State of Minnesota  
Emergency Medical Services Regulatory Board  
Executive Committee Meeting Agenda  
December 17, 2020, 10:00 a.m.

Note: Minnesota Statutes section 13D.021 requires a public body to determine that an in-person meeting is "not practical or prudent because of a health pandemic or an emergency declared under chapter 12." At this time, the Board Chair has determined that an in-person meeting is not practical or prudent because of the COVID health pandemic. This meeting therefore will not be held in-person. It will only be held by WebEx and telephone.

Join Teams Meeting Link  
Call-in Number: 763 317 4323  
Meeting Number (Access code): 168 086 984#

1. Call to Order and Introductions – 10:00 a.m.  
2. Public Comment – 10:05 a.m.  
The public comment portion of the Board meeting is where the public is invited to address the Board on subjects which are not part of the meeting agenda. Persons wishing to speak are asked to email melody.nagy@state.mn.us Please limit remarks to three minutes.

3. Review and Approve Agenda – 10:10 a.m.

4. Review and Approve Meeting Minutes – 10:15 a.m.  M 1

5. Board Chair Report – 10:20 a.m.  
   • Update on Emergency Meeting of Executive Committee  BC 1
   • Policy Discussion on any other Recommendations or Guidance Pertaining to Vaccination of EMS Personnel

6. Executive Director Report – 10:50 a.m.  
   • FEMA Summary Report of Ambulance Deployment  ED 1
   • Workforce issues related to COVID  ED 2
   • M Health Fairview Temporary License Report  ED 3
   • EMSRB Agency Report  ED 4
   • Survey Results Regarding Driver Requirements  ED 5
   • National Registry (End of Issuing Provisional Certification)  ED 6

8. New Business – 11:35 p.m.  

9. Adjourn – 11:40 a.m.  

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: https://mn.gov/emsrb  

Next Meeting:  
February 18, 2021, 10:00 a.m.  
TBD
The Mission of the EMSRB is to protect the public’s health and safety through regulation and support of the EMS system.
comprehensive system that allows an electronic platform. The hospital hub will provide an advantage to allow hospitals to receive the information in a timely manner. This will be a complete system. He said a feature was recently added; the ability to scan IDs from an IPad.

Mr. Miller asked about statutory requirement to leave a record at the hospital. Mr. Rogers said this meets the requirement as soon as the record is posted to the system. Mr. Rogers said the agency would like to see services post their records within one day. This will provide timely data. He said he is pulling data every day and providing it to MDH for COVID statistics. Mr. Rogers said addendums and corrections can be added to a record after a record has been posted. Mr. Rogers said outcome data can be added to the record and that can be shared to give feedback to the crew.

Mr. Spector quoted Minnesota Statute 144E subpart 2 that says a copy of the ambulance report will be provided to the receiving hospital but it does not say who and it does not say when. From an operational perspective if a patient is transported and if the wait for the copy of the report is 24, 48 or 72 hours how does this impact patient care. That is not addressed in statute.

Ms. Hartigan said this is a patient safety issue that she has presented information on nationally. She said the record is only matched 30% of the time if the record is faxed. Transition of care is huge for patient safety.

Mr. Rogers said there are discussions for integration for medical records systems. He said the next version of NEMSIS will be friendlier to HL7 and an easier transition.

Mr. Spector said there is a price tag for this software solution. The cost for this system is $24,000 this year and the EMSRB will absorb the cost this year but I do not know what the cost will be in the future. The EMSRB is exploring our options.

Mr. Spector said Mr. Soucheray and Mr. Shorten are doing a great job conducting advanced exams. He invited Mr. Soucheray to speak on this topic. Mr. Soucheray said he has done 12 exams since January. He said some things have been more difficult due to COVID and the interruption of teaching. Mr. Spector said staff will have analytics for the November Board meeting.

Mr. Soucheray said the National Registry will offer provisional certification through the end of the year then it will be re-evaluated and they are waiving the distributive education requirements for the next year.

Mr. Soucheray said information regarding COVID is that there is an uptick in numbers that is concerning. Staff are participating in meeting at the SEOC and also in discussions about a vaccine rollout with a priority status for EMS workers.

Mr. Rogers said he is posting response trending information to the website and sharing information with MDH. Mr. Guiton asked about trends.

Dr. Ho asked about trends for COVID in outstate areas. Mr. Rogers said he has not analyzed by regions.

Mr. Spector offered congratulations to Dr. Ho for his promotion at Hennepin Health Care.

Mr. Guiton said he would like to see an analysis by region. Mr. Rogers said there is one agency that is not using the COVID response codes and that was a decision by their medical director. Mr. Guiton suggested that Dr. Burnett could have a conversation with this service on their reporting.
Mr. Shorten said he is working with customers on a daily basis (phone calls and emails). He said he is processing requests for EMT exam approvals. Allied Medical is one of the few agencies doing EMT psychomotor exams. He is participating in the on call duties at the SEOC. He said he is doing inspections and they are going well. There was a recent inspection at Gaylord for part-time ALS. He said he is working with Ashby on their application for part-time ALS. He is working with Ms. Jacobs on updated PSA information for Nextgen 911. He said he is also working with Mr. Soucheray on advanced exams. He said he is working with Brian Edwards on the base of operations language workgroup. NASEMSO is doing survey of data from all 50 states but very few states have language on base of operations.

Ms. Nagy reported on the Cooper/Sams applications received. There were 116 application received that will be paid in the spring. Mr. Spector said Ms. Nagy is also doing data entry for credit history in the elicense system.

Mr. Spector said EMR renewals are due on 10/31 of this year. He said some applicants are still struggling with renewal that are in their grace period.

Mr. Shorten said people are asking for extensions of their expiration date and looking for refresher classes. There was a spike in calls when the system sent a message regarding expirations. Mr. Shorten said he sees this as an opportunity for education.

Mr. Spector said there have been questions about non-transport agencies having a roster in the system. He said a work around is to have them register as a MRU.

Mr. Spector said there was a discussion at the Board meeting about non–certified drivers. He said that Representative Huot is providing information on a survey. Staff are conducting a survey of ambulance services. Information being sought from a NASEMSO survey of all 50 states. Mr. Spector said this data will be shared.

Mr. Spector said Nextgen (pologon) 9-1-1 information is being posted to the EMSRB website. The EMSRB is waiting for a service level agreement from MNiT to move forward with the project. There will be a pilot of 80 hours to understand how many hours it will take to complete the project.

Mr. Spector said Minnesota Statute 144E.266 suspends ambulance rules and regulations during a peacetime emergency. He said most ambulance services are working within the requirements and that no one expected a seven month emergency. He suggested a future conversation take place regarding this statutory language and possible changes needed.

Mr. Spector said the EMSRB has been working with the other agencies and the Department of Administration on the move to a new building. He said information was provided to him yesterday on the costs. He quoted the cost for the current lease for office space, storage and parting to be $80,000.00 per year. He said the cost would increase to $200,000.00 per year. He said this will affect our operating budget and as a general fund agency the EMSRB cannot pay this increase. He said the response was that it would need to come out of the operating budget and that you may need to cut staffing. He said he is working on hiring staff and apologized for the delays in this process. He said he is having conversations with SMART and the Department of Administration about this. He said the EMSRB cannot cut staff. He said he wanted to share his concerns and the target for moving is May/June. He said the Department of Administration is working with the owner of the building to extend the current lease. Mr. Schaefer asked about other bids (alternative locations). Mr. Spector said an RFP was issued and the selection committee narrowed the choices to two locations. The majority of Executive Director’s voted for the new construction choice.
7. **New Business – 10:45 a.m.**

None.

8. **Adjourn – 11:15 a.m.**

Mr. Guiton asked for a motion to adjourn.

Motion: Mr. Miller moved to adjourn. Dr. Ho seconded. Motion carried on a roll call vote.

Reviewed and Approved By:

Megan Hartigan (by email) 12/4/20
Board Secretary/Treasurer Date
Follow-Up Information Summary

Emergency Meeting of Executive Committee

On Monday, December 7th, the EMSRB called an emergency meeting of its Executive Committee to discuss a recommendation from the EMSRB to the Minnesota Department of Health concerning the definition of EMS personnel for the Tier 1A group of the COVID Vaccine Distribution Plan.

Nearly 100 people attended the virtual meeting held via Microsoft Teams. The two-hour public meeting welcomed input from all who were in attendance. The Executive Committee ended up voting in favor of the following definition of EMS personnel for the Tier 1A group of the COVID Vaccine Distribution Plan:

*Individuals providing direct patient care as part of the EMS system: Air Ambulance Pilots, Ground Ambulance Drivers, Physicians, Physician Assistants, Nurses, and those personnel certified or registered by the EMSRB: Paramedics, Advanced Emergency Medical Technicians, Emergency Medical Technicians, and Emergency Medical Responders.*

This definition was then forwarded to the Minnesota Department of Health.

Please contact the EMSRB with questions at EMSRB@state.mn.us or at (651) 201-2800.
The Mission of the EMSRB is to protect the public’s health and safety through regulation and support of the EMS system.

FEMA Ambulance Strike Team Tracking

<table>
<thead>
<tr>
<th>Date</th>
<th>Calls</th>
<th>Sourced to FEMA</th>
<th>Sourced in Region</th>
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<tbody>
<tr>
<td>20-Nov</td>
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<tr>
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<tr>
<td>9-Dec</td>
<td>14</td>
<td>13</td>
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<tr>
<td>Totals</td>
<td>186</td>
<td>170</td>
<td>16</td>
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</tbody>
</table>
On November 25th, there were six (6) requests outside the scheduled operational period of 9:00 a.m. to 9:00 p.m.
On November 26th, two (2) teams in Central and South Central Minnesota went into 24-hour operational periods,
and on November 28th, the remaining teams went into a 24-hour operational period.

Requests for transport originating outside the State of Minnesota were denied.
MEMORANDUM

Date: December 16, 2020

To: EMSRB Executive Committee

From: Tony Spector

Re: EMS COVID-Related Staffing Issues Across Minnesota

Introduction

Last week, EMSRB staff were asked to explore whether services across Minnesota are experiencing staffing issues related to COVID positive staff, COVID quarantine, or whether staff are choosing not to work because of risks of COVID.

EMS staff sought assistance from the eight EMS regional directors who provided the following:

Southwest Region
27 ambulance services responded
  o 11 ambulance services having issues
    ▪ 3 services have COVID positive staff
    ▪ 5 services have staff on COVID quarantine
    ▪ 2 services have staff choosing not to work because of the risks of COVID
    ▪ 1 service has all of the above

Southeast Region
21 ambulance services responded
  o 12 ambulance services having issues
    ▪ 8 services have COVID positive staff
    ▪ 9 services have staff on COVID quarantine
    ▪ 9 services have staff choosing not to work because of the risks of COVID

South Central Region
16 ambulance services responded
  o 5 ambulance services having issues
    ▪ 5 services have COVID positive staff
    ▪ 3 services have staff on COVID quarantine
    ▪ 1 service has both
West Central Region
Most services responded
- Only a few have had staff quarantined
- No staff have tested positive

Central Region
Central Region reported that all its services report that they are operating normally. Some have staff out due to COVID, but it is not negatively impacting their service. However, some services are starting to indicate that while they are able to operate normally, they may no longer have the capacity to assist if there were regional needs to help transport patients.

Northeast Region (Arrowhead EMS)
Northeast Region submitted a blank document without any data. Staff still need to follow up with the Northeast Region.

Northwest Region
Northwest Region did not respond to our request for information.

Metro Region
Due to staff illness, Metro Region’s response is delayed

ACTION SOUGHT

EMSRB staff seek direction from the Executive Committee if more information or more detail is requested.
MEMORANDUM

Date: December 15, 2020

To: EMSRB Executive Committee

From: Tony Spector

Re: M Health Fairview Site Visit -- Temporary License No. 9234

M Health Fairview Eagan Ambulance Facility Inspection Report

On Thursday, December 11, 2020, EMSRB EMS Specialists Brian Shorten and Charles Soucheray visited the M Health Fairview ambulance facility located at 4390 Pilot Knob Road in Eagan, Minnesota. This visit occurred at the request of Tom Edminson, EMS Chief for M Health Fairview EMS, to determine if this location qualifies as a base of operations for Temporary License No. 9234.

A Base of Operations is defined by Minnesota Statutes section 144E.001, subdivision 4:

Base of operations means the address at which the physical plant housing ambulances, related equipment, and personnel is located.

A Base of Operations also is defined in Minnesota Rules section Minnesota Rule 4690.0100, subp. 3:

Base of operations means the address at which the physical plant housing ambulances, related equipment, and personnel is located.

These definitions are different that the definition of a Substation which is defined in Minnesota Rules section 4690.0100, subp. 33:

Substation means the location from which ambulances and personnel operate to provide ambulance service which is supplementary to that provided from the base of operation and which enables the licensee to serve all points in its primary service area in accordance with the requirements in parts 4690.3400 to 4690.3700.
This location actually is a new base of operations for M Health Fairview for Temporary License No. 9234. Previous disclosures by M Health Fairview and its predecessor entity, Health East Medical Transportation, noted its Base of Operations at 799 Reaney Avenue in Saint Paul, Minnesota.

This facility was formerly Eagan Fire Station No. 3 now being leased from the City of Eagan by M Health Fairview. The building has three bay doors and can fit three ambulances inside the structure. There is additional parking space outside for other units. There is a sign on the outside of the building that reads “M Health Fairview Emergency Medical Services” and there is ample parking for several ambulance crews. This is a report to work/end shift location for crews, and there are three ambulances permanently assigned to the base. There is a time clock and an office for employees inside, as well as a crew lounge, kitchenette, restrooms, locker room, supervisor’s office, ambulance cleaning supplies, and storage for crew respirator masks inside.

This location has a storage room for ambulance supplies and equipment, it is restocked as needed and can resupply the ambulances upon their return from a call. This storage room also contains spare Lucas batteries and a portable ventilator unit. The Pyxis pharmacy dispenser is also located in this room, and it is their secure medication dispensing/disposal device. The exterior doors and the doors to the equipment/pharmaceutical area are secured by both electronic scan readers with a code input backup.

Interior and exterior photographs are found on the following pages of this memorandum.

Per the letter dated November 24, 2020 from M Health Fairview, the following locations are substations for Temporary License No. 9234:

Mendota Heights Fire Department
2121 Dodd Road
Mendota Heights, MN 55120

Rosemount Fire Department Station 1
14700 Shannon Parkway
Rosemount, MN 55068

Inver Grove Heights Fire Department
Station 3
2059 Upper 55th Street East
Inver Grove Heights, MN 55077

South Metro Fire Department, Station 1
1650 Humboldt Ave.
West St. Paul, MN 55118

South Metro Fire Department, Station 2
310 Marie Ave
South St. Paul, MN 55075

Note: These locations were not visited or inspected as part the preparation of this report.
Site Photographs

Exterior of building from north side showing parking area
Exterior of building from south side showing bay doors and M Health Fairview EMS sign
Interior of ambulance bay facing north
Interior of ambulance bay facing south
Pyxis Dispenser
Equipment/Supplies
Equipment/Supplies
Crew Lounge
Crew Kitchenette
Ambulance Cleaning Supplies/Workbench Area
Equipment maintenance room
Supervisor’s Office
### Number of Active EMS Personnel by Certification Level

<table>
<thead>
<tr>
<th>Certification Level</th>
<th>Number of Active Personnel</th>
</tr>
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<tbody>
<tr>
<td>Emergency Medical Responder (EMR)</td>
<td>13,827</td>
</tr>
<tr>
<td>Emergency Medical Technician (EMT)</td>
<td>10,079</td>
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<tr>
<td>Advanced Emergency Medical Technician (AEMT)</td>
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<tr>
<td>Paramedic</td>
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<tr>
<td>Provisional EMT</td>
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<td>Provisional Paramedic</td>
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<tr>
<td>Community EMT/EMT</td>
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<tr>
<td>Community EMT/Paramedic</td>
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<tr>
<td>Community Paramedic (CMPA)</td>
<td>155</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>27,602</strong></td>
</tr>
</tbody>
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3,403 EMRs with an October 31, 2020 registration expiration renewed their credential.

3,520 EMRs with an October 31, 2020 registration expiration did not renew their credential.
MEMORANDUM

Date: October 19, 2020

To: Tony Spector, Executive Director

From: Holly Jacobs, EMS Specialist

Re: Minnesota Ambulance Driver Survey

Minnesota Ambulance Services were surveyed between the dates of October 12, 2020 and October 19, 2020. There were 129 responses received, of which 31 ambulance services use non-credentialed drivers and 98 services use the minimum of an EMR driver. The level of service answering the survey was not a data point.

When asked the question, “Does your service use non-credentialed ambulance drivers?” services who responded with the answer of “No”, were sent to the end of the survey. Services who provided an answer of “Yes”, answered additional questions as indicated in the summary below. All services who answered “Yes”, are located outside the metro area.

What type of medical training do your ambulance drivers receive?

A course in cardiopulmonary resuscitation (CPR) is required by 17 of the services who use non-credentialed ambulance drivers and 5 services require both CPR and Stop the Bleed training. The remaining agencies indicated that they use their fire department or law enforcement as drivers, while four services require no medical training at all.

What type of drivers training do your ambulance drivers receive?

Minnesota Statute 144E.101, subd.10 indicates “a driver of an ambulance must possess a valid driver’s license issued by any state and must have attended an emergency vehicle driving course approved by the licensee. The emergency vehicle driving course must include actual driving experience.

Survey responses revealed 10 of the 31 respondents using non-credentialed ambulance drivers require the Certified Emergency Vehicle Operator (CEVO) course, while 21 service have a program of their own.

In addition to the driving course, all 31 respondents require a valid driver’s license and 18 of those services use their human resources department, local police department, or the League of Minnesota Cities through their municipal insurance.
To Representative John Huot  
From Elisabeth Klarqvist, Legislative Analyst  
Subject Ambulance staffing and driver qualification requirements; other states

This memo is in response to your request for information on laws in other states that establish requirements for ambulance staffing and ambulance driver qualifications. I examined laws from 31 states governing ambulance services, and this memo includes information I found on staffing and driver qualification requirements from those states. I used the December 2019 report from the National Highway Traffic Safety Administration, *Characterizing Ambulance Driver Training in EMS Systems*¹, as a resource.

States that have addressed ambulance service staffing and qualifications for ambulance drivers in statute or rule have done so in a range of ways. Section 1 provides general information about the approaches of various states to ambulance staffing and ambulance driver qualifications. Section 2 consists of a table with citations to and summaries of staffing and driver qualification requirements in the statutes and rules examined.

**Section 1: State Approaches to Ambulance Staffing and Driver Qualifications**

**General requirements for staffing and driver qualifications.** Several states establish ambulance staffing and ambulance driver qualification requirements in statute or rule. Some states may allow local units of government to establish more stringent ambulance staffing and driver qualification requirements than those in state law, and those local requirements are not examined here.

- Some states, such as Kentucky, Missouri, and Tennessee, generally require ambulances to be staffed with individuals who at least are licensed EMTs. Kentucky also allows EMRs employed as drivers before January 1, 2018, to continue driving as long as they continue to be employed by the agency for which they worked before 2018. California requires ambulance drivers to comply with the training and education requirements to become an ambulance attendant within one year after obtaining an ambulance driver certificate.
- A number of states require ambulance drivers to at least be certified as EMRs. These states include Alabama (also allows a certificate from the state Fire College emergency care provider course), Maryland, Montana except in certain cases, New

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Hampshire, North Carolina, Oklahoma, Pennsylvania for ambulances staffed with two people, Vermont.

- Several states require ambulance drivers to be at least age 18 and to hold a current driver’s license. Tennessee requires ambulance drivers to be at least age 19 and to have at least three years of driving experience.
- Other states require ambulance drivers to comply with specific education and training requirements. These education and training requirements may include having attended an emergency vehicle operators course (EVOC) or earning an EVOC or EMS driver certificate (Alabama, Delaware, Florida, Mississippi, North Dakota, Pennsylvania, Virginia); having training or certification in first aid, CPR, or the use of automatic external defibrillators (Alabama, Delaware, Florida, North Dakota, Oregon, South Dakota, Washington); or attending a driver training course (Iowa, South Carolina).

Alternate staffing. A number of states establish alternate staffing requirements for certain types of ambulance services, or authorize a board or commissioner to permit an ambulance service to staff ambulances according to alternate requirements upon an application from the ambulance service. An ambulance service may staff an ambulance with staff who do not meet the general licensing, certification, or education and training requirements based on the location where the ambulance service operates, whether staff used by the ambulance service are volunteers, the situation in which services are provided, or the type of transport being provided. Some states require multiple criteria to be satisfied for an ambulance service to staff ambulances according to an alternate staffing plan. States allow an ambulance service to use alternate staffing:

- if the ambulance service provides service in a rural area of the state. A rural area may be described as a county, service area, or municipality with a population below a certain number or unincorporated parts of a county or service area (Arizona, California if the service also meets certain staffing conditions, Illinois if the service also meets certain staffing conditions, Montana, Washington, Wisconsin);
- in unusual or extraordinary circumstances such as an emergency or disaster (Missouri, Oklahoma, Tennessee);
- if the ambulance service is staffed entirely or substantially with volunteers (Illinois if staffed with volunteers or paid-on-call personnel, Missouri, Montana, Ohio); or
- for certain types of transports, such as nonemergency transports (Montana if the service also meets certain staffing conditions) or medical ambulance/evaluation bus vehicles and pediatric specialty care ground ambulances (North Carolina).

States take a range of approaches to staffing ambulances according to an alternate staffing plan. Some examples follow.

- Arizona allows an ambulance service serving a rural area to be staffed with two staff, one of whom is an EMR who drives the ambulance.
- California allows ambulance services to apply for a waiver exempting volunteer drivers in rural areas from the requirement to comply with the training and
education requirements for ambulance attendants within a year after obtaining an ambulance driver certificate.

- Illinois allows an ambulance service serving a rural area and using volunteer or paid-on-call personnel to apply for authorization to staff an ambulance with one EMT or higher and one EMR. Illinois also allows an ambulance service to apply to the regulating department for a staffing waiver if it cannot staff an ambulance according to the alternate staffing plan.
- Missouri allows an ambulance staffed with volunteers to be staffed with one EMT and one EMT, nurse, physician, PA, or EMR.
- Montana allows an ambulance service staffed primarily with volunteers to be staffed with an EMT or higher and a driver trained in emergency vehicle operations for nonemergency transports and transports in or from a rural area.
- North Carolina allows the ambulance service medical director to determine the number and combination of personnel needed to staff medical ambulance/evacuation bus vehicles and pediatric specialty care ground ambulances.
- With approval from the Department of Health, Washington allows an ambulance service in a rural area to use a driver who does not have medical or first aid training as long as other requirements are met.
- Wisconsin allows ambulance services in rural areas or ambulance services with a staffing waiver to staff ambulances with one emergency medical services practitioner plus one person with an EMR credential or higher.

Section 2: State Statutes and Rules

The following table summarizes the requirements from the statutes and rules of 31 states for ambulance service staffing and ambulance driver qualifications. The citations are linked to the most recent version of the statute or rule I found. In some states requirements for ambulance service staffing and ambulance driver qualifications are established at the local level, and I did not examine local requirements or include them in this table.

<table>
<thead>
<tr>
<th>State</th>
<th>Citation to Statute or Rule</th>
<th>Requirements for Staffing and Driver Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td><a href="#">Alabama Administrative Code 420-2-1-.15; Alabama Administrative Code 420-2-1-.19</a></td>
<td>An emergency vehicle operator must have a valid driver’s license, a current emergency vehicle operations certificate from an approved course, a current approved CPR card, and a certificate of completion of a Department of Transportation Emergency Medical Responder Curriculum Course or from the Alabama Fire College Emergency Care Provider Course. A ground ambulance must, at a minimum, be staffed with an emergency vehicle operator and the required number of licensed personnel. A BLS provider transport service shall, at a minimum, be staffed with an emergency vehicle operator and a licensed EMT.</td>
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<tr>
<td>Arizona</td>
<td><a href="#">Arizona Revised Code § 36-2202J</a></td>
<td>Establishes two staffing models for an ambulance service. An ambulance service serving a rural area with a population of less than 10,000 must have at least one attendant who is an EMT, AEMT, EMT I-99, or paramedic who cares for the patient, and one</td>
</tr>
<tr>
<td>State</td>
<td>Citation to Statute or Rule</td>
<td>Requirements for Staffing and Driver Qualifications</td>
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| California  | California Vehicle Code, § 12527 | To obtain an ambulance driver certificate an applicant must be at least 18, hold a valid CA driver’s license, be trained and competent in ambulance operation and the use of safety and emergency care equipment as required in rule, and have an ambulance driver certificate after passing an examination and submitting a medical examination report and a fingerprint card. An ambulance driver must complete training to assist the ambulance attendant in the care and handling of the ill and injured and must either:  
- within one year after obtaining an ambulance driver certificate, comply with the training and education requirements for ambulance attendants; or  
- be a volunteer driver driving for a volunteer ambulance service and working in unincorporated parts of a county with a population of less than 125,000 people. To obtain a driver certificate under this provision, the county board of supervisors and another listed entity must submit to the Department of Motor Vehicles information substantiating the public health necessity for an exemption. |
| Colorado    | 6 CCR 1015-3 ch. 4 § 7       | Counties must establish staffing requirements for ambulances. An ambulance driver must at a minimum have a current, valid driver’s license. |
| Delaware    | Delaware Administrative Code 710 7.2.4 | The minimum acceptable crew staffing when transporting a patient is a driver and one state-certified EMT. An ambulance service driver is required to have completed the Emergency Vehicle Operators course conducted by the Delaware State Fire School or an equivalent program approved by the commission, and to maintain current CPR/AED certification approved by the commission. |
| Florida     | Florida Statutes § 401.281; Florida Rules 64J-1.013 | Ambulance drivers must be at least 18, be free from convictions for driving under the influence in the past three years, possess a valid driver’s license, be trained in the safe operation of emergency vehicles, complete an emergency vehicle operator’s course, and possess a valid American Red Cross or National Safety Council first aid course card and CPR card. Basic life support and advanced life support providers must document that each driver has completed at least a 16-hour course on driving an authorized emergency vehicle that includes the specified content. |
| Illinois    | Illinois Administrative Code title 77 § 515.830 | Establishes the following personnel requirements for ambulances: |
### Requirements for Staffing and Driver Qualifications

- **basic life support ambulance and intermediate life support ambulance:** two staff who must be an EMT, AEMT, EMT-I, paramedic, nurse, or physician;
- **advance life support ambulance:** one staffperson who is a paramedic or nurse and one staffperson who is an EMT, AEMT, EMT-I, paramedic, nurse, or physician;
- a service provider that serves a rural or semirural population of 10,000 or fewer inhabitants and exclusively uses volunteers, paid-on-call personnel or a combination to provide patient care may apply for alternate rural staffing authorization to staff the ambulance with one EMS personnel licensed at or above the level at which the vehicle is licensed and one EMR, when a second EMT, AEMT, EMT-I, paramedic, nurse, or physician is not available to respond; and
- a service provider that cannot meet the alternate rural staffing authorization above may apply to the department for a staffing waiver.

### Iowa

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<tr>
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<tbody>
<tr>
<td>Iowa</td>
<td>Iowa Administrative Code, 641-132.3(4); Iowa Administrative Code, 641-132.1</td>
<td>Defines emergency vehicle driver as a currently licensed driver rostered with the service program or other emergency response personnel with emergency vehicle driver training. On emergency calls, a primary response ambulance must be staffed at least by one certified emergency medical care provider certified at the service program full level of authorization, and one driver. On nonemergency calls, a primary response ambulance must be staffed at least by one certified EMT and one driver. Service program members who operate motorized emergency response vehicles, ambulances, and rescue vehicles when used by a service member responding as a member of the service must have a valid driver’s license and attend driver training before driving an emergency vehicle. The driver training must include a review of Iowa laws regarding emergency vehicle operations, policies and criteria for responding with lights or sirens, speed limits, procedures for approaching intersections, and use of communications equipment. A provision in rules from 2016 required drivers to be trained in CPR, but I could not find that provision in 2020 rules.</td>
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### Kentucky

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<tr>
<td>Kentucky</td>
<td>Kentucky Administrative Regulations 7:560</td>
<td>A person driving an ambulance must be certified as an EMT, be at least 18, hold a valid driver’s license, and complete at least four hours of driver training and education every two years. An emergency medical responder who was employed by a class I, II, or III ambulance agency as a driver before January 1, 2018, may continue in that role if the emergency medical responder’s employment relationship with that agency does not lapse. Alternative staff shall not operate a licensed vehicle until the agency administrator so directs or the vehicle is out of service.</td>
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### Maryland

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<tr>
<td>Maryland</td>
<td>Code of Maryland Regulations 30.09.07.02</td>
<td>A driver of a basic life support or advanced life support ground ambulance must be certified as an emergency medical responder or higher and have a valid motor vehicle license.</td>
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<tr>
<td>State</td>
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<td>Mississippi</td>
<td>2019 Mississippi Code, § 41-59-29; Miss. Administrative Code, title 15, part 12, subpart 31, chapters 1, 5</td>
<td>An ambulance must be staffed by at least two people, one of whom may be a driver with a valid resident driver's license. Rules 1.11.1 and 1.11.3 require an ambulance to be staffed in part with a driver who has a valid EMS driver state certificate and a valid driver’s license. Ch. 5 provides that to obtain an EMS driver certificate, an applicant must possess a valid driver’s license, be at least 18, and within the past two years have completed an EMS driver course in MS or another state that meets the guidelines for MS EMS driver training program. The driver course must be at least eight hours and must contain didactic instruction and practical evaluation of knowledge that will allow student to safely operate emergency vehicles.</td>
</tr>
<tr>
<td>Missouri</td>
<td>Missouri Statutes § 190.105.2; Missouri Statutes § 190.094</td>
<td>No individual shall drive, attend, or permit the operation of an ambulance unless the ground ambulance is under the immediate supervision and direction of a person currently holding a Missouri license as an EMT. Each ambulance service is responsible for assuring any persons driving its ambulance is competent in emergency vehicle operations and has a safe driving record. In emergency situations, an emergency medical responder, firefighter, or law enforcement officer with a valid driver’s license and prior experience driving emergency vehicles may drive the ground ambulance as long as this practice is permitted in operational policies. Each ambulance must be staffed with a minimum of two licensed individuals, except that an ambulance staffed with volunteer staff may be staffed with a minimum of one EMT and one other crew members who may be an EMT, nurse, physician, PA, or emergency medical responder.</td>
</tr>
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</table>
| Montana  | Montana Code 50-6-322; Montana Administrative Rules 37.104.316                             | An emergency medical service that is staffed primarily by volunteer emergency care providers may staff an ambulance with an EMT or higher and a driver trained in the operation of emergency vehicles for the following responses:  

- nonemergency ambulance transports;  
- emergency medical services provided by an ambulance company located in a county with a population of fewer than 20,000 residents; and  
- emergency medical services provided by an ambulance company located in a county with a population of 20,000 residents or more if the ambulance company is transporting the patient from a community of 1,5000 residents or less to the nearest health care facility that can meet the patient’s medical needs.  

Other basic life support ground ambulance services must be staffed by two staff who are EMTs, physicians, or EMRs (no more than one may be an EMR). All persons used as ambulance drivers must complete training equivalent to the emergency vehicle operation objectives in a board-approved EMT course. |
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<tr>
<td>Nebraska</td>
<td>Nebraska Revised Statutes 38-1226, 38-1227</td>
<td>An ambulance transporting a patient must be staffed by at least one licensed emergency care provider. The driver of a licensed motor vehicle ambulance must hold a valid driver’s license.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>New Hampshire Rules Saf-C 5902.06</td>
<td>The minimum staffing level in each EMS land or water vehicle must include two providers licensed as an EMR, EMT basic, EMT, AEMT, or paramedic. While transporting a patient the provider responsible for patient care must be an EMT basic, EMT, AEMT, or paramedic.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>New Jersey Regulations 8:40-4.1</td>
<td>A crewmember operating a vehicle must possess a valid driver’s license, be at least 18, and have knowledge and skills in the operation of medical equipment in the vehicle, potential transport complications, the procedures for the operation of an ambulance, safety operations for vehicle accident and incident procedures, communications equipment, relevant laws and rules, and the scope of practice for the crewmember’s level of certification.</td>
</tr>
<tr>
<td>New York</td>
<td>New York Code 800.21(h)</td>
<td>A licensed driver shall drive the ambulance.</td>
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<tr>
<td>North Carolina</td>
<td>North Carolina Statutes § 131E-158; North Carolina Administrative Code 10A 13P.0219; North Carolina Administrative Code 10A 13P.0220</td>
<td>An ambulance when transporting a patient must be occupied by at least one EMT responsible for the medical aspects of the mission and one EMR responsible for operation of the vehicle and rendering assistance to the EMT. Medical ambulance/evacuation bus vehicles are exempt from these staffing requirements, and the EMS System Medical Director may determine the number and combination of personnel that are sufficient to manage the patients transported in the vehicle. Pediatric specialty care ground ambulances operated within an approved specialty care transport program dedicated for inter-facility transport are also exempt from these staffing requirements, and the Specialty Care Program Medical Director may determine the staffing that is sufficient to manage the patients transported in the vehicle.</td>
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<tr>
<td>North Dakota</td>
<td>North Dakota Administrative Code 33-11-02-01; North Dakota Administrative Code 33-11-03-01</td>
<td>A driver of a basic life support ground ambulance must have completed the emergency vehicle operations course within one year of joining the ambulance service; and have current CPR certification, unless there are two primary care providers or one primary care provider plus one other person with current CPR certification. For an advanced life support ground ambulance staffed by two persons, the minimum staffing requirement is a paramedic and an EMT. If an ALS ambulance is staffed by three or more persons, the paramedic and EMT crew may have a CPR-trained driver who has also completed the emergency vehicle operations course within one year of joining the ambulance service.</td>
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<tr>
<td>Ohio</td>
<td>Ohio Revised Code § 4765.43</td>
<td>An ambulance driver must:</td>
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<td>▪ be at least 18 and hold a valid driver’s license; and</td>
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<td>▪ meet one of the following: be certified as a first responder, EMT, AEMT, or paramedic; hold a fire training certificate; be employed as a sheriff, deputy sheriff, constable, police</td>
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<tr>
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<tr>
<td>Oklahoma</td>
<td><strong>Oklahoma Administrative Code § 310:641-3-15</strong></td>
<td>A ground ambulance service must have a driver who at a minimum is certified as an EMR and successfully completes an emergency vehicle operator course within 120 days of employment and a refresher course every two years thereafter. In unique and unexpected circumstances, including a disaster, the minimum driver requirements may be altered, and an attendant may ask a law enforcement officer or firefighter familiar with the operation of the emergency vehicle to drive the vehicle.</td>
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<tr>
<td>Oregon</td>
<td><strong>Oregon Administrative Rules 333-250-0270</strong></td>
<td>A driver of a ground ambulance must either:</td>
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<td>▪ be a licensed EMS provider (this term appears to mean EMT, EMT-Intermediate, AEMT, EMR, or paramedic) and have a valid driver’s license; or</td>
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<td>▪ have a valid driver’s license; have a current basic life support provider card or proof of course completion that meets or exceeds the American Heart Association CPR and Emergency Cardiovascular Care guidelines; have completed emergency ground ambulance operator’s training, bloodborne pathogen and infectious disease training, and hazardous materials awareness training; sign a statement that the driver is not addicted to drugs or alcohol, is free from physical or mental impairments, and is physically capable of helping lift and move patients; have passed a criminal background check; and have been certified by the Department of Public and Safety Standards and Training in the past year.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td><strong>Pennsylvania Code title 28 §§ 1023.22, 1027.33</strong></td>
<td>A ground EMS vehicle may be operated by an EMS vehicle operator, or EMSVO. An individual may be certified as an EMSVO if the individual is 18 or older, has a current driver’s license, has successfully completed an emergency vehicle operator’s course, is not addicted to alcohol or drugs, is free from physical or mental impairments, and has not been convicted of certain crimes. Minimum staffing for a BLS ambulance is an EMR or higher, an EMT or higher, and an EMSVO, except that only a two-person crew is required if the EMSVO is also an EMR or higher.</td>
</tr>
<tr>
<td>South Carolina</td>
<td><strong>South Carolina Regulations 61-7 § 403, 404</strong></td>
<td>A basic life support ambulance must be staffed with at least one EMT and one driver. A non-credentialed ambulance driver may drive an ambulance if the driver is at least 18, is physically able to drive, has a driver’s license, has a criminal background check, and completes a nationally accredited safe driving course within six months after hire. In emergencies that require a third crew member, an ambulance may be driven by a member of a fire department, law enforcement agency, or rescue squad.</td>
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<tr>
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| South Dakota    | South Dakota Codified Laws 34-11-6, South Dakota Rules 44:05:03:04.01                      | All ambulance drivers and attendants on duty must have certification of completing an emergency care course. A licensee must be staffed by a minimum of:  
  ▪ one advanced life support personnel or one EMT; and  
  ▪ one driver or EMR.  
  The driver must complete a state-approved course to demonstrate competencies in CPR and AED, HIPAA, infection control, patient movement, equipment communication systems, and emergency vehicle operations. |
| Tennessee       | Tennessee General Rules §§ 1200-12-01-.10, 1200-12-01.14                                    | An ambulance operator or driver must possess the special class licenses and endorsements as are required for ambulances, be at least 19, and have at least three years of licensed driving experience. In extraordinary circumstances when both ambulance service personnel are providing patient care or are incapacitated, another individual may operate the ambulance. Staffing requirements are based on the category and level of services provided. The minimum staffing level for a basic life support ambulance operated by a licensed ambulance transport service is two EMTs. |
| Vermont         | Code of Vermont Rules 13-140-013.4.1.4, 13-140-013.4.1.2                                    | A driver of an ambulance transporting a patient must be at least 18 and hold a valid motor vehicle operator’s license. An ambulance must be staffed by at least two Vermont-licensed EMS providers (it appears this term is defined to mean EMR, EMT, AEMT, or paramedic). The patient must be attended by a physician or at least one person licensed at the EMT level or higher. |
| Virginia        | Virginia Administrative Code 12 VAC5-31-1230                                              | A ground ambulance transport must be staffed with a minimum of two persons, an operator who at a minimum possesses a valid motor vehicle operator’s permit and has successfully completed an approved emergency vehicle operator’s course, and an attendant in charge who meets the requirements listed for the type of transport to be performed. For a basic life support transport, for instance, the attendant in charge must be at least certified as an EMT or equivalent. |
| Washington      | RCW 18.73.150                                                                              | An ambulance driver must at least have a certificate of advanced first aid qualification (advanced Red Cross training or its equivalent), except that if there are at least two certified emergency medical technicians in attendance of the patient a driver is not required to have this certificate. With approval of the Department of Health, an ambulance service established by a volunteer or municipal corporation in a rural area with insufficient personnel may use a driver without any medical or first aid training as long as the driver is at least 18, successfully passes a background check, possesses a valid driver’s license with no restrictions, is accompanied by a nondriving EMT, and only provides medical care to the level the driver is trained. |
| Wisconsin       | Wisconsin Statutes § 256.15(4)                                                              | A ground ambulance must be staffed with at least:  
  ▪ any two of the following: emergency medical services practitioners, RNs, PAs, or physicians; |

**Notes:**
- **EMT:** Emergency Medical Technician
- **EMR:** Emergency Medical Responder
- **AEMT:** Advanced Emergency Medical Technician
- **paramedic:** Paramedic
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<td>- one emergency medical services practitioner plus one individual with a training permit; or</td>
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<td>- for an ambulance service provider serving a service area in which the largest single municipality has a population of less than 10,000 or for an ambulance service provider with a staffing waiver, one emergency medical services practitioner plus one person with an emergency medical responder credential or higher.</td>
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<td>An ambulance service provider may apply for a staffing waiver if the largest single municipality in the service area has a population between 10,000 and 20,000, has made efforts to recruit and train emergency medical services practitioners, emergency medical services practitioners are not available in sufficient numbers, and without a waiver the ambulance service provider cannot meet the staffing requirements that require at least two emergency medical services practitioners on every service call.</td>
</tr>
<tr>
<td>Wyoming</td>
<td><a href="#">Wyoming Rules ch. 4 § 2</a></td>
<td>Ground ambulances must be staffed with a driver and at least one licensed EMT.</td>
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EK/mc
MEMORANDUM

Date: December 16, 2020

To: EMSRB Executive Committee

From: Tony Spector

Re: National Registry Provisional EMS Certification

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**Background**

Earlier this year, the National Registry created a Provisional EMS Certification Level for EMTs and Paramedics who successfully completed their EMS education and passed the cognitive test offered at the Pearson VUE testing centers but were unable to complete the psychomotor examinations due to education programs suspending their operations.

Provisional certifications from the National Registry have a December 31, 2021 expiration date. Minnesota also offers a provisional EMS certification which matched the level and expiration date of the National Registry provisional certification.

Last month, the National Registry’ Board of Directors decided at its monthly meeting to cease issuing provisional certifications after December 31, 2020 while still maintaining the December 31, 2021 expiration date and allowing those holding a provisional certification the ability to convert to full National Registry certification on or before December 31, 2021.

Subsequent to this decision by the National Registry, its Board heard concerns from some states about the continued need for provisional certification due to the ongoing COVID pandemic.

Last week, the National Registry thereafter published a quick survey seeking input from each state as to whether the National Registry should

A. Cease offering new provisional certifications on December 31, 2020;
B. Cease offering new provisional certifications on March 31, 2021; or
C. Continue offering new provisional certifications until an undetermined future date when conditions improve.

The survey closed at the end of the day on December 14, 2020. Staff discussed internally and due to the very tight timeline to submit a response informed the National Registry of its recommendation that the National Registry should cease offering new provisional certifications on March 31, 2021.

**The Mission of the EMSRB is to protect the public’s health and safety through regulation and support of the EMS system.**

An Equal Opportunity Employer
ACTION SOUGHT

The above is provided for information purposes only; no action is sought. Staff will inform the Board of any follow-up from the National Registry.
EMS Base of Operations and Substations

A WORKGROUP REPORT FOR THE MINNESOTA EMERGENCY MEDICAL SERVICES REGULATORY BOARD
PREPARED BY BRIAN EDWARDS, BS, MPO, NRP
Introduction
This report has been prepared at the request of the Emergency Medical Services Regulatory Board (EMSRB) Chairperson J.B. Guiton. The principal author of this report is Brian Edwards, EMSRB member. The topic is the statutes and rules regarding the terms “base of operations” and “substation,” as those terms are used in Minnesota Statutes, chapter 144E and Minnesota Administrative Rules, chapter 4690.

Background
Directive
In the July 2020 special meeting of the EMSRB, board chair J.B. Guiton requested the formation of a work group to address the issue of “base of operations” and “substations” as those terms are used in Chapter 144E of Minnesota statutes and Chapter 4690 of Minnesota administrative rules. The specific wording of the directive as taken from the meeting minutes reads, to wit:

“Mr. Miller moved the Board create an ad hoc workgroup to identify and bring back to the Board suggestions regarding the substation statute and base of operations statute and appropriate administrative rules. Dr. Pate seconded. Ms. Nagy conducted a roll call vote. Motion carried unanimously.”

The board chair tasked Brian Edwards, Board member, to chair this ad hoc workgroup. In addition, Mr. Guiton instructed this workgroup to “work with the legislative workgroup,” ostensibly after this report will have been reviewed by the Executive Committee of the EMSRB.

Workgroup
Four members of the workgroup were selected, in addition to the appointed chair; each member possesses a unique view of EMS operations and history (including statutory history). The members of the workgroup are as follows:

- BJ Jungmann, Burnsville Fire Department; fire-based EMS provider
- Brad Hanson, CentraCare EMS; rural single-station EMS provider that has recently merged with a larger multi-station licensee
- Bruce Hildebrandt, Minnesota Ambulance Association
- Thomas “Tom” Fennell, Mayo Clinic Ambulance Service; large, multi-station/license provider
- Brian Shorten, EMSRB staff (support)
- Holly Jacobs, EMSRB staff (support)
- Brian Edwards, EMSRB (Chair); rural single-station provider

Minnesota Statutes and Rules
There are a limited number of statutes and rules regarding the terms base of operations and substations. None provide a meaningful, objective measurement of what constitutes a base of operations or substation.
Definitions

**Base of Operations:** This term is defined in statute, section §144E.001, subdivision 4, to wit: “Base of operations means the address at which the physical plant housing ambulances, related equipment, and personnel is located.” The term is also defined in administrative rules chapter 4690.0100, subpart 3, with an identical definition to the statute.

**Substation:** This term is not defined in statute but is defined in administrative rules chapter 4690.0100 subpart 33, to wit: “Substation means the location from which ambulances and personnel operate to provide ambulance service which is supplementary to that provided from the base of operations and which enables the licensee to serve all points in its primary service area in accordance with the requirements in parts 4690.3400 to 4690.3700.”

Location

No statutes specifically direct where a base of operations or substation must be **located**, although some suggest it must be located in the licensee’s PSA. Of the administrative rules, only 4690.3400 (“Designation of Primary Service Area”) expressly states a base of operations must be located in the licensee’s primary service area, to wit: A **primary service area must contain one base of operation and may contain substations.** This rule seems to be the only place in law where the location of the base of operations is distinctly specified.

One statute and one administrative rule reference the **relocation** of a base of operations. Section §144E.15 lists specific measures a licensee must take if they wish to move their base of operations: “To relocate the base of operations to another municipality or township within its primary service area, a licensee must provide written notification to the board prior to relocating. The board shall review the proposal to determine if relocation would adversely affect service coverage within the primary service area. The applicant must furnish any additional information requested by the board to support its proposed transfer. If the board does not approve the relocation proposal, the licensee must comply with the application requirements for a new license under section 144E.11.” It is worth noting two things about this particular statute: first, §144E.11 (application procedure) does not specify that an ambulance service must have a base of operations in its service area, and secondly, §144E.15 does not expressly prohibit the base of operations from being outside the primary service area.

Administrative rule 4690.0100 subpart 7 defines the term, “change of base of operations,” to wit: “Change of base of operation means the relocation of vehicles, related equipment, and personnel housed at one location to another location such that it is no longer possible for the service making the change to meet the conditions of its license regarding its designated primary service area.” It might be reasonable to assume that even a relocation outside of the PSA might not adversely affect the licensee’s ability to provide service.

It should be noted that §144E.15 is very specific with the steps a licensee must take to relocate the base of operations. It is also noteworthy that, if requested by the board, “the applicant must furnish additional

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1 Subpart 3400 describes the designation of a primary service area, the reasonableness of a primary service area, and the maximum primary service area as defined by miles and travel time. Rules 4690.3500 and 4690.3700 have been repealed, and 4690.3600 references aeromedical licensees.
information requested by the board to support its proposed transfer.” In a review of chapter 144E, however, the workgroup could find no additional specifics as to what the board might request or what a licensee might provide, or what recourse the board might have if it found the supplemental information unfavorable other than “not approve the relocation proposal.”

Historically, the original version of 144E.15 (1997) contained the exact same language as the current version. The genesis of the statute seems to be the original Minnesota Department of Health EMS statutes. The workgroup did not exam historical references for other statutes and rules.

Additional Information

Other statutes and rules reference the term base of operations, but none provide clarity as to what actually constitutes a base of operations. Some, however, do present interesting questions as to where a base of operations must be located.

Section §144E.10, “Ambulance Service Licensing” stipulates that a license applicant must “specify the base of operations,” but does not stipulate where that base of operations must be located.

Section §144E.101, “Ambulance Service Requirements,” does not have any language specifying the location of a base of operations, nor does it specify what makes for a base of operations.

Section §144E.11, subdivision 2 and subdivision 5 mention the term “base of operations.” Subdivision 2 mentions the posted notice location (newspaper) “in the municipality in which the base of operation is or will be located…” Subdivision 5 discusses the contested case procedure for a license application. Interestingly enough, subdivision 5 (d) specifies steps to be taken if the applicant’s base of operations is located outside the state of Minnesota, although this could simply be a poorly worded clause.

Section §144E.14 prescribes the process for a transfer of license or ownership: A license, or the ownership of a licensed ambulance service, may be transferred only upon approval of the board, based upon a finding that the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of sections 144E.101 to 144E.127. If the proposed transfer would result in an addition of a new base of operations, expansion of the service’s primary service area, or provision of a new type or types of ambulance service, the board shall require the prospective licensee or owner to comply with section 144E.11. The board may approve the license or ownership transfer prior to completion of the application process described in section 144E.11 upon obtaining written assurances from the proposed licensee or proposed new owner that no expansion of the service’s primary service area or provision of a new type or types of ambulance service will occur during the processing of the application. If requesting a transfer of its base of operations, an applicant must comply with the requirements of section 144E.15.

Administrative Rule 4690.0200 “Contents of All Applications” does not specify what a base of operations should or must include, nor does it stipulate the location of a base of operations, only that the address must be included in the application.

Aside from the above listed statutes and rules, there are no other specific metrics for what constitutes a base of operations or substation, or where one must be located.
Other States

The members of the work group solicited feedback from other state EMS officials about different states’ statutory or administrative language regarding terms such as base of operations and substations. Of the fifty states, replies came from seventeen. Of those seventeen, six indicated they have language in statute about base of operations; eleven do not. The following is a comprehensive list of the responses.

<table>
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<tr>
<th>State</th>
<th>Response</th>
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<tr>
<td>Indiana</td>
<td>(1) Each application shall include the following information: (A) A description of the service area; (B) Hours of operation; (C) Number and location of ambulances. List the address of each station with a physical address or general staging / positioning plan that addresses each emergency medical services certified vehicle. <em>(For (C), black text is current language; red text is proposed language in process).</em></td>
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<tr>
<td>Kansas</td>
<td>(g) Each operator shall park all ground ambulances in a completely enclosed building with a solid concrete floor. Each operator shall maintain the interior heat of the enclosed building at no less than 50 degrees Fahrenheit. Each operator shall ensure that the interior of the building is kept clean and has adequate lighting. Each operator shall store all supplies and equipment in a clean and safe manner.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>(e) All transporting land vehicles shall: 1. Be garaged in a shelter constructed of material other than fabric or plastic sheeting; 2. Be kept free from snow, sleet, and ice; and 3. Have the interior maintained at a minimum of 50 degrees Fahrenheit when the vehicle is not in use.</td>
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<tr>
<td>Oklahoma</td>
<td>&quot;Base Station&quot; means the primary location from which ambulances and crews respond to emergency calls on a twenty-four (24) hour basis. The Base Station may include the principal business office, living quarters for personnel, training institution, and/or communications center. &quot;Licensed Service Area&quot; means the contiguous geographical area identified in an initial ambulance service application or in an amendment to an existing license. The geographic area is identified by the application and supported with documents provided by the local governmental jurisdictions. For ground ambulance services, this is the geographic area the ambulance service has a duty to act within. &quot;Substation&quot; means a permanent structure where an ambulance(s) is/are stationed and available for calls on a twenty-four (24) hour basis.</td>
</tr>
<tr>
<td>Texas</td>
<td>(F) Declaration of the address for the main location of the business, normal business hours and provide proof of ownership or lease of such location. (i) The normal business hours must be posted for public viewing. (ii) A service area map must be provided. (iii) Only one EMS provider license will be issued to each fixed address. (iv) The applicant shall attest that no other license EMS provider is at the provided business location or address. (v) The emergency medical services provider must remain in the same physical location for the period of licensure, unless the department approves a change in location.</td>
</tr>
<tr>
<td>Virginia</td>
<td>An EMS agency shall maintain a fixed physical location. Any change in the address of the primary business location and any satellite location require notification to the Office of EMS before relocation of the office space.</td>
</tr>
</tbody>
</table>
Workgroup Discussions

Assumptions

Members of the workgroup discussed the meaning and intent of the statute. It is difficult to determine what might have been the original purpose; it appears to be a hold-over from the original MDH EMS statutes and does not look to have been modified since at least 1997. None of the workgroup members know the origin of the statute, despite at least one member having been actively involved in EMS at the time the EMSRB was formed and 144E was written.

However, despite the lack of historical context, the workgroup is able to offer suggestions as to the “why” of the statute. Of course, all are assumptions and should not be considered de facto explanations for the statute.

First, it is reasonable to assume that, if the statute was a holdover from the MDH statutes, the terms “base of operations” and “substation” are merely copies of the original statutes and reflected terms in use at the time. This explanation does nothing to provide us with a direction in updating or defining the current terms, however.

Secondly, and a much more useful assumption, is that a “base of operations” might represent better, or quicker, service to a particular geographic area. This assumption is supported by the wording of other statutes and rules, namely 144E.15 that states in part, “…to determine if relocation [of the base of operations] would adversely affect service coverage within the primary service area.” In addition, administrative rule 4690.3400, subpart 2 applies a reasonableness standard to the size of a primary service area, and that size is directly linked to the physical location of a base of operations and substations.

Lastly, and possibly equally important to local authorities and end users, it is possible the belief at the time of writing was that an ambulance service would demonstrate more devotion to its license area if it were compelled to have a physical, brick-and-mortar presence in that area. This physical presence might demonstrate a bond and loyalty to its patients and customers. It might also have served to discourage transient, non-Minnesota EMS companies from attempting to establish a presence in Minnesota.2

Aside from the above listed assumptions, there is no clear indication in current statutes or rules, or historical references, as to why a base of operations must be located within the primary service area of a licensee, or to what actually constitutes a base of operations or substation.

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2 In the early to mid-90’s, ambulance services throughout the United States were undergoing significant ownership changes and mergers, with ambulance services disappearing and emerging literally overnight. This fact must have certainly been on the minds of the original legislative authors and industry experts involved in drafting 144E.
Meeting the board’s request

The workgroup members considered the language of the current statute as well as the language in statutes/rules of the states that responded. While the workgroup did not develop a comprehensive list, there was some common themes in what might constitute a base of operations and substation. If statutory language were to be changed, or administrative rules written or updated, they might include elements of the following:

- **Base of operations**
  - A building capable of holding one or more vehicles, where if out of service, they are protected from extremes of weather;
  - A place where staff report to work;
  - A place where staff are housed;
  - A place where supplies are kept;
  - A place where the EMSRB license is posted;
  - A building where regulatory legacy files are stored (i.e., complaints, schedules, etc.);
  - A place that the public recognizes as the official location of the ambulance service;
  - Perhaps most importantly: a place where someone responsible for the ambulance service can be found.
  - Regardless of what constitutes a base of operations, it should be publicly listed, and the physical address must be disclosed, and kept current, with the regulatory authority and local stakeholders.

- **Substation**
  - A site (or building) capable of holding one or more vehicles, where if out of service, they are protected from extremes of weather;
  - A site (or building) where staff might report to work;
  - A site (or building) where supplies might be kept;
  - A site (or building) that prepositions ambulances and staff to achieve shorter response times in distant parts of the service area.
  - Substation sites may or may not be publicly listed (and indeed, there may be some benefit to keeping these locations private for safety and security reasons).

There are frankly too many nuances, and service-specific differences, to develop an all-inclusive list. For example, some non-workgroup persons had suggested “the place where the licensee receives its mail.” That might be impractical for an agency that has a staffed, vehicle-housing station, but gets its mail delivered to the service director who might be officed in city hall. The same could be said for “the place where the licensee’s financial records are kept,” which would be meaningless, not to mention possibly onerous, to a large system that has a centrally located corporate office distant to its operational bases.

It is noteworthy that the workgroup did not suggest an appropriate location for a base of operations, such as within the confines of a licensee’s primary service area. Aside from the assumed historical reasons, there seems to be no current need to have a base of operations in a defined location. There may be a need to have substations, though, if an ambulance service has a service area of sufficient size, and/or volume, and/or shape. Furthermore, it may be entirely reasonable that, for financial, environmental, or technological reasons, a licensee would be better served by a base of operations outside of its PSA but supported by one or more substations within the PSA.
Additional thoughts from the workgroup

Current paradigm

There was a consensus amongst the workgroup members that the terms “base of operations” and “substation” are perhaps obsolete, or at least geographically meaningless. Many EMS systems with larger service areas and significant volumes place more emphasis on actual performance rather than brick-and-mortar structures. They do this by employing two strategies to assure prompt response times: 1) some version of medical dispatch using trained emergency medical dispatchers, and 2) system status management (also known as dynamic deployment). An explanation of these two strategies is beyond the scope of this document, but these are useful links for more information:

- Medical priority dispatch
- System status management

While traditional brick-and-mortar stations may serve some communities and services very well, especially fire-based EMS systems and smaller, geographically limited services, that model may not work as well for larger, high-volume systems. The very concept of a base of operations and/or substations, as defined by law, may be meaningless and serve no useful purpose other than regulatory compliance. Even with a physical building within a defined service area, there are no guarantees of prompt response times or improved outcomes.

For example, a system that serves a small area of, say, twenty square miles and a population of 200,000 persons could have a large, modern, technologically advanced building in the geographic or practical center of its service area. However, if that system’s volume is of sufficient quantity, that ambulance service would find it very difficult to respond to all requests for service were they to only have one ambulance. The service would rely heavily on mutual aid, and if that mutual aid were distant, response times would suffer. Similarly, a system with a much lower run volume but a much larger service area, still with an impressive base of operations, might find it very difficult to have prompt and timely service to the far edges of its service area. It is likely some EMS systems in Minnesota, especially in the far northern border counties, already fall into this latter category. In both instances, the ambulance services are meeting statutory requirements, but are they serving their patients and constituency effectively?3

Conversely, consider systems with a decentralized, dynamic deployment model. Even without a locally situated base of operations, that service may still be able to provide prompt, reliable service, even better than a station-based system of similar characteristics, simply because staffed ambulances are posted near where the historical data shows they should be located. Coupled with effective medical dispatching services and prearrival instructions, patients can and do receive timely, effective care. The use of substations, whether physical buildings or geographic locations, further enhances the ability of the licensee to respond quickly to requests for service.

3 This question is rhetorical and is in no way meant to malign the many wonderful EMS systems throughout the state that routinely provide prompt, timely, effective, and compassionate care to their patients, sometimes in harsh and unfavorable circumstances.
**Recommendations**

While not within the original request of the workgroup, members felt it best to share their thoughts on what might constitute better options for licensing requirements instead of keeping with traditional yet obsolete terms.

The primary solution the workgroup kept coming back to is the concept of performance measures. While there are numerous licensing standards, a perfunctory review of the EMS statute and rules revealed very few performance standards. Of those performance standards that are in the regulations, one is related to prehospital data collection⁴, most are related to EMS personnel⁵, ⁶, and one is related to education programs⁷ (pass rates). Local control is allowed but must pass muster with the board⁸. Even current statutes do not allow the board to establish performance standards, despite giving it rule-making authority in establishing many other licensing and operational standards⁹.

All members of the group share the belief that EMS systems should be held accountable to their patients and constituency. The group proposes that the state regulatory authority, working with EMS systems, establish performance standards.

How those standards can or should be established is not within the scope of this report, but the workgroup members suggest the following be considered if, or when, the board or the industry decide to establish performance standards. The standards should be:

- Objective;
- Measurable;
- Well-defined;
- Nationally recognized;
- Scalable based on service area size, volume, population, population density, and licensure level;
- Modifiable based on evolving practices and science (i.e., not be tied to the legislative process);
- Approved and supported by the service medical director (regarding treatment metrics);
- Measured against similar systems in similar circumstances.
- Of course, strong consideration should be given to whether the standards should be modified based on staffing models (volunteer versus career, part-time versus full-time, etc.).

As to what the actual standards might be, group members suggest elements such as response time metrics, outcome-based measurements, clinical bundles of care for sentinel illnesses and injuries, and safety goals. Ideally, these standards, and an EMS system’s actual performance, would be publicly reported, as are performance standards in many other parts of healthcare (especially hospitals). For transparency, as many performance standards as practical would use mandatory reporting systems to collect information. Indeed, some of these metrics can already be accessed through the statewide data collection system and/or NEMSIS (National EMS Information System).

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⁴ [https://www.revisor.mn.gov/statutes/cite/144E.123](https://www.revisor.mn.gov/statutes/cite/144E.123)
⁵ [https://www.revisor.mn.gov/statutes/cite/144E.27#stat.144E.27.5](https://www.revisor.mn.gov/statutes/cite/144E.27#stat.144E.27.5);
⁶ [https://www.revisor.mn.gov/statutes/cite/144E.28#stat.144E.28.5](https://www.revisor.mn.gov/statutes/cite/144E.28#stat.144E.28.5)
⁷ [https://www.revisor.mn.gov/statutes/cite/144E.285#stat.144E.285.1](https://www.revisor.mn.gov/statutes/cite/144E.285#stat.144E.285.1)
⁸ [https://www.revisor.mn.gov/statutes/cite/144E.16#stat.144E.16.5](https://www.revisor.mn.gov/statutes/cite/144E.16#stat.144E.16.5)
⁹ [https://www.revisor.mn.gov/statutes/cite/144E.16#stat.144E.16.4](https://www.revisor.mn.gov/statutes/cite/144E.16#stat.144E.16.4)
The following sites present good information regarding EMS performance metrics:

- [Emergency Medical Services Performance Measures](#) (PDF document)
- [Clinical Performance Measures that Matter – Are you Ready?](#) (JEMS article)

### Summary and Conclusion

The summary conclusions of the workgroup:

- Chapter §144E and Rules 4690 do not currently provide ample information to determine what may constitute a base of operations or substation.
- Administrative rule 4690.3400 is the only unambiguous requirement for a base of operations to be located within a licensee’s primary service area. Other statutes and rules suggest the base of operations must be located in the PSA, but none forbid it from being located outside of the PSA. Statute §144E.11 subdivision 5 even goes so far as to suggest a base of operations could be located outside of the state.
- Only thirty-five percent of other states that responded to the query have language in their statutes or rules about base of operations or substations. Based on the lack of replies, it is likely most states have no such requirements. Of the ones that did respond, none require the base of operations to be within a designated area.
- The terms *base of operations* and *substations*, while useful in a practical sense, are outdated and likely serve no useful regulatory purpose. Any relationship to performance is speculative at best. However, the workgroup acknowledges that a licensee must have some physical location that is considered its “place of business,” a point which is likely defined in other statutes regarding businesses and corporations.
- The workgroup suggests abandoning the terms *base of operations* and *substations* and instead focus on performance standards that are measurable, reportable, and enforceable. This simple act alone may allay the concerns of municipalities that are dissatisfied with their local licensee’s performance.

### Further discussions

While in agreement about the need for performance measures, all members of the workgroup share unique, and sometimes differing, opinions about adding standards to statute. Discussion amongst the group included numerous ideas for actual standards, how to regulate and hold systems accountable, and where control should rest. Members voiced a willingness to continue this conversation in more detail and stand ready to serve the board should the opportunity arise.
The members of the workgroup thank the board and Chairperson Guiton for the opportunity to research this topic and provide what they hope is useful feedback. If any board member has questions, concerns, or wishes additional clarification, the members of the workgroup are available through the EMSRB Executive Director, Tony Spector.

Thank you.

- Brad Hanson
- Bruce Hildebrandt
- BJ Jungmann
- Tom Fennell
- Brian Edwards
- With our appreciation to Holly Jacobs and Brian Shorten, EMSRB Staff.

Signed: Date:

Brian Edwards