1. Call to Order – Dr. Burnett – 9:00 a.m.

2. Public Comment – 9:05 a.m.
   The public comment portion of the Medical Direction Standing Advisory Committee meeting is where the public may address the Committee on subjects which are not part of the meeting agenda. Persons wishing to speak are asked to complete the participation form provided at the meeting room door prior to the start of the meeting. Please limit remarks to 3 minutes. The Committee will listen attentively to comments but, in most instances, will not respond at the meeting. Typically, replies to issues or concerns expressed will be made via letter or phone call within a week.

3. Approve Agenda – 9:15 a.m.

4. Approve Minutes – 9:20 a.m.  
   • Approve Minutes of September 8, 2016

5. MDSAC Committee Chair Report – Dr. Aaron Burnett, 9:25 a.m.  
   • EMS Crisis Standards of Care (Action Item)
     http://mn.gov/boards/assets/EMS%20CSC%20v5.2_09_16_16_tcm21-273691.pdf
   • Opioid Hospital Visits-Publication
   • Critical Care Paramedic and Critical Care Flight Paramedic
   • “A course in cardiopulmonary resuscitation as approved by the board. . . .”
   • “A course in advanced cardiac life support as approved by the board. . . .”
   • Senate File 1023

6. Executive Director Report – Tony Spector, 10:30 a.m.  
   • Agency Update

7. Update on MDH Inter-Facility Stroke Workgroup – Dr. Andrew Stevens, 10:40 a.m.

8. Regions Approach to Coordinated Emergency Care (RACE-Care) – Dr. John Hick, 10:50 a.m.  

9. Community EMT Education Program, Dr. Mike Wilcox – 11:00 a.m.

10. New Business – 11:30 a.m.
11. **Next Meeting Date Discussion – 11:50 a.m.**

12. **Adjourn – 12:00 p.m.**

**Note:** Some Committee members may be attending this meeting by telephone. In accordance with Minn. Stat. § 13D.015, subd. 4, the public portion of this meeting, therefore, may be monitored by the public remotely and telephonically. If you wish to attend by telephone, please contact Melody Nagy at 651-201-2802 or by email at melody.nagy@state.mn.us for connection information. There may be a nominal fee for members of the public to participate by telephone. Please contact Ms. Nagy no later than 10:00 a.m. on Wednesday, March 1, 2017 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](http://www.emsrb.state.mn.us)
State of Minnesota  
Emergency Medical Services Regulatory Board  
Medical Direction Standing Advisory Committee  
Meeting Minutes  
September 8, 2016, 7:00 p.m.  
Arrowwood Conference Center  
Alexandria, Minnesota 56308

Attendance: Aaron Burnett, M.D., Chair; J.B. Guiton, Board Chair; Marc Conterato, M.D.; Gary Foley, M.D.; R.J. Frascone, M.D.; Dan Hankins, M.D.; Paula Fink Kocken, M.D.; Charles Lick, M.D.; Pat Lilja, M.D.; John Lyng, M.D.; John Pate, M.D.; Kevin Sipprell, M.D.; Mari Thomas, M.D.; Michael Wilcox, M.D.; Tony Spector; Executive Director; Tom Frost, EMS Specialist; Chris Popp, Compliance Supervisor; Melody Nagy, Office Director; Rose Olson, Licensing Coordinator; Greg Schaefer, Assistant Attorney General.

1. Call to Order

Dr. Burnett called the meeting to order at 7:02 p.m.

2. Public Comment

Ms. Devon Green, Reservation Ambulance Service, White Earth, asked to speak to the committee. She said Dr. Carson Gardner is not able to attend the meeting. Ms. Green stated the position of their service in requesting a variance to allow for use of a new syringe-volume-limiting clip to administer epinephrine. Dr. Burnett said this is being suggested as an alternative for a volume limited syringe. The committee discussed methods of epinephrine administration. Dr. Lilja asked for clarification of the memo provided by the state. Mr. Schaefer quoted the statute. Dr. Burnett said the ambulance service medical director makes the determination if the devise meets the law.

3. Approve Agenda

Dr. Lick moved approval of the agenda. Dr. Pate seconded. Motion carried.

4. Approve Minutes

Dr. Lick moved approval of the March 4, 2016 minutes. Dr. Lilja seconded. Motion carried.

5. MDSAC Committee Chair Report

Welcome New Member Dr. Andrew Stevens  
Dr. Burnett said that Dr. Stevens could not attend tonight. Dr. Burnett provided background information about him.

Burnsville Fire Department EMS Pilot Project No. 2  
Chief B.J. Jungmann of the Burnsville Fire Department provided a Power Point presentation. He discussed a timeline for implementation of this project and commented that there are a number of programs that are similar to this. He referenced a white paper regarding triage. He provided a sample of a triage protocol. Burnsville Fire Department will never deny service to a patient. The question Chief Jungmann posed to MDSAC: is there something Burnsville Fire needs to do regarding its pilot projects to be compliant with the EMSRB? Dr. Lilja asked if this is allowed under current statute. His
The reading of the statute is that a service must respond when called. Should the committee be suggesting a change to rule? Dr. Burnett said that this is being offered as an option. (Patient choice.)

Dr. Lyng moved to refer this topic to the Legislative Ad-Hoc Work Group and Executive Committee and asked the Attorney General to provide an opinion for:

a. What triggers the requirement for a response?
b. What constitutes a response?
c. What is a request for an ambulance?
d. Is secondary focused medical triage of a 9-1-1 caller who is requesting an ambulance under the regulatory authority of the EMSRB? (If so, how does EMSRB compliance fit into secondary triage?)

Dr. Pate seconded. Motion carried.

**POLST Form**

Dr. Burnett said the Board has supported the POLST form in the past. There are minor updates to this form. A Power Point presentation was referred to that was also provided in the handouts. Mr. Guiton said this form was updated to meet national standards. The goal is to have a physician sit with the patient and the family to clarify the patient’s wishes. Dr. Lilja said use of the form should not be limited to someone who has less than 12 months to live. There should be a form that anyone can use. Mr. Guiton said the Minnesota Ambulance Association (MAA) has approved the updated form and the EMSRB is being requested to endorse the form. The committee discussed the format of the form. Several physicians suggested modifications to the form. Dr. Burnett suggested that he would like specific to see language for trial of intubation with a fill in for number of days.

Dr. Lilja suggested sending a letter to the MAA expressing the concerns of the MDSAC.

Dr. Burnett moved to recognize that a POLST form is the best way for a patient to communicate their wishes to EMS. The following suggestions were offered:

a. Stronger emphasis for a patient that prefers no transport to the hospital. (Similar to the previous form.)
b. Adding if a patient requests a call to 9-1-1 or an alternate source. (i.e., hospice)
c. Amend the form to make more bullet points or checkbox format.
d. POLST form could be part of any individual’s health care planning regardless of their life expectancy.

Dr. Frascone seconded. Motion carried.

Dr. Lyng said he would like to know how this information can be communicated in a secure data base in real time and honor peoples wishes.

Mr. Guiton asked if the committee would be able to meet before March to discuss this issue. Dr. Burnett said this issue alone, no. If there are enough agenda items to call a meeting, this could be included.
Role of MDSAC in State EMS Crisis Standards of Care
Dr. Burnett said the Minnesota Department of Health formed a committee to discuss EMS Crisis Standards of Care. Dr. Burnett suggested the MDSAC would be the subject experts for medical care advice. The draft document developed by the committee is open for public comment.

Physician Involvement in Rural Ambulance Assessments
Dr. Burnett said the EMSRB has conducted several rural ambulance assessments recently. Physician involvement is critical to the quality of these assessments. A medical director provides insight that no one else can provide. Dr. Burnett said he is looking for volunteers from this committee for the assessment team.

Medical Director’s Course
Dr. Pate said this course is being offered for new or newer medical directors. Twelve attendees are registered to attend. This is a one-hour presentation and provides a basic review for a new medical director. Mr. Spector said that this is being presented at no charge. Dr. Burnett thanked Dr. Pate and the Medical Director’s Association.

6. Education Standards Transition

Mr. Spector referred to the handouts that list the requirements for ACLS and CPR. He said Board member Lisa Consie was present to provide clarification of the committee’s discussions. Mr. Spector asked for a recommendation from MDSAC. The EMSRB would need to develop language for any suggested changes to statute. The Post Transition Education Standards Work Group suggested that CPR be included as a requirement for EMR. This would require a statute change. Should ACLS be required? The current statute lists a course or approved by the medical director.

Dr. Lilja said there should be a broad interpretation of what is included as a CPR course. Dr. Lilja said sometimes the protocol is different than what is taught as CPR.

Dr. Burnett said that the national core competency requirements do not require CPR and ACLS. Minnesota statute requires CPR. Dr. Lyng suggested endorsement of the concept but not name a specific course.

Dr. Pate asked if use of an AED would be included in the CPR course. Dr. Burnett responded that would depend on the wishes of the medical director.

Mr. Spector said the EMSRB is certifying EMR renewals and the EMR on an ambulance should have CPR.

Motion: Dr. Foley moved to require a course in CPR approved by the Board or a medical director for EMR. Dr. Thomas seconded. Motion carried.

Dr. Lilja asked about medical director verification for renewals. How do you maintain paramedic certification without a medical director to sign the form? The National Registry has an inactive status.

7. Executive Director Report

Mr. Spector said that he is presenting agency information at the Board meeting and at the conference. He said the agency has reached its 20-year anniversary. He acknowledged the persons in the room that have served EMS for 20 years or more. He acknowledged staff with 20 years of service.
Mr. Spector mentioned the EMSRB mission is to regulate and support the system. Discipline is one tool and the EMSRB has had requests for assistance that did not require discipline. An engaged medical director makes a difference for an ambulance service. The EMSRB seeks medical directors who are willing to lend their assistance as the EMSRB works with services that are struggling.

8. EMSC Pediatric BLS/ALS Guidelines Approval

Dr. Fink Kocken provided a handout and Power Point presentation. When the American Heart Association makes changes to their recommendations it is necessary to update our guidelines. These are guidelines and every service has their own protocols but may adopt these guidelines if they wish. These guidelines were reviewed by a small committee. This information will be posted on our website and the EMSRB website. The updated ALS/BLS combined format will be provided. New sections have been added.

Dr. Burnett asked if adrenal insufficiency is included in the guideline. Dr. Fink Kocken said yes.

Dr. Fink Kocken said the roll out date is September 23. The guidelines will be available for download. EMSC will have flash drives to provide at future conferences.

Dr. Fink Kocken said if there are suggested additions, I will be happy to discuss this with you.

9. U of M Cardiac Care Consortium

Dr. Burnett said that Lucinda Hodgson and Kim Harkins could not attend the meeting tonight so Dr. Lick presented information regarding this program. Dr. Lick said that this not specifically a University of Minnesota program. This is system based care and a national program for heart rescue. The Minnesota program remains strong and there are lots of partners in the program. The goal is to improve survival. There is a registry for data on cardiac arrest. Dr. Lick provided statics on participation. You can compare your service with regional and national data. This provides performance data. He referred to the handouts provided to the committee. Dr. Lick suggested if services are not using CARES, contact Ms. Hodgson to join.

10. New Business

Mr. Spector thanked staff for their work in organizing this meeting.

11. Next Meeting

The next meeting will be scheduled to be at the Long Hot Summer Conference in Brooklyn Park, on March 3, 2017.

12. Adjourn

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

Meeting adjourned at 9:00 p.m.
SURGE OPERATIONS and CRISIS CARE –
PLANNING AND IMPLEMENTATION GUIDANCE FOR
EMERGENCY MEDICAL SERVICES

A JOINT PROJECT OF THE MINNESTOA DEPARTMENT OF HEALTH (MDH) AND MINNESOTA
EMERGENCY MEDICAL SERVICES REGULATORY BOARD (MN EMSRB)

November, 2016

Here is the link to the document:

http://mn.gov/boards/assets/EMS%20CS%20v5.2_09_16_16_tcm21-273691.pdf
EMS IN DISASTERS – CRISIS PLANNING FOR RURAL AND URBAN ENVIRONMENTS

John L. Hick, MD
Hennepin County Medical Center
September 11, 2016

asprtracie.hhs.gov

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

ASPR’s Technical Resources, Assistance Center, and Information Exchange
EMS Crisis Care Planning

What is crisis care?

- Crisis standards of care – systems response including formal government recognition of situation – prolonged event
- Crisis care – situational – inadequate resources – must provide ‘best care possible’ given the situation despite some risks to the patient(s) – *much* more common
Key Points

- Crisis care cannot wait for official declarations / actions – must be part of surge operations planning
- Agencies must have surge plans that include crisis strategies
- Delegate authority to trigger - avoid paralysis
- Proportional is critical - dynamic event
- Capacity is focus of the document
  - Capability – Ebola, pediatrics, HAZMAT, etc.
Dispatch
- Call volumes 3x rural vs. urban
- Large, no-notice responses
- Mutual aid
- Breaking point
  - Auto-answer
  - Rollover
  - EMD available?
  - What can be declined / postponed?
  - What other assets can be sent?

Response (Send)
- ALS / BLS units
  - How many per unit?
- Jump Car
- Fire
- Police
- WC van
- Bus
- Taxi
- MD / RN call / visit
- Nothing
Staff

- Usual staff / borrow
- EMT plus EMR, EMT plus ‘other’ driver
- First responders (other)
- Medical Reserve Corps
- ARC / NGOs
- Neighbors?

Stuff

- Spinal immobilization
- Tourniquets
- Medications
- Oxygen
- PPE
- Specialty – burn, pediatric

- Conserve, substitute, adapt, re-use
Treatment

- SOPs – any changes in disaster?
- Ability to leave at scene
  - Hennepin County Pandemic Plan
- Generally limited treatment in disaster settings

Transport

- Ambulance – batch transports
- AST
- Federal
- Mass Casualty Bus
- Rotor-wing
- Fixed wing
- Private vehicle
  - Appendix
- Military
Destination

- Distribution
  - ‘First Wave’ assignments in metro – MRCC
  - Judgment call in outstate
  - Trauma level
  - ‘Closest hospital’ vs. choice

- Non-hospital destinations
  - Pandemic
  - Damaged infrastructure
  - Hospital to overflow facility

EMS Dispatch - Triage Tree

- Ambulance requested and available?
  - Yes: Send ambulance
  - No: Re-assign other local ambulance to call?
    - Yes: Re-assign / batch transport or split crew
    - No: Mutual aid available within XX minutes?
      - Yes: Obtain mutual aid and notify any additional local first responders (re-page)
      - No - (notify dispatch supervisor or chief)
        - Able to walk and alternative transport available (e.g. family)?
          - Yes: Recommend self-transport
          - No: Any available first responders?
            - Yes: Send any available responder to assess, request nearest available mutual aid response
            - No: Able to transfer call to remote Emergency Medical Dispatcher?
              - Yes: Transfer call, request nearest available mutual aid response
              - No: Obtain call-back and incident information, pass to local EMS supervisor

Further actions:
- Log calls and resources assigned / disposition
- Self transport, waiting transport, transport completed, no transport needed
- Monitor local and mutual aid resources and assign resources as available
- Support EMS supervisor / hospital communication needs
- Obtain additional dispatch support / reserve support as required per supervisor
Non-EMD Dispatch Prioritization

Coalitions / Coordination

- Regional planning
  - Healthcare coalitions
  - RTACs

- Incident
  - Communications methods
  - Coordination methods
    - Multi-agency coordination (MAC)
Regulatory

- EMSRB during state declared disaster automatically suspends:
  - Staffing requirements
  - Licensure requirements
  - PSA rules
  - Equipment and safety restraint rules
  - ALS/BLS care requirements
- CMS 1135 waiver

Develop the Plans

- Analyze options – resources, limitations, response options
  - Dispatch
  - Response
  - Treatment
  - Transport
- Establish triggers
  - Scripted – line personnel (if x, then y)
  - Non-scripted – notifications of management staff
Develop the Plans (cont.)

- Acquire resources (if possible) based on hazard / current resource assessment
- Write the plans / incorporate decision points into job aids
- Educate, exercise, modify
- Assure agency / regional process
  - information sharing
  - incident action planning for continued response / recovery actions – dynamic needs

Conclusion

- Crisis situations are relatively common
- Develop practical solutions for your service
- Empower employees to implement
- Bite-sized pieces of planning
- Engagement of medical directors
- Coordination with neighboring services
Opioid-Related Inpatient Stays and Emergency Department Visits by State, 2009–2014

Audrey J. Weiss, Ph.D., Anne Elixhauser, Ph.D., Marguerite L. Barrett, M.S., Claudia A. Steiner, M.D., M.P.H., Molly K. Bailey, and Lauren O’Malley

Introduction

The opioid epidemic has reached alarming levels in many parts of the United States, affecting the lives of thousands of individuals and families. Between 2000 and 2014, the rate of overdose deaths involving opioids in the United States increased 200 percent. Between 2013 and 2014 alone, the rate of opioid overdose deaths increased 14 percent, from 7.9 to 9.0 per 100,000 population. Hospitalizations related to opioid misuse and dependence also have increased dramatically, with the rate of adult hospital inpatient stays per 100,000 population nearly doubling between 2000 and 2012. The substantial increase over the past decade in the misuse of opioids, which include prescription opioids and illicit opioids such as heroin, has been declared an “opioid epidemic” by the U.S. Department of Health and Human Services (HHS).

* This Statistical Brief was revised to include opioid-related external cause of injury codes (E codes) for accidental poisoning and adverse effects (E850.0–E850.2, E935.0–E935.2, E940.1) in the calculation of the State-level rates. This affected the number of inpatient stays and emergency department (ED) visits involving opioids at the State level, resulting in an increase in the rates reported for all States. Consequently, some shifts occurred in the rankings among States, both in the 2014 rate and in the percent change in rate between 2009 and 2014. Additionally, Maine was added to the list of States reported with inpatient data. The numbers for national rates, both inpatient and ED, are unchanged as E codes were included originally for national estimates.

2. Ibid.
In March 2015, HHS launched its Opioid Initiative to help reverse the increasing trend in opioid misuse, use disorder, and overdoses, and to support State efforts to address the opioid crisis.\(^5\) In response to HHS initiatives, in December 2016 the Agency for Healthcare Research and Quality released statistics on opioid-related hospital use by State in the interactive, online tool for the Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats.\(^6\)

This HCUP Statistical Brief presents data from HCUP Fast Stats on the national rate of opioid-related hospital inpatient stays and emergency department (ED) visits from 2005 to 2014. Rates for more than 40 individual States and the District of Columbia are provided for 2014 along with changes in rates for the 6-year period from 2009 to 2014. Identification of opioid-related stays and visits is based on all-listed diagnoses and includes events associated with prescription opioids or illicit opioids such as heroin. Differences greater than 10 percent between estimates are noted in the text.

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Findings

National rate of opioid-related inpatient stays and ED visits, 2005–2014

Figure 1 presents the national rate per 100,000 population of opioid-related inpatient stays and ED visits from 2005 through 2014.

Figure 1. National rate of opioid-related inpatient stays and emergency department visits, 2005–2014

Abbreviation: ED, emergency department

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats, Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP National (Nationwide) Inpatient Sample (NIS) and the HCUP Nationwide Emergency Department Sample (NEDS)

- Overall, the population rate of opioid-related inpatient stays was higher than the rate of opioid-related ED visits.

  Between 2005 and 2014, the population rate of opioid-related inpatient stays ranged from approximately 25 to 90 percent higher than the population rate of opioid-related ED visits.

- The rate of increase for opioid-related ED visits was greater than that for opioid-related inpatient stays.

  Between 2005 and 2014, the rate of opioid-related inpatient stays increased 64.1 percent, from 136.8 per 100,000 population in 2005 to 224.6 per 100,000 population in 2014. This represented a 5.7 percent average annual growth rate. During this same time period, the rate of opioid-related ED visits increased 99.4 percent, from 89.1 per 100,000 population in 2005 to 177.7 per 100,000 population in 2014. This represented an 8.0 percent average annual growth rate.
State rates of opioid-related inpatient stays, 2014

Figure 2 presents the rate per 100,000 population of opioid-related inpatient stays among 44 States and the District of Columbia that provided data in 2014. States are ordered according to their rate of opioid-related stays.

Figure 2. Rate of opioid-related inpatient stays by State, 2014

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats, Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP National Inpatient Sample (NIS) and the HCUP State Inpatient Databases (SID)
The rate of opioid-related inpatient stays varied by a factor of 5.6 across 44 States and the District of Columbia in 2014.

In 2014, the highest rate of opioid-related inpatient stays was in Maryland (403.8 stays per 100,000 population), which was 5.6 times higher than the lowest rate in Iowa (72.7). Following Maryland, the next highest rates of opioid-related inpatient stays were in Massachusetts (393.7), the District of Columbia (388.8), Rhode Island (377.4), and New York (360.5).

The next lowest rates of opioid-related inpatient stays above Iowa were in Nebraska (78.6), Wyoming (96.7), Texas (98.6), and Kansas (104.3).
Figure 3 illustrates the percent change in the population rate of opioid-related inpatient stays from 2009 to 2014 among 43 States with data available in both years. States are ordered according to the percent change in their rate of opioid-related stays over the 6-year time period.

**Figure 3. Cumulative percent change in the rate of opioid-related inpatient stays by State, 2009–2014**

- Georgia: 99.8
- North Carolina: 70.9
- Oregon: 60.2
- Washington: 60.1
- South Dakota: 59.6
- Pennsylvania: 58.9
- Rhode Island: 54.6
- Ohio: 52.0
- Utah: 51.0
- West Virginia: 49.4
- Vermont: 47.4
- Tennessee: 42.6
- Massachusetts: 41.8
- Arizona: 39.9
- Florida: 39.3
- Virginia: 38.3
- Colorado: 36.1
- Missouri: 34.4
- Indiana: 32.2
- South Carolina: 31.7
- California: 30.0
- Connecticut: 28.5
- Hawaii: 27.8
- Nevada: 26.3
- New Mexico: 25.1
- Montana: 24.5
- Kentucky: 24.2
- Arkansas: 23.8
- Michigan: 21.4
- Minnesota: 20.7
- Wisconsin: 19.1
- Oklahoma: 17.2
- Wyoming: 16.8
- Texas: 15.6
- New Jersey: 14.2
- Iowa: 11.5
- Nebraska: 8.0
- New York: 2.9
- Maine: 2.7
- Louisiana: -2.7
- Illinois: -5.5
- Maryland: -9.7
- Kansas: -18.0

Note: Percent change could not be calculated for North Dakota or the District of Columbia because data were not available in 2009.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats, Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP National (Nationwide) Inpatient Sample (NIS) and the HCUP State Inpatient Databases (SID)
Most States had an increase in the rate of opioid-related inpatient stays between 2009 and 2014, with Georgia having the largest increase at 99.8 percent.

The vast majority of States (36 of 43 States) had an increase of at least 10 percent in the population-based rate of opioid-related inpatient stays between 2009 and 2014. The largest increases occurred in Georgia (99.8 percent increase), North Carolina (70.9 percent increase), Oregon (60.2 percent increase), Washington (60.1 percent increase), and South Dakota (59.6 percent increase).

Six States had a relatively stable rate of opioid-related inpatient stays, with a 6-year change in rate (increase or decrease) of less than 10 percent: Nebraska, New York, Maine, Louisiana, Illinois, and Maryland. In 2014, New York, Illinois, and Maryland were among the top 10 States in rate of opioid-related inpatient stays, as shown in Figure 2.

Only one State, Kansas, showed a substantial decrease in the rate of opioid-related hospital inpatient stays (18.0 percent decrease). In 2014, Kansas was among the States with the lowest rate of opioid-related inpatient stays (104.3 stays per 100,000 population, as shown in Figure 2).
State rates of opioid-related ED visits, 2014

Figure 4 presents the rate per 100,000 population of opioid-related ED visits among 30 States that provided data in 2014. States are ordered according to their rate of opioid-related ED visits.

**Figure 4. Rate of opioid-related emergency department visits by State, 2014**

<table>
<thead>
<tr>
<th>State</th>
<th>Rate of Opioid-Related ED Visits (per 100,000 Population)</th>
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<tbody>
<tr>
<td>Massachusetts</td>
<td>450.2</td>
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<tr>
<td>Maryland</td>
<td>300.7</td>
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<tr>
<td>Rhode Island</td>
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<td>New Jersey</td>
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<td>New York</td>
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<td>North Carolina</td>
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<tr>
<td>Missouri</td>
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<td>Iowa</td>
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</tr>
</tbody>
</table>

Abbreviation: ED, emergency department

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats. Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP Nationwide Emergency Department Sample (NEDS) and the HCUP State Emergency Department Databases (SEDD)

- The rate of opioid-related ED visits varied 10-fold across 30 States in 2014.

In 2014, the highest rate of opioid-related ED visits was in Massachusetts (450.2 visits per 100,000 population), which was approximately 10 times higher than the lowest rate in Iowa (45.1). Following Massachusetts, the next highest rates of opioid-related ED visits were in Maryland (300.7), Rhode Island (298.3), Ohio (287.9), and Connecticut (254.6).
The next lowest rates above Iowa were in Nebraska (52.8), South Dakota (63.1), Arkansas (71.6), and Kansas (81.8).

States with the highest opioid-related rate for inpatient stays also tended to have the highest opioid-related rate for ED visits: there was a strong, positive correlation (0.85) between States’ opioid-related population rates for inpatient stays and ED visits.

Figure 5 illustrates the percent change in the population rate of opioid-related ED visits from 2009 to 2014 among 27 States with data available in both years. States are ordered according to the percent change in their rate of opioid-related ED visits over the 6-year time period.

**Figure 5. Cumulative percent change in the rate of opioid-related emergency department visits by State, 2009–2014**

abbreviation: ED, emergency department

notes: Percent change could not be calculated for three States (Arkansas, Nevada, North Dakota) because rates were not available in 2009.

source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), HCUP Fast Stats. Opioid-Related Hospital Use (http://www.hcup-us.ahrq.gov/faststats/landing.jsp) based on the HCUP Nationwide Emergency Department Sample (NEDS) and the HCUP State Emergency Department Databases (SEDD)
Almost all States had an increase in the rate of opioid-related ED visits between 2009 and 2014, with Ohio having the largest increase at 106.4 percent.

Almost all States (26 of 27 States) had an increase of at least 10 percent in the population rate of opioid-related ED visits between 2009 and 2014. The highest rate increases occurred in Ohio (106.4 percent increase), South Dakota (94.7 percent increase), and Georgia (85.2 percent increase).

Only one State, Iowa, showed a substantial decrease in the rate of opioid-related ED visits (15.6 percent decrease). Iowa also had the lowest rate of opioid-related ED visits (45.1 visits per 100,000 population, as shown in Figure 4).
Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) 2005–2014 National (Nationwide) Inpatient Sample (NIS), 2005–2014 Nationwide Emergency Department Sample (NEDS), 2009–2014 State Inpatient Databases (SID), and 2009–2014 State Emergency Department Databases (SEDD). The statistics were generated from HCUP Fast Stats, a free, online tool that provides users with easy access to the latest HCUP-based statistics for health information topics, including opioid-related hospital use.7


Emergency department (ED) statistics from HCUP Fast Stats were available for the following 30 individual States in 2009 and 2014: Arizona, Arkansas (2014 only), California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada (2014 only), New Jersey, New York, North Carolina, North Dakota (2014 only), Ohio, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, and Wisconsin.

Definitions

Diagnoses and ICD-9-CM

The principal diagnosis is that condition established after study to be chiefly responsible for the patient’s admission to the hospital. Secondary diagnoses are concomitant conditions that coexist at the time of admission or develop during the stay. All-listed diagnoses include the principal diagnosis plus these additional secondary conditions.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses. There are approximately 14,000 ICD-9-CM diagnosis codes.

Case definition

Opioid-related hospital use was identified using the following all-listed ICD-9-CM diagnosis codes:

- 304.00–304.02: Opioid type dependence (unspecified; continuous; episodic)
- 304.70–304.72: Combinations of opioid type drug with any other drug dependence (unspecified; continuous; episodic)
- 305.50–305.52: Opioid abuse (unspecified; continuous; episodic)
- 965.00–965.02; 965.09: Poisoning by opium (alkaloids), unspecified; heroin; methadone; other opiates and related narcotics
- 970.1: Poisoning by opiate antagonists
- E850.0–E850.2: Accidental poisoning by heroin; methadone; other opiates and related narcotics
- E935.0–E935.2: Heroin, methadone, other opiates and related narcotics causing adverse effects in therapeutic use
- E940.1: Opiate antagonists causing adverse effects in therapeutic use

It should be noted that ICD-9-CM diagnosis codes related to opioid dependence or abuse “in remission” were not used to identify opioid-related hospital use because remission does not indicate active use of opioids. Potential changes in the use of ICD-9-CM codes identifying opioid use cannot be isolated in these analyses.

Types of hospitals included in the HCUP National (Nationwide) Inpatient Sample
The National (Nationwide) Inpatient Sample (NIS) is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). The NIS includes obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Beginning in 2012, long-term acute care hospitals are also excluded. However, if a patient received long-term care, rehabilitation, or treatment for a psychiatric or chemical dependency condition in a community hospital, the discharge record for that stay will be included in the NIS.

Types of hospitals included in the HCUP Nationwide Emergency Department Sample
The Nationwide Emergency Department Sample (NEDS) is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). The NEDS includes specialty, pediatric, public, and academic medical hospitals. Excluded are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Hospitals included in the NEDS have hospital-owned emergency departments (EDs) and no more than 90 percent of their ED visits resulting in admission.

Types of hospitals included in HCUP State Inpatient Databases
This analysis used State Inpatient Databases (SID) limited to data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). Community hospitals include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded for this analysis are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. However, if a patient received long-term care, rehabilitation, or treatment for a psychiatric or chemical dependency condition in a community hospital, the discharge record for that stay was included in the analysis.

Types of hospitals included in HCUP State Emergency Department Databases
This analysis used State Emergency Department Databases (SEDD) limited to data from community hospitals with a hospital-owned emergency department. Community hospitals are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). Community hospitals include specialty, pediatric, public, and academic medical hospitals. Excluded for this analysis are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals.

Unit of analysis
The unit of analysis for inpatient data is the hospital discharge (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in 1 year will be counted each time as a separate discharge from the hospital. Inpatient stays include those admitted through the emergency department (ED).

The unit of analysis for ED data is the ED visit, not a person or patient. This means that a person who is seen in the ED multiple times in 1 year will be counted each time as a separate visit in the ED. ED visits exclude those for patients admitted to the hospital, including patients transferred to other hospitals.

Average annual percent change
Average annual percent change (i.e., growth rate) was calculated using the following formula:

\[
\text{Average annual percent change} = \left( \frac{\text{End value}}{\text{Beginning value}} \right)^{\frac{1}{\text{change in years}}} - 1 \times 100
\]

About HCUP
The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, and
private data organizations (HCUP Partners) and the Federal government to create a national information resource of encounter-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

- **Alaska** State Hospital and Nursing Home Association
- **Arizona** Department of Health Services
- **Arkansas** Department of Health
- **California** Office of Statewide Health Planning and Development
- **Colorado** Hospital Association
- **Connecticut** Hospital Association
- **District of Columbia** Hospital Association
- **Florida** Agency for Health Care Administration
- **Georgia** Hospital Association
- **Hawaii** Health Information Corporation
- **Illinois** Department of Public Health
- **Indiana** Hospital Association
- **Iowa** Hospital Association
- **Kansas** Hospital Association
- **Kentucky** Cabinet for Health and Family Services
- **Louisiana** Department of Health and Hospitals
- **Maine** Health Data Organization
- **Maryland** Health Services Cost Review Commission
- **Massachusetts** Center for Health Information and Analysis
- **Michigan** Health & Hospital Association
- **Minnesota** Hospital Association
- **Mississippi** Department of Health
- **Missouri** Hospital Industry Data Institute
- **Montana** MHA - An Association of Montana Health Care Providers
- **Nebraska** Hospital Association
- **Nevada** Department of Health and Human Services
- **New Hampshire** Department of Health & Human Services
- **New Jersey** Department of Health
- **New Mexico** Department of Health
- **New York** State Department of Health
- **North Carolina** Department of Health and Human Services
- **North Dakota** (data provided by the Minnesota Hospital Association)
- **Ohio** Hospital Association
- **Oklahoma** State Department of Health
- **Oregon** Association of Hospitals and Health Systems
- **Oregon** Office of Health Analytics
- **Pennsylvania** Health Care Cost Containment Council
- **Rhode Island** Department of Health
- **South Carolina** Revenue and Fiscal Affairs Office
- **South Dakota** Association of Healthcare Organizations
- **Tennessee** Hospital Association
- **Texas** Department of State Health Services
- **Utah** Department of Health
- **Vermont** Association of Hospitals and Health Systems
- **Virginia** Health Information
- **Washington** State Department of Health
- **West Virginia** Health Care Authority
- **Wisconsin** Department of Health Services
Wyoming Hospital Association

About Statistical Briefs

HCUP Statistical Briefs are descriptive summary reports presenting statistics on hospital inpatient, ambulatory surgery, and emergency department use and costs, quality of care, access to care, medical conditions, procedures, patient populations, and other topics. The reports use HCUP administrative health care data.

About the NIS

The HCUP National (Nationwide) Inpatient Sample (NIS) is a nationwide database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, nonrehabilitation hospitals). The NIS includes all payers. It is drawn from a sampling frame that contains hospitals comprising more than 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use. Over time, the sampling frame for the NIS has changed; thus, the number of States contributing to the NIS varies from year to year. The NIS is intended for national estimates only; no State-level estimates can be produced.

The 2012 NIS was redesigned to optimize national estimates. The redesign incorporates two critical changes:

- Revisions to the sample design—starting with 2012, the NIS is now a sample of discharge records from all HCUP-participating hospitals, rather than a sample of hospitals from which all discharges were retained (as is the case for NIS years before 2012).
- Revisions to how hospitals are defined—the NIS now uses the definition of hospitals and discharges supplied by the statewide data organizations that contribute to HCUP, rather than the definitions used by the American Hospital Association (AHA) Annual Survey of Hospitals.

The new sampling strategy is expected to result in more precise estimates than those that resulted from the previous NIS design by reducing sampling error: for many estimates, confidence intervals under the new design are about half the length of confidence intervals under the previous design. The change in sample design for 2012 makes it necessary to recalculate prior years’ NIS data to enable analyses of trends that use the same definitions of discharges and hospitals.

About the NEDS

The HCUP Nationwide Emergency Department Database (NEDS) is a unique and powerful database that yields national estimates of emergency department (ED) visits. The NEDS was constructed using records from both the HCUP State Emergency Department Databases (SEDD) and the State Inpatient Databases (SID). The SEDD capture information on ED visits that do not result in an admission (i.e., treat-and-release visits and transfers to another hospital); the SID contain information on patients initially seen in the emergency department and then admitted to the same hospital. The NEDS was created to enable analyses of ED utilization patterns and support public health professionals, administrators, policymakers, and clinicians in their decisionmaking regarding this critical source of care. The NEDS is produced annually beginning in 2006. Over time, the sampling frame for the NEDS has changed; thus, the number of States contributing to the NEDS varies from year to year. The NEDS is intended for national estimates only; no State-level estimates can be produced.

About the SID

The HCUP State Inpatient Databases (SID) are hospital inpatient databases from data organizations participating in HCUP. The SID contain the universe of the inpatient discharge abstracts in the participating HCUP States, translated into a uniform format to facilitate multistate comparisons and analyses. Together, the SID encompass more than 95 percent of all U.S. community hospital discharges. The SID can be used to investigate questions unique to one State, to compare data from two or more
States, to conduct market-area variation analyses, and to identify State-specific trends in inpatient care utilization, access, charges, and outcomes.

About the SEDD

The HCUP State Emergency Department Databases (SEDD) include information from hospital-owned emergency departments (EDs) from data organizations participating in HCUP, translated into a uniform format to facilitate multistate comparisons and analyses. The SEDD capture information on ED visits that do not result in an admission to the same hospital (i.e., patients who are treated in the ED and then discharged, transferred to another hospital, left against medical advice, or died). The SEDD contain a core set of clinical and nonclinical information on all patients, including individuals covered by Medicare, Medicaid, or private insurance, as well as those who are uninsured. The SEDD can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market-area variation analyses, and to identify State-specific trends in injury surveillance, emerging infections, and other conditions treated in the ED.

About HCUP Fast Stats

HCUP Fast Stats is an interactive, online tool that provides easy access to HCUP-based statistics for select State and national health information topics. HCUP Fast Stats uses side-by-side comparisons of visual statistical displays, trend figures, or simple tables to convey complex information at a glance. Topics currently available in HCUP Fast Stats include the Effect of Health Insurance Expansion on Hospital Use by State; National Hospital Utilization and Costs; and Opioid-Related Hospital Use, National and State. HCUP Fast Stats presents statistics using data from HCUP’s National (Nationwide) Inpatient Sample (NIS), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For other information on mental health and substance abuse, including opioids, refer to the HCUP Statistical Briefs located at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb_mhsa.jsp.

For additional HCUP statistics, visit:

- HCUP Fast Stats at http://www.hcup-us.ahrq.gov/faststats/landing.jsp for easy access to the latest HCUP-based statistics for health information topics
- HCUPnet, HCUP’s interactive query system, at http://hcupnet.ahrq.gov/

For more information about HCUP, visit http://www.hcup-us.ahrq.gov/.

For a detailed description of HCUP and more information on the design of the National (Nationwide) Inpatient Sample, Nationwide Emergency Department Sample (NEDS), State Inpatient Databases (SID), or State Emergency Department Databases (SEDD), please refer to the following database documentation:


Suggested Citation


Acknowledgments

The authors would like to acknowledge the contributions of Brian Eppert of Coding Leap, LLC, and Minya Sheng of Truven Health Analytics.

* * *

AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

David Knutson, Director
Center for Delivery, Organization, and Markets
Agency for Healthcare Research and Quality
5600 Fishers Lane
Rockville, MD 20857

This Statistical Brief was posted online on December 15, 2016.
The revised version of this Statistical Brief was posted online on January 26, 2017.
Critical Care Definition for 2015

From the Board Minutes of 7/17/2014

Mr. Guiton moved the following: In response to the letter from the MAA the EMSRB offers the following motion: Specialty Care Transport (SCT) According to CMS (Center for Medicare and Medicaid Services,) to be eligible to provide Specialty Care Transport, the paramedic of the Minnesota licensed ambulance service shall be certified as an EMT-Paramedic, and have completed education beyond the training of the EMT-Paramedic. The Minnesota EMSRB recognizes that the Ambulance Medical Director under Minnesota Statutes 144E.265, subdivision 2, will approve the additional education and training necessary in furnishing higher level medical services required by critically ill or critically injured patients. Ms. Deschaine seconded. Motion carried.
144E.28 CERTIFICATION OF EMT, AEMT, AND PARAMEDIC.

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.
Courses in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support
A Fifty-State Survey

Introduction:
Minnesota Statutes section 144E.28, subd. 7 requires that EMTs and AEMTs renewing their certification must complete a course in cardiopulmonary resuscitation approved by the EMSRB or the ambulance service’s medical director. That same statute requires that Paramedics renewing their certification must complete a course in advanced cardiac life support approved by the EMSRB or the ambulance service’s medical director. The EMSRB, however, cannot find any documentation identifying any such courses ever approved by the Board. Accordingly, the Board instructed staff to prepare a fifty-state survey of courses approved in cardiopulmonary resuscitation and advanced cardiac life support to be presented to MDSAC for consideration and discussion with the goal of a recommendation to the Board.

Information Gathering Process:
All fifty (50) States and three (3) Territories were surveyed on their requirements related to approved CPR or ACLS courses.

Information Gathering Summary:
• Fifteen (15) States (including Minnesota) do not have any approved CPR or ACLS course/organizations
• Twenty six (26) States approve specific CPR or ACLS courses/organizations
• Fifteen (15) States have equivalency/guidelines required for CPR or ACLS courses to be accepted for certification or renewal of EMS personnel certification. Figure 1

<table>
<thead>
<tr>
<th>No Courses Approved</th>
<th>Identify Approved Courses</th>
<th>Equivalency/Guidelines To Be Followed</th>
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<tbody>
<tr>
<td>Delaware</td>
<td>Alaska</td>
<td>Alabama</td>
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<tr>
<td>Iowa</td>
<td>Alaska</td>
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<td>Vermont</td>
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<td>South Dakota</td>
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<td>Guam</td>
<td>Nevada</td>
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<td>Wyoming</td>
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<td>US Virgin Islands</td>
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</tbody>
</table>

15 23 15
Of the 23 States with Approved CPR and ACLS Courses, the following course types were most common: Figure 2

<table>
<thead>
<tr>
<th>CPR Programs</th>
<th>ACLS Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association (AHA)</td>
<td>American Heart Association (AHA)</td>
</tr>
<tr>
<td>American Red Cross (ARC)</td>
<td>American Safety and Health Institute (ASHI)</td>
</tr>
<tr>
<td>American Academy of Orthoped Surgeons (AAOS)</td>
<td>Military Training Network (MTN)</td>
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<tr>
<td>American Safety and Health Institute (ASHI)</td>
<td></td>
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<tr>
<td>Emergency Care and Safety Institute (ECSI)</td>
<td></td>
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<tr>
<td>Military Training Network (MTN)</td>
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</tr>
<tr>
<td>National Safety Council</td>
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<tr>
<td>Pro CPR LLC (ProCPR.org)</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that some of the above-named organizations provide blended on-line and face-to-face instruction. Generally, States accepting the blended type courses had language indicating courses “can be taught via blended learning, but must have a face-to-face/in-person skills competency evaluation” documented and verified.

The 15 States having equivalency or guideline language generally referenced following: American Heart Association, American Red Cross or National Safety Council for Healthcare Providers and Professional Rescuers. Equivalency for ACLS was the American Heart Association. Additionally, States referenced following the ILCOR (International Liaison Committee on Resuscitation) standards and ECC (Emergency Cardiac Care) guidelines.

**Massachusetts Language:** “Successful completion of a course provided by a nationally recognized organization and reflecting current cardiopulmonary resuscitation (CPR) and emergency cardiac care resuscitation science and treatment recommendations issued by the International Liaison Committee on Resuscitation (ILCOR)’s International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations (CoSTR) or successor body, as documented by a current training certificate, renewed biennially, in Basic Cardiac Life Support health care professional CPR. CPR training must be obtained through an instructor-led program or blended learning experience with an in-person hands-on skills evaluation, and must include a cognitive examination.”

**National Registry of EMTs (NREMT):**
The National Registry of EMTs (NREMT) requires current CPR-BLS for Healthcare Providers or an equivalent credential. The NCCP (National Continued Competency Program) incorporates CPR and ACLS into the core instructional topics at the NCCR (National Continued Competency Requirements) levels for EMT, AEMT and Paramedic.

**Appendix A** of this report includes examples of documents obtained through the information-gathering process on organizations and course approvals by selected states.

The following pages in this summary report include additional detail and links to State language related to completion of CPR and ACLS courses for certification or recertification of EMS personnel certification/licensure.
**States at a Glance**

Please Click on the Link for Each State for Additional Information and Web-Links

**Alabama** – *(No State Approved Courses – CPR & ACLS Courses Must Follow ECC Guidelines)*

**Alaska** – *(Approve CPR Courses)*

**Arizona** – *(CPR and ACLS Mirrors the Process of American Heart Association)*

**Arkansas** – *(CPR must follow AHA Guidelines – ACLS must be AHA Card)*

**California** – *(No State Approved Courses – Recognize “Equivalent” Courses)*

**Colorado** – *(State Approved/Accepted CPR and ACLS)*

**Connecticut** – *(Recognized CPR Programs that Satisfy Requirements)*

**Delaware** – *(BLS Healthcare Provider Card and Paramedics must also have ACLS – EMR References AHA)*

**Florida** – *(CPR/ACLS Courses Deemed Equivalent to American Heart Association or American Red Cross Courses for EMTs and Paramedics)*

**Georgia** – *(Approved Courses Listed)*

**Hawaii** – *(No State Approved Courses Annual Certification in CPR; Paramedics must have ACLS or Equivalent)*

**Idaho** – *(No State Approved Courses)*

**Illinois** – *(No State Approved Courses - Health Care Provider - Cardiopulmonary Resuscitation)*

**Indiana** – *(Standards Read AHA or Equivalent just like the NREMT)*

**Iowa** – *(No State Approved Courses)*

**Kansas** – *(Presumptively Approve State Courses)*

**Kentucky** – *(Approves CPR and ACLS Courses)*

**Louisiana** – *(Approved State Courses)*

**Maine** – *(No State Approved Courses – References CPR - BLS Healthcare Provider/Professional Rescuer and Advanced Cardiac Life Support (ACLS))*

**Maryland** – *(Gone away from approving particular CPR and ACLS courses - 1. Courses must meet the current AHA Guidelines; 2. Can be taught via blended learning, but must have a face-to-face/in-person skills competency evaluation)*

**Massachusetts** – *(Regulatory Requirements a CPR or ACLS Course must meet to be Accepted/Approved)*

**Michigan** – *(Approves CPR Courses – No ACLS – Michigan Approved CPR Courses Document)*

**Minnesota** – *(No State Approved Courses)*

**Mississippi** – *(No Approved Courses – Follow NREMT Requirements at all Levels)*

**Missouri** – *(Approved State Courses - AHA or American Red Cross or National Safety Council Standards; Current ACLS Required)*

**Montana** – *(No Approved Courses – Follow NREMT Requirements)*

**Nebraska** – *(CPR Approval Criteria – Starting on Bottom of Page 30)*

**Nevada** – *(Requires EMS Providers have specific CPR and ACLS provider cards for certification and recertification)*
**New Hampshire** – *(No State Approved Courses)*

**New Jersey** – *(Approved State Courses CPR and ACLS)*

**New Mexico** – *(No longer requires specific CPR/ACLS Courses)*

**New York** – *(Courses must adhere to the current AHA ECC Guidelines as published for both CPR and ACLS)*

**North Carolina** – *(No State Approved Courses)*

**North Dakota** – *(No State Approved Courses)*

**Ohio** – *(Do Not Require Specific Courses)*

**Oklahoma** – *(Has Approved CPR and ACLS Courses)*

**Oregon** – *(Current AHA Healthcare Provider or equivalent; ACLS not Specified as a Requirement)*

**Pennsylvania** – *(Has Approved CPR and ACLS Courses)*

**Rhode Island** – *(Approves Specific Courses via Regulation)*

**South Carolina** – *(Does specify certain BLS and ACLS credentials for certification and recertification)*

**South Dakota** – *(No State Approved Courses – Requires specific skills must be verified for EMT level)*

**Tennessee** – *(No State Approved Courses – Reference CPR Healthcare Provider or Equivalent - Expired Paramedics must complete ACLS from AHA for Reinstatement)*

**Texas** – *(No State Approved Courses – Determined by Local Medical Director)*

**Utah** – *(Approved CPR Course – Requires ACLS to be Completed – No Specific Course Reference)*

**Vermont** – *(No State Approved Courses – Maintain Requirements with NREMT)*

**Virginia** – *(Do Approve CPR Courses - Approval process for ACLS type courses for CE purposes – Item 3)*

**Washington State** – *(No State Approved Courses for CPR or ACLS)*

**West Virginia** – *(Reference to AHA Requirements)*

**Wisconsin** – *(Approved CPR Courses)*

**Wyoming** – *(American Heart Association or Equivalent – CPR and ACLS)*

**Territories:**

**Guam** - *(No Approved Courses CPR or ACLS)*

**Northern Mariana Islands** – *(No Approved Courses)*

**US Virgin Islands** – *(Approved Courses CPR and ACLS)*
DETAILED INFORMATION BY STATE

Alabama:

- **CPR and ACLS**: Follow ECC (Emergency Cardiovascular Care) Guidelines

  No specific courses approved: Courses CPR and ACLS must follow ECC guidelines.

Alaska:

The following CPR training programs have been approved by the EMS Unit of the Section of Community Health and EMS based on the training program’s compliance with 7 AAC 26.985. A credential obtained through the successful completion of one of these programs can be applied towards initial certification or recertification as an EMT-I, EMT-II or EMT-III.

- **CPR**:
  - American Heart Association-BLS for Health Care Providers
  - American Red Cross-CPR for the Professional Rescuer
  - Medic First Aid-Advanced-CPR component
  - EMP America-Basic Life Support for Professionals (BLSPRO)
  - American Safety & Health Institute-CPR for the Professional Rescuer
  - Respond Systems-AED/CPR
  - AAOS Emergency Care and Safety Institute-Professional Rescuer CPR
  - ProTrainings--ProCPR or Pro First Aid Advanced
  - Emergency First Response-CPR & AED
  - Military Training Network-BLS
  - National Safety Council-Basic Life Support for Health Care & Professional Rescuers
  - EMS Safety-CPR/AED for Professional Rescuers

- **ACLS**:
  - ACLS is required criteria for Paramedic graduation

With the MICP license, Paramedic must keep up their ACLS certification.

Full List of approved CRP courses: [http://dhss.alaska.gov/dph/Emergency/Pages/ems/training/cme.aspx](http://dhss.alaska.gov/dph/Emergency/Pages/ems/training/cme.aspx)

Arizona:

- **CPR and ACLS**:
  - Current CPR and ACLS that mirrors the process of American Heart Association

The rule in Arizona states that a provider has to have current CPR and ACLS that mirrors the process of American Heart Association. This of course opened the door for Bob and Doug’s excellent CPR school. Most of those have been shut down because stakeholders would not accept the cards.

Arkansas:

- **CPR**:
  - American Heart Association (AHA) Guidelines for CPR

- **ACLS**:
  - American Heart Association (AHA) card/certification for ACLS

Arkansas rules state any nationally recognized CPR course that follows AHA guidelines and has a hands-on component. ACLS reads that it must be AHA ACLS card. [See the rules for Arkansas](http://dhss.alaska.gov/dph/Emergency/Pages/ems/training/cme.aspx). The licensure rules begin on Page 42.
California:
- CPR:
  - CPR training “equivalent” to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level
- ACLS:
  - No State ACLS requirements.

The State of California does not approve specific CPR or ACLS courses for EMS providers. It does, however, recognize “equivalent” courses. Here is the specific language from EMT, AEMT, and paramedic regulations as it pertains to eligibility for admission to one of these respective courses:

EMT eligibility for admission to an EMT course
A statement verifying CPR training equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course.

AEMT eligibility for admission to an AEMT course
Possess a current Basic Life Support (CPR) card according to the American Heart Association 2005 Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level.

Paramedic eligibility for admission to a paramedic course
Possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association’s Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level.

California does not have any specific requirements in regulation related to ACLS. Because California is divided into 33 local EMS systems, some of those local EMS systems may have a requirement for continuous CPR and in the case of paramedics, ACLS certification based on local policy.

Colorado:
- CPR:
  - American Heart Association (AHA)
  - American Red Cross (ARC)
  - American Safety & Health Institute (ASHI)
  - American Academy of Orthopedic Surgeons (AAOS)
  - American College of Emergency Physicians (ACEP)
  - Canadian Red Cross
  - Department of Defense Fire & EMS Certification (DoD)
  - Emergency Care and Safety Institute
  - Emergency University (The department does not accept on-line only courses. You must have an on-site instructor providing a hands-on skill evaluation.)
  - EMS Safety Services
  - National Safety Council
  - Military Training Network (MTN)
  - Pro Trainings (ProCPR.org)
- ACLS:
  - American Heart Association (AHA)
  - American Safety & Health Institute (ASHI)
  - American College of Emergency Physicians (ACEP)
  - Military Training Network (MTN)
Colorado does not regulate to the course level, however, it publishes a list of approved CPR and ACLS cards. Here is the link – Accepted CPR and ACLS cards

The rules that require CPR and ACLS course completion are found in our rules at 6 CCR 1015-3 Section 5.2.2 (C and D) for initial and Section 5.3.2 (B.2 and B.3) for renewals. Here is a link to the rules: EMS Rules

**Connecticut:**
- **CPR:**
  - American Heart Association
  - American Red Cross
  - American Safety and Health Institute
  - American Academy of Orthopedic Surgeons
  - National Safety Council

Documentation of CPR card is not required for renewal but certification such as CPR for Healthcare Providers in such nationally recognized programs as the AHA, ARC, ASHI, AAOS, NSC, etc. satisfy the requirement for BLS providers.
- **ACLS:** No State-Approved courses

**Delaware:**

Does not approve courses but the following are requirements:
- EMR - must maintain a current AHA (American Heart Association) CPR BLS for Healthcare certification
- EMT - BLS Healthcare Provider Card
- Practicing Paramedics - Basic Cardiac Life Support-Healthcare Provider; Advanced Cardiac Life Support

EMR must maintain a current AHA CPR BLS for Healthcare certification.
EMT must possess a current certification in CPR/AED at the Healthcare Provider level; BLS Healthcare Provider Card. Practicing Paramedics in Delaware must maintain the following certifications: Basic Cardiac Life Support-Healthcare Provider; Advanced Cardiac Life Support

EMR and EMT requirements:
- Paramedic Requirements: [http://www.dhss.delaware.gov/dph/ems/paramediceducation.html](http://www.dhss.delaware.gov/dph/ems/paramediceducation.html)

**Florida:**
- American Heart Association **CPR and ACLS**
- Red Cross for **CPR**
- **The following are equivalency course approved:**
  - American College of Emergency Physicians – CPR and ACLS
  - AAOS/ACEP Emergency Care & Safety Institute – CPR and ACLS
  - American Health and Safety Institute - 24/7 – CPR and ACLS
  - Emergency Medicine Learning and Resource Center – CPR and ACLS
  - EMS Safety Services – CPR
  - Kaplan Fire And EMS Training – CPR
  - ProTraining, LLC – CPR

Participants will complete the training and testing online at www.procpr.org or www.profirstaid.com. After successfully completing the training and passing the written test, the participant must complete a hands-on skill evaluation with a currently certified Skill Evaluator/Instructor from ProTrainings LLC. When the participant successfully passes the skill evaluation, the Skill Evaluator/Instructor signs or has his or her digital signature printed on the back of the card on the skill evaluator line. The Skill Evaluator/Instructor faxes the participant’s skill evaluation checklist to ProTrainings LLC. After successful completion the participant is issued a certification valid for 2 years.

By statute, Florida requires individuals maintain current CPR or ACLS for initial and renewal certification. By statute, it accepts AHA, ARC for CPR or ACLS courses deemed equivalent to CPR or ACLS courses conducted by the AHA or ARC. Our statutory authority for requiring CPR and ACLS can be found in Florida Statute, Section
401.27. Our rule for defining equivalency is Florida Administrative Code, Rule 64J-1.02. (attached). A listing of courses other than AHA and ARC Florida accepts is also attached.

**Georgia:**
- **CPR and ACLS Courses:**
  - **American Heart Association**
    - CPR: Basic Life Support (BLS) Health Care Provider or Instructor.
    - ACLS: Advanced Cardiac Life Support (ACLS) Provider or Instructor.
  - **American Red Cross**
    - CPR: CPR/AED for the Professional Rescuer and Health Care Providers or instructor.
  - **American College of Emergency Physicians**
    - ACLS: eACLS
  - **American Safety & Health Institute**
    - CPR: ASHI CPR Pro for the Professional Rescuer or Instructor.
    - ACLS: ASHI ACLS or Instructor.
  - **Emergency Care & Safety Institute**
    - CPR: ECSI Health Care Provider CPR or Instructor.
    - ACLS: ECSI eACLS or Instructor.

[http://dph.georgia.gov/ems-license-requirements](http://dph.georgia.gov/ems-license-requirements)

**Hawaii:**
- Follow NREMT Requirements – ACLS certification or training equivalent approved medical director of the training program.

§16-85-55 RECERTIFICATION REQUIREMENTS
(a) Certificate holders may comply with recertification requirements by having a current certificate from the National Registry of Emergency Medical Technicians (NREMT).
(b) Certificate holders who do not have a current certificate from the NREMT shall submit evidence of continuing education (CE) requirements that includes:

(1) For EMT-Basic:
   (A) State approved EMT refresher training – twenty-four hour minimum;
   (B) Annual cardiopulmonary resuscitation (CPR) certification; …

(2) For EMT-Paramedic:
   (A) Forty-eight hours of paramedic refresher training, which shall include advanced cardiac life support (ACLS) certification or training deemed to be equivalent to that required for ACLS certification by the medical director of the training program;
   (B) Annual CPR certification…


**Idaho:**
- **CPR and ACLS:** No State-Approved Courses
Illinois:

- **CPR:**
  - Equivalent Healthcare Provider (Must Include Didactic and Skill)
  
A copy of your current Health Care Provider cardiopulmonary resuscitation card (Must include didactic and skill).


Indiana:

- **CPR:**
  - American Heart Association or Equivalent

Indiana standards read AHA or equivalent just like the NREMT.

- **ACLS:** No State-Approved courses

Iowa:

- No State Approved courses for CPR and ACLS

Providers must have a current course completion card for cardiopulmonary resuscitation (CPR) that includes CPR, automated external defibrillation (AED) and obstructed airway procedures for all age groups.


Kansas:

- **CPR and ACLS** – Do Not Require for Certification or Recertification:
  
  - Continuing Education for CPR and ACLS CECBEMS/CAPCE Accredited Courses

In a generic sense as we do not require these as certification and recertification items. We do however require approval of continuing education which is done in a couple of different fashions, probably not an item of interest to you. But one method if you are would be those courses presumptively approved which are those courses accredited by CECBEMS/CAPCE. If memory serves me, AHA has acquired this and all of their instruction would be approved by Kansas standards in regulation. I have attached one of our regulations that deals with continuing education. [K.A.R. 109-5-1](http://idph.iowa.gov/Portals/1/userfiles/61/EMS%20PDFs%20and%20Zips/renewal_guidance.pdf)

Kentucky:

- **CPR:**
  
  - American Heart Association
  - American Red Cross
  - National Safety Council
  - American Safety & Health Institute
  - American Academy of Orthopedic Surgeons/ECSI-Emergency Care and Safety Institute
  - ProTrainings, LLC
  
  **ACLS:**
  
  - American Heart Association
  - American Safety & Health Institute


Each provider regulation has CPR listed in section 2:

**Louisiana:**

- **CPR:**
  - American Heart Association
  - American Red Cross
- **ACLS:**
  - American Heart Association
  - American Safety and Health Institute

According to Louisiana Department of Health regulations, all medical personnel working in an ambulance shall have either a current Health Care Provider or a Professional Rescuer CPR certification from the American Heart Association or the American Red Cross.

Source: [www.dhh.louisiana.gov/assets/medicaid/hss/docs/EMT_regs.doc](http://www.dhh.louisiana.gov/assets/medicaid/hss/docs/EMT_regs.doc)

**Maine:**

- **CPR Equivalency:** BLS Healthcare Provider/Professional Rescuer
- **ACLS Equivalency:** Nothing Named

According to the Standardized Continuing Education list: CPR - BLS Healthcare Provider/Professional Rescuer and Advanced Cardiac Life Support (ACLS)


**Maryland:**

- **CPR and ACLS Equivalency:**
  - American Heart Association Guidelines

The State of Maryland EMS/MIEMSS has gone away from approving particular CPR and ACLS courses. In order for a course to be accepted, it must:
1. Meet the current AHA Guidelines
2. Can be taught via blended learning, but must have a face-to-face/in-person skills competency evaluation

**Massachusetts:**

- **CPR Equivalency:**
  - American Heart Association
  - American Red Cross
  - Emergency Care and Safety Institute
  - National Safety Council
- **ACLS Equivalency:**
  - American Heart Association
  - American Safety and Health Institute

Massachusetts has no state-approved CPR and/or ACLS classes for certification. That said, it does have regulatory requirements for classes. The usual providers of a course (AHA, ARC, ECSI, NSC, etc.) meet the requirements.

Certification requirements for EMT Basic, specifically 105 MCR 170.810 (C)(1) - *Successful completion of a course provided by a nationally recognized organization and reflecting current cardiopulmonary resuscitation (CPR) and emergency cardiac care resuscitation science and treatment recommendations issued by the International Liaison Committee on Resuscitation (ILCOR)'s International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations (CoSTR) or successor body, as documented by a current training certificate, renewed biennially, in Basic Cardiac Life Support health care professional CPR. CPR training must be obtained through an instructor-led program or blended learning experience with an in-person training program.*
hands-on skills evaluation, and must include a cognitive examination. 

**Michigan:**
- **CPR:**
  - American Heart Association
  - American Red Cross
  - American Safety and Health Institute
  - American Academy of Orthopedic Surgeons/ECSI-Emergency Care and Safety Institute
  - ProTraining, Blended

Michigan does not require ACLS, but most MCAs (Medical Control Affiliates) do. [Michigan Approved CPR Courses](http://www.mass.gov/eohhs/docs/dph/regs/105cmr170.pdf) document.

**Minnesota:**
- **CPR and ACLS:** No State-Approved courses

**Mississippi:**
- **CPR and ACLS:** No State Approved courses

Valid CPR Certification (Health Care Provider) - Follow NREMT Requirements – Must maintain NREMT certification. Source: [http://msdh.ms.gov/msdhsite/_static/47,6490,307,368.html](http://msdh.ms.gov/msdhsite/_static/47,6490,307,368.html)

**Missouri:**
- **CPR:**
  - American Heart Association
  - American Red Cross
  - National Safety Council
- **ACLS:**
  - Confirmed by EMS Medical Director

CPR training must adhere to AHA, American Red Cross or National Safety Council Standards; Current ACLS required or ACLS knowledge and skills confirmed by EMS Medical Director.


**Montana:**
- **CPR and ACLS:** No State-Approved courses

Current NREMT certification or American Board of Pre-Hospital Care Board Certification or proof of state licensure that is NREMT equivalent


**Nebraska:**
- **CPR Equivalency Must Include:**
  - Two person adult resuscitation;
  - One person adult resuscitation;
  - Procedure for treating an adult with an obstructed airway;
  - One person child resuscitation;
  - Procedure for treating a child with an obstructed airway;
  - One person infant resuscitation;
  - Procedure for treating an infant with an obstructed airway;
- Using barrier devices; and
- Requiring a written and practical skills evaluation for each student.

**CPR Must be Taught by an Instructor For:**
- American Heart Association
- American Red Cross
- National Safety Council
- ACLS: No-State-Approved courses

Nebraska does not approve specific courses as names as content may change. Rather it lists the specific requirements that must be met in order for the course to be acceptable for licensing purposes. The following information is taken from statutes and regulations. All applicants/licensees must at least hold a basic cardiopulmonary certification, but can hold higher levels in order to fulfill the basic CPR certification requirements.

Neb. Rev. Stat. §38-1217 Rules and regulations. The board shall adopt rules and regulations necessary to: (9) Establish criteria for approval of organizations issuing cardiopulmonary resuscitation certification which shall include criteria for instructors, establishment of certification periods and minimum curricula, and other aspects of training and certification.

172 NAC 11-003.02(2) Documentation: The applicant must submit the following documentation with the application: (g) Documentation of a Board approved Cardiopulmonary Resuscitation Certification as specified in 172 NAC 13-017.

172 NAC 11-007 Continuing Competency Requirements: 11-007.01 (1a) (2a) (3a) (4a) (5a) All levels of licensure must hold a current CPR certification from an organization that has been approved by the Board.

172 NAC 11-007.03 The following types of activities will be accepted as continuing education for renewal of a license: (7) Basic cardiopulmonary resuscitation certification (Initial or recertification course).

172 NAC 13-017 Requirements For Approving Organizations Issuing A Cardiopulmonary Resuscitation Certification: Items 1-6 outline requirements for curriculum, instructors, certificates, expiration dates, and records to be eligible for approval by the Board.


**New Hampshire:**
- **CPR and ACLS:** No State-Approved courses

**New Jersey:**
- **CPR:**
  - American Heart Association
  - American Red Cross
  - National Safety Council
- **ACLS:**
  - American Heart Association

The following is a list of approved CPR vendors/classes that are recognized by the Department of Health and Senior Services which meet the requirements for CPR certification as defined in New Jersey Statutes Annotated (N.J.S.A.) 26:2K 39-47 and 52-62. "CPR certification" means valid certification in cardiopulmonary resuscitation to the level of the Professional Rescuer or Health Care Provider as issued by either the American Heart Association, the American Red Cross, the National Safety Council or other entity determined by the Department to comply
with AHA CPR Guidelines. ACLS required for Paramedic – “ACLS certification” or “certification in ACLS” means valid certification in Advanced Cardiac Life Support as issued by the American Heart Association.


**New Mexico:**

- **CPR:**
  - Documentation of Training
- **ACLS:**
  - Meets or exceeds the current national standard for advanced cardiac life support (ACLS) on emergency cardiac care (ECC)

New Mexico no longer requires specific CPR/ACLS courses. We require “documentation” of the training. Our rule states “present proof of current bureau approved training which meets or exceeds the current national standard for advanced cardiac life support (ACLS) on emergency cardiac care (ECC)”.

**New York:**

- **CPR and ACLS:**
  - Adhere to current AHA (American Heart Association) ECC Guidelines as published for both CPR and ACLS

We do not approve CPR courses to be conducted within a state EMS certification course. The requirement is for the student to receive and be evaluated on CPR in all courses, but we don’t require a structured “course” to be taught within the programs. They must adhere to the current AHA ECC Guidelines as published for both CPR and ACLS.

Our Bureau and State EMS Council are required to approve PAD (Public Administration Directed) courses, but they also must meet the current AHA ECC Guidelines.

The biggest issue we have had is that there are so many entities coming up with their own CPR and ACLS “courses”, that we don’t have the staffing to review all of them. Not like the good old days when you only had ARC and AHA.

**Nevada:**

- **CPR:**
  - American Heart Association
  - American Red Cross
  - Emergency Care and Safety Institute
  - Military Training Network – BLS for Healthcare Providers – Equivalent Accepted
- **ACLS:**
  - American Heart Association

Nevada requires EMS providers have specific provider cards for certification and recertification:

NAC 450B.355 states that any person who wishes to become certify, or renew their certification, at the Emergency Medical Responder level must have and maintain a certificate to provide cardiopulmonary resuscitation issued by the American Heart Association or equivalent as approved by the our office.

NAC 450B.360 states that any person who wishes to become certify, or renew their certification, at the Emergency Medical Technician, Advanced Emergency Medical Technician or Paramedic level must have an maintain a certificate to provide cardiopulmonary resuscitation by the American Heart Association or equivalent as approved by our office.
NAC 450B.360 also states that any person who wishes to become certified, or renew their certification, at the Paramedic level must also have:
- A certificate to provide Advanced Cardiac Life Support by the American Heart Association or equivalent as approved by our office.
- A certificate to provide Pediatric Advanced Life Support by the American Heart Association or equivalent as approved by our office.
- A certificate to provide International Trauma Life Support or equivalent as approved by our office.

For cardiopulmonary resuscitation - only the following courses are accepted:
- American Heart Association – BLS for Healthcare Providers – Primary Requested
- Military Training Network – BLS for Healthcare Providers – Equivalent Accepted
- American Red Cross – BLS for Healthcare Providers – Equivalent Accepted
- Emergency Care and Safety Institute – CPR Pro – Equivalent Accepted.

Although the law states “or equivalent as approved…” Nevada only accept American Heart Association for Advanced Cardiac Life Support and Pediatric Advanced Life Support.

As for International Trauma Life Support, our office only accepts ITLS Advanced Provider cards or Pre-Hospital Trauma Life Support (PHTLS) provider cards as equivalent.

**NAC 450B.355 Certification of emergency medical responders. (NRS 450B.120)**
1. To be certified as an emergency medical responder, an applicant must:
   (a) Be 16 years of age or older;
   (b) Have successfully completed the national standard for emergency medical responders developed by the National Highway Traffic Safety Administration of the United States Department of Transportation and approved by the Division;
   (c) Maintain a certificate to provide cardiopulmonary resuscitation issued by the American Heart Association or an equivalent certificate approved by the Division;
   (d) Submit a statement indicating he or she has complied with the provisions of NRS 450B.183; and
   (e) Submit the appropriate form and the fee prescribed in NAC 450B.700.
2. The applicant shall submit verification to the Division, signed by the person responsible for conducting the training, that the applicant has successfully completed the national standard specified in paragraph (b) of subsection 1.
3. Upon certification, an emergency medical responder may function within the scope of practice identified by the National Highway Traffic Safety Administration of the United States Department of Transportation in its publication designated “National EMS Scope of Practice Model” dated February 2007, which is hereby adopted by reference. A copy of the publication is available, free of charge, at the Internet address http://www.ems.gov/education/EMSScope.pdf.
4. An initial certificate as an emergency medical responder is valid for not more than 2 years as determined by the Division and expires on the date appearing on the face of the certificate. (Added to NAC by Bd. of Health, eff. 8-1-91; A by R045-97, 10-30-97; R182-01, 3-5-2002; R024-14, 10-24-2014)

**NAC 450B.360 Certification of emergency medical technicians, advanced emergency medical technicians and paramedics: Requirements. (NRS 450B.120, 450B.180)**
1. To be certified as an emergency medical technician, advanced emergency medical technician or paramedic, an applicant must:
   (a) Submit an application to the Division on a form prepared by it;
   (b) Maintain a certificate to provide cardiopulmonary resuscitation issued by the American Heart Association or an equivalent certificate approved by the Division;
   (c) Submit a statement indicating compliance with the provisions of NRS 450B.183; and
   (d) Submit the fee prescribed in NAC 450B.700.
2. An emergency medical technician, advanced emergency medical technician or paramedic who is registered by the National Registry of Emergency Medical Technicians, or its successor organization, shall be deemed to have satisfied the requirements of paragraph (b) of subsection 1.
3. In addition to the requirements of subsection 1, to be certified as a paramedic, the applicant must maintain:
(a) A certificate to provide Advanced Cardiovascular Life Support issued by the American Heart Association or an equivalent certificate approved by the Division;
(b) A certificate to provide Pediatric Advanced Life Support issued by the American Heart Association or an equivalent certificate approved by the Division; and
(c) A certificate to provide international trauma life support or an equivalent certificate approved by the Division.

[Bd. of Health, Ambulance Reg. §§ 14.001 & 14.002, eff. 12-3-73; A and renumbered as §§ 16.2 & 16.3, 2-28-80] — (NAC A 8-22-86; 11-12-87; 8-1-91; 11-1-95; R182-01, 3-5-2002; R024-14, 10-24-2014)

**North Carolina:**

- **CPR and ACLS:** No State-Approved courses

**North Dakota:**

- **CPR and ACLS:** Follow NREMT Requirements

We are currently working on revisions to our state rules and this is one of the issues at hand since NREMT no longer requires these things for recertification and we require NREMT for licensure. Previously, by default, we required it, now our language does not support that. We are not far enough along in approved draft language for me to feel comfortable sharing what will be new language as it changes every time someone new looks at it.

**Ohio:**

- **CPR and ACLS:** No State-Approved courses

We do not require specific courses, rather we say, for example, 12 hours of pediatric, 6 hours of cardiac, 8 hour of trauma etc. All of which can be accomplished by specific courses such as ACLS, ITLS etc. We do not specify agencies.

**Oklahoma:**

- **CPR:**
  - American Heart Association
  - American Red Cross
  - Green Cross
  - Gold Cross
- **ACLS:**
  - American Heart

d) The renewing Paramedic shall also submit: (1) verification that 24 hours of continuing education on topics within the EMT DOT instruction guidelines. No more than twelve (12) hours is permitted in any one topic area.

310:641-5-19. Renewal requirements for licensed emergency medical personnel

(2) current copy of a provider level of BLS CPR that meets or exceeds AHA standards, and
(3) Complete biennial certification requirements for Advanced Cardiac Life Support (ACLS), in accordance with the American Heart Association. If a structured ACLS course is not available, the medical control may affirm, in writing, that ACLS skills and knowledge has been demonstrated;

**Oregon:**

- **CPR and ACLS:**
  - American Heart Association "Health Care Provider or Equivalent"
Pennsylvania:

- **CPR:**
  - American Academy of Orthopedic Surgeons – Emergency Care & Safety Institute
  - American Heart Association
  - American Red Cross
  - American Safety & Health Institute
  - EMS Safety Services, Inc.
  - Military Training Network Resuscitative Medicine and Trauma Program
  - National Safety Council
  - Pro CPR LLC

- **ACLS:**
  - All ACLS courses accepted thru the continuing education credits application process.

All levels of Pennsylvania EMS Provider Certification specified within the EMS Act and the associated Rules & Regulations indicate: “Has a current certificate evidencing successful completion of a CPR course acceptable to the Department.” The list of approved CPR Programs is noted below and will be being updated again shortly. All of the courses must cover procedures for infant, child, and adult airway maneuvers, CPR, and use of an AED.

Advanced Cardiac Life Support Courses:

- Physicians (MD or DO) are required by the EMS Act to have “… successfully completed programs approved by the Department in Advanced Cardiac Life Support…” in order to become certified as a Prehospital EMS Physician. All ACLS courses have been accepted thru the continuing education application process for continuing education credits. All of the aforementioned information may be located on our website at: [www.health.pa.gov](http://www.health.pa.gov)

- My Health
- Emergency Medical Services
- EMS Regulations • Act 37 of 2009 as amended (PDF) • 8113. Emergency medical services providers
- 8120. Prehospital emergency medical services physicians

Rhode Island:

- **CPR and ACLS Equivalency:**
  - BLS CPR/ACLS that meet current ILCOR (International Liaison Committee on Resuscitation)

Rhode Island approves specific courses via regulation and accepts BLS/ACLS that meet current ILCOR (International Liaison Committee on Resuscitation) standards.

South Carolina:

- **CPR and ACLS:**
  - American Heart Association
  - American Red Cross
  - American Health and Safety Institute
  - Military Network
  - Emergency Care Safety Institute

South Carolina does specify certain BLS and ACLS credentials for certification and recertification. State Regulation states that applicants for certification and recertification must submit, "other credential(s) as required by the Department (state-approved CPR credential and/or Advanced Cardiac Life Support (ACLS) credential ([Regulation 61-70 Section 900](http://www.health.pa.gov) page 34). Continuing Education Program policies and EMT Training program specify healthcare professional level AHA (American Heart Association), ASHI (American Safety & Health Institute), or American Red Cross with an instructor led skills portion. Any other credential is approved on a case by case basis. We accept
the Military Network card and an ECSI (Emergency Care Safety Institute) card (the ECSI is one specific type of program they offer that allows for an instructor led skills examination and is taught by a local training program similar to AHA). We do not accept any online only course.

**South Dakota:**

- **CPR Criteria Equivalency:**
  - Adult 1 and 2 rescuer CPR
  - Adult obstructed airway
  - Child 1 and 2 rescuer CPR
  - Child obstructed airway
  - Infant CPR
  - Infant obstructed airway.

CPR verification is required of every state certified EMT. The applicant is required to tape a photocopy of the front and back of their current CPR wallet card in the boxes provided or have the instructor sign, date, and write the expiration date of the current CPR certification on the lines provided. CPR verification must include all of the following skills: Adult 1 and 2 rescuer CPR, Adult obstructed airway, Child 1 and 2 rescuer CPR, Child obstructed airway, Infant CPR, and Infant obstructed airway.


**Tennessee:**

- **CPR Equivalency:**
  - Healthcare Provider or Equivalent

- **ACLS Equivalency:**
  - American Heart Association Guidelines

Current Cardiopulmonary Resuscitation Healthcare Provider or equivalent. Paramedic expired personnel must submit a current Advanced Cardiac Life Support (ACLS) provider or instructor certification from the American Heart Association. Course must meet AHA guidelines. [https://www.tn.gov/health/article/ems-licensure#sthash.6StMYgC0.dpuf](https://www.tn.gov/health/article/ems-licensure#sthash.6StMYgC0.dpuf)

**Texas:**

- **CPR and ACLS:**
  - Local Medical Direction

No State Approved Courses – It goes back to the local medical director.

**Utah:**

- **CPR and ACLS Equivalency:**
  - American Heart Association Guidelines

This is the verbiage in our Re-licensure protocol manual for CPR, PALS and ACLS: [https://bemsp.utah.gov/ems-personnel-licensure/](https://bemsp.utah.gov/ems-personnel-licensure/)

EMT Requirements: Provide documentation of completion of 98 hours of BEMSP-approved CME. Eight (8) of these hours must be Health Care Professional BLS CPR certification or equivalent training that meets the most current AHA guideline as approved by the department.

AEMT Requirements: Maintain and submit documentation of completing the following courses:
a. A CPR course within the past two years that is consistent with the most current version of the American Heart Association Guidelines for Health Care Professional BLS CPR and ECC. CPR must be kept current during certification period.
b. Pediatric Education for Prehospital Professionals (PEPP), Pediatric Advanced Life Support (PALS), Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) or equivalent that is consistent with the most current version of the American Heart Association Guidelines.

Paramedic Requirements: Submit verification of completion of a BEMSP-approved course in CPR, adult and pediatric advanced cardiac life support, and maintain current status as set by the entity sponsoring the course. CPR, ACLS, and PALS or their equivalent must be current during certification.

**Vermont:**
- CPR and ACLS: Follow NREMT requirements/guidelines.

Vermont has no state approved courses. We require NREMT certification (with a few exceptions) so our providers must keep a CPR certification in line with NREMT requirements.

**Virginia:**
- CPR:
  - American Heart Association
  - American Red Cross
  - American Safety and Health Institute
  - EMS Safety Services, Inc.
  - Military Training Network
  - National Safety Council
  - ProCPR
  - ACLS:
    - American Heart Association (Continuing Education)

We do approve CPR and it is required for certification. See links below:
http://www.vdh.virginia.gov/emergency-medical-services/cpr-requirements/
See pages: 96 of 197
See page: 125 of 197 (12VAC5-31-1417
See page: 140 of 197 (12VAC5-31-1503 item 4)

We do not require ACLS or an equivalent for initial or recertification. We do have an approval process for ACLS type courses for CE purposes.
http://www.vdh.virginia.gov/emergency-medical-services/policy-section-1/ see item T-010 (this is a policy as opposed to a regulation as listed above.)

**Washington State:**
- CPR and ACLS: No State-Approved courses

**West Virginia:**
- CPR Equivalency:
  - American Heart Association
- ACLS Equivalency:
  - American Heart Association
  - Military Training Network
CPR meeting WV §64 CSR 48-6.8.a.4. Reference Made to AHA (American Heart Association) in WVOEMS Education Policy. Source: http://www.wvoems.org/ems-programs/policies-and-memos

**Wisconsin:**

- **CPR:**
  - American Heart Association
  - American Red Cross
  - American Safety and Health Institute (includes Medic First Aid)
  - Emergency Care and Safety Institute - (AAOS)
  - Emergency University - (CPR Pro Course)
  - EMS Safety Services
  - National Safety Council
  - ProTrainings, LLC
  - T-E-A-M CPR and AED
  - ACLS
  - American Heart Association

Here is the link to the Wisconsin EMS website where the CPR information is located: https://www.dhs.wisconsin.gov/ems/licensing/cpr.htm

Regulatory information are found in our Administrative Rule DHS 110.17 as shown below:

DHS 110.17  CPR and AED training and instruction.

1. Organizations approved for CPR training. All of the following organizations are approved by the department to provide CPR training:
   - (a) American Heart Association.
   - (b) American Red Cross
   - (c) American Safety and Health Institute.
   - (d) American Academy of Orthopedic Surgeons.
   - (e) Medic First Aid.
   - (f) EMS Safety Services.
   - (g) Any other organization identified and approved by the department.

2. Training content and frequency.
   - (a) Any person who provides CPR and AED instruction to an EMT or first responder shall successfully complete any one of the following courses with a certification period not to exceed 2 years:
     2. American Red Cross-CPR for the Professional Rescuer course.
     3. American Safety and Health Institute — CPR Pro-Professional Level CPR and AED course.
     5. Medic First Aid-Basic Life Support for Professionals course.
     6. EMS Safety Services-Professional Rescuer.
     7. Any other course identified and approved by the department.
   - (b) All of the training courses specified under par. (a) shall be taught by an instructor who is affiliated with, employed by, or under contract with an organization specified under sub. (1), and shall include instruction in all of the following:
     1. How to recognize life-threatening cardiac emergencies.
     2. How to perform adult, child and infant CPR at the professional level, including the performance of CPR by one person and by 2 persons, and the use of medical devices to help an individual breathe.
     3. How to use an automated external defibrillator on persons of any appropriate age.
     4. How to clear the airway of a conscious or unconscious person who is choking.

3. Instructor qualifications.
(a) An individual who provides CPR or AED instruction to an EMT, first responder, or a person who is required as a condition of licensure, certification, or registration to have current proficiency in the use of an AED, shall meet all of the qualifications, including qualifications for frequency of training, that are specified by the approved provider with whom the instructor is affiliated, employed or under contract.
(b) An instructor certification in CPR or AED that is issued to an individual by an approved provider may not be valid for more than 2 years from the date the certification is issued.

Training center initial and renewal certification requirements.
(1) Authorized actions and qualifications. No person may provide training that is represented as qualifying an individual for first responder certification or EMT licensure or renewal unless the person is certified by the department as a training center.
(2) Application requirements. An applicant for training center certification shall submit a fully and accurately completed application obtained from the department, which shall include all of the following:
   (a) Documentation of the community need, showing that there are not adequate resources for EMS training available through any current training center in the area.
   (b) A description of the organization's capabilities to train students in the provision of emergency medical care in pre-hospital, interfacility and hospital settings.
   (c) A copy of the résumé and Wisconsin physician license of the training center's medical director.
   (d) A copy of the résumé of the training center's program director.
   (dm) A copy of the résumé of the center's EMS instructor II.
   (e) A copy of the position description for the EMS instructor II, which shall specify the responsibilities of the EMS instructor II.
   (f) An explanation of how the training center will evaluate the training program and the instructors and a statement of how often the evaluations will occur.
   (g) A completed training center application including the requested check list items contained within the application.
   (h) Proof of national EMS education program accreditation if applying for a training center certification to train paramedics.
   (i) Any other information requested by the department.

Note: Training center applications are submitted by the applicant to the department electronically through the department's E-Licensing system available at www.dhs.wisconsin.gov/ems. Completed applications are processed electronically through this system. For further information contact the Emergency Medical Services Section, 1 W. Wilson St., P.O. Box 2659, Madison, WI 53701-2659.

(3) Renewal requirements. A training center shall renew its certification by every June 30 of the even year of the biennium by submitting to the department an updated application and materials required under sub. (2). If a training center does not timely renew its certification, its certification expires and any training provided before the training center has renewed its certification will not count toward qualifying a student for department certification or licensure.

**Wyoming:**
- **CPR:**
  - American Heart Association
  - American Red Cross
  - American Safety and Health Institute
  - American Academy of Orthopedic Surgeons / American College of Emergency Physicians
  - Department of Defense Fire and EMS Certification
  - National Safety Council
  - Military Training Network
  - ProTraining, LLC
- **ACLS:**
  - American Heart Association
  - American College of Emergency Physicians
Military Training Network

Wyoming Rules Chapter 5 Section 3 (ix) & (x).

(ix) Proof of current certification in American Heart Association BLS
(Basic Life Support) for Healthcare Providers or equivalent; and

(x) Proof of current certification in American Heart Association
Advanced Cardiac Life Support if the applicant is applying for licensure at the IEMT or Paramedic level.

Territories:

Guam:
- CPR and ACLS: No Approved course
Provide a valid and current CPR (BLS or ACLS) certification

Northern Mariana Islands:
- CPR and ACLS: No Approved course

US Virgin Islands:
- CPR:
  - American Heart Association
- ACLS:
  - American Heart Association

Proof of current certification in cardiopulmonary Resuscitation /Basic Cardiac Life Support, according to current American Heart Association standards. Licensed EMT-C and Paramedics must maintain current Advanced Cardiac Life Support certification according to American Heart Association standards.)
Appendix A
BLS/CPR and ACLS Education Organizations Approved for EMS Provider Certification and Recertification

The Colorado EMTS Professional Standards section has reviewed and evaluated BLS/CPR and ACLS organizations and courses to ensure that they satisfy the requirements as stated in Colorado Board of Health Rules 6-CCR-1015-3, Chapter 1- EMS Rules. The approved BLS/CPR and ACLS organizations and courses are listed below.

NOTE: The department does not accept online only courses or courses that offer any type of remote skills evaluation. You must have an on-site instructor providing a hands-on skill evaluation.

- For more information regarding on-line only courses, visit http://news.hsi.com/onlineonlycpr

**ALL** EMS candidates seeking initial state certification or renewal of an existing state certification must submit evidence of completion of a current and valid professional healthcare provider-level **Basic Cardiac Life Support (BLS CPR)** from a national or local organization that has been reviewed and approved by the department.

In addition, EMT-Intermediate and paramedic candidates seeking initial state certification or renewal of an existing state certification must submit evidence of completion of a current and valid **Advanced Cardiac Life Support (ACLS)** course from a national or local organization that has been reviewed and approved by the department.
Approved BLS\CPR Courses

The following list of BLS CPR organizations and courses are currently recognized by the department. It is the responsibility of the individual provider to submit satisfactory evidence that organizations and courses not on this list should be recognized.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Courses Approved by the Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association (AHA)</td>
<td>▪ BLS for Healthcare Providers (BLS eCard also accepted)</td>
</tr>
<tr>
<td></td>
<td>▪ BLS for Healthcare Providers Renewal, including Resuscitation Quality Improvement (RQI)</td>
</tr>
<tr>
<td></td>
<td>▪ BLS Instructor</td>
</tr>
<tr>
<td></td>
<td>▪ BLS Training Center Faculty</td>
</tr>
<tr>
<td>American Red Cross (ARC)</td>
<td>▪ BLS for Healthcare Providers</td>
</tr>
<tr>
<td></td>
<td>▪ CPR/AED for the Professional Rescuers and Healthcare Providers</td>
</tr>
<tr>
<td></td>
<td>▪ BLS for Healthcare Providers-Instructor</td>
</tr>
<tr>
<td></td>
<td>▪ CPR/AED for the Professional Rescuers and Healthcare Providers-Instructor</td>
</tr>
<tr>
<td></td>
<td>▪ Lifeguarding &amp; Lifeguarding Review</td>
</tr>
<tr>
<td></td>
<td>▪ Lifeguarding with Bundle &amp; Lifeguarding with Bundle Review</td>
</tr>
<tr>
<td>American Safety &amp; Health Institute (ASHI)</td>
<td>▪ BLS for Healthcare Providers</td>
</tr>
<tr>
<td></td>
<td>▪ CPR Pro for Healthcare Providers</td>
</tr>
<tr>
<td></td>
<td>▪ CPR Pro for the Professional Rescuer</td>
</tr>
<tr>
<td></td>
<td>▪ BLS Instructor</td>
</tr>
<tr>
<td>American Academy of Orthopedic Surgeons (AAOS)</td>
<td>▪ Professional Rescuer CPR</td>
</tr>
<tr>
<td></td>
<td>▪ Professional Rescuer CPR Instructor</td>
</tr>
<tr>
<td></td>
<td>▪ ECSI Healthcare Provider CPR</td>
</tr>
<tr>
<td></td>
<td>▪ ECSI Healthcare Provider CPR Instructor</td>
</tr>
<tr>
<td>American College of Emergency Physicians (ACEP)</td>
<td>▪ Professional Rescuer CPR</td>
</tr>
<tr>
<td></td>
<td>▪ Professional Rescuer CPR Instructor</td>
</tr>
<tr>
<td>Canadian Red Cross</td>
<td>▪ CPR Level HCP and AED Provider</td>
</tr>
<tr>
<td></td>
<td>▪ CPR Level HCP and AED Instructor</td>
</tr>
<tr>
<td>Department of Defense Fire &amp; EMS Certification (DoD)</td>
<td>▪ Healthcare Provider CPR</td>
</tr>
<tr>
<td></td>
<td>▪ Healthcare Provider CPR Instructor</td>
</tr>
<tr>
<td>Department</td>
<td>Courses</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Emergency Care and Safety Institute | • Healthcare Provider CPR & AED  
                                 | • Healthcare Provider CPR & AED Instructor                              |
| Emergency University              | • BLS Healthcare Provider CPR  
                                 | • Back of card must have a BLS-skills completion date, instructor name and instructor signature |
| EMS Safety Services               | • CPR/AED for Professional Rescuers                                    |
|                                   | • Emergency Response Instructor for Professional Rescuer CPR/AED        |
| National Safety Council           | • BLS Healthcare and Professional Rescuer                               |
|                                   | • Instructor - PR designation                                           |
| Military Training Network (MTN)   | • Health Provider                                                       |
|                                   | • Healthcare Provider Instructor                                        |
|                                   | • BLS Instructor                                                        |
|                                   | • BLS Training Site Faculty                                             |
| Pro Trainings (ProCPR.org)        | • ProCPR                                                                |
|                                   | • ProFirstAid Advanced                                                 |
|                                   | • Back of provider cards must include an instructor name and instructor ID number |
|                                   | • ProCPR Instructor                                                     |
|                                   | • ProFirstAid Advanced Instructor                                      |
Approved ACLS Courses

The following list of ACLS organizations and courses are currently recognized by the department. It is the responsibility of the individual provider to submit satisfactory evidence that organizations and courses not on this list should be recognized.

### Advanced Cardiac Life Support (ACLS) Courses

<table>
<thead>
<tr>
<th>Organization</th>
<th>Courses Approved by the Department</th>
</tr>
</thead>
</table>
| American Heart Association (AHA) | ▪ ACLS Provider  
▪ ACLS Instructor  
▪ ACLS for the Experienced Provider  
▪ ACLS for the Experienced Provider Instructor  
▪ ACLS Training Site Faculty  
▪ ACLS Regional Faculty  
▪ ACLS Renewal, including Resuscitation Quality Improvement (RQI) |
| American Safety & Health Institute (ASHI)  
(Some cards may display the St. John’s seal) | ▪ ASHI ACLS for Healthcare Professionals  
▪ ASHI ACLS Instructor |
| American College of Emergency Physicians (ACEP) | ▪ eACLS Provider (Renewal cards only)  
▪ eACLS Instructor (Renewal cards only) |
| Military Training Network (MTN) | ▪ ACLS Provider  
▪ ACLS Instructor  
▪ ACLS Training Site Faculty |
# Florida Emergency Medical Services
## CPR and ACLS Providers

### American College of Emergency Physicians
1125 Executive Circle
Irving, Texas 75038
Phone: (972) 550-0911

<table>
<thead>
<tr>
<th>Courses</th>
<th>Course Approval #</th>
<th>CE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Rescuer CPR</td>
<td>20-142748</td>
<td>3</td>
</tr>
<tr>
<td>eACLS</td>
<td>20-142777</td>
<td>6</td>
</tr>
</tbody>
</table>

### AAOS/ACEP Emergency Care & Safety Institute
40 Tall Pine Drive
Sudbury, MA 01776
Phone: (978) 579-8136

<table>
<thead>
<tr>
<th>Courses</th>
<th>Course Approval #</th>
<th>CE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Rescuer CPR Pro (Initial)</td>
<td>20-142794</td>
<td>3</td>
</tr>
<tr>
<td>Professional Rescuer CPR Pro (Renewal)</td>
<td>20-142795</td>
<td>3</td>
</tr>
<tr>
<td>eACLS (initial)</td>
<td>20-142797</td>
<td>6</td>
</tr>
<tr>
<td>eACLS (Renewal)</td>
<td>20-142798</td>
<td>3</td>
</tr>
</tbody>
</table>

### American Health and Safety Institute - 24/7
1450 Westec Drive
Eugene, OR 97402
Phone: (800) 800-7099

<table>
<thead>
<tr>
<th>Courses</th>
<th>Course Approval #</th>
<th>Expiration</th>
<th>CE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR Pro for the Professional Rescuer (Initial)</td>
<td>20 - 141920</td>
<td>September 18, 2017</td>
<td>5</td>
</tr>
<tr>
<td>CPR Pro for the Professional Rescuer (Renewal)</td>
<td>20 - 141951</td>
<td>September 18, 2017</td>
<td>2.5</td>
</tr>
<tr>
<td>Advanced Cardiac Life Support (Initial)</td>
<td>20 - 141952</td>
<td>February 26, 2018</td>
<td>15</td>
</tr>
<tr>
<td>Advanced Cardiac Life Support (Renewal)</td>
<td>20 - 141953</td>
<td>February 26, 2018</td>
<td>8</td>
</tr>
</tbody>
</table>

### Emergency Medicine Learning and Resource Center
3717 South Conway Road
Orlando, Fl 32812
Phone: (407) 281-7396

<table>
<thead>
<tr>
<th>Course</th>
<th>Course Approval #</th>
<th>Expiration</th>
<th>CE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Critical Care Course (C4)</td>
<td>20-141990</td>
<td>December 1, 2016</td>
<td>8</td>
</tr>
</tbody>
</table>

### EMS Safety Services
1046 Calle Recodo Suite K
San Clemente, CA 92673
Phone: (949) 388-3393

<table>
<thead>
<tr>
<th>Course</th>
<th>Course Approval #</th>
<th>Expiration</th>
<th>CE Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR/AED for the Professional Rescuer</td>
<td>20-221534</td>
<td>September 30, 2017</td>
<td>6</td>
</tr>
</tbody>
</table>
Participants will complete the training and testing online at www.procpr.org or www.profirstaid.com. After successfully completing the training and passing the written test, the participant must complete a hands-on skill evaluation with a currently certified Skill Evaluator/Instructor from ProTrainings LLC.

When the participant successfully passes the skill evaluation, the Skill Evaluator/Instructor signs or has his or her digital signature printed on the back of the card on the skill evaluator line. The Skill Evaluator/Instructor faxes the participant’s skill evaluation checklist to ProTrainings LLC. After successful completion the participant is issued a certification valid for 2 years.
The Wyoming Office of Emergency Medical Services (OEMS) has evaluated Basic Life Support / Cardiopulmonary Resuscitation (BLS/CPR) and Advanced Cardiac Life Support (ACLS) courses to determine that they meet the requirements for licensure or re-licensure. The following courses meet the requirements of the OEMS. To have an unlisted course evaluated please contact the Office of EMS.

### Basic Life Support / Cardiopulmonary Resuscitation (BLS/CPR)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Acceptable Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association (AHA)</td>
<td>BLS Provider, BLS Instructor, BLS Training Center Faculty</td>
</tr>
<tr>
<td>American Red Cross (ARC)</td>
<td>CPR/AED for the Professional Rescuer, Lifeguard Challenge CPR and AED</td>
</tr>
<tr>
<td>American Safety &amp; Health Institute (ASHI)</td>
<td>CPR Pro for Healthcare Providers and First Responders, CPR Pro for the Professional Rescuer, BLS Instructor</td>
</tr>
<tr>
<td>American Academy of Orthopedic Surgeons (AAOS)</td>
<td>Professional Rescuer CPR</td>
</tr>
<tr>
<td>American College of Emergency Physicians (ACEP)</td>
<td>Instructor</td>
</tr>
<tr>
<td>Department of Defense Fire &amp; EMS Certification</td>
<td>Healthcare Provider CPR</td>
</tr>
<tr>
<td>National Safety Council</td>
<td>BLS Healthcare and Professional Rescuer, Instructor - PR designation</td>
</tr>
<tr>
<td>Military Training Network (MTN)</td>
<td>Health Care Provider, Healthcare Provider-Instructor, BLS Instructor, BLS Training Center Faculty</td>
</tr>
<tr>
<td>ProTrainings, LLC</td>
<td>ProCPR (Skills Evaluation required) (effective 12/10/11), ProCPR Instructor</td>
</tr>
</tbody>
</table>

### Advanced Cardiac Life Support (ACLS)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Acceptable Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association (AHA)</td>
<td>ACLS Provider, ACLS Instructor, ACLS Experienced Provider, ACLS EP Instructor, ACLS Regional Faculty</td>
</tr>
<tr>
<td>American College of Emergency Physicians (ACEP)</td>
<td>eACLS Provider (* renewal only), eACLS Instructor (* renewal only)</td>
</tr>
<tr>
<td>Military Training Network (MTN)</td>
<td>ACLS Provider, ACLS Instructor, ACLS Training Site Faculty</td>
</tr>
</tbody>
</table>

WYOEMS-10

Revised 2/6/2017
Policy # XX-XXX
Approved Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Certifications

<table>
<thead>
<tr>
<th>Approval:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R. Keith Wages, Director of Office of EMS and Trauma</td>
<td>Date</td>
</tr>
<tr>
<td>Pat O’Neal, Director of Health Protection</td>
<td>Date</td>
</tr>
</tbody>
</table>

1.0 PURPOSE

This policy identifies the cardiopulmonary resuscitation (CPR) and the advanced cardiac life support (ACLS) courses that are approved by the department for both initial and renewal licensure for all medics licensed by the department.

1.1 Authority – Georgia Department of Public Health, Office of EMS and Trauma is authorized under the following:

1.1.1 Rules of the Department of Public Health, section 511-9-2-.02(a)

1.1.2 Rules of the Department of Public Health, section 511-9-2-.02(w)

1.1.3 Rules of the Department of Public Health, section 511-9-2-.13(1)(a)

2.0 SCOPE

This policy applies to all medics licensed by the department.

3.0 POLICY

The department approves the following CPR and ACLS courses.
3.1 **American Heart Association**

3.1.1 CPR: Basic Life Support (BLS) Health Care Provider or Instructor.

3.1.2 ALCS: Advanced Cardiac Life Support (ACLS) Provider or Instructor.

3.2 **American Red Cross**

3.2.1 CPR: CPR/AED for the Professional Rescuer and Health Care Providers or instructor.

3.3 **American College of Emergency Physicians**

3.3.1 ACLS: eACLS

3.4 **American Safety & Health Institute**

3.4.1 CPR: ASHI CPR Pro for the Professional Rescuer or Instructor.

3.4.2 ACLS: ASHI ACLS or Instructor.

3.5 **Emergency Care & Safety Institute**

3.5.1 CPR: ECSI Health Care Provider CPR or Instructor.

3.5.2 ACLS: ECSI eACLS or Instructor.

4.0 **DEFINITIONS**

4.1 **ACLS** - means advanced cardiac life support, a course, which utilizes nationally recognized advanced cardiac care standards.

4.2 **CPR** - means cardiopulmonary resuscitation.

4.3 **Department** - means the Department of Public Health.
5.0 RESPONSIBILITIES

5.1 The license officer shall ensure that all applicants for an initial medic license issued by the department shall properly document current certification in CPR and/or ACLS from at least one of the courses approved in Section 3.0.

5.1.1 Emergency Medical Technicians: CPR
5.1.2 Emergency Medical Technicians - Intermediate: CPR
5.1.3 Advanced Emergency Medical Technician: CPR
5.1.4 Cardiac Technician: CPR and ACLS
5.1.5 Paramedic: CPR and ACLS

5.2 The license officer shall ensure that all applicants for the renewal of a medic license issued by the department shall properly document current certification in CPR and/or ACLS from at least one of the courses approved in Section 3.0.

5.2.1 Emergency Medical Technicians: CPR
5.2.2 Emergency Medical Technicians - Intermediate: CPR
5.2.3 Advanced Emergency Medical Technician: CPR
5.2.4 Cardiac Technician: CPR and ACLS
5.2.5 Paramedic: CPR and ACLS

6.0 PROCEDURES

6.1 Proof of Certification

6.1.1 The license officer may accept any of the following documents as proof of certification:

6.1.1.1 Copy of CPR and/or ACLS card with appropriate signatures and date.
6.1.1.2 Copy of class roster with the instructor’s signature.
6.1.1.3 Copy of a certificate with the instructor’s signature.

7.0 REVISION HISTORY
8.0 RELATED FORMS

C-01-C Licensure Renewal Form
C-08-A In-State License Request
C-08-B Reciprocity License Request
A bill for an act relating to health; authorizing the Emergency Medical Services Regulatory Board to adopt rules authorizing certified emergency medical services personnel to assist with administering certain emergency prescription medications and participate in care coordination; requiring rulemaking; amending Minnesota Statutes 2016, section 144E.16, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 144E.16, is amended by adding a subdivision to read:

Subd. 9. Authority for patient-assisted medication administration and care coordination. (a) The board shall adopt rules authorizing EMTs, AEMTs, and paramedics certified under section 144E.28 to assist, in emergency situations, with administering prescription medications that are:

(1) carried by a patient;

(2) administered via routes of delivery that are:

(i) within the scope of training for the EMT, AEMT, or paramedic; and

(ii) approved by the ambulance service medical director for the service area in which the EMT, AEMT, or paramedic provides care; and

(3) intended to treat a specific life-threatening condition.

EMTs, AEMTs, and paramedics assisting with medication administration according to this subdivision must do so under the authority of guidelines approved by the ambulance service medical director or under the direction of orders from direct medical control.
(b) The board shall adopt rules to:

(1) establish standards for use by ambulance services to communicate with patients, and their caregivers, in their service area who are diagnosed with specific health conditions about the patient's health condition, the likelihood that the patient will need emergency medical services, and how to collaboratively develop emergency medical services care plans to meet the patient's needs; and

(2) establish standards for ambulance service medical directors to participate in care coordination for patients in the service area who are diagnosed with specific conditions. Care coordination may include developing potential treatment plans, determining the optimal prehospital approach and treatment for the patient, and establishing alternative approaches and treatment.
Regional Approach to Coordinate Emergency Care (RACE-Care)
DRAFT February 21, 2017

Coordination of emergency medical care is critical to survival, particularly for a small group of conditions where timely recognition, treatment, and appropriate referral can greatly improve outcomes including:

- Cardiac arrest,
- Acute myocardial infarction (heart attack),
- Trauma including traumatic brain injury,
- Stroke, and
- Sepsis

Time is of the essence for these medical conditions: every minute of delay in care can adversely affect outcomes. The State of Minnesota has regional programs in place for trauma, stroke, and recently for heart attacks (ST Elevation Myocardial Infarction - STEMI) as well as for disaster preparedness. These programs all involve the same basic partners of EMS and hospitals with state and local public health having a role as well.

End-to-end systematic approaches to the treatment of out-of-hospital cardiac arrest have been implemented in some areas of Minnesota under the Take Heart America campaign with support from the MN Resuscitation Consortium. The program goal is to coordinate care, from the moment cardiac arrest was observed by a bystander and early CPR started, to protocol-driven care by first responders, advanced-life support by paramedics, and best-practice care at receiving hospitals. Receiving hospitals were assigned Levels based on their capacity to provide advanced care similar to the trauma system with a Cardiac Arrest Center being the highest Level. By creating expectations for care delivery at every level from 911 call to receiving referral hospital, the program creates a consistent model of care that can be the basis for planning and training.

Currently, the above programs are independent, which creates training, data reporting, and coordination demands that could be improved with an integrated approach. Minnesota has an opportunity to develop a single unified system of care with disease-specific protocols and education for first responders, BLS and ALS providers, receiving and referral hospital providers which could offer significant survival benefits to patients, particularly those in outlying areas of Minnesota where prevention of delays and provision of the best local care can have the greatest impact. Instead of being addressed by multiple uncoordinated systems, all conditions requiring structured response and referral should be united under a tiered program similar to the Take Heart America program and current state-wide trauma, STEMI, stroke, and emergency preparedness programs which currently have separate funding, champions, protocols, databases, and information sharing systems.
The unified plan would include developing disease specific protocols and modular training for optimal care including:

- EMS diagnosis, triage, hospital alerts, and treatment
- Early mobilization of inter-facility transfer
- Receiving hospital response to EMS alert, evaluation and treatment
- Critical care transfer team management
- Referral hospital expectations for management (designation systems)

Outcomes would be followed by the state program coordinators with integration of data from EMS, receiving, and definitive care facilities. We would anticipate using the data to benchmark outcomes and find areas for system improvement similar to the current stroke and trauma data collection. We would anticipate that these efforts would be coordinated with existing programs in Minnesota for each condition as well as with the MN Department of Health (MDH) and other State agencies that are currently involved with emergency care and preparedness. The EMS Regulatory Board’s regional structure and personnel offer an opportunity to build off of existing regional boundaries and relationships.

This new initiative will require a multi-step process to assess current program attributes, goals, and systems, evaluate potential training and education support, examine integration of data collection and analysis, and define any existing or necessary authorities to develop the program leveraging existing regional structures. With current statewide trauma, stroke, and STEMI systems in varying degrees of sophistication and mechanisms for provision of education and dissemination of materials already exists for EMS services and hospitals, we will be able to substantially leverage existing systems to establish a coordinated approach and over time, this program synergy will reduce competing priorities for time and funding.

- **2016-2017 Analysis Objectives:**
  - Identify current systems including their goals, vision, training/education, and available data collection, analysis and reporting
  - Develop priorities for integration of efforts
  - Identify an umbrella agency to foster pilot and other efforts (e.g. MN ACEP)

- **2017-2018 Development Objectives:**
  - Initiate workgroups as required
  - Develop educational materials with support of workgroups, SMEs and roll out to providers (EMS and hospital)
  - Develop provisional quality measures for each condition

- **2018-2019 Implementation Objectives:**
  - Regional prioritization of educational efforts based on needs
  - Establish sustainable regional system for administration and provider engagement
  - Determine information exchange process with regions
2019-2020 Improvement Objectives:
  o Provide benchmarking of data by region
  o Initiate regional quality improvement efforts based on data available
  o Update and evaluate educational / training materials and
effectiveness

We believe that existing cooperative programs in trauma, cardiac, stroke care
and emergency preparedness form a strong foundation on which a public-private
partnership can improve outcomes for multiple emergency conditions that
depend on timely and effective interventions at every level of care.

RACE-Care Partners:
American Heart Association
Centracare
Hennepin County Medical Center
MN Comprehensive Advanced Life Support (CALS) program
MN EMS Regulatory Board
MN Dept. of Health (MDH)
Minnesota Resuscitation Consortium
MN American College of Emergency Physicians
Minnesota Statute §144E.275

Subd. 7. Community medical response emergency medical technician. (a) To be eligible for certification by the board as a CEMT, an individual shall:

1. be currently certified as an EMT or AEMT;
2. have two years of service as an EMT or AEMT;
3. be a member of a registered medical response unit as defined under this section;
4. successfully complete a CEMT education program from a college or university that has been approved by the board or accredited by a board-approved national accrediting organization. The education must include clinical experience under the supervision of the medical response unit medical director, an advanced practice registered nurse, a physician assistant, or a public health nurse operating under the direct authority of a local unit of government;
5. successfully complete an education program that includes education in providing culturally appropriate care; and
6. complete a board-approved application form.

(b) A CEMT must practice in accordance with protocols and supervisory standards established by the medical response unit medical director in accordance with section 144E.265.

c) A CEMT may provide services within the CEMT skill set as approved by the medical response unit medical director.

d) A CEMT may provide episodic individual patient education and prevention education but only as directed by a patient care plan developed by the patient's primary physician, an advanced practice registered nurse, or a physician assistant, in conjunction with the medical response unit medical director and relevant local health care providers. The patient care plan must ensure that the services provided by the CEMT are consistent with 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.

e) A CEMT is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMTs under this chapter.

(f) A CEMT may not provide services as defined in section 144A.471, subdivisions 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

1. take a regularly scheduled medication, but not to provide or bring the patient medication; and
2. follow regularly scheduled treatment or exercise plans.

History: 2002 c 310 s 1; 2012 c 193 s 32; 2015 c 71 art 9 s 9,10; 2016 c 88 s 3
MODULE TITLE HOURS OBJECTIVES

Module 1
Role of the Community EMT in the Healthcare System

2 Hours

The Community EMT will be able to:
1. Define and describe the community paramedicine.
2. Discuss the history and future of the Primary Care Technician.
3. Explain Scope of Practice of the Primary Care Technician to stakeholders.
4. Differentiate relationships the Primary Care Technician will have with members of the healthcare team.
5. Define and defend strategies of advocacy and liaison work as a Primary Care Technician.
6. Identify common local, regional, state, and national organizations that can provide support for clients.

Module 2
Social Determinants of health

2 Hours

The Community EMT will be able to:
1. Define the social ecology model and determinants of health.
2. Identify the impact organizational policies, societal regulations and laws have on health behaviors.
3. Understand and defend the social margin.
MODULE TITLE OBJECTIVES

Module 3 (4 Hours)

Health Care System and Primary Care System

The Community EMT will be able to:
1. Describe health promotion education activities.
2. Describe injury prevention activities.
3. Describe chronic disease management.

Module 4

Cultural Awareness
2 Hours
1 Lecture
1 Lab

The Primary Care Technician will be able to:
1. Provide a broad definition of culture as it is used by the PCT.
2. Describe how culture influences health.
3. Discuss and defend culturally specific care and its impact.
Module 5
Understanding Special Needs Population

4 Hours

Hours
The Community EMT will be able to:
1. Understand best practices for working with individuals throughout the lifespan.
2. Understand how best to serve clients of various ages, mental, behavioral and psychosocial health needs.
3. Discuss common behavioral emergencies.
4. Understand how best to serve clients of various ages and physical health needs.
5. Understand how best to serve clients of various ages with substance related disorders.
6. Understand how best to serve individuals with dementia (neurocognitive disorder).
7. Understand how best to serve veterans.
8. Understand how best to serve clients with cognitive, congenital, affective, and sensory issues.
9. Understand how to best serve individuals with hearing, speech, and visual impairments.
10. Understand how to best serve individuals with a history of abuse and/or neglect.
11. Understand how best to serve the diverse needs of families with members with special needs.
Module 6 The Primary
The Community EMT Role in the Community

6 hours

The Community EMT will be able to:
1. Discuss Community Health Needs Assessment (CHNA).
2. Recognize potential patient profiles.
3. Evaluate gaps in the healthcare care needs of the client.
4. Define outreach.
5. Discuss the purpose of community outreach.
6. Approach a client, introduce self in a manner that sets the tone
   For effective outreach
7. Identify and communicate the need for medical interventions aimed
   at bridging the gap between the field and other sources of care.
8. Discuss the documentation used during a client contact
9. Discuss different types of documentation to use when a client is contacted through the 911
   system.
10. Conduct an ongoing documentation for a client.
Module 7
The Community EMTs Personal Safety and Wellness

2-hours

The Community EMT will be able to:
1. Discuss the components of well-being.
2. Discuss the physiological effects of stress.
3. Discuss the concept and warning signs of stress and burnout.
4. Discuss medical, legal, and ethical boundaries that must be established with the client.
5. Identify how to recognize and implement personal protective equipment.

Module 8

The Pre-Clinical experience

4 Hours

Utilizing an OSCE or scenario format for evaluation, The Community EMT will be able to:

1. Defend various legal protections for clients.
2. Define infectious disease and demonstrate personal protective equipment (universal precautions) used to prevent transmission.
3. Discuss and implement OSHA blood-borne pathogen standards.
4. Identify and demonstrate how to minimize risks of infection.
5. Identify and mitigate hazards while working in the home visit environment.
6. Demonstrate competency with various home care equipmen
Module 9
The Clinical Experience
20 Hours Minimum
(8) patient contacts

Must be complete within 6 months.

The Community EMT will be able to:
1. Compile a history on a non-acute client.
2. Perform a physical examination and document an appropriate patient history, using a standardized form.
3. Assist with in-home devices
4. Identify the need for Psychological First Aid (PFA) as it pertains to the individual experiencing a crisis.
5. Assist clients and families with end-of-life issues.
6. Collaborate with other healthcare professionals to provide injury and illness prevention services.
7. Recognize and assist patients with common, chronic conditions encountered in the community.
8. Apply physical examination techniques, critical thinking and previously obtained skill and knowledge and apply to a minimum of 8 patient contacts and complete documentation.