State of Minnesota
Emergency Medical Services Regulatory Board
Board Meeting Agenda
March 19, 2020, 10:00 a.m.
2829 University Avenue Southeast
Conference Room A, Fourth Floor
Minneapolis, MN 55414

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 Governor has declared a peacetime emergency under Minnesota Statutes chapter 12.31. The EMSRB Board Chair has determined that this board meeting may be attended via telephone. The Board Chair and Vice Chair will be attending in-person. Other board members and members of the public are encouraged to attend via telephone using the following number:

Telephone: 1-888-742-5095 Code: 3908550771#

Map and Directions

---

1. Call to Order and Introductions – 10:00 a.m. **Attachments**

2. Review and Approve Agenda – 10:05 a.m.

3. Review and Approve Meeting Minutes – 10:10 a.m. **M 1**

4. Public Comment – 10:15 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 complete the participation form located at the meeting room door prior to the start of the meeting. Please limit remarks to three minutes.

5. Board Chair Report – 10:20 a.m.

- Summary Report of February 20, 2020, Executive Committee Meeting
- Board Vacancies
- Approval to Proceed with Biospatial, Inc.

6. Executive Director Report – 10:40 a.m.

- Continuity of Government Operations (COOP) during COVID-19 – Update
- Extending the certification of EMS personnel with expiration of March 31, 2020

7. Medical Direction Standing Advisory Committee 11:40 a.m.

- Committee Report **MD 1**
- COVID-19 Update
- Crisis Standards of Care Update **MD 2 - 4**
- Personal Protective Equipment Update

8. New Business – 12:30 p.m.

9. Adjourn – 12:35 p.m.

If you plan to attend the meeting and need accommodations for a disability, please contact Melody Nagy at (651) 201-2802. In accordance with the Minnesota Open Meeting Law and the Internal Operating Procedures of the Emergency Medical Services Regulatory Board, this agenda is posted at: https://mn.gov/emsrb

Next Meeting:

May 21, 2020, 10:00 a.m.
2829 University Avenue Southeast
Room TBD
Minneapolis, MN 55414

Attachment Key:
M = Minutes
MD = Medical Director

EMSRB
Minnesota Emergency Medical Services Regulatory Board

2829 University Avenue Southeast, Suite 310
Minneapolis, Minnesota 55414-3222

(651) 201-2800 ▪ (800) 747-2011 ▪ FAX (651) 201-2812 ▪ TTY (800) 627-3529

www.emsrb.state.mn.us

M 1

Meeting Minutes

Emergency Medical Services Regulatory Board
Board Meeting

Thursday, January 16, 2020, 10:00 a.m.
2829 University Avenue Southeast
Conference Room A, Fourth Floor
Minneapolis, Minnesota

Attendance: J.B. Guiton, Board Chair; Aaron Burnett, M.D.; Lisa Consie; Steve DuChien; Brian Edwards; Scott Hable; Megan Hartigan; Tim Held; Jeffrey Ho, M.D.; Representative John Huot; Paula Fink-Kocken, M.D.; Senator Andrew Lang; Kevin Miller; John Pate, M.D.; Matthew Simpson; Tony Spector, Executive Director; Ryan Brodsky, EMSRB Staff; Melody Nagy, EMSRB Staff; Dave Rogers, EMSRB Staff; Brian Shorten, EMSRB Staff; Charles Soucheray, EMSRB Staff; Greg Schaefer, Assistant Attorney General: Dan Schueppert, Assistant Attorney General

Absent: Jason Amborn, Michael Jordan

1. **Call to Order – 10:03 a.m.**
   Mr. Guiton called the meeting to order.

2. **Review and Approve Board Meeting Agenda – 10:05 a.m.**
   Mr. Guiton asked for a motion to approve the agenda.

   Motion: Dr. Burnett moved to approve the agenda. Dr. Pate seconded. Motion carried.

3. **Review and Approve Board Meeting Minutes – 10:10 a.m.**
   Mr. Guiton asked for a motion to approve the minutes. Mr. Edwards provided a clarification on page three on regulations from other states but said he did not consult with Iowa.

   Motion: Mr. Simpson moved to approve the minutes from the November 21, 2019, meeting with the noted correction. Dr. Ho seconded. Motion carried.

4. **Closed Session – 10:15 a.m.**
   Closed per Minn. Stat. § 144E.28, subd. 5 and Minn. Stat. § 13D.05, subd. 2(b) (Complaint Review Panel)

   A disciplinary action was discussed and voted on by Board members.

5. **Re-Open Meeting – 10:45 a.m.**
   Mr. Guiton re-opened the meeting.

6. Public Comment – 10:48 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 complete the participation form located at the meeting room door prior to the start of the meeting. Please limit remarks to three minutes.

None.

7. Board Chair Report – 10:50 a.m.

Summary Report of December 19, 2019, Executive Committee Meeting

Mr. Guiton summarized the topics discussed:

- Discussion with a Danny's Dose advocate regarding implementation of guidelines for patients with rare conditions
- Presentation by MDH staff regarding need and use of MNSTAR data and the legality of data sharing according to Minnesota Statutes
- Ambulance service licensure changes
- Mr. Spector provided an agency update

Board Member Vacancies for 2020

Mr. Guiton said that Mr. Coyne has resigned his position at North Memorial and that creates an additional vacancy for the Board.

The Board vacancies for 2020 include:

- Ambulance Service Director
- Local Board of Health Representative
- Emergency Physician
- Professional Firefighter
- Volunteer Firefighter
- Pediatrician

Mr. Guiton said applications have been received for ambulance service director, emergency physician, professional firefighter, volunteer firefighter, and pediatrician. Mr. Guiton said additional applications are being encouraged by the Governor's office to promote integration.

Election of Officers

Mr. Guiton said the Internal Operating Procedures call for two nominations for each position. Ballots have been provided if needed. He asked for nominations for the Vice Chair.

Mr. Miller said he would be willing to continue as vice-chair. Ms. Hartigan nominated Mr. Miller for vice chair. Mr. Guiton asked if there were any other nominations. There was no other nomination. Mr. Guiton called for a vote on the nomination.

Motion: Dr. Pate moved to elect Mr. Miller as the vice-chair. Dr. Fink-Kocken seconded. Ms. Hartigan conducted a roll call vote and Mr. Miller was elected unanimously.

Mr. Guiton asked for nominations for secretary/treasurer. Ms. Hartigan said she would be willing to continue in the position. Dr. Fink-Kocken nominated Ms. Hartigan. Mr. Guiton asked if there were any other nominations. There was no other nomination. Mr. Guiton called for a vote on the nomination.

Motion: Mr. Hable moved to elect Ms. Hartigan as the secretary/treasurer. Dr. Fink-Kocken seconded. Ms. Nagy conducted a roll call vote and Ms. Hartigan was elected unanimously.

Mr. Guiton asked for nominations for the at-large member. Dr. Ho said he would be willing to continue in the position. Mr. Edwards expressed that he would be interested in serving as the at-large member. Mr. Guiton asked if there were any other nominations and then offered each candidate a chance to speak to the Board. Mr. Guiton called for a vote. Ballots were collected and the result of the election is that Dr. Ho will continue as the at-large member by a vote of seven to six.

8. Executive Director Report – 11:15 a.m.

Agency Report

Mr. Spector said he attended a meeting with Governor's office staff, and they offered an apology regarding how long it took to make the recent Board appointments. There were an overwhelming number of appointments to make. The Governor's office said they will review a certain amount of appointments each month and the EMSRB is slated for April.

Mr. Spector said the EMS Specialists have been communicating with ambulance services and the regional programs regarding their assignments and responsibilities. He provided a chart and explained the boundaries for each staff person.

MNSTAR Version 2/MNSTAR Version 3

Mr. Rogers provided a handout and said he has communicated with all services that are still reporting in version 2. He said 108 agencies are still reporting in version 2. He said he is working with agencies on their transition.

Rep. Huot asked if there is there a cost for the transition. Mr. Rogers said there is no cost for version 3 available from ImageTrend.

Mr. Spector said one of the goals when bringing Mr. Rogers onboard is management of data practices requests. He said he and Mr. Rogers met with a vendor to discuss how to effectively fulfill and track these data requests.

Rep. Huot said he is doing a statewide tour of listening sessions with EMS agencies. He said agencies need to improve data such as time of call to time of response to scene. Better data will help make better decisions at the Capitol.

Mr. Rogers said he has been working with services regarding accuracy of the data received. He said version 3 will provide much better data. Mr. Spector complimented Mr. Rogers for his work.

Regional Program Discussion

Mr. Spector said that with the loss of the grants and financial planner in April there were questions on how the Board should proceed with the regional program Request for Proposal (RFP). Mr. Spector said he reached out to a grants specialist Ms. Kelly Anderson who recommended a panel of three persons to evaluate the regional program proposals. Mr. Spector said he approached his brother-in-law Mr. Klein and Mr. Schreckengaust to contract with the EMSRB. Mr. Spector described the background of Mr. Klein. He said it was not a secret that Mr. Klein is my brother-in-law. Mr. Spector said while this was occurring the other activities at the EMSRB office also included hiring of the two EMS Specialists.

Mr. Spector said this was also the timeframe for the remodel of the office. Mr. Klein has also worked in commercial real estate and could manage this project. He said he did not want the remodel to fail as it has in the past. He asked Mr. Klein to assist with this project.

Mr. Spector said it was recently brought to his attention by the Department of Administration that they view the contract with Mr. Klein as a conflict of interest. Mr. Spector said he did not see this as a conflict because there is no financial gain. Mr. Spector said he notified Mr. Klein of the discussion with the Department of Administration and without someone to provide project management there continues to be an unfinished punch list from the remodel. He said he will not allow the vendor to complete this project without supervision. Mr. Spector said it was not a deliberate attempt to hide his relationship with Mr. Klein. He said he wants to make this clear to the Board and staff. He asked if anyone has questions.

Agency Staffing
Mr. Sector said Mr. Brodsky has been a student worker for the EMSRB and recently completed his four-year degree in computer science. Mr. Spector said Mr. Brodsky applied for a full-time job in his field and was accepted and will be leaving the EMSRB as of January 24th. Mr. Spector said Mr. Berris who has been working part-time will also be leaving.

Mr. Spector commented there are a lot of projects that are competing for his time. He said he will be having a discussion with staff of the SmART human services division tomorrow. He will be crafting a position description for an administrative aid/officer manager to cover tasks that can assist the agency. He offered the quote: "If you do not have a plan to succeed you have a plan to fail."

Mr. Spector said results-based accountability is the expected norm. He said he is implementing having a project plan for each project and is seeking Board support for project plans. It is necessary to have fully functional plans available for all staff to meet necessary timelines.

Children's Minnesota Ambulance License Application – Update
Mr. Spector said the Children's license was issued on January 10. He said when the inspection was conducted it was satisfactory; the minor issues discussed were resolved. He said Mr. Rogers worked with Children's staff on implementation of a data reporting plan.

Ambulance Service License Changes of Ownership Update
Mr. Spector said Mr. Soucheray, Mr. Miller, and Mr. Schaefer met to discuss the statutes related to a change of ownership versus s a license change or a new application. Mr. Schaefer provided clarification of an expansion versus acquiring a PSA. He said a transfer of ownership does not require a new license application. Mr. Miller described the three criteria that would trigger a new license application. Mr. Schaefer said staff will be recommending the appropriate action for each of the applications that have been submitted.

Rep. Huot asked for a definition of base of operation. Mr. Schaefer said the definition is in statute and provided the definition.

Mr. Guiton said it was a good decision to have a subcommittee discuss the requirements in statute so Board decisions can be made appropriately. Rep. Huot asked about the EMSRB authority regarding these decisions. Mr. Schaefer said the EMSRB is the responsible Board for making these determinations.

Mr. Miller said PSA changes must be reported prior to a change being made. This has often been reported within the renewal process.

- CentraCare Health Systems and Carris Health/Rice Memorial Hospital
  Mr. Spector said the group determined this change does not require a license process. The change will be granted.

- Granite Falls Health and Avera Health
  Mr. Spector said the group also determined this change does not require a license process. The change will be granted.

- HealthEast and Fairview
  Mr. Spector said further clarification is being requested. Staff will be meeting with HealthEast representatives.

Mr. Guiton said the Board would take a short break for lunch.

9. Committee Reports – 1:25 p.m.

Legislative Ad Hoc Workgroup

Mr. Miller said there is a proposed clean-up bill and much of it was discussed by the Education Workgroup and they made recommendations for statutory changes. There were delays in moving this forward, but he wanted to thank Rep. Huot because he was able to get this document formatted at the revisor's office. (handouts provided) Mr. Miller said the Legislative Ad Hoc Workgroup met and discussed the proposed statutory changes and suggested very few changes.

Mr. Miller said an additional statutory change being recommended by the Complaint Review Panel to remove the language which provides an applicant the ability to apply for reinstatement of a license in six months after a Board action. This change will assure that the EMSRB has standard language with other boards.

Mr. Edwards asked for a clarification of the language on page 8 number 13. He asked if the reinstatement language would be for all levels. Mr. Miller responded yes, that is correct. Mr. Edwards asked about inactive status that is allowed by the National Registry. Mr. Spector said Minnesota does not have a distinction of active or inactive. Minnesota allows persons with current National Registry certification to obtain Minnesota certification.

Dr. Burnett asked about primary instructor qualifications on page 8 section 1. He said physicians would be qualified to be a primary instructor especially one trained in emergency medicine. Ms. Consie said this was discussed by the work group and is meant to limit non-qualified physicians from leading the training program. Dr. Burnett suggested an amendment include to a physician that is board certified in EMS. Ms. Hartigan asked for the same amendment for nurses. Dr. Fink-Kocken agreed and asked to include pediatricians. Dr. Pate said he would speak for family physicians and in many rural areas the family physician is the medical director and would be qualified to be a primary instructor.

Motion: Dr. Burnett moved to include the three specialty physicians identified or the ambulance service medical director as primary instructors. Dr. Pate seconded.

Mr. Edwards said he would like to see the stricken language included because there are other persons qualified to be the primary instructor.

Mr. Miller clarified that all those individuals can be instructors but not the primary instructor. Dr. Ho said the primary instructor is responsible for content. He said he supports the language as written.

Rep. Huot said he wants this bill to be proposed right away and said it would need to go through several subcommittees before it reaches a vote. He said there will also need to be a fiscal note. Senator Lang said he wants to support the EMSRB's efforts. He said he would welcome input from Board members.

Mr. Spector asked for the timeline for the legislative session. Senator Lang described the process for meeting legislative deadlines.

Mr. Guiton asked for a vote on the motion to include physicians in the language. Motion carried.

Motion: Mr. Miller moved to include the other emergency medical content professionals in lines 8 and 24 and 25 and update the language. Mr. Edwards seconded. Motion carried.

Dr. Ho said he wanted to understand the definition of primary instructor. Mr. Guiton said a primary instructor is an individual who teaches 51% of the course.

Motion: Ms. Hartigan moved that the update the language as agreed upon by Board members be allowed to be forwarded for legislative action. Dr. Fink Kocken seconded. Motion carried.

Ambulance Standards Workgroup
Mr. Guiton said since Mr. Coyne is no longer on the Board this workgroup will need a chairperson. Mr. Edwards volunteered.

CRP/HPSP
Mr. Simpson said he will be seeking one additional member for the complaint review panel (CRP).

Data Policy Standing Advisory Committee
Ms. Hartigan said she appreciates Mr. Rogers' work. She said the next job for the committee is to look at what the agency is doing with the MNSTAR data.

Ms. Hartigan said the Department of Administration discussed with EMSRB staff that MNSTAR data is private and can't be shared. Data sharing with MDH has been suspended. Ms. Hartigan said there was a meeting yesterday that included EMSRB staff, MDH staff and an MDH attorney and Mr. Schaefer of the Attorney General's office and there was a discussion on how to share MNSTAR data. Ms. Hartigan quoted Minnesota Statutes 144E.123 that allows data sharing with a designee.

Ms. Hartigan said DPSAC is requesting the Board to designate the Commissioner of Health as a designee. This would require a memorandum of understanding and a data sharing agreement. She said is the intent to develop this memorandum of understanding and bring it back to the Board for a vote. Dr. Burnett said both agencies should have full access to all data shared between the two agencies.

Dr. Fink-Kocken said she would like to request information to do research. She said the request would be for summary data. Mr. Schaefer responded that requests can be submitted to the Board and can be granted based on the content of the request and there would possibly be costs to the applicant.

Ms. Consie asked if there is a possibility that there would be other requests for a designee. Ms. Hartigan responded that this request is for a designee as the Commissioner of Health (another state agency). Mr. Schaefer agreed and said this would need to be determined by the Board on a case by case basis. He said MDH cannot release non-public information.

Dr. Ho suggested caution in moving forward with data sharing. Ms. Hartigan agreed and said the memorandum of understanding will be provided to the Board for review and approval. Mr. Guiton said he wanted to remind everyone that this is the patient's data.

Mr. Held said thank you for the meeting yesterday and he agrees that these assurances need to be in place to achieve the greater goals.

Medical Direction Standing Advisory Committee
Dr. Burnett said he did not have anything to report. Mr. Guiton asked if more than two meetings per year are needed. Dr. Burnett said he would be happy to discuss that after the Board appointments are made.

The next MDSAC Meeting will be on March 6th during the Long Hot Summer Conference.

10. New Board Business – 1:45 p.m.

Mr. Edwards said he and Mr. Schaefer met with the Department of Human Services (DHS) regarding interpretation of the DHS statute for transports across state lines. Mr. Schaefer said DHS can write agreements with outstate facilities. Ambulance services would need to have contracts. North Dakota has contracts with some counties. He said DHS staff understood why this should be reactivated. This will be discussed further by DHS.

Ms. Polzin said EMS for Children's was able to achieve a 94% response rate for their survey.

11. Adjourn – 1:50 p.m.

Motion: Mr. Hable moved to adjourn the meeting. Dr. Fink-Kocken seconded. Motion carried.

Next Board Meeting:
March 19, 2020, 10:00 a.m.
2829 University Avenue S.E.
Conference Room A, Fourth Floor
Minneapolis, MN

Reviewed and Approved By:

Megan Hartigan (by email) 1/31/20
Board Secretary Date

MD 1

State of Minnesota
Emergency Medical Services Regulatory Board
Medical Direction Standing Advisory
Committee Meeting Notes[1]

March 6, 2020, 9:00 a.m.
Minneapolis Marriott North
Brooklyn Park, Minnesota

Attendance: Aaron Burnett, M.D. (Chair); Marc Conterato, M.D.; Jennifer Fischer, M.D.; Paula Fink Kocken, M.D.; R. J. Frascone, M.D. (by phone); Pat Lilja, M.D.; John Lyng, M.D.; John Pate, M.D.; Jonathan Shultz, M.D.; Nick Simpson, M.D.; Kevin Sipprell, M.D.; Andrew Stevens, M.D.; Peter Tanghe, M.D.; Christopher Ward, M.D.; Mike Wilcox, M.D. (by phone); J.B. Guiton, EMSRB Board Chair; Tony Spector; EMSRB Executive Director; Melody Nagy, EMSRB staff; Dave Rogers, EMSRB staff; Brian Shorten, EMS Specialist; Charles Soucheray, EMS Specialist; Greg Schaefer, Assistant Attorney General.

The meeting was called to order at 9:03 a.m. Agenda and minutes approved.

Biospatial Discussion

Dr. Pate moved the committee recommend the Board consider engaging Biospatial. Dr. Lilja seconded. A roll call vote was conducted. Motion carried unanimously.

Coronavirus Messaging Discussion

Dr. Burnett said Minnesota has pandemic plans in place. EMS in Minnesota is well prepared. Key documents (links) are available on the EMSRB website. Dr. Burnett said the crisis of care document discusses what we are facing. This document was updated in 2018. This document is on the MDH website and the EMSRB has placed a link to this document on the COVID-19 portion of its website. He referred to page 100 – specific to EMS. This is the plan in case of pandemic where demand for EMS services outpaces supply and describes the actions to be taken. Describes the priority of action. This is a guideline. Dr. Burnett stated the Metro Region Emergency Services Board EMS medical directors committee will review the metro region EMS crisis standards of care document next week. Once finalized this document will be presented to the EMSRB and MDH. The MESB medical director committee has significant overlap in membership with MDSAC. Specifically, 12/14 physicians present at the MDSAC meeting today also practice in the metro region. The metro region has offered to make these planning documents public for other EMS regions to see and incorporate if they want.

Dr. Burnett recognized Judy Seberg and Tim Held (EMSRB board member) in the audience as representatives of MDH. Dr. Burnett stressed that the EMSRB and MDH will work collaboratively to ensure the health and safety of the citizens of MN. Dr. Burnett stated he hoped the presence and participation of MDH representatives at MDSAC is a very visible sign to the public of the collaboration of the EMSRB and MDH on the COVID-19 response.

Dr. Tanghe moved to post meeting minutes that have not been approved by the committee but have been reviewed by the committee chair. Dr. Sipprell seconded. A roll call vote was conducted. Motion carried unanimously.

POLST Task Force Member Replacement

Dr. Tanghe was nominated and accepted this assignment.

---

[1] These notes are unofficial and have not been approved by MDSAC as formal minutes but are being provided at the direction of Aaron Burnett, MD, chair of MDSAC.

Legislative Report

Mr. Spector said an EMSRB cleanup bill was introduced on Wednesday. There is a suggested modification regarding instructor requirements. The Board's Executive Committee approved this modification.

Mr. Spector provided a handout and said that numerous bills have been introduced that were not introduced or authorized by the EMSRB.

The Board's Executive Committee was asked for their thoughts on a bill regarding a change to the law for lights/siren (HF 3332/SF 3416). The Executive Committee discussed the issue and had various opinions. The Executive Committee decided to remain neutral on this issue. It was asked to be discussed at the MDSAC meeting.

Dr. Burnett said this is permissive language. (further discussion)

The MAA decided not to support the bill for liability issues.

Dr. Lilja moved that ambulances not always use siren when using lights 24 hours a day. Dr. Pate seconded. A roll call vote was conducted. Motion carried.

Collection of Blood Samples from Source Individuals with Consent Authorization (HF 3161/SF 3158)

Dr. Stevens moved to support this legislation. Dr. Pate seconded. Motion carried.

Dr. Burnett suggested a change to the language under section (4) "a physician with specialty training in infectious diseases" – change to "licensed physician".

Dr. Lyng moved to support this language change. Dr. Sipprell seconded. Motion carried.

EMS personnel applicant data: Mandatory data to be collected from EMSRB applicants for MDH (HF 3521/SF 3417)

Mr. Spector said this bill was introduced without discussion with the EMSRB. The survey could be longer than the renewal requirements. There is no statutory authority to collect this information. Mr. Spector said EMSRB staff currently have information available.

Mr. Held said his office collects information from these surveys. He said that he has discussed with Representative Huot that this language needs revision. He suggested that the Board and MDH could discuss this over the next year. Dr. Burnett said he feels that the EMSRB should be the lead agency for this task.

Dr. Stevens moved that MDSAC does not support this language and would like clarification of gaps and that the EMSRB be the lead agency for this information. Dr. Simpson seconded. Motion carried.

Mr. Spector referred to a bill regarding "Patient Hold" (HF 3544/SF 3416). The committee discussed the issue and made the following motion.

Dr. Lilja moved that MDSAC does not support the legislation as written. Dr. Sipprell seconded. Motion to support and opposed. Tie vote.

Dr. Burnett asked Dr. Stevens to have a discussion with the sponsors of the legislation to included additional representation.

Dr. Lyn said he would like to see the record of the meeting reflect the feelings of the committee that the legislation should not be rejected but should be revised.

Mr. Spector said an EMS Task Force bill was introduced yesterday (HF 4171). There is currently not a companion bill in the Senate. There is no representation from the EMSRB in this bill. Dr. Burnett said there is no physician representation.

Dr. Stevens moved that the MDSAC not support this legislation. Dr. Lilja seconded. Further discussion. Motion carried unanimously.

Mr. Spector said handouts were provided in the packet regarding the number of EMRs, EMTs, AEMTs, and Paramedics by County. Mr. Spector provided a handout listing correction orders issued by the EMSRB. Mr. Spector said password requirements have been changed for accessing MNSTAR. Mr. Spector asked Mr. Rogers to provide information on the transition for ambulance services from MNSTAR version 2 to version 3. This is a goal for EMSRB staff and an ongoing project. Mr. Rogers said the EMSRB can create hospital integration accounts. This would allow integration of MNSTAR data to hospitals.

Meeting adjourned 12:26 p.m.

MD 2

MN Metro Region EMS System
Crisis Contingency Strategies
Approved March 12, 2020 EMS TOC Executive Committee

Metro Region EMS System

Real Time Adaptations

Trigger:
- Emergent requests for service in queue
- No mutual aid available
- Duty Chief Authorization

- Hold over crews
- Closest Hospital
- Limit responders – per call type, limit initial response to EMS or Fire only

>1h anticipated duration ?

No → Resume Normal Operations

Yes

Notify primary PSAPs & MRCC of change to limit responders and consider auto-answer
MRCC will create an advisory on MNTrac
Request supervisor / MD / CP jump car to augment ambulances

Able to resume normal operations?

Yes → Resume Normal Operations

No

Medical Director consultation to approve: Reference Response Matrix
- Discretionary 'left' SOP
- Batch transport
- Limit responses based on availability of private transport or patient complaint relative to resources available (may involve RN or MD call screening depending on duration)
- Coordinate alternate transportation – Metro Mobility, BLS, WC, ride-share, etc.
- Cardiac arrest – VF resuscitation only, consult with MD if no response to airway, initial meds, three shocks
- If further triage of calls needed may implement real-time MD review/call-taking subject to resources available

As system volumes allow, work backwards up algorithm to normal operations;
Update MRCC as needed

Shift Adaptations

- Jump car(s)
- Adjusted shift duration / frequency (open additional shifts / ill calls)
- EMR / paramedic staffing
- FF / paramedic staffing (paramedic drives to scene, FF drives to hospital)
- Staff some ambulances BLS

MD 3

MN Metro Region EMS System
COVID-19 Response Matrix
Approved March 12, 2020 EMS TOC Executive Committee

	Conventional (Few cases)	Contingency (Many cases)	Crisis (Overwhelming number cases)
Dispatch	• Travel and exposure screening • Communicate information to crews via CAD	• Possible travel and exposure screening • Increased dispatch discretion for call/acuity priority	• No travel screening • Auto-answer system may be needed – emergency calls only – roll info and other calls to 311 or other hotlines • Additional call triage – possibly with paramedic / MD assistance • Consider recommend private transport if delays >30min to answer priority calls • Modify/suspend Pre-Arrival Instructions
Send	• Full response	• May institute selective response (i.e. sending fire or EMS alone on certain responses to conserve resources – fire only on down, PI, EMS only for CP, SOB, etc. – see call code document)	• Consider community paramedic response? • Scheduled BLS provider? WC van? • Consider sending taxi/Uber/other? • Police or fire transport?
Staffing	• Normal staffing	• Curtail special event staffing? • Adjust shift duration? • Supervisors on streets? • MDs on streets?	• Paramedic and EMT-B crews? • EMR drivers? • MFD / first response agency drivers? • Public works drivers? • National Guard?
Destination	• Hospital of choice	• Closest hospital • Batch transports?	• Closest hospital • Alternate care location • Batch transports as appropriate
Lefts	• Per SOP	• Broaden discretion with call to MD	• Broaden discretion for lefts (HC pandemic plan) • Consider restricting cardiac arrest resuscitations
PPE	• Mask symptomatic patients • N95, barrier gown, eye protection, gloves for suspect cases	• Mask symptomatic patients • N95, barrier gown, eye protection, gloves for suspect cases • Simple mask, gloves, eye protection on all calls	• Wearing of simple masks by all patients encouraged • Staff may need to wear N95 all patients vs. selected • Daily temperature and symptom checks • Consider work when ill with mask / early return after illness
Supplies	• Per usual	• Conserve, substitute, adapt, re-use medications / supplies as required based on shortages	• Allocate medications / supplies to most likely to benefit (per MD guidelines)

Notes:

- Strategies may vary by the day and shift (i.e. may have to adjust dispatch priority / institute selective response during daytime hours and not at night)
- Strategies are not listed in order – at dispatch level will create thresholds – changes should be least intensive first – i.e. closest hospital, then selective response, then batch transports, then increased discretion to send EMS/recommend private transport

MN Metro Region EMS System
Pandemic Response Matrix

Approved March 12, 2020 EMS TOC Executive Committee

Metro Region EMS System

PANDEMIC CRISIS CONDITIONS TRANSPORT GUIDANCE

Policy context

These standing orders will be used to provide the best pre-hospital care to the greatest number of people during an extreme situation. They will only be put into place on approval from the EMS medical directors under conditions in which EMS services are pending or not answering calls for which there is a significant risk of death for the patient. They do not supersede other protocols. You will be notified when this status is in effect.

Our ethical commitments are:

A. **Proportionality:** All individuals should receive the highest level of care given the resources available at the time.

B. **Transparency:** Governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publicly debated.

C. **Fairness:** The proposed triage process relies on the principle of maximization of benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria, and when these criteria do not clearly favor a particular patient, "first come, first serve" rules will apply…

D. **Assurance:** In order to ensure "procedural justice," EMS triage processes will be regularly evaluated to assure that the process has been followed fairly and consistently.

E. **Documentation:** Patient records will include notation that crisis care transport rules were in effect.

When an ambulance arrives on scene during crisis conditions, instead of automatically offering transport to an emergency department, as under normal practice, you will assess the patient's objective condition and triage him/her into the following categories:

	o provide homecare information
	o refer to a clinic or other medical destination
	o refer to use of alternate transportation to a hospital, clinic or other medical destination
	o transport by (and at the discretion of) law enforcement
	o transport by ambulance to a hospital or other medical destination

MN Metro Region EMS System
Pandemic Response Matrix
Approved March 12, 2020 EMS TOC Executive Committee

Standing Orders

A. If the patient's complaint or symptoms are not listed in this Appendix, Paramedic's discretion is advised if the decision is not in conflict with SOP.

B. During crisis care conditions **automatically offer to transport** patients with the following presentations:

	1. Paramedic discretion – suspicion of critical illness/injury
	2. Altered vital signs (or age-specific abnormal vital signs), including any one of these: o SBP < 90 o SpO2 < 92% o RR > 30 (or respiratory distress) o HR > 120, or delayed capillary refill
	3. Breathing: o Respiratory distress o Cyanosis, or pallor/ashen skin
	4. Circulation/Shock: o Signs or symptoms of shock o Severe/uncontrollable bleeding o Large amounts of blood (or suspected blood) in emesis or stool
	5. Neurologic: o Unconscious or altered level of consciousness o New focal neurologic signs (CVA, etc.) o Status, multiple or first-time seizure o Severe headaches – especially sudden onset or accompanied with neck pain/stiffness o Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting
	6. Trauma: o Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable o Suspected fractures or dislocations that cannot be safely transported by private vehicle

C. When resources are at crisis care levels **consider patients with the following presentations for:**

- **Transportation by ambulance** - Note that many 'transport by ambulance' patients will not require emergency transport to the hospital – in which case, the crew may answer additional calls until the ambulance is full, or a critical patient is picked up, depending on system call volumes.
- **Transportation by alternate means:**

  private vehicle **or first responder transport** **to clinic, hospital, or alternate care site.** Except in very limited cases, the patient should NOT self-transport to the hospital/clinic but could be driven by someone else.

- **Homecare** Give patient the Homecare form for their complaint and advise to contact PMD if symptoms persist or worsen. The form will have information pertaining to their complaint and list ways of caring for themselves, as well as what to look for that would prompt self-transport to a clinic or hospital, or transport via ambulance to the hospital. Advise the patient that this does not restrict them from seeking care at a clinic or hospital on their own, should they desire.

1. ABDOMINAL PAIN:

	o AAA history or suspected o Marked tenderness/guarding o Pain radiating into back and/or groin/inner thighs o Recurrent severe vomiting not associated with diarrhea
	o Recurrent severe vomiting associated with diarrhea – to emergency if associated with signs/symptoms of dehydration, to urgent care or clinic if no dizziness nor vital sign changes and normal exam
	o Intermittent vomiting and/or diarrhea without blood or evidence of dehydration

MN Metro Region EMS System
Pandemic Response Matrix
Approved March 12, 2020 EMS TOC Executive Committee

2. ANAPHYLAXIS/STINGS:

	o Patients who have had epinephrine administered for symptoms o Patients experiencing airway, hypotension, or respiratory symptoms, after an allergy exposure o Vomiting with a history of anaphylaxis in the past
	Patients with itching after exposure – if rapid onset of symptoms, may require EMS transport; if delayed > 1hour, safe for private transport. All patients with history of anaphylaxis should be seen in emergency room if possible. Others may be seen in clinic or urgent care. EMS may administer diphenhydramine prior to clearing scene, up to 1mg/kg.

3. BACK PAIN:

	o Acute trauma with midline bony spinal tenderness o New onset of extremity weakness, sensory deficits, other neurological changes, incontinence of urine or bowel, urinary retention, or bloody urine o Concern for abdominal aortic aneurysm o Pain radiating into abdomen, or groin/inner thighs o Fever and back pain
	o Inability to ambulate/care for self o Concern for kidney stone, bloody urine
	o Muscular back pain without neuro changes, fever, or trauma

4. BEHAVIORAL:

	o Uncontrolled agitation requiring sedation by EMS
OR	o Suicidal ideation – must be left with a responsible party
OR	o Other emotionally disturbed patients may be transported at law enforcement's discretion or by other means

5. BLEEDING (LACERATIONS, ABRASIONS OR AVULSIONS):

	o Patient is on anticoagulant with significant ongoing bleeding or large hematoma
	o Significant lacerations after bandaging – heavily contaminated, bite-related, likely to involve foreign body, deep structure injury, sensory/motor deficit – to emergency room o Lacerations requiring simple repair – consider self-transport to physician's office or urgent care center (however, some offices do not do procedures; patient will need to call ahead)
	o Abrasions or avulsions not requiring suturing or repair, no significant contamination. o Minor lacerations that do not require sutures

6. BURNS:

	o All chemical or electrical burns o Suspected inhalant burn o Significant third degree burns o Second degree burns to ≥5% of body area o Second degree burns to face, mouth o Severe pain
	o Second degree burns to hands or feet, or to other location 1%-5% body surface area (size of patient's palmar surface)
	o Second degree burns < 1% body surface area, non-critical location o First degree burns

7. CARDIAC ARREST:

	o Witnessed down time ≤ 10 minutes – follow usual resuscitation protocols
	o All others – report death to dispatch and return to service; do not wait for law enforcement or medical examiner arrival

MN Metro Region EMS System
Pandemic Response Matrix
Approved March 12, 2020 EMS TOC Executive Committee

8. CHEST PAIN:

	o Chest pain or other signs or symptoms suspicious for cardiac ischemia, pulmonary embolus, or other life threat
	o Chest pain ongoing for >12 hours and a normal ECG o Pleuritic chest pain without hypoxia o Chest pain reproducible on physical exam to palpation is generally NOT concerning; unless ECG changes or known cardiac disease, unlikely to require treatment for acute coronary syndrome

9. DIABETIC:

OR	o Any patient on oral diabetes medications with low blood glucose – if transported by private vehicle must NOT drive self o Critical high glucose or signs of Diabetic Ketoacidosis/dehydration o By EMS for any Kussmaul respirations, tachypnea, or hypotension
	o Patients with typical hypoglycemia due to insulin and explanation for low sugar (did not eat, etc.) can be left without medical control contact as long as family/friend is present and patient is eating

10. ENVIRONMENTAL:

	o Heat-related illness with any alteration in mental status (confusion, decreased LOC) o Frozen extremity o Hypothermia with AMS
OR	o Frostbite to face, hands, feet, other location suspected deeper injury, blisters
	o Heat-related illness without alteration in mental status – initiate external cooling at home under supervision of friends/family o Minor frostbite with tissues now soft, pink, no blisters, and NOT involving digits

MN Metro Region EMS System
Pandemic Response Matrix
Approved March 12, 2020 EMS TOC Executive Committee

11. ETOH/SUBSTANCE ABUSE:

	o Very decreased LOC or other confounding issues (head injury, suspicion of aspiration)
	o Otherwise may be transported at law enforcement's discretion
	o Patient may be left with a responsible individual who can assist the patient o Able to ambulate safely without assistance

12. EYE PAIN:

	o Impaled objects or possible penetrating injury to eye, or globe rupture o Chemical exposures (alkaline) – after decontamination and initial rinsing
OR	o Eye pain and/or acute changes to vision should receive transport for urgent evaluation to emergency department or other qualified clinic (e.g. eye clinic) o Chemical exposures (non-alkaline) – consult poison control for instructions; transport if symptoms / dangerous exposure
	o Chemical exposures (non-alkaline) – consult poison control for instructions; if no symptoms and limited toxicity likely, give instruction sheet

13. FEVER:

	o Fever plus altered mental status including confusion o Fever plus severe symptoms by paramedic assessment o Fever plus seizures, lethargy, stiff neck, rash, or blistering
OR	o ≤ 3 months with fever estimated at 100.5 degrees – to emergency room or clinic urgently o > 3 months with fever that does not reduce with anti-pyretics, or fever lasting more than 5 days – emergency room, urgent care, or clinic

14. HEADACHE:

	o With vision deficit, lethargy, or page 1 qualifiers (fever, etc.) o On anticoagulants o Trauma related HA worse than mild and/or with LOC
	o New headaches for patient require assessment o Usual headaches for patient may require treatment

15. MUSCULOSKELETAL INJURIES (ISOLATED):

	o Loss of distal pulses o Unable to effectively splint the affected part o Neurological changes or deficits o Open fractures o Displaced fractures or pain requiring injectable narcotics
	o Suspected fractures that are stable and do not require injected analgesia may be splinted appropriately and transported by private vehicle
OR	o Neck pain and back pain after MVC, that is delayed in onset and not associated with midline tenderness or neurologic symptoms

16. NOSEBLEED:

	o Signs of hypovolemia or dizziness upon standing o Patient is on blood thinners (Coumadin, lovenox, clopidogrel, etc.) o Continued high blood pressure (SBP >200) in setting of nosebleed o Continued severe bleeding despite EMS efforts to control
	o All other

17. OB/PREGNANCY:

	o Imminent delivery o Pain in abdomen or back o Profuse vaginal bleeding o Third trimester (>24 weeks) bleeding o Pre/eclampsia – syncope, seizure, altered mental status, SBP≥140
	o All other

18. SYNCOPE:

	o History of coronary disease or heart failure o Age =>55 o Pregnant o Chest pain, headache, or shortness of breath (or other symptoms concerning to paramedics)
	o Likely dehydration, with dizziness preceding the syncope o Other underlying medical conditions

19. TRAUMA

	o Elderly o Unable to ambulate o Serious mechanism o On blood thinners or other severe underlying disease with trauma
	o Discretion based on degree of injury, ability to ambulate

20. TOXICOLOGIC:

	o Overdose or other toxic exposure – contact Poison Control and/or on-line medical control o If intentional, see **Behavioral Health** in this Appendix

21. VULNERABLE PERSON IN POTENTIAL DANGER:

	o EMS should assure that person will not be left in dangerous environment o If safe disposition and transport can be arranged and the injuries do not otherwise require medical evaluation, other transport may be appropriate

22. INTER-FACILTY TRANSFERS:

	o Requests for emergent EMS inter-facility transfers should be considered in the presence of a time-sensitive injury or diagnosis.