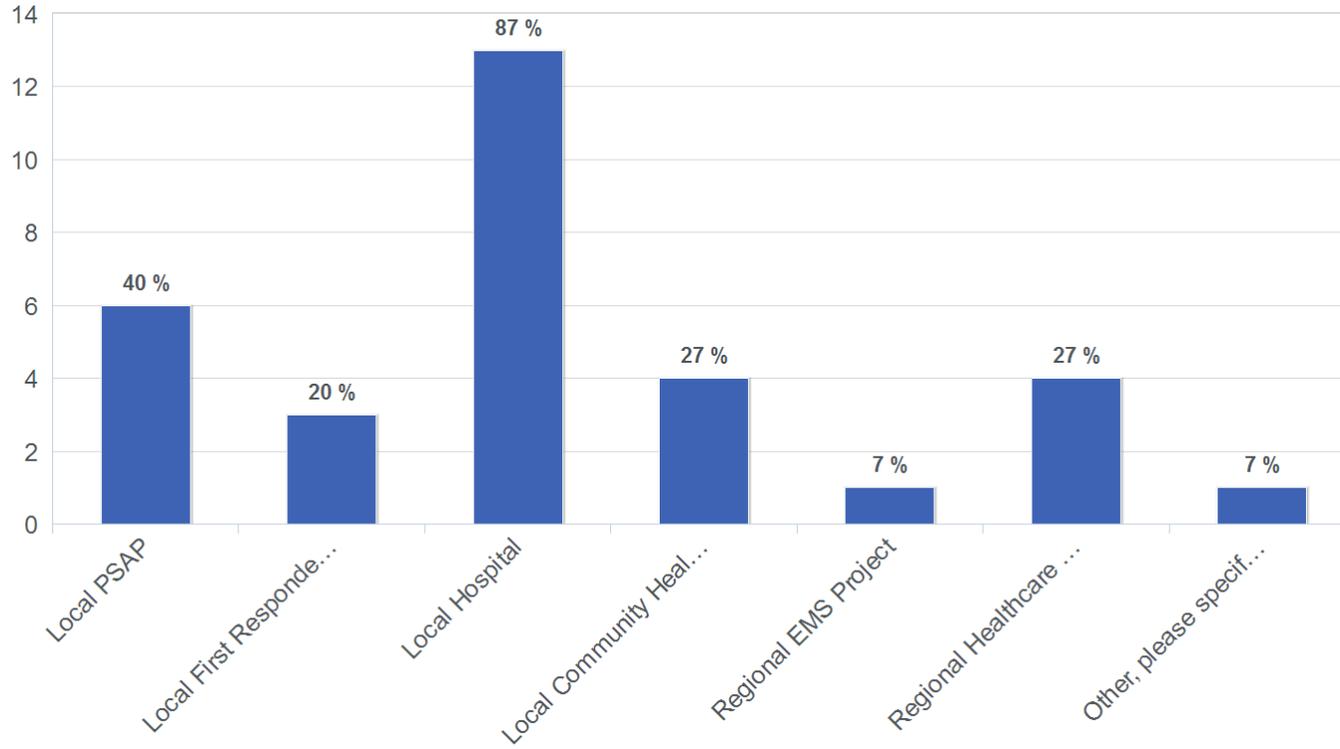
With an emerging infectious disease threat, are there other areas of information or infectious disease training your ambulance service personnel need from local public health, regional EMS program, EMSRB or MDH?

Response – Other - Comment - 1
 We have a designated Infectious Disease Transport Team. There are 4 in the state of ND

Has your service conducted or participated in an Ebola patient response and transport exercise?

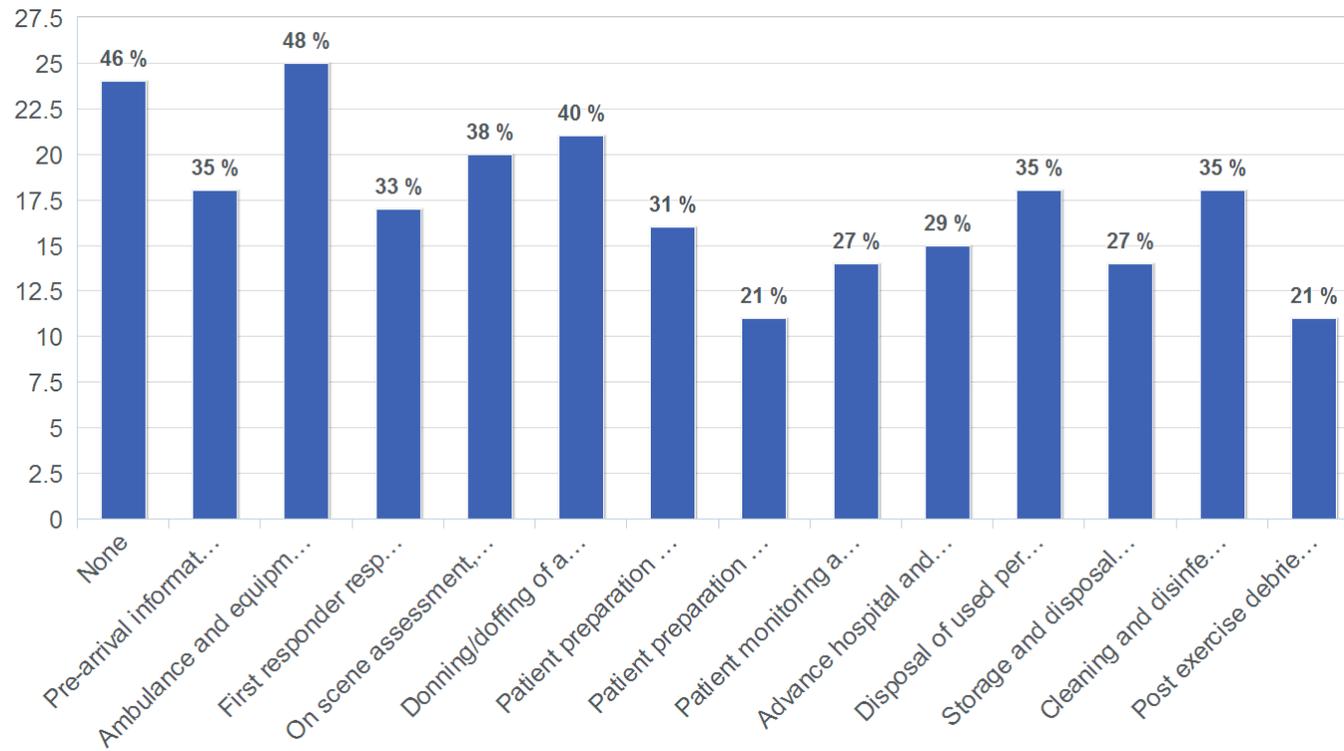


If you participated in a Ebola patient and transport exercise, did the exercise include:

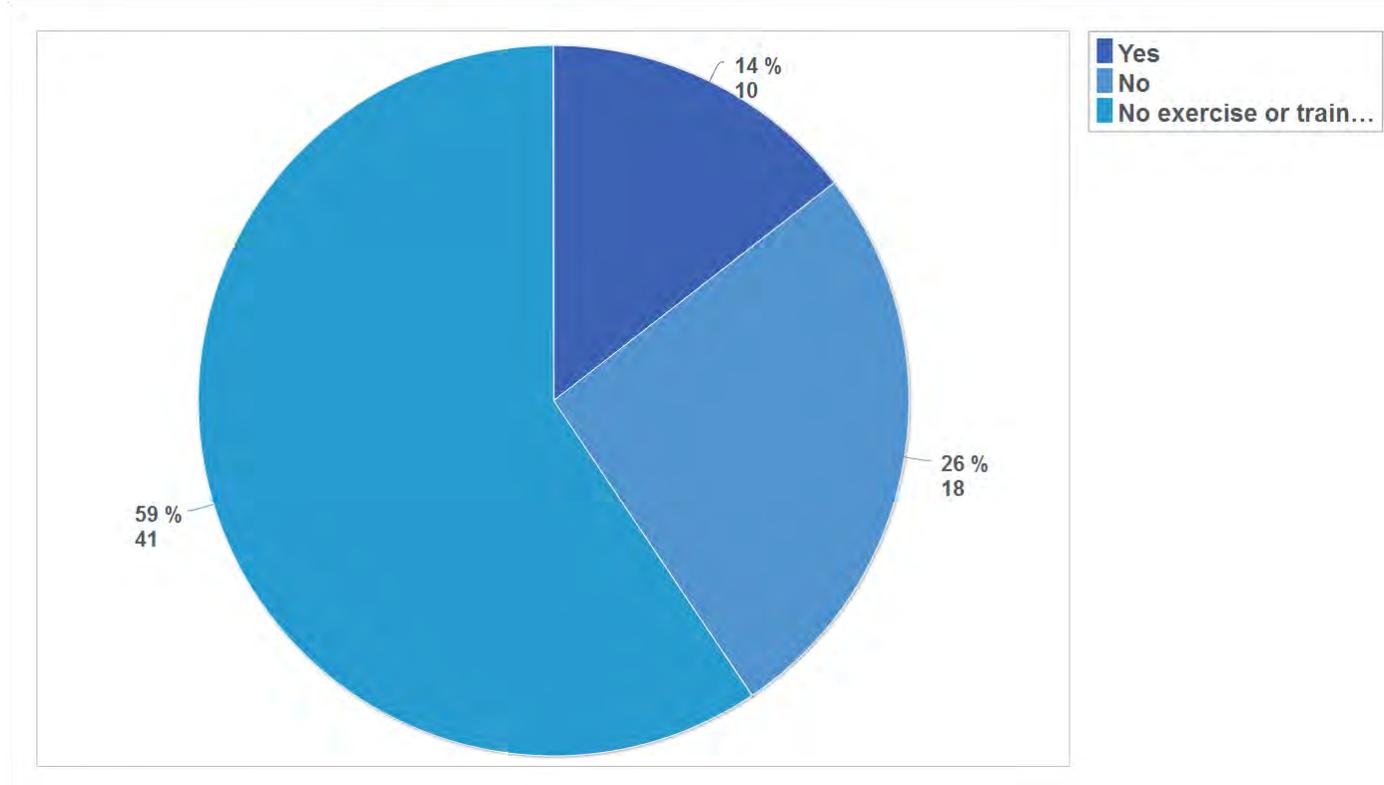


Response – Other - Comment - 1
In-house

Number of ambulance services and what aspects of an Ebola patient response have EMS personnel exercised or participated in:



Was an After Action Report completed following the exercise?





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.