

**State of Minnesota**  
**Emergency Medical Services Regulatory Board**  
**Medical Direction Standing Advisory**  
**Committee Meeting Minutes**  
**March 3, 2017, 9:00 a.m.**  
**Minneapolis Marriott Northwest**  
**Brooklyn Park, Minnesota 55428**

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**Attendance:** Aaron Burnett, M.D., Chair; J.B. Guiton, Board Chair; Marc Conterato, M.D.; Gary Foley, M.D.; John Hick, M.D.; Jeffrey Ho, M.D.; Paula Fink Kocken, M.D.; Pat Lilja, M.D.; John Lyng, M.D.; John Pate, M.D.; Andrew Stevens, M.D.; Peter Tanghe, M.D.; Mari Thomas, M.D.; Michael Wilcox, M.D.; Tony Spector; Executive Director; Melody Nagy, Office Coordinator; Greg Schaefer, Assistant Attorney General. (Bjorn Peterson, Carson Gardner on the phone for a small portion of the meeting)

**1. Call to Order**

Dr. Burnett called the meeting to order at 9:02 a.m.

**2. Public Comment**

None.

**3. Approve Agenda**

Dr. Burnett suggested an additional agenda item. Siren grant to University of Minnesota.

Dr. Pate moved approval of the revised agenda. Dr. Conterato seconded. Motion carried.

**4. Approve Minutes**

Dr. Pate moved approval of the September 8, 2016 minutes. Dr. Lilja seconded. Motion carried.

**5. MDSAC Committee Chair Report**

EMS Crisis Standards of Care

Dr. Burnett said he is looking for a motion endorsing this document. Dr. Hick provided an example of a mass casualty incident. He commented there needs to be pre-planning at the dispatch level and at the operational level. Dr. Hick provided a power point presentation that was included in the meeting packet. Dr. Hick said that this document will also be discussed at regional meetings and workshops throughout the state.

Dr. Lyng moved endorsement of the Surge Operations and Crisis Care document by the MDSAC and that MDSAC agrees with the general principals as outlined in the document and feel that it is a valuable resource for EMS services throughout the state. Dr. Lilja seconded. Motion carried.

Opioid Hospital Visits-Publication

Dr. Burnett said that he wanted to provide a quick overview of a document that has been discussed at the National Association of State EMS Officials. Dr. Burnett said he is the secretary of the Medical Director's Council.

Dr. Burnett provided a handout and highlighted data for Minnesota statistics versus other states and the national average. Dr. Lilja said that in Minnesota these persons may not have been admitted to the hospital. Dr. Burnett said this information should be available for legislative use.

Dr. Lilja asked if the EMSRB has been asked to comment on legislation. He said that his opinion is that legislators should not be practicing medicine. Physicians should not be mandated to implement something they did not have input on developing.

Dr. Pate said guidelines are needed. He provided an example of opioid abuse in his local area.

Dr. Lilja said that we should develop a “paper” for distribution to medical directors. (Sample protocols or care plans). Dr. Ho said services have care plans in place but cannot share information across PSAs. Dr. Burnett said that a health information exchange would be helpful in this situation and this has been previously discussed by this committee.

Dr. Lyng said there needs to be a decision that this is a priority. There have been discussions of what agency should take ownership of this. The technology exists. There is a model to use in the prescription monitoring program data base.

Dr. Conterato said we are discussing this at the Hennepin County EMS Council. There are several models in existence. This is in statute in Florida. One roadblock is the interpretation of what is HIPAA for EMS and hospitals.

Dr. Burnett suggested development of a subcommittee of members willing to further this issue. Dr. Ho said that this should be discussed again by the Board. The committee discussed and revised the above motion. Dr. Hick repeated the motion and it was voted on.

Dr. Hick moved that the MDSAC recommends that the EMSRB and the Minnesota Attorney General's Office release a joint statement to be circulated by the Minnesota Hospital Association and other partners affirming the importance of EMS quality improvement and the legality under HIPAA and the Minnesota Medical Records Act of sharing specific patient outcome information with the licensed ambulance service or the medical director of a state-registered EMS responder agency that provided the patient's care. Dr. Lyng seconded. Motion carried. Dr. Lilja voted no.

Dr. Lilja moved to add to future agendas a legislative report from the EMSRB. Dr. Thomas seconded. Motion carried.

Dr. Lilja moved to develop a subcommittee of MDSAC to discuss a health information exchange. Dr. Lyng seconded. Motion carried.

Dr. Ho volunteered to chair the subcommittee.

#### Critical Care Paramedic and Critical Care Flight Paramedic

Dr. Lilja said medical directors should provide the training for their staff as they see fit. Mr. Spector said that this is being represented publicly with “rockers” on uniforms. What does this mean? Are the standards different at different agencies? The EMSRB's goal is to protect the public health and safety.

Dr. Lyng said that this has been discussed at the National Association of EMS Physicians. NAEMSP was asked to endorse this and they did not. There is a gap in the verification of this competency level. There is no formal recommendation in any state that I know of. My concern is in setting a specific standard there may be exclusion of persons. It may be too restrictive or limit competition.

Dr. Hick said we should have a “floor” on this. Dr. Lilja asked how this would be validated. He suggested a workgroup to discuss this and bring a recommendation back to the committee. Dr. Pate said the “floor” needs to come from a nationally recognized entity. Dr. Lilja we discussed a Minnesota standard for certification levels and decided to go with the National Registry. Who makes these decisions? How do you write a rule for this?

Mr. Spector said legislation was developed for Community EMT and Community Paramedic. The level of care needs to be defined. Does the MDSAC have specific thoughts as to what is needed? Staff is reviewing data to present to MDSAC. (50 state survey) Currently this is misleading to the public.

Dr. Wilcox asked where EMS is going in the country. EMS should be professionalized for the public. Training should be provided in an academic setting and be controlled by the medical director.

Dr. Burnett asked that this discussion continue in September. EMSRB staff will provide a 50 state survey and the document provided by Dr. Hick can be discussed again in September.

A Course in Cardiopulmonary Resuscitation as Approved by the Board/A Course in Advanced Cardiac Life Support as Approved by the Board

Mr. Spector said this refers to Minnesota Statute 144E.28, subdivision 7. What is “as approved by the board?” Mr. Spector said the Board is looking for a recommendation from MDSAC on this issue. He provided a handout with information from a 50 state survey.

Mr. Spector said their currently is no practical skills test for EMT renewal. Applicants could view this the same way that if there is no course approved by the Board they do not have to comply with this requirement.

Mr. Schaefer said we cannot ignore this question. Who would approve courses? It is detrimental to the Board to not have this in place. Mr. Schaefer said you cannot create a monopoly.

Mr. Guiton said that this refers to medical directors who are not licensed ambulance service medical directors.

Dr. Lilja suggested the committee should develop a recommendation. American Heart Association or Red Cross would be acceptable. He asked if the EMSRB would then be approving courses as requested by education programs that have a medical director. Mr. Spector asked about a recognized course or equivalency. It is a course or is it content in the education. Dr. Lilja said we do not want to confuse people. Dr. Burnett said we should approve a course or equivalent.

Dr. Lyng said the previous discussion was to establish a standard. Now we are discussing a course or content. These are conflicting. What is approved by the medical director should be vetted at the state level. Do not dilute the standard.

Dr. Stevens said this is two separate things. An applicant that has a medical director is different. What would a pre-arrival dispatchers use.

Mr. Spector said this is in current statute. What do the physicians want as the standard? How do we integrate classroom versus what happens in the real world. Mr. Guiton suggested accepting the programs that are accepted in other states. (see Figure 2 in 50 State Survey)

Mr. Spector asked if this would pass legal muster? Dr. Stevens said a guideline is the basic step “set the floor”.

Dr. Fink-Kocken asked how staff handles this mandate? Dr. Burnett suggested CRP provided by an approved education program would be acceptable.

Dr. Lilja moved that MDSAC recommend to the Board CPR and ACLS courses listed in Figure 2 of the 50 state survey and courses or content provided by an EMSRB approved education program. Dr. Hick seconded. Motion carried.

*Figure 2*

<b>Cardiopulmonary Resuscitation</b>	<b>Advanced Cardiac Life Support</b>
American Heart Association (AHA)	American Heart Association (AHA)
American Red Cross (ARC)	American Safety and Health Institute (ASHI)
American Academy of Orthopedic Surgeons (AAOS)	Military Training Network (MTN)
American Safety and Health Institute (ASHI)	
Emergency Care and Safety Institute (ECSI)	
Military Training Network (MTN)	
National Safety Council	
Pro CPR LLC (ProCPR.org)	

Senate File 1023

Mr. Spector said this bill was just introduced and the EMSRB was not consulted on this legislation. This document is provided for your information. This relates to patient-assisted medication administration and seems to be targeted for patients with rare conditions. Dr. Lyng said that this is very similar to a position statement that was approved by the National Association of EMS Physicians. NAEMSP.

Dr. Burnett said this would require the Board to develop rules. Mr. Snoke said he knew of a patient situation where there was a problem. He said that this would require training of all EMTs on all drugs statewide.

Mr. Spector said that this would require the EMSRB to develop rules and there would be significant cost (\$50,000). The rule writing would be controversial and would require another committee for rule development.

Dr. Pate said it would be impossible to train for all the different possibilities. Dr. Lyng said the intent is to provide collaboration for patient administration and EMS providers being able to provide the care to the person. Dr. Burnett suggested a change in language to allow assistance with permission of online medical control.

Dr. Stevens said that we need to communicate with the author of this bill that the MDSAC has concerns about the current language.

Mr. Snoke said this bill is not currently scheduled for hearing.

Dr. Burnett moved that Dr. Lyng and Dr. Stevens work with Mr. McAlpin and Mr. Snoke and the Legislative workgroup of the EMSRB to develop language that parallels the National Association of EMS Physicians language. Dr. Hick seconded. Motion carried.

Dr. Fink-Kocken asked what happens in other states. It would be a problem to have mandated medications. Mr. Spector repeated this would require rule writing.

#### **6. Executive Director Report – Tony Spector**

Mr. Spector said the budget initiative released by the Governor's office includes additional staffing for the EMSRB. The Southwest EMS Specialist position has been offered and accepted. The person will be on board in a few weeks.

The e-licensing system is not functional. We are working on a paper system. We are bringing on extra temporary staff to work on renewals and currently have a one week turnaround time for documents submitted.

Mr. Spector commented that the Legislative Ad-Hoc Workgroup is a subgroup of the Board and EMS stakeholders. The workgroup has suggested changes that need to be made but staff do not have bandwidth or expertise to make these changes. I will be bringing on a contract vendor to clean up the statute. There will not be policy legislation advanced by the EMSRB this year. This needs to be developed and vetted before it is proposed at the legislature.

Mr. Spector said that he wanted to bring to the Committees attention legislation proposed regarding an interstate compact for REPLICA related to cross boarder patient care. REPLICA would allow for staffing access across state boarders. In theory it makes sense. This legislation excludes EMRs. The compact being proposed requires 10 states to pass the legislation. Member states would be required to conduct criminal background checks within 5 years. This would cause at least two week delays for certification while waiting for the background check results. This would also require investigation and finger print fees and would be costly.

Mr. Guiton said backgrounding people is a good concept. The other health licensing boards are requiring this. Mr. Spector said that this would increase reporting for disclosures.

Dr. Ho left the meeting.

#### **7. Update on MDH Inter-Facility Stroke Workgroup – Dr. Andrew Stevens**

Dr. Stevens thanked members for welcoming him to this committee. Dr. Stevens said that he and Dr. Hick worked on this together and that research is an interest for him. The stroke protocols came from statute and a grant. This can be a model for medical directors.

Dr. Stevens said that the rural survey will be presented at the Minnesota Ambulance Association (MAA) meeting. I would like to share this information with medical directors and will be presenting further information at the Medical Directors Conference in September.

Dr. Hick said that there is a document on highly infectious disease being circulated and this document has inaccuracies. There is no Ebola in Minnesota. There needs to be changes in the document to emphasize that crews must provide emergency lifesaving care while waiting for other resources.

Dr. Hick said the EMSRB is working with ImageTrend to integrate trauma records with EMSRB records to develop meaningful reports.

**8. Regions Approach to Coordinated Emergency Care (RACE-Care) – Dr. John Hick**

Dr. Hick said there are multiple initiatives being developed. It is hard to balance all the needs and interests. We are looking for support from ACEP. We are looking for funding for a pilot project. The EMSRB could focus the efforts of patient care activities at a regional level. The goal is consistent expectations for best practices. We want to provide information for QA and enhance education and development of triage processes.

Dr. Wilcox said there needs to be a determination of what data elements provide better patient outcomes.

**9. Community EMT Education Program – Dr. Wilcox**

Dr. Wilcox said that a program exists for Community Paramedics. This is a step in the development of a Community EMT Education Program. The statute was passed in 2016.

Dr. Wilcox said to educate persons we needed to develop a framework of educational elements for approval by the EMSRB. This is a framework for an academic setting for education that includes a 48 hour program. This would be classroom and web based with a clinical component. A gap analysis would be developed for in the community wanting to implement the Community EMT.

Mr. Snoke said Community EMT does not include persons working on an ambulance service. The personnel can also work for an ambulance service. The person also needs to be a member of a medical response unit.

Dr. Burnett said this provides the framework for the curriculum.

Dr. Lyng asked what the term primary provider means. This is problematic.

Mr. Spector said to advance EMS as a profession the statute refers to the education program approved by the Board. Community EMT cannot move forward without Board approval. This module is being offered.

Mr. Guiton suggested approval of a pilot project.

Dr. Hick moved approval of the document provided for a pilot project with changes to terminology from primary provider to Community EMT. Dr. Lilja seconded. Motion carried.

**10. New Business**

Dr. Lyng said the NAEMSP guidelines will be available for public comment soon. Dr. Burnett said that this is a good tool for medical directors.

**11. Adjourn**

Dr. Lilja moved to adjourn. Dr. Fink-Kocken seconded. Motion carried.

Meeting adjourned 11:53 a.m.