

**EMS ADVISORY COMMITTEE MEETING
MINUTES
JUNE 28, 2007
FORT TOTTEN ROOM, CAPITOL BUILDING**

Members Present: Dr. Roller, Nancy Capes, Cheryl Flick, Janelle Pepple, Dan Ehlen, Mark Weber and Neil Frame

Others Present: Ed Gregoire, Darleen Bartz, Dean Lampe, Tim Meyer, Shirley Hagemeister and Kari Kuhn

Welcome and Introductions

Neil welcomed everybody to the meeting and introductions were done around the room.

Approval of Meeting Minutes from May 3, 2006

Minutes for the previous meeting were approved via email so no discussion is needed.

Discussion of ND DEMS Scope of Practice for EMS Providers

While Ed and Tim were comparing the First Responder / EMT-B scopes of practice, they discovered some errors in the original approved version. Some skills listed under the First Responder scope of practice have been moved to be included in "First Responder w/enhanced skills". These skills include Bag-Valve-Mask, cricoid pressure, modified jaw thrust, oxygen therapy, upper airway suctioning, pressure point hemorrhage control, auto-injected epinephrine, oral glucose, spinal immobilization using a long board, vacuum splinting, and manual / automated blood pressure. Ventilators – Automated will be removed from the EMT-I85 scope and added to the "EMT-I85 w/enhanced skills". There was discussion over the role of EMT-I85 and intubation. This will be changed to state intubation skills may be utilized only with cardiac arrest patients.

Motion #1. Dr. Roller made a motion to approve changes to the list of allowable skills. Mark Weber seconded the motion. No objections, motion carried.

Mark Weber began discussion of developing a system for tracking additional training for variance skills. Presently DEMS has modules available and tracks the completion of enhanced skills including epinephrine for First Responders; multi-lumen airway, manual defibrillation, nebulized medications, and IV maintenance for EMT-B; manual defibrillation, nebulized medications and D50 for EMT-I85. Other variance skills are allowed on a local level, but are not tracked or supplied by DEMS.

Motion #2. Dr. Roller made a motion to table this discussion until the Department has had time to review this and the possibility of creating a process for this. Mark Weber seconded the motion. No objections, motion carried.

Discussion of Multi-Lumen Airway vs King Airway

Ed did a brief demonstration of the King Airway. This is a single lumen airway that some ambulance services have requested using instead of the multi-lumen airway. Ed proposed that the module be changed from 'multi-lumen airway' to 'limited advanced airway insertion'. Dr. Roller expanded on Ed's demonstration and expressed concerns that go hand in hand with using any airway device.

Motion #3. Dr. Roller made a motion to accept the module name change and add the King Airway as an option. Mark Weber seconded the motion. No objections, motion carried.

Discussion of Administrative Rules Changes

23-27-04.6 Dean brought up the certification of QRUs as being optional and wanted to know if this could be changed. Tim stated that they are encouraged to become certified as only certified QRUs can apply for grants. Mark Weber mentioned that there is a waiver that dispatch has that states that a service cannot / will not be dispatched unless they are a licensed emergency medical service. Janelle Pepple will locate a copy of this waiver.

33-11-01-01

#3 “. . . no transports, and standby events where. . .” The question was raised whether ‘standby events’ needs to be listed. Tim stated that this is reportable to NEMSIS and it is a way of accounting for what EMS does for North Dakota.

#9 The definition of EMT has been changed as NR EMTs and state licensed EMT will now have the same title. NR EMTs will now be given the option of doing a 24 hour refresher course and retesting the practical test and becoming a state licensed EMT upon recertification rather than the additional 48 hours of continuing education to remain an NREMT.

A definition will be added for “industrial site ambulance service” as it is mentioned in 33-11-05.

#15 There was discussion over the meaning of “nonemergency health transportation”. This is intended to mean services provided by a nursing home or some other health care facility rather than an ambulance service. Tim will change this definition for more clarification.

#23 The following change will be made: “. . . means strategically ~~stationing~~ *positioning* ambulances. . .”

33-11-01-02

#6 After reviewing the definition of “nonemergency health transportation”, the following change will be made: “. . . transportation services ~~may are not be~~ required to obtain. . .”.

33-11-01-06

#1 There was discussion about removing “owned” from this requirement. It was decided to leave it as originally stated.

#5. There was discussion about clarifying this from “. . . established in an area already. . .” to “. . . established in a *city that already has a licensed ambulance service*”. After debate it was decided that this would have to be reviewed for legality.

It was stated that it is unwritten policy by the Division that if a service moves into a community that already contains a licensed ambulance service, the new service must be licensed at the same level as the existing service.

~~33-11-01-06~~ 33-11-01-07

#2 Tim will clarify this: “. . . respond to calls within that area *if no closer ambulance is available to respond.*”

~~33-11-01-09~~ 33-11-01-10

#4 It was decided that a service’s decontamination policy should be checked during their ambulance inspection.

#7 It was decided that this should be on the check list during the service’s inspection.

#9 Tim will check on the number of years a service should be required to keep these.

#10 Typo will be fixed: “. . . be kept on file with the ~~with~~ ambulance. . .”

#11 There was discussion regarding the amount of damage that must be done before the Division would require reporting. It was decided that if a police report is required to be filed by law, the Division should get a copy of this. This rule will be changed to reflect this.

33-11-01-17

#6 The following typo will be fixed: “~~Criterion~~ Criteria for grant approval. . .”

33-11-01-18

1 Will be changed to the following “. . .with the referring *or accepting* physician’s. . .”.

#2c There was a long discussion over the best use of the ambulance services in the state and providing the best patient care. The benefit of transporting all patients exhibiting signs of stroke to the most appropriate facility vs taking a vehicle out of service for too long to transport that patient was discussed. The question was raised whether or not a BLS service would have the knowledge to eliminate other causes of stroke symptoms and if they should take the time to transport every patient with any form of stroke symptom. Nancy suggested adding “evolving stroke” or limiting the ground transport time.

Motion #4. Mark Weber made a motion to remove 33-11-01-18 2c. Cheryl Flick seconded the motion. Neil called for a vote. Five voted in favor of the motion, two against. Motion carried. 33-11-01-18 2c will be struck from the rules.

33-11-01-19 Typo will be fixed: “. . .must call for ~~and~~ rendezvous. . .”

d After discussion about the added cost to the patient and the thought that this opens the door to price gouging to BLS services, “Stroke symptoms” will be removed and “Respiratory distress or arrest” will be added.

33-11-02

Neil Frame suggested that there be a population based requirement for ALS services such as any city with a population of 15,000 people or more must have a licensed ALS Ambulance Service. Neil stated the this requirement would not be an issue for any currently licensed services. The purpose for this is to assist ALS services in receiving appropriate reimbursement. Currently reimbursement may be at a BLS rate, unless it’s mandated to be licensed as an ALS service. Darleen Bartz and Dr. Roller did not agree that the purpose of these rules should be to assist with ambulance reimbursement, but rather with patient care requirements.

33-11-02-03

#8 To be changed to: “Spine boards – one full-size, *and* one seated spinal immobilization device with retaining straps ~~and one pediatric~~ *to accommodate adult and pediatric patients.*” After much discussion it was decided that pediatric backboards are too costly for the ambulance services to purchase and that it is possible to appropriately immobilize a pediatric patient on a non-pediatric specific board.

#38 Mark Weber requested more detail regarding required channels. Tim will clarify this.

#42 There was a request for clarification on the type of mask required. Tim will clarify this.

33-11-02-04

The following change will be made: “. . .equipment, ~~and~~ maintaining current training requirements for personnel, *as well as the oversight of a QA program.*”

33-11-03-02

#1 Change to: “*Manual* cardiac defibrillator / *monitor* with pediatric capabilities.”

#2 The question was asked as to why ALS services are required to carry portable radios, but BLS services are not. Tim replied that ALS services are simply held to a higher standard.

33-11-02-05

The following change will be made: “. . .equipment, ~~and~~ maintaining current training requirements for personnel, *as well as the oversight of a QA program.*”

#5 The following correction will be made: “The *biennial* ~~annual~~ license fee. . .”.

33-11-04-14

The following change will be made: “. . .equipment, ~~and~~ maintaining current training requirements for personnel, *as well as the oversight of a QA program.*”

33-11-06-01

The following change will be made: “One of the crew members must be a ~~national registry emergency medical technician~~ licensed paramedic or its equivalent ~~and must have current cardiopulmonary resuscitation certification.~~”

33-36-01-03 Mark Weber questioned the process of course application and approval. He feels that this rule as stated means that the Division cannot approve a course if the authorization request is submitted after the course begins. Tim stated that the Division may in fact approve a course if it sees fit, but it would be against the rules for an instructor to begin a class without receiving prior approval.

#2e There was a question raised concerning the “field internship preceptor”. A definition will be added explaining who qualifies and what the process is to make somebody a “field internship preceptor”. The possibility of changing this to “the primary care provider” was discussed.

#2h3 This is a new option for recertification of EMTs. This is an option in other states and nobody has ever used it. It provides an option for those who complain about the number of hours of continuing education that are required to be Nationally Registered. Candidates will be limited to one test site attempt and the testing must be successfully completed prior to expiration of their NR certification. If they fail and do not successfully recertify in this manner, the candidate must reenter the system through the National Registry process.

#5 Mark Weber made the recommendation that all Paramedics must go through an accredited program. Tim stated that this is not the time for that change and that in time, the National Registry requirements will take care of that issue.

Motion #5. Mark Weber made a motion that for an instructor of initial courses to recertify as an EMS instructor they must have a 70% pass rate for their students who complete the National Registry test. Nancy Capes seconded the motion. No objections, motion carried.

#6c It will be added that the course coordinator must also be licensed as a paramedic.

#7i It will be added that the course coordinator must also be licensed as a paramedic.

#8c It will be added that the course coordinator must also be licensed as a paramedic.

33-36-02-08

#3 Mark Weber brought up the possibility of raising the certification percentage for training institutions. It was decided to leave as is.

33-36-02-10

#6 This will be changed to clarify the meaning. The intent is that if a person has been an instructor on a specific topic, that person may not be the evaluator on that particular station.

33-36-03-02

#1 There was brief discussion regarding mandatory EVOC training for all drivers listed on a service's roster. It was decided that this was not going to be pursued at this time.

#1a Typo will be fixed: “. . .primarily focuses on. . .”.

Nancy Capes stated that a driver with CPR will have been trained in Healthcare Provider CPR and therefore will have received training in bag-valve-mask. Tim stated that as this may be true, but BVM does not fall under a driver's scope of practice.

#1e Typo will be fixed: “. . .supervised *by* the. . .”.

#2c 'Successfully' will be added: “. . .have *successfully* completed training. . .”.

33-36-04-02

#1e Mark Weber inquired as to the legality of an EMT standing by at an event that is an untypical response situation. It was decided that it was legal for an EMT to act in that way as long as they have received permission from their medical director.

#7d It was clarified that this does not imply that a Paramedic must quit caring for a patient in an emergency situation when arriving at a facility.

#7f The following change will be made so that it is stated the same as it is in statute: “. . .supervised by ~~nursing staff~~ *the nurse executive*.”

Adjourn

Motion #6. Dan Ehlen made a motion to adjourn. This motion was seconded by Mark Weber.