NORTH DAKOTA
EMERGENCY MEDICAL SERVICES

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION SITE VISIT
APRIL 7 – 10, 2008

John Hoeven, Governor
Dr. Terry Dwelle, State Health Officer
Dr. Darleen Bartz, Section Chief
Tim Meyer, State EMS Director

NORTH DAKOTA
DEPARTMENT of HEALTH

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WELCOME

On Behalf of the North Dakota Department of Health Division of Emergency Medical Services, I would like to welcome you to the state of North Dakota and thank you for your participation in the reassessment of our Emergency Medical Services System. Your expertise will provide a genuine asset in reviewing our system and your suggestions for improvement will be welcomed by us. We are both excited and enthusiastic about the assessment process.

This project was made possible by the Sixtieth Legislative Assembly of North Dakota during the 2007 Legislative Session. Several EMS-related bills had been introduced, and I believe the Legislative Assembly has a genuine concern for the future of EMS. Therefore, they added language in House Bill 1162 to require the Department of Health to study the minimum requirements for reasonable EMS coverage for North Dakota, and House Bill 1296 included an appropriation for the department to contract with a third party to perform an assessment of the state's EMS system. In addition to this assessment, our division will be facilitating an American College of Surgeons statewide trauma system evaluation/consultation during the last week of April.

Many of the very best things that are well established in North Dakota EMS came directly from our 1992 assessment; a statewide trauma system, adhering to national education standards for EMS providers, and evolving regulation for our EMS industry. We would anticipate this reassessment to guide us in policymaking in the near future when we establish what "reasonable" EMS coverage is for our state and as we develop a strategic plan for North Dakota EMS.

I've asked our presenters to frame their presentations with system building in mind. I hope that you find the facilities comfortable and adequate and the presentations informative. The people of North Dakota are friendly and informal. Please feel free to ask any questions that might come to you. We want you to have an accurate accounting of our state's EMS system.

I would like to thank the NHTSA Office of EMS including Drew Dawson and Susan McHenry for their assistance in providing this service for North Dakota. We are fortunate to have federal partners that have a strong and diverse background in EMS.

Feel free to contact me anytime if you have questions or concerns; my office number is 701.328.4728. Once again, thank-you for your assistance in this important project.

Best regards,

Tim Meyer, Director
Division of Emergency Medical Services

ROSTER

EMS Reassessment
North Dakota
April 8-10, 2008

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Monday, April 7th 2008		
NHTSA/EMS Team Travel Day		
7:00 pm	Introduction Dinner	NHTSA/EMS Team

Tuesday, April 8th 2008		
TIME	TOPIC	PRESENTER(s)
7:00-7:45 am	BREAKFAST	
8:00-8:15 am	Introductions	NHTSA Tim Meyer
8:15-8:30 am	Welcome DL and Traffic Safety/EMS Relationship	Darleen Bartz Karin Mongeon
8:30-9:00 am	State EMS Program Briefing ➢ Geographic Demographic Overview ➢ General overview of EMS System	Tim Meyer
Comprehensive Discussion of State's EMS System		
9:00-10:00 am	Regulation and Policy Resource Management	Tim Meyer and Neil Frame Tim Meyer
10:00-10:15 am	BREAK	
10:15-11:00 am	Human Resources and Training	Ed Gregoire Mark Weber Sherm Syverson
11:00-Noon	Transportation	Ed Gregoire Tyrone Johnson Ken Krupich
Noon-1:00 pm	LUNCH	
1:00-1:45 pm	Public Information and Education	Mark Weber Karin Mongeon
1:45-2:30 pm	Emergency Preparedness	Tim Wiedrich Brenda Vossler
2:30-3:15 pm	Trauma Systems ➢ Amy Eberle to present information	Amy Eberle Howard Walth Lindsey Narloch Dr. Steven Hamar
3:15-3:30 pm	BREAK	
3:30-4:00 pm	Communication	Russ Timmreck Tammy Lapp-Harris
4:00-5:00 pm	Evaluation	Tim Meyer Lindsey Narloch Karin Mongeon LeeAnn Domonoske
5:30 pm	RECEPTION	

Wednesday, April 9th 2008		
7-8:00 am	BREAKFAST	
8:00-9:00 am	Medical Direction	Tim Meyer Dr. Ben Roller Dr. Jeff Sather
9:00-10:00 am	Facilities ➢ Chip Thomas to present information	Chip Thomas Amy Eberle
10:00-10:15 am	BREAK	
10:15-10:45 am	EMS for Children	Kelli Rice
10:45-Noon	Clarification/Questions	All
Noon-1:00 pm	LUNCH	
1:00-4:30 pm	NHTSA Team Discussion & Formulation of Recommendations	NHTSA TEAM

Thursday, April 10th 2008		
7:00-8:00 am	BREAKFAST	
8-3:30 pm	NHTSA Team Discussion Continued/Draft Final Report	NHTSA TEAM
3:30-4:30 pm	Debrief with State & Issue Final Report	All

Friday, April 11th 2008
NHTSA/EMS Team Travel Day

DEPARTMENT OVERVIEW

Mission Statement

The mission of the North Dakota Department of Health is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. To accomplish our mission, the NDDoH is committed to:

- Improving the health status of the people of North Dakota.
- Improving access to and delivery of quality health care.
- Preserving and improving the quality of the environment.
- Promoting a state of emergency readiness and response.
- Achieving strategic outcomes within available resources.
- Strengthening and sustaining stakeholder engagement and collaboration.

State Health Council

The State Health Council serves as the North Dakota Department of Health's advisory body. The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.

Organizational Overview

The North Dakota Department of Health employs about 300 people dedicated to making North Dakota a healthier place to live. The seven sections of the department are under the administrative supervision of the state health officer and the deputy state health officer. They include:

- Administrative Support
- Community Health
- Emergency Preparedness and Response
- Medical Services
- Health Resources
- Environmental Health
- Special Populations

Employees in these sections provide the following core public health services promulgated by Public Health in America:

- Preventing epidemics and the spread of disease
- Protecting against environmental hazards
- Preventing injuries
- Promoting and encouraging healthy behaviors

- Responding to disasters and assisting communities in recovery
- Ensuring the quality and accessibility of health services

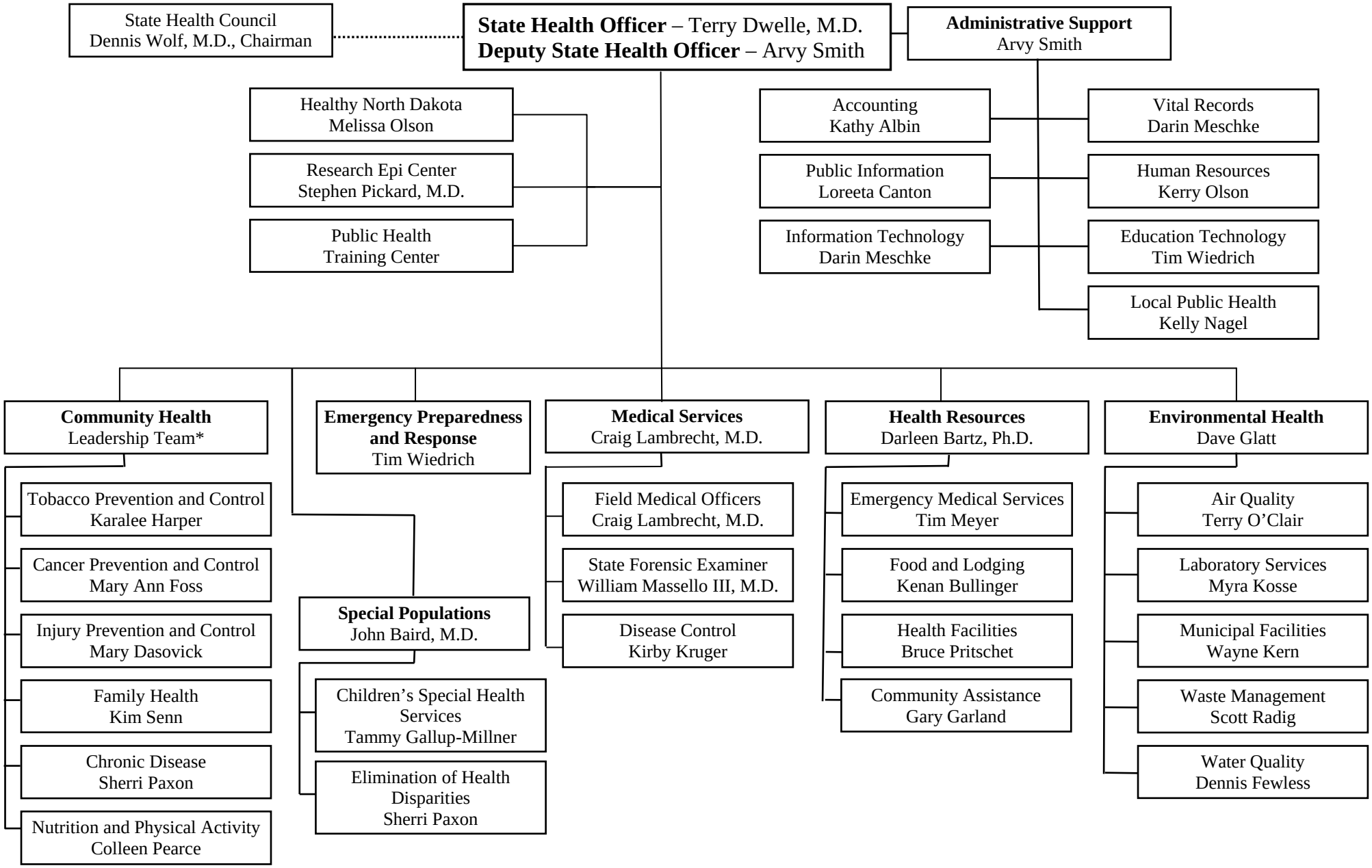
The department logo is a representation of both apples and wheat. An apple is the universal symbol of good health and well-being; the wheat represents the richness of North Dakota's environment.

Division of Emergency Medical Services

The Division of Emergency Medical Services (DEMS) is the lead agency for North Dakota's Emergency Medical Services (EMS) System. DEMS employs 8.5 FTEs, including state EMS director, state EMS training coordinator, state trauma coordinator, EMS for Children Program manager, research analyst, EMS specialist, and three administrative support personnel. DEMS is located at the state capitol in Bismarck; there is no field staff. The division conducts the following activities:

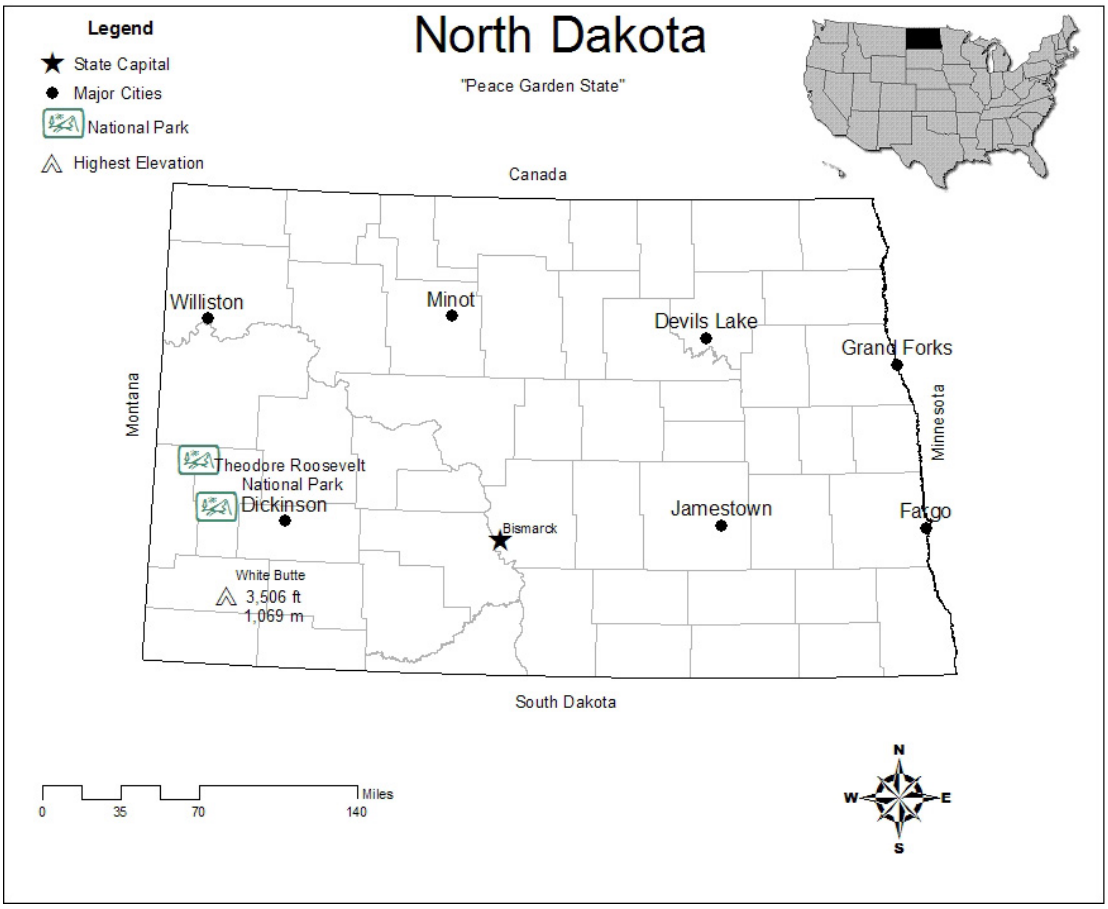
- Annually licenses 137 ground- and four air-ambulance services that meet standards for service availability, equipment and training.
- Updates and maintains training, testing, certification and licensure programs for EMS basic and advanced life support personnel, including emergency medical technicians and paramedics.
- Administers an EMS grant program of about $620,000 per year for training ambulance service personnel.
- Provides technical assistance to EMS services regarding patient care, system design, administration and operational issues.
- Maintains data system with about 20,000 EMS certification and licensure records.
- Maintains ambulance run-report data system that adds about 60,000 records per year.
- Provides critical incident stress debriefing services to law enforcement, fire and EMS personnel engaged in EMS.
- Coordinates and maintains Emergency Medical Services for Children Program.
- Provides continuing education to emergency medical services through distance learning and DVD presentations.
- Implements and maintains a statewide trauma system.
- Inspects and licenses EMS training institutions.
- Reviews continuing education curricula.

North Dakota Department of Health
Organizational Chart
July 2007



*The six division directors share responsibility for management of the Community Health Section.

NORTH DAKOTA STATE OVERVIEW



One trip to North Dakota and you'll understand why it's known as the friendliest and safest state to visit. In fact, from agricultural products to quality of life North Dakota is often at the top of the charts. Of the 50 states, North Dakota is 17th in size, with 70,665 square miles. North Dakota is 212 miles long north to south and 360 miles wide east to west. 1,710 square miles of the state are covered in water, with the major rivers being the James River, the Missouri River and the Red River. Major lakes in North Dakota include Lake Sakakawea and Lake Oahe. The highest point in the state is at White Butte, reaching 3,506 feet, and the lowest point is at the Red River at 750 feet. North Dakota is bordered to the east by Minnesota, Montana to the west, South Dakota to the south, and Canada to the north and consists of 53 counties.

From east to west, North Dakota is divided into three geographic regions. In the east is the Red River Valley. To the west of the Red River Valley is the Drift Prairie. The southwestern half of North Dakota is covered by the Great Plains.

The Red River Valley is flat. It lies along the border of Minnesota and is one of the most fertile areas in the world. This area of North Dakota is farm country, and wheat and other crops cover the area, along with livestock.

Source: www.wikipedia.com

To the west of the Red River Valley is the Drift Prairie, rising from 200 to 2,000 feet over the Red River Valley. The Drift Prairie is separated from the Red River Valley in the north by the Pembina Hills. This area is marked by rolling hills, stream valleys, and numerous lakes where thousands of ducks nest every year. In the north are the Turtle Mountains.

About half of North Dakota is covered by the Great Plains. The Great Plains, in the southwestern section of the state, rise about 300 to 400 feet above the Drift Prairie east of the Missouri River. The area is hilly and rich in mineral deposits. Along the Missouri River, the land is lower. This area is called the Missouri Break. To the south and west of the river is an area of rugged valleys and buttes called the Slope.

The Badlands lie in southwestern North Dakota. This strip of beautiful monuments to nature stretches about 190 miles and is about 6 to 20 miles wide. The Badlands are a valley of stone and clay, where wind and water have shaped the land into strange and beautiful formations: buttes, pyramids, domes and cones colored in shades of browns, reds, grays and yellows. In some areas of the Badlands, the rocks contain lignite coal that has been burning for many years. The clay above these coal beds has turned bright pink and red. White Butte, the highest point in North Dakota, stands 3,506 feet above sea level in the Badlands.

The current population is roughly the same as in 1920. The 2000 census showed a population of 642,200, ranking North Dakota 47th in the US. The population is made up of the following: Male - 320,524 (49.9%), Female - 321,676 (50.1%), white - 593,181 (92.4%), African American - 3,916 (0.6%), American Indian - 31,329 (4.9%). The median age of a North Dakotan is 36.2, with 18 to 65 year olds making up 75 percent, of the population and people 65 and older, 14.7 percent.

North Dakota State History: North Dakota is the most rural of all the states with farms covering more than 90 percent of the land. The geography of North Dakota varies widely from the fertile Red River Valley in the east to the butte-spotted and rugged Badlands of the west. The Missouri River cuts through the state as the major water-way. German is by far the largest ancestry group in North Dakota, with nearly 44% of the population citing German heritage.

Archeological investigations document the presence of big game hunting cultures after the retreat of the continental glaciers about 10,000 years ago and later settlements of both hunting and gathering and farming peoples date from 2000 BC to 1860 AD.

The first recorded visitor to North Dakota was La Verendrye, a French explorer who reached the Missouri River from Canada in 1738 while searching for a water route to the Pacific Ocean. Most contact resulted from the Canadian fur trade until Meriwether Lewis and William Clark led the American “voyage of discovery” up the Missouri from St. Louis in 1804. The Lewis and Clark expedition encountered its first grizzly bears in North Dakota

Source: www.wikipedia.com

North Dakota was part of the Louisiana Territory and was considered the wild, wild west for many years. Lewis and Clark explored the region in 1804 – 1806 and the first settlements were made at Pembina in 1812 by Scottish and Irish families while this area was still in dispute between the United States and Great Britain. In 1818, the United States obtained the northeast part of North Dakota by treaty with Great Britain and took possession of Pembina in 1823. However, the region remained largely unsettled until the construction of the railroad in the 1870s and 1880s.

American Settlement of the northern plains commenced in earnest after 1861, when Dakota Territory was organized by congress. Significant immigration commenced when the westbound Northern Pacific Railway built to the Missouri River in 1872 and 1873. Spurred by the 1862 Federal Homestead Law, farming settlement developed gradually after the first claim west of the Red River was filed in 1868.

Several parts of the struggle between opposing cultures yet remain sources of legend and controversy. In 1876, units of the 7th Cavalry commanded by Lt. Col. George A. Custer left Fort Abraham Lincoln near Bismarck to search for Dakota who had refused confinement on the reservations. The resulting annihilation of Custer's immediate command at the Little Big Horn River in Montana Territory made the names such as Crazy Horse, Gall and Sitting Bull familiar throughout the nation. Many Dakota moved to Canada to escape relentless punitive expeditions sent by the army, and remnants finally surrendered at Fort Buford in 1881.

The influence of the railroads and their business allies guided northern Dakota from its earliest territorial days. In 1883 the territorial capitol was moved from Yankton to Bismarck on the main line of the Northern Pacific Railway.

President Benjamin Harrison went to great lengths to obscure the order in which the statehood proclamations of North and South Dakota were signed on Nov. 2, 1989, so the exact order in which the two states entered the union is unknown. However, because of alphabetical position, North Dakota is often considered the 39th state.

Thanks to historic figures like Sitting Bull, George Custer and Teddy Roosevelt, North Dakota retained its reputation as a rough and wild place even after becoming a state in December 1889. However, this reputation was far from the truth. Most of the residents of North Dakota were farmers and ranchers. Many were emigrants from European and Scandinavian countries. These cultures, as well as many Native American cultures, live on in today's North Dakota. As it was in 1889, North Dakota remains a social, cultural and economic state; a producer of raw materials; and an exporter of educated young people.

Known for its waterfowl, grouse, pheasant and dear hunting and bass, trout and pike fishing, North Dakota has 20 state parks and recreation areas. Points of interest include the International Peace Garden near Dunseith, Fort Union Trading Post National Historic Site near Williston, Knife River Indian Villages National Historic Site in Stanton, the

Source: www.wikipedia.com

State Capitol at Bismarck, the Badlands, Theodore Roosevelt National Park, and Fort Abraham Lincoln State Park.

Climate

North Dakota lies in the northwestern continental interior of the United States. Characteristically, summers are hot, winters very cold, and rainfall sparse to moderate, with periods of drought. Annual mean precipitation ranges from 13 inches in the northwest to more than 20 inches in the southeast. The average yearly precipitation (1971–2000) was about 16.8 inches at Bismarck. The total annual snowfall averages 44 inches at Bismarck. The average yearly temperature ranges from 37 degrees in the northeast to 43 degrees in the south. January is the coldest month on average, with an average temperature range from 2 degrees in the northeast to 17 degrees in the southwest. July, being the warmest, runs average temperatures of 67 degrees in the northeast to 73 degrees in the south. The all time high was 121 degrees at Steel on July 6, 1936, and the all-time low was minus 60 degrees at Parshall in February of the same year.

The North Dakota State Flag: Colonel John H. Fraine introduced a resolution to the North Dakota Legislative Assembly to adopt a state flag that would take the color, size and form of the regimental flag carried by the North Dakota Infantry in the Spanish American War and the Philippine Island Insurrection. The only exception was that the name of the state, North Dakota, was to be displayed on the scroll below the bald eagle.

Introduced on Jan. 21, 1911, his resolution was adopted by the Legislative Assembly on March 3, 1911.

A dark blue field displays a bald eagle grasping an olive branch and a bundle of arrows in its claws. The eagle carries a ribbon with the words "One nation made up of many states." On its breast is a shield with 13 stripes representing the original thirteen states. The fan-shaped design above the eagle represents the birth of the United States and includes 13 stars echoing the 13 stripes on the shield. The red scroll below the eagle displays the state name, North Dakota.

A bill to change the state flag because it too closely resembled the Coat of Arms of the United States and was not particularly symbolic of North Dakota was introduced and defeated in 1953.

Source: www.wikipedia.com

The Great Seal of North Dakota is an attractive blend of images, symbols and text. Prairies, mountains, agriculture and the state's Indian heritage are all depicted on the official seal. In the center of the seal stands a single oak tree in the middle of wide open territory. A buffalo, followed by an Indian on horseback, moves across the land. Bundles of harvested wheat and a farmer's plow stand near the oak tree. A bow and arrows, and a sledge and anvil complete the scene. The motto "Liberty and Union, Now and Forever, One and Inseparable" arcs over forty-two stars, symbolizing North Dakota's union with the other states. Around the perimeter of the seal are the date that North Dakota gained statehood, October 1st, 1889, and the words "Great Seal, State of North Dakota."

The North Dakota State Capitol is the seat of government of North Dakota. The Capitol, a 19-story tower, is located in Bismarck, on a 160-acre campus that is home to many other government buildings. The capitol building itself and the surrounding office buildings house the state's legislative and judicial branches, as well as many government agencies. It is the tallest building in the state of North Dakota and is commonly known as the “skyscraper on the prairie.”

The State Capitol grounds serve as a hub for the state's government departments. The park, walking trails and monuments on the grounds give visitors an insight into the state's history, making it one of the city's tourist attractions. Six buildings currently exist on the grounds; all were built in various time periods as the government grew. Not all state agencies are housed on the grounds, however; a large percentage of them are spread out throughout the city in various facilities.

The original North Dakota State Capitol building built between 1883 and 1884 burned to the ground on the night of Dec. 28, 1930. The fire was said to be started by oily rags in a janitor's closet on the top floor of the building. The rags had been used to clean and varnish the legislators’ desks in anticipation of the next legislative session. Secretary of State Robert Byrne was able to save the original copy of the state's constitution, but he suffered cuts and burns on his hands while breaking a window to reach the document.

This disaster required the construction of a new building in the middle of the Great Depression. The tower and wing were built by the Works Progress Administration between 1931 and 1934, at a cost of $2 million. Ground was broken for the building by Governor George F. Shafer on Aug. 13, 1932. Workers on the building were paid only 30 cents an hour and, after multiple worker strikes, the capitol grounds went under Martial Law in June of 1933. The state sold half of the original capitol campus to defray the cost of construction.

While the new 19-story Capitol building was expected to have plenty of space for years to come, the space quickly filled up as the government of the state expanded. The Liberty Memorial Building, which was completed in 1924, was able to contain some of the additional workers, but more space was needed by 1955, when ground was broken for the

Source: www.wikipedia.com

State Office Building. The building originally housed Bismarck Junior College, but the Legislature purchased it in 1959. This preceded a period of rapid expansion of the grounds in the 1960s. In 1960, the new North Dakota Governor's Residence was built on the grounds to replace the old residence that was beginning to malfunction. In1968, the North Dakota Department of Transportation building was constructed to accommodate an expanding Transportation Department, and, in 1981, the North Dakota Heritage Center was built to accommodate the expanding North Dakota State Historical Society. It is the last new building built as of 2008, although a Judicial Wing was added on to the base of the Capitol tower in 1977. While the space needed by state government has grown since the original construction of the Capitol in the 1930s, the state's population has actually decreased during that time.

The south side of the Capitol building features a drive-thru tunnel that leads to an entrance to the building. This was accessible by public vehicles until 2001 when it was closed due to security measures taken after the September 11, 2001 attacks. Today, only pedestrians are able to enter the tunnel. In 1988, U.S. President George H. W. Bush presented and dedicated an American Elm tree near the Capitol steps in commemoration the state's Centennial in 1989.

North Dakota Industry

North Dakota ranks first in the nation's production of spring and durum wheat; other agricultural products include barley, rye, dry edible beans, honey, oats, flaxseed, sugar beets, hay, beef cattle, sheep and hogs. North Dakota grows more sunflowers than any other state. North Dakota also claims the largest state-owned sheep research center in the United States with the North Dakota State University Research Experiment Station in Hettinger.

Recently, manufacturing industries have also grown in the state, especially food processing and farm equipment. The state's coal and oil reserves are plentiful, and it also produces natural gas, lignite, clay, sand and gravel. Dakota Gasification Company in Beulah is the nation's only synthetic natural gas producer. Tourism, fishing and hunting are also major industries of the state.

The Garrison Dam on the Missouri River provides extensive irrigation and produces 400,000 kilowatts of electricity for the Missouri River Basin areas.

Famous Natives and Residents of North Dakota:

Actress Angie Dickinson, basketball great Phil Jackson, author Louis L'Amour, Singer Peggy Lee, baseball player Roger Maris, entertainer Bobby Vee, and band leader Lawrence Welk are some of the famous names to have come from North Dakota.

North Dakota Facts

- 10 largest cities: Fargo, 90,672; Bismarck, 57,377; Grand Forks, 49,792; Minot, 34,984; West Fargo, 19,487; Mandan, 17,225; Dickinson, 15,666; Jamestown, 14,826; Williston, 12,193; Wahpeton, 8,220

Source: www.wikipedia.com

- Governor: John Hoeven
- Dakota is a Sioux word meaning friends or allies.
- “Only the Best Come North” is the motto of the Minot Air Force Base located a few miles outside Minot’s city limits.
- North Dakota passed a bill in 1987 making English the official state language.
- Organized as territory: March 2, 1861
- The geographical center of North America is located in North Dakota, near the town of Rugby.
- The geographical center of North Dakota is Sheridan, which is 5 miles southwest of McClusky.
- State motto: Liberty and Union, now and forever, one and inseparable.
- Nickname: Peace Garden State / Flickertail State / Roughrider State
- The International Peace Garden straddles the international boundary between North Dakota and the Canadian province of Manitoba. In 1956, the North Dakota motor vehicle department, on its own initiative, placed the words “peace garden state” on license plates; the name proved so popular that it was formally adopted by the 1957 legislature.
- State bird: Western meadowlark is approximately the size of a robin. The meadowlark sports a yellow breast with a black bib over its mottled brown body. These songbirds are found from Wisconsin to Texas and westward to the Pacific.
- State flower is the wild prairie rose. The flower sports five bright pink petals with a tight cluster of yellow stamens in the center. The wild prairie rose grows along roadsides, in pastures and in native meadows.
- State tree is the American elm which is common across the state and often reaches 120 feet or taller
- Milk is the official state beverage.
- State fruit is the chokecherry.
- State fish is the northern pike.
- State grass is western wheatgrass.
- State fossil is Teredo petrified wood (a worm-shaped mollusk that burrowed into trees and is preserved in petrified wood).
- State dance is the square dance.

Source: www.wikipedia.com

REGULATION AND POLICY

To provide a quality, effective system of emergency medical care, each EMS system must have in place comprehensive enabling legislation with provision for a lead EMS agency. This agency has the authority to plan and implement an effective EMS system, and to promulgate appropriate rules and regulations for each recognized component of the EMS system (authority for statewide coordination; standardized treatment, transport, communication and evaluation, including licensure of out-of-hospital services and establishment of medical control; designation of specialty care centers; PIER programs).

There is a consistent, established funding source to adequately support the activities of the lead agency and other essential resources that are necessary to carry out the legislative mandate.

The lead agency operates under a single, clear management structure for planning and policy setting, but strives to achieve consensus among EMS constituency groups in formulating public policy, procedures and protocols.

The role of any local/regional EMS agencies or councils who are charged with implementing EMS policies is clearly established, as well as their relationship to the lead agency. Supportive management elements for planning and developing effective statewide EMS systems include the presence of a formal EMS medical director, a medical advisory committee for review of EMS medical care issues and an EMS advisory committee (or Board). The EMS advisory committee has a clear mission, specified authority and representative membership from all disciplines involved in the implementation of EMS systems.

Where We Are Today

Comprehensive enabling legislation that provides for a lead EMS agency. Chapter 23-27 of North Dakota Century Code (N.D.C.C.) establishes the North Dakota Department of Health as the lead agency responsible for regulation of the EMS industry. Chapter 23-01.2 of N.D.C.C. establishes the state trauma system. The Division of Emergency Medical Services (DEMS) is within the North Dakota Department of Health. Specifically, N.D.C.C. 23-27 enables DEMS to:

- License headquarters ambulance operations (air and ground). Fees for licensure may not exceed $25 per year. Ambulance licensure fees generate roughly $3,500 per year and are deposited in the state's general fund.
- License substation ambulance operations.
- License industrial site ambulance services. Industrial site ambulance services are not offered to the general public.
- License non-transporting quick response units. QRU licensure is optional.
- License EMS training institutions. EMS training institution licensure is optional.

- Establish administrative rules to regulate the EMS personnel and EMS operations.
- License EMS personnel.
- Distribute grants, if appropriated.

Specifically N.D.C.C. 23-01.2 enables DEMS to:

- Establish a trauma system.
- Designate hospitals as trauma centers.
- Establish a trauma registry and quality improvement program.

Administrative rules have been adopted for the following:

- Article 33-11 Licensing of Emergency Medical Services
  - 33-11-01.1 North Dakota Quick Response Units
  - 33-11-01.2 North Dakota Ground Ambulance Services
  - 33-11-02 Basic Life Support Ground Ambulance Licensure
  - 33-11-03 Advanced Life Support Ground Ambulance Services
  - 33-11-04 North Dakota Air Ambulance Services
  - 33-11-05 Basic Life Support Air Ambulance License
  - 33-11-06 Advanced Life Support Air Ambulance License
  - 33-11-07 Critical Care Air Ambulance License
  - 33-11-08 Emergency Medical Services Grants

- Article 33-36 Emergency Medical Services Personnel
  - 33-36-01 Emergency Medical Services Personnel Training, Testing, Certification and Licensure
  - 33-36-02 Licensing of Emergency Medical Services Training Institutions
  - 33-36-03 Scope of Practice for Unlicensed Emergency Medical Services Personnel
  - 33-36-04 Scope of Practice for Emergency Medical Services Professionals

- Article 33-38 State Trauma System
  - 33-38-01 Trauma System Regulation

This agency has the authority to plan and implement an effective EMS system, and to promulgate appropriate rules and regulations for each recognized component of the EMS system. One could argue that DEMS has the authority to regulate all components by virtue of N.D.C.C. § 23-27-04(1)(h), which allows DEMS to adopt rules to include "Other requirements as may be found necessary to carry out the intent of this chapter." We do have statutes and rules that clearly establish the relationship of physician medical directors (off-line medical control) with pre-hospital care providers. We have not promulgated rules that mandate:

- Statewide coordination of EMS operations.
- Standardized treatment protocols.
- Communications and evaluation.
- Establishment of online medical control.
- Designation of specialty care centers other than trauma centers (optional).

There is a consistent established funding source. The funding for DEMS is has several funding streams. Specifically, those streams are:

- Section 402 funds. $140,000 per year is granted by the North Dakota Department of Transportation (NDDoT) to be used to support training, testing, certification and licensure. 2.0 FTEs are funded to accomplish these goals.
- Section 408 funds. $106,500 per year is granted from the NDDoT to support data collection and a 1.0 FTE research analyst.
- HRSA EMSC Grant. $115,000 per year is granted to support EMSC activities as well as 2.0 FTEs.
- State Funds support:
  - $605,000 per biennium for state EMS office operations. This includes $60,000 per biennium for the State Trauma Program and funding for 3.5 FTEs in the state EMS office.
  - $1.24 million per biennium for EMS training grants.
  - $1.25 million per biennium for EMS staffing grants.
  - $125,000 per biennium for grants to agencies establishing QRUs.
  - $75,000 for a statewide trauma assessment (one-time appropriation).

The lead agency operates under a single, clear management structure for planning and policy setting. Statutory authority for approving regulation rests with the State Health Council. The membership of the State Health Council is appointed by the governor. When promulgating rules or establishing policy, DEMS employs an EMS advisory committee (EMSAC) to broaden stakeholder involvement in the process. Although EMSAC decisions are non-binding because they have no statutory authority, DEMS takes its conclusions very seriously and rarely contradicts its decisions. The EMSAC membership is composed of the following representatives, all of whom must work in North Dakota, except for the public member:

1. State trauma committee representative. A voting member of the North Dakota state trauma committee.
2. EMS Association advanced life support representative. A North Dakota certified and licensed paramedic recommended by the North Dakota EMS Association currently working for a North Dakota licensed advanced life support ambulance service.
3. EMS Association basic life support representative. A North Dakota certified or licensed emergency medical technician, or its equivalent, recommended by the North Dakota EMS Association currently working for a North Dakota licensed basic life support ambulance service.
4. EMS for Children (EMSC) representative. A current member of the EMSC

advisory committee.

5. Critical Incident Stress Management (CISM) team representative. An active CISM team member administered by DEMS.
6. EMS Association instructor coordinator society representative. A North Dakota state licensed instructor coordinator recommended by the North Dakota EMS Association Instructor Coordinator Society.
7. Legislative representative. A current North Dakota state senator or state representative as recommended by the North Dakota EMS Association.
8. Injury prevention representative. A representative of the Division of Injury Prevention and Control at the North Dakota Department of Health.
9. Medical director representative. A North Dakota licensed physician member of the North Dakota EMS Association Medical Director's Society currently serving as a medical director for a North Dakota licensed ambulance service.
10. Air ambulance representative. A representative from a North Dakota licensed air ambulance service.
11. Communications specialist representative. A Communications specialist recommended by the North Dakota 9-1-1 Association currently working for a public safety dispatching entity.
12. Rescue Society representative. A North Dakota certified rescue squad member recommended by the North Dakota EMS Association Rescue Society.
13. Quick response unit (QRU) Representative. A current member of a Certified North Dakota QRU, recommended by the North Dakota EMS Association.
14. Medical Association representative. A physician member or designee of the North Dakota Medical Association.
15. Healthcare Association representative. A member or designee of the North Dakota Healthcare Association representing North Dakota licensed hospitals.
16. Indian Health Service (IHS) representative. A representative employee of the U.S. Department of Health and Human Services, Indian Health Services.
17. EMS consumer.
18. North Dakota Department of Health – Administrative Support Section representative.
19. North Dakota Department of Health – Health Resources Section chief.
20. North Dakota Department of Health – director of the Division of Emergency Medical Services.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• Establish formal regulatory oversight of voluntary certifications and other EMS programs. This would include QRUs, light and heavy rescue units and all types of ambulance services and vehicles.	In the mid 1990s the legislature gave DEMS the authority to fully regulate QRUs. Subsequently, that authority was weakened by the legislature and that certification became optional. Light and heavy rescue squad certification has never been mandated. In 2003, DEMS established regulation for air ambulance and in 2005 regulations were established for EMS training institutions.
• The state should take steps to ensure the reliable enforcement capability for existing and planned EMS laws and regulations.	In 2005 and 2007, new regulations for revocation or withholding personnel licensure were added. Enforcement for EMS agencies has not been adequately addressed.
• The state should identify a stable source of funding for DEHS and the programs it supports. Dependency on federal highway safety funds for maintenance of essential programs should be eliminated.	Dependency on highway safety funds remains high. Historically one FTE in DEMS was funded by the Preventive Health Block Grant (PHBG). In 2007, that position was moved into state general funds due to the PHBG's volatility.

REGULATION AND POLICY SUPPORTING DOCUMENTS

CHAPTER 23-27
LICENSING OF EMERGENCY MEDICAL SERVICES OPERATIONS

23-27-01. License required - Licensing of emergency medical services operations - Exception - Waiver.

1. The state department of health shall license emergency medical services operations. After June 30, 2001, the department shall limit the issuance of a license for any new emergency medical services operation based on the needs of the service area if the applicant for the new license was licensed before July 1, 2001, and was subsequently relicensed under section 23-27-04.5. A license for an emergency medical services operation is nontransferable.

2. Emergency medical services may not be advertised, offered, or provided to the public except by an emergency medical services operator that provides the emergency medical services through emergency medical services personnel.

3. Except as otherwise provided under subsection 4, an emergency medical services operator must be separately licensed for each of the operator's emergency medical services operations and an operation that is headquartered from a separate location must be considered a separate operation. Under this subsection, an operation with a single headquarters site may dispatch vehicles and emergency medical services personnel from more than one location if calls requesting services are received and orders for vehicle dispatch are made at the single headquarters site.

4. Notwithstanding subsection 3, an operator of an emergency medical services operation may operate one or more substation ambulance services operations under a single license if:

   a. The headquarters ambulance services operation is not a substation ambulance services operation of another emergency medical services operation;

   b. The substation ambulance services operation area borders the headquarters ambulance services operation area or borders another substation of the headquarters ambulance services operation;

   c. The headquarters ambulance services operation and the substation ambulance services operation are dispatched by the same entity; and

   d. The operator of the emergency medical services operation pays a license fee for each of its substation ambulance services operations.

5. The provisions of this chapter do not apply to an operator from another state which is headquartered at a location outside of this state and transports patients across state lines, but the operator may not treat patients within this state or pick up patients within this state for transportation to locations within this state, except as provided by rule.

6. The state health council shall adopt rules for special licenses and waiver provisions for an operator of an emergency medical services operation intended for industrial sites not available to the general public.

23-27-02. Definitions. For the purpose of this chapter, unless the context otherwise requires:

1. "Department" means the state department of health.

2. "Emergency medical services" means the prehospital medical stabilization and transportation of individuals who are sick, injured, wounded, or otherwise incapacitated or helpless by emergency medical services personnel with physician oversight. The term includes assessing, stabilizing, and treating life-threatening and non-life-threatening medical conditions.

3. "Emergency medical services operation" means an entity licensed to offer and provide emergency medical services by emergency medical services personnel with physician oversight. The term includes basic life support ambulance services, advanced life support ambulance services, air ambulance services, and quick-response unit services.

4. "Emergency medical services personnel" means individuals who provide emergency medical services for emergency medical services operations. The term includes emergency medical services professionals, drivers, and department-certified emergency medical services providers, such as cardiopulmonary resuscitation drivers and first responders.

5. "Emergency medical services professional" means an individual licensed by the department as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic.

23-27-03. License fees. The fee for an emergency medical services operation license to operate an emergency medical services operation or a substation ambulance services operation must be set by the state health council at a sum of not more than twenty-five dollars annually, as may be required to defray the costs of administration of the licensing program. This operation license fee does not apply to licensure or certification of emergency medical services personnel. All license fees must be paid to the state department of health and deposited with the state treasurer and credited to the state general fund.

23-27-04. Standards for operators.

1. An emergency medical services operation within this state may not operate unless the operation is licensed in accordance with this chapter and rules adopted by the state health council. The rules must include:

   a. Time when operator's services must be available.

   b. Type of motor vehicle operator's license needed for drivers of ground vehicles.

   c. Training standards for operation personnel.

   d. Equipment and ground vehicle standards.

   e. Annual license fees.

   f. Number of personnel required for each run.

   g. The scope of practice for uncertified drivers, certified personnel, and emergency medical services professionals.

   h. Other requirements as may be found necessary to carry out the intent of this chapter.

2. An officer, employee, or agent of any prehospital emergency medical services operation may refuse to transport an individual for which transport is not medically necessary and may recommend an alternative course of action to that individual if the prehospital emergency medical service has developed protocols that include direct medical control to refuse transport of an individual.

23-27-04.1. Emergency care or services rendered by officers, employees, or agents of emergency medical services operations - Physician medical direction.

1. An officer, employee, or agent of an emergency medical services operation and a physician licensed in this state who provides medical direction to an emergency medical services operation, who is a volunteer, who in good faith renders emergency care, services, or medical direction, is not liable to the recipient of the emergency care, services, or medical direction for any civil damages resulting from any acts or omissions by the person in rendering the emergency care, services, or medical direction provided the person is properly trained according to law.

2. For the purpose of this section, "volunteer" means an individual who receives no compensation or who is paid expenses, reasonable benefits, nominal fees, or a combination of expenses, reasonable benefits, and nominal fees to perform the services for which the individual volunteered, provided that the fees do not exceed ten thousand dollars in any calendar year.

3. For a volunteer physician providing medical overview to an emergency medical services operation and the operation's personnel, the ten thousand dollar maximum fees amount is calculated separately for each emergency medical services operation for which the physician volunteered medical overview. This section does not relieve a person from liability for damages resulting from the intoxication, willful misconduct, or gross negligence of the person rendering the emergency care or services.

4. An officer, employee, or agent of any emergency medical services operation and a physician licensed in this state who provides medical direction to any emergency medical services operation who in good faith does not render emergency care, service, or medical direction to an individual based on a determination that transport of that individual to a hospital is not medically necessary is not liable to that individual for damages unless the damages resulted from intoxication, willful misconduct, or gross negligence.

23-27-04.2. Emergency medical services - State assistance. The state department of health shall assist in the training of emergency medical services personnel of certain emergency medical services operations as determined by the department and financially shall assist certain emergency medical services operations as determined by the department in obtaining equipment. Assistance provided under this section must be within the limits of legislative appropriation. The department shall adopt criteria for eligibility for assistance in the training of emergency medical services personnel of various types of emergency medical services operations. To qualify for financial assistance for equipment an emergency medical services operation shall certify, in the manner required by the department, that the operation has fifty percent of the amount of funds necessary for identified equipment acquisitions. The department shall adopt a schedule of eligibility for financial assistance for equipment. The schedule must provide for a direct relationship between the amount of funds certified and the number of responses during the preceding calendar year for the purpose of rendering medical care, transportation, or both, to individuals who were sick or incapacitated. The schedule must require that as the number of responses increases, a greater amount of funds certified is required. The schedule must classify responses and the financial assistance available for various classifications. The department may establish minimum and maximum amounts of financial assistance to be provided to an emergency medical services operation under this section. If applications for financial assistance exceed the amount of allocated and available funds, the department may prorate the funds among the applicants in accordance with criteria adopted by the department. No more than one-half of the funds appropriated by the legislative assembly each biennium and allocated for training assistance may be distributed in the first year of the biennium.

23-27-04.3. Emergency medical services personnel training, testing, certification, licensure, and quality review - Penalty. The state health council shall adopt rules prescribing minimum training, testing, certification, licensure, and quality review standards for emergency

medical services personnel, instructors, and training institutions. Rules adopted must include a definition of minimum applicable standards, a definition of emergency medical services personnel, provide for a mechanism for certifying or licensing persons who have met the required standards, provide a mechanism to review and improve the quality of care rendered by emergency medical services personnel, and define minimum standards for emergency medical services training institutions. Licensing as an emergency medical services training institution is optional. It is a class B misdemeanor for an individual to willfully misrepresent that individual's certification or licensing status as emergency medical services personnel. Quality review and improvement information, data, records, and proceedings are not subject to subpoena or discovery or introduction into evidence in any civil action.

23-27-04.4. Supervision of certified or licensed emergency medical technician hospital personnel. Certified or licensed emergency medical technicians-intermediate and paramedics, who are employed by a hospital and who are working in a nonemergency setting may provide patient care within a scope of practice established by the department. Under this section, these emergency medical services professionals are under the supervision of the hospital's nurse executive.

23-27-04.5. Quick-response unit service pilot program. Expired under S.L. 2001, ch. 246, § 14.

23-27-04.6. Quick-response units. Notwithstanding contrary licensing and certification requirements under this chapter, department licensure or certification as a quick-response unit is optional.

23-27-04.7. Study of standards of reasonable coverage - County reporting - Use of property tax levies.

1. During the 2007-08 interim, the state health council shall study the minimum requirements of reasonable emergency medical services coverage which must take into account the response time for emergency medical services. Before July 1, 2008, the state health officer shall report to the legislative council the outcome and recommendations of this study.

2. The board of county commissioners of every county in this state shall conduct an annual review of the emergency medical services coverage within that county and shall submit an annual report to the state health officer in a format approved by the state department of health.

3. A taxing district that levies property taxes for support of emergency medical services shall ensure that every emergency medical services operation that operates in that taxing district receives a benefit of this tax.

23-27-05. Penalty. Any person violating the provisions of this chapter is guilty of an infraction.

RESOURCE MANAGEMENT

Central coordination and current knowledge (identification and categorization) of system resources is essential to maintain a coordinated response and appropriate resource utilization within an effective EMS system.

A comprehensive State EMS plan exists which is based on a statewide resource assessment and updated as necessary to guide EMS system activities.

A central statewide data collection (or management information) system is in place that can properly monitor the utilization of EMS resources; data is available for timely determination of the exact quantity, quality, distribution and utilization of resources.

The lead agency is adequately staffed to carry out central coordination activities and technical assistance. There is a program to support recruitment and retention of EMS personnel, including volunteers.

Where We Are Today

It is estimated that 90 percent to 95 percent of EMS providers in North Dakota are volunteers. Generally, basic life support (BLS) ambulance services are volunteer based; of the 141 licensed ambulance services, 119 are BLS. Seventy-three of the BLS services have fewer than 10 providers on their roster, and 25 of those have a median age of greater than 50 years. Clearly, EMTs in our state are getting older, and volunteerism is on the decline.

Although it would be beneficial to add volunteers to the ranks of all ambulance services in our state, it would not address the quality of care delivered. In calendar year 2007, the 10 busiest ambulance services did 71 percent of all calls in North Dakota; 49 ambulance services did fewer than 50 calls per year; and 17 did fewer than 10. The opportunities to gain practical experience for many ambulance services are almost nonexistent. The required continuing education does have some impact on this; however, medical direction, quality assurance, and quality improvement have been left as local issues. DEMS provides tools for services to use; however most do not have an adequate oversight/QA or quality improvement program.

DEMS does have a robust web-based personnel management system. All personnel demographics and licensure information is collected. This system went online in 2005, and historical information is not available, such as number of years of service, historical age analysis, and prior years' numbers of volunteers.

No statewide comprehensive resource plan exists. However several programs are designed to promote recruitment and retention of EMS providers:

- The state legislature appropriates $1. 24 million per biennium in funding to

support education of EMS providers.

- Each volunteer agency can receive up to $2,000 per year to support continuing education.
- Each newly trained EMT is eligible for a $750 grant if they obligate six months of service to a volunteer EMS agency.
- DEMS will pay $175 of the practical testing fees during the initial testing of EMT, EMT-I, or paramedic candidates.
- DEMS will pay $75 for any active EMS provider to attend a North Dakota regional conference, and pay up to $120 for an active EMS provider to attend the spring statewide conference.
- DEMS provides a "Critical Staffing Shortage Grant" of up to $5,000 for an ambulance service to hold an EMT class locally.
- DEMS also awards a "Rural Paramedic Training Assistance Grant" of $4,000 for new paramedics who obligate two years of full-time work for a rural ALS ambulance service.

- The state legislature appropriated $1.25 million per biennium for funding of a new project for rural ambulance services to pay for staffing. Certain ambulance services that have been determined to be "access critical" are eligible to apply for up to $45,000 per year to use towards staffing of the ambulance.

- The state legislature appropriates $150,000 per biennium to establish new quick response units. Specifically, the grants are to be used for:
  - Ambulance services that choose to downgrade to QRU are eligible for $10,000.
  - Newly established QRUs are eligible for $5,000.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• The state of North Dakota should provide sufficient staff and related resources to the DEHS to accomplish the EMS resource management tasks associated with the development of a comprehensive statewide EMS system.	DEMS has grown to six program managers and three support staff. All aspects of the State EMS Office are support from a centralized location at the State Capitol. Recently DEMS has added a research analyst to manage the data systems and provide technical expertise to North Dakota ambulance services in developing a QA/QI program. However, not having regional personnel continues to be a weakness for North Dakota EMS.

• Develop an EMS Plan for the state of North Dakota, with adequate attention given to the resource management aspects of the system.	A five-year plan for EMS in North Dakota was developed in 1997. It has not been updated since that time. In the most recent legislative session, HB 1296 required that we establish and regularly update a strategic plan for an integrated EMS system.
• Develop a network of emergency medical response units to provide the capability of meeting defined response times in both urban and rural portions of the state (QRUs, ground and air ambulances, and rescue-extrication organizations). The law enforcement first responder program should be expanded.	North Dakota does have a network of ambulance services, quick response units, and rescue squads throughout the state. Quick response unit licensure and rescue squad certification remain optional to local agencies. Unregulated QRUs and rescue squads permeate the system. Law enforcement officers are required to be initially trained as first responders but continual certification is determined by individual agency policy.
• Licensure standards should be developed for air ambulance services, rescue-extrication units and QRUs.	Air ambulance licensure standards were developed and implemented in 2005. Although QRU licensure standards have existed for many years, North Dakota Century Code specifically makes this licensure optional. Many QRUs choose to not become state licensed primarily because they do not want to be obligated to 24/7 coverage. DEMS has never had statutory authority to regulate rescue squads. Some choose to be state certified; many do not.
• The prehospital aspects of the EMS system should be fully integrated with the hospital care aspects, as part of the effort to develop a comprehensive EMS system in North Dakota. This includes identifying capabilities, and also the designation of centers of excellence for trauma and other categories of patients with critical, life-threatening problems.	North Dakota has a well developed trauma system, with 38 of 45 hospitals designated as trauma centers. Recently enacted administrative rules require ambulance services to transport certain types of patients to facilities that have capabilities to treat those conditions.

RESOURCE MANAGEMENT SUPPORTING DOCUMENTATION

CHAPTER 33-11-08
EMERGENCY MEDICAL SERVICES GRANTS

Section
33-11-08-01 Eligibility for Emergency Medical Services Grants
33-11-08-02 Use of Funds

33-11-08-01. Eligibility for emergency medical services grants. Certain ambulance services may be eligible for grants on an annual basis dependent upon legislative appropriation. In addition to compliance with chapter 23-40 of the North Dakota Century Code the following conditions must be met to be eligible for an emergency medical services grant.

1. Application for the grant shall be made in the manner and timeframe prescribed by the department.

2. The ambulance service must be based in North Dakota.

3. The ambulance service must be licensed as a basic life support ground ambulance as described in chapter 33-11-02 or licensed as an advanced life support ground ambulance as described in chapter 33-11-03 for at least twelve months prior to the filing of the application.

4. The ambulance service must bill for services at a level at least equivalent to the medicare billing level.

5. Criteria for grant approval shall be established by the state health council and shall at a minimum include consideration of:

   a. The transportation distance to hospitals.

   b. The size of the ambulance service area.

   c. Contributing factors that may affect the number of patient care providers on the ambulance service.

   d. The volume of ambulance runs.

History: Effective January 1, 2008.
General Authority: NDCC 23-40-01
Law Implemented: NDCC 23-40-01

33-11-08-02. Use of funds. The state health officer or designee shall determine the scope of the project, eligibility of emergency medical services operations, and distribution amounts on an annual basis. Considerations shall include:

1. How the emergency medical services operation fits into the overall structure of provision of emergency medical services in the state;

2. The needs of the emergency medical services operation and neighboring operations;

3. Compliance with the requirements set forth in section 23-40-06 of the North Dakota Century Code; and

4. Existence of local matching funds.

History: Effective January 1, 2008.
General Authority: NDCC 23-40-01
Law Implemented: NDCC 23-40-01

North Dakota

EMS Plan

1997 - 2001

Division of Emergency Health Services
North Dakota Department of Health

Acknowledgments

We would like to express our gratitude to the North Dakota Five Year Emergency Medical Services (EMS) planning committee for their contribution in the creation of this planning document. Their sincere concern about the EMS system and their effort to create attainable goals for improving the delivery of EMS care is appreciated.

We would also like to thank the North Dakota Department of Transportation for providing the National Highway Traffic Safety 402 Funds used to implement and complete this planning process.

Executive Summary

The creation of this five year EMS plan attempts to establish attainable goals for each of the nine EMS system components. The trauma system was not addressed in this planning process since a separate planning process and plan exist for that component.

The EMS plan was created through a nominal group process involving 19 representatives from medical stakeholder organizations. Three objectives were created and prioritized for each of the nine components. Implementation strategies were created for each objective.

The nine EMS system components and their highest priority objectives are as follows:

Regulation and Policy: Legislatively establish an adequate, stable, dedicated funding source for the Division of Emergency Health Services (DEHS) and the programs it supports by July 1, 2000.

Resource Management: Conduct a thorough review of staff functions and increase the DEHS staffing level to a size between 6.5 and 7.5 FTEs. Those functions which can be delegated to entities outside of the DEHS should be delegated. This activity should be accomplished by July 1, 2000.

Human Resources and Training: Legislatively establish a comprehensive EMS practice act which defines the scope of practice for EMS personnel, more closely regulates the practice of EMS personnel and establishes a funding source to provide the necessary resources to carry out this function. The EMS practice act should be established by July 1, 2000.

Transportation: Develop standards which address requirements for the ambulance vehicle including vehicle design, lighting and interior compartment specifications and road worthiness. This objective should be completed by July 1, 1998.

Hospital Facilities: Hospital capabilities should be categorized for medical emergency patients in a manner similar to the categorization that has occurred for trauma capabilities. This objective should be completed by July 1, 2001.

Communications: Re-implement standards for 9-1-1 dispatch centers which establish appropriate training requirements for dispatcher to assure that medical emergency calls are handled appropriately. The standards must include the provision of pre-arrival care instructions. This objective should be completed by July 1, 1999.

Medical Direction: Medical Direction must be required for all ambulance services, as part of the licensure process, to include a formal quality improvement program. This objective should be implemented by July 1, 1998.

Public Information and Education: Utilize any and all agencies, organizations and entities to promote EMS education and awareness to the general public by January 1, 1999.

Evaluation: Develop educational materials for instruction on the use of the run report bubble form. This will increase compliance and produce more reliable and accurate data. This objective should be completed by July 1, 1998.

Process Overview

The creation of this five year EMS plan was accomplished through the use of a nominal group process. Stakeholder organizations were identified by the Division of Emergency Health Services. Each stakeholder organization appointed representatives which formed an 19 member adhoc planning committee. The committee met once a month for a period of three months. Members of the planning committee are as follows:

JerriEllen Feldner, North East Region, North Dakota Emergency Medical Services Association

Dale Severson, South East Region, North Dakota Emergency Medical Services Association

Alan Smith, North West Region, North Dakota Emergency Medical Services Association

Paul Schwartz, Southwest Region, North Dakota Emergency Medical Services Association

Shirley Hagemeister, Basic Life Support Ambulance Services, North Dakota Emergency Medical Services Association

Todd Porter, Advanced Life Support Ambulance Services, North Dakota Emergency Medical Services Association

Roseann Krantz, Fixed Wing Aeromedical Services, North Dakota Emergency Medical Services Association

Ryan Visina, Rotorwing Aeromedical Services, North Dakota Emergency Medical Services Association

Derek Hanson, Rescue Services, North Dakota Emergency Medical Services Association

Deb McCoy, Quick Response Units, North Dakota Emergency Medical Services Association

Mary Jagim, North Dakota Emergency Nurses Association

Kathy Seidel, North Dakota Nurses Association

Lowell Herfindahl, North Dakota Hospital Association

Gordon Leingang, DO, North Dakota Medical Association

Oliver Repnow, North Dakota Fireman's Association

Ann Lunde, North Dakota Department of Transportation

Pat Scott, North Dakota Department of Emergency Management

Harley Steffen, North Dakota Highway Patrol

Wes Hendrickson, North Dakota Department of State Radio Communications

The EMS plan consists of 10 components. The components include Regulation and Policy, Resource Management, Human Resources and Training, Transportation Facilities, Communications, Medical Direction, Public Information and Education, Evaluation and Trauma. While the Trauma component was not addressed by this planning process, it was previously covered through a separate planning process and is incorporated into the EMS Plan as a separate document.

At each of the planning meetings, staff from the Division of Emergency Health Services provided an overview of the current status of the component. Staff then reviewed the recommendations of the National Highway Traffic Safety Administration EMS Technical Assistance Review conducted in 1992. Committee members created objectives through the use of a Snow Card exercise. During the Snow Card exercise, committee members wrote suggested objectives which were posted around the room. The posted objectives were grouped into categories containing similar objectives. The objective categories were then prioritized by the group through a voting process.

Once prioritization was completed, the planning committee formed small groups and wrote implementation strategies for each of the top three objective categories. The small groups appointed a representative who presented their implementation strategy to the large group. The large group then engaged in discussion of the implementation strategy and in some cases offered additional components or created revisions to the implementation strategy.

Staff from the Division of Emergency Health Services synthesized the objectives contained in the top three objective categories into a single objective.

REGULATION AND POLICY

STANDARD

To provide a quality, effective system of emergency medical care for adults and children, each EMS system must have in place comprehensive enabling legislation with provision for a lead EMS agency, as well as a funding mechanism, regulations and operational policies and procedures.

CURRENT STATUS

North Dakota Century Code 23-27 establishes the North Dakota Department of Health as the licensing authority for surface ambulance services, as well as the authority for the training testing and certification of EMS personnel, and the distribution of EMS grants. The ambulance licensure statute and the training, testing and certification of EMS personnel statutes are accomplished through Administrative Rules that are created by the North Dakota State Health Council. The State Health Council is made up of 9 members, representing both health care providers and consumers. The council is a public body who's members are appointed by the Governor and is mandated to promulgate public health rules and standards. In addition the council plays a major role in setting health issues, and making policy suggestions to the Governor, State Legislature, and the Department of Health.

Ambulance licensure standards establish minimum levels of training, equipment requirements, and call availability for both Basic Life Support (BLS) and Advanced Life Support (ALS) ambulance services. The EMS grant statute provides for grant standards and distribution mechanisms established through State Health Department policies.

The Division of Emergency Health Services (DEHS) is the lead agency responsible for developing and maintaining effective statewide programs which address prehospital emergency care. In order to accomplish this responsibility, the division provides the following services:

- Annually license and biannually inspect 16 ALS and 125 BLS surface ambulance services.

- Certifies 23 quick response units based on a voluntary certification program. We know of over 50 QRUs who do not chose to voluntarily certify with this office.

- Certifies 4 light and 28 heavy rescue units based on a voluntary certification program. We know of over 60 rescue squads who do not voluntarily certify with this office.

- Conduct and coordinate EMS personnel training, testing and certification programs.

- Administers EMS grants to ambulance services. Maintains a data system to process ambulance run reports.

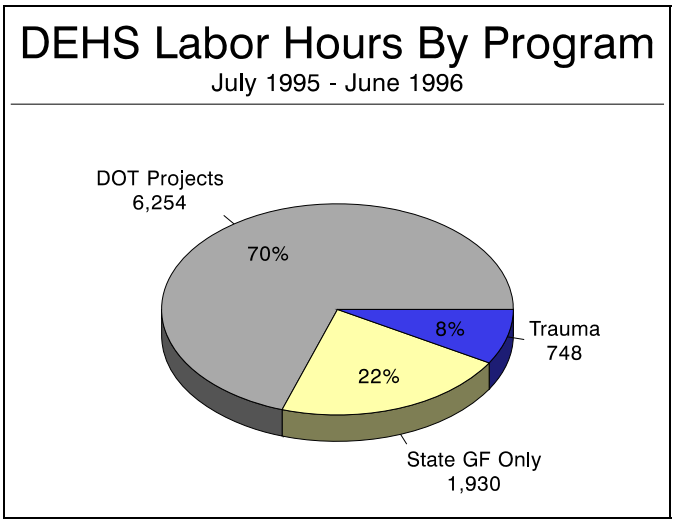
- Maintains an EMS personnel data system which contains approximately 16,000 certification training records and approximately 8400 demographic files.

- Provides direction and consultation to EMS services and personnel. Maintains a Trauma Care System.

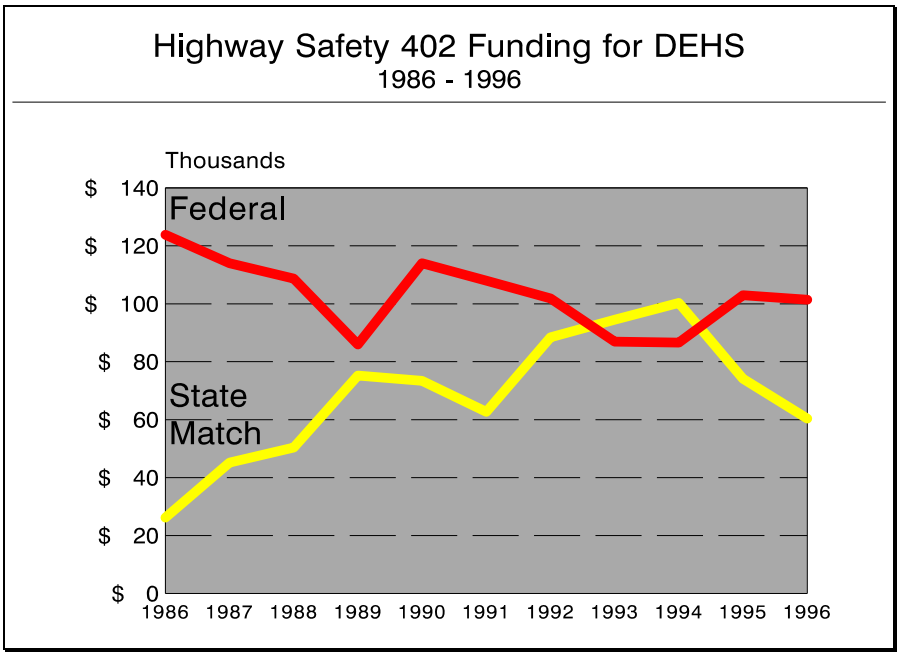
- Maintains a system for reporting significant exposure episodes for blood borne, body fluid, or airborne pathogens.

Funding for the EMS programs provided to DEHS has been unstable. The primary two funding sources are state general funds and Highway Safety 402 funds. An EMS assessment conducted in 1992 by the National Highway Traffic Safety Administration recommended that an increase in financial resources occur and that Highway Safety 402 funds not be used to fund the DEHS core programs.

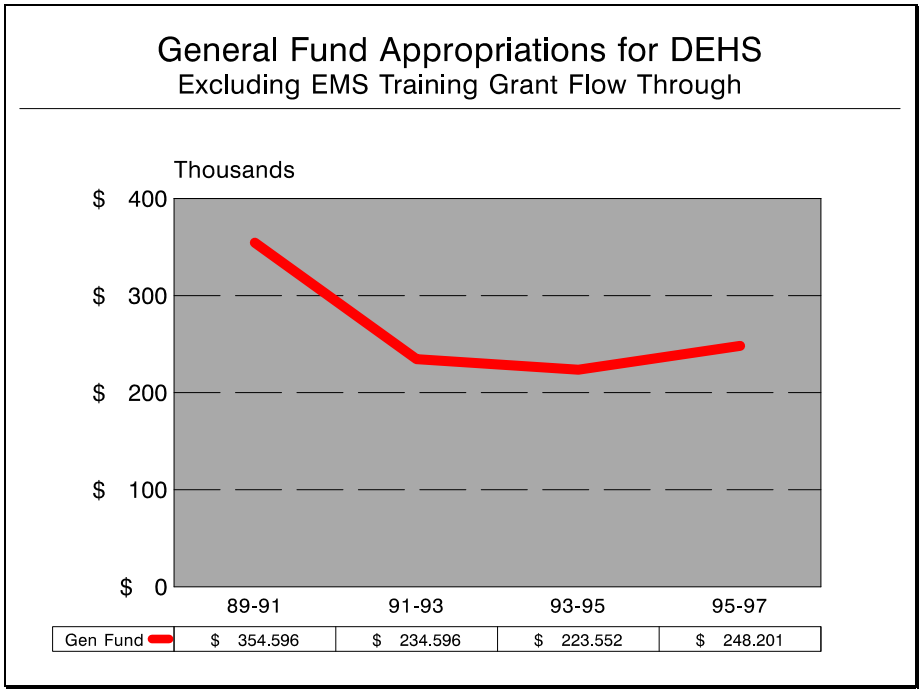
The DEHS labor hours for a twelve month period indicate most of the labor time is consumed by Highway Safety funded projects. In the period from July 1995 to June 1996, DEHS staff labor was involved in Highway Safety projects 70% of the time, state general fund activities 22% of the time and trauma 8% of the time.



Highway Safety 402 funds have been used since the creation of the North Dakota EMS system in the late 1970s. Their use requires a match from the state general fund. While the amount of Highway Safety 402 funds has declined in the last decade, the amount of state general fund match has substantially increased. This has occurred in an environment where the total amount of state general funds available to DEHS has declined substantially from the 1987-89 biennium.

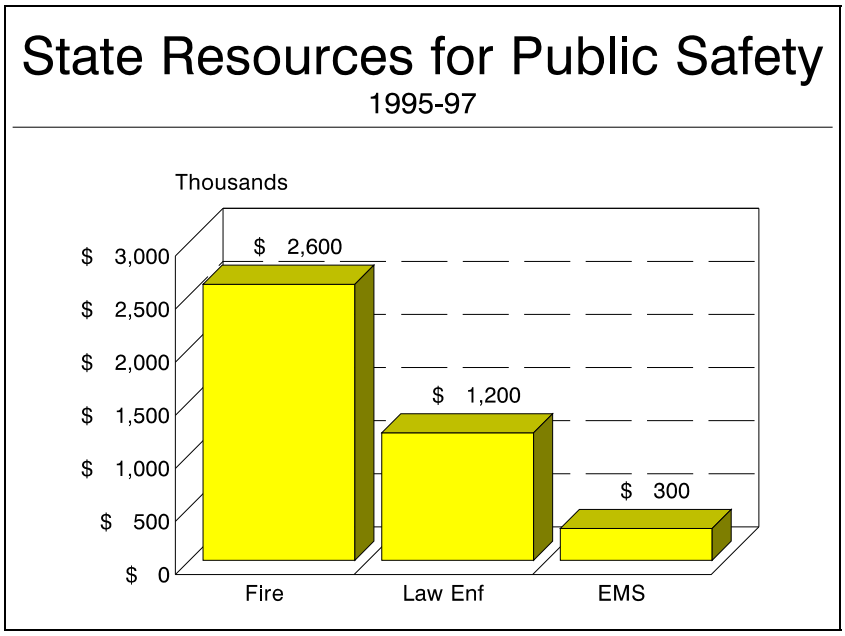


The net result is a situation where the DEHS is constantly experiencing a shortage of state general funds and must continually develop new projects in order to access the Highway Safety 402 funds.



The EMS grant program implemented by the North Dakota Legislature has been very successful in defraying out of pocket expenses for personnel (largely volunteers) receiving EMS training. The appropriation for the current biennium was $500,000. It consisted of $300,000 state general funds and $200,000 Department of Transportation Section 153 funds.

Department of Transportation Section 153 funds were created through federal legislation requiring states which lack both seat belt and motor cycle helmet mandates to set aside a portion of their highway construction funds for use by public safety programs. That legislation was recently rescinded resulting in a $100,000 short fall in the training grant fund. We addressed the short fall by eliminating proposed continuing education grants to rescue services and quick response units. As the budget process begins for next biennium, we are faced with a current general fund appropriation of $300,000 (which is $100,000 less than the general fund appropriation from the previous biennium) and no identified federal funding source to restore the fund to the $500,000 level. We are concerned whether another federal funding source can be identified to restore the fund.



Substantial state expenditures do occur for the provision of public safety. A $1.2 million expansion of the North Dakota Law Enforcement Academy, for example, will be funded this biennium from a $2 one time surcharge on all North Dakota motor vehicle registrations. Another example can be found with North Dakota fire services which will respond to approximately 2,800 fire calls this biennium and will receive $2.6 million from state revenues. These revenues are generated from a surcharge on property insurance premiums. The North Dakota EMS system will respond to approximately 30,000 ambulance calls this biennium and will receive $300,000 from the state general fund. An on going dedicated funding source needs to be identified for North Dakota's EMS system.

1992 NHTSA RECOMMENDATIONS

- The State Health Council and DEHS should establish formal regulatory oversight of the current voluntary certification and other EMS programs. This would include QRUs, light and heavy rescue units and all types of ambulance services and vehicles.

- The State should take steps to ensure the reliable enforcement capability for existing and planned EMS laws and regulations.

- The State should identify a stable source of funding for DEHS and the programs it supports. Dependency on federal highway safety funds for maintenance of essential programs should be eliminated.

-

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Legislatively establish an adequate, stable, dedicated funding source for the Division of Emergency Health Services and the programs it supports by July 1, 2000.

Discussion: Current financial and human resources for the DEHS and it's programs are inadequate. Additional state funds should be committed to the EMS programs conducted by the DEHS commensurate with the state resources used to support other forms of public safety such as law enforcement and fire services.

Federal funds have been used extensively to support EMS programs. While federal funds should be utilized to support specific enhancements to the EMS system when they are available, stable, dedicated state resources should be provided to support the ongoing core functions of the EMS program. Those core functions include the establishment of standards for EMS services including minimum equipment, personnel, and availability; training, testing and certification standards for personnel; coordination of the overall system including data collection, establishment of quality improvement systems and establishment of system policies; maintenance of trauma systems and the distribution of training and equipment grants.

Because we have a highly mobile population, persons living in both urban and rural areas need to be concerned about the availability and quality of care rendered by the entire EMS system. EMS services need to be recognized as part of North Dakota's infra-structure not unlike roads and public school systems.

Implementation Strategy:

Step One: Gather data from other states which have dedicated funding sources in place.

Step Two: Educate North Dakota State Legislators regarding the necessity of establishing the funding source. The education process should consist of local contact with legislators prior to the legislative session, identification of specific

legislators who may champion EMS issues and the development of a presentation package depicting the present funding resources and the problems associated with those funding sources.

Step Three: A comprehensive EMS program budget should be developed.

Step Four: Identify funding source options and resources including but not limited to sunset dedicated funding currently utilized to finance the law enforcement training academy, surcharges on alcohol, tobacco or drivers licenses and vehicle insurance surcharges. Additionally, all current fees collected by the DEHS including licensing, testing and certification fees should be retained for use of EMS programs rather than being deposited in the State General Fund.

Step Five: An EMS coalition comprised of the major medical organizations should be established to assist in securing funding or the current medical alliance committee should be used in this capacity.

Objective Two: Legislatively establish licensure standards for quick response units, rescue services and air ambulance services which address minimum standards for equipment, availability and personnel. The licensure standards should be implemented by July 1, 2000.

Discussion: North Dakota's EMS system is comprised of multiple service units. The current service licensure standards only address ground ambulance services. The EMS system consists of other forms of emergency medical service units which are of equal importance to ambulance services but for whom no standards exist. Uniform minimum standards need to be established for all service units within the EMS system in order to provide public protection, identify participating entities and integrate the services into an efficient system.

Currently, EMS service units other than ground ambulance service units can exist without meeting recognized standards for equipment, training and availability. In some situations unlicensed EMS services exist without integrating into the formal EMS system and provide services in a manner which is detrimental to the patient. The EMS system has matured beyond the licensure regulations which were initially established for ground ambulance services. The establishment of minimum standards for EMS services must be comprehensive to include all of the service units participating in the system.

Implementation Strategy:

Step One: Legislation must be drafted which amends the current ambulance licensure law to include licensure standards for quick response units, rescue services and air ambulance services.

Step Two: Legislative sponsors must be identified and the legislation introduced.

Step Three: Adequate staffing and equipment resources must be identified for the DEHS to carry out these functions.

Objective Three:

Legislatively establish a comprehensive EMS practice act which defines the scope of practice for EMS personnel, more closely regulates the practice of EMS personnel and establishes a funding source to provide the necessary resources to carry out this function. The EMS practice act should be established by July 1, 2000.

Discussion: Currently, EMS personnel are regulated under state law through administrative rules established by the North Dakota State Health Council. The regulations mandate standards for certification of EMS personnel and establish a process for the revocation of the certification. The certification standards establish training curricula, course length, instructor requirements, testing processes, initial certification requirements and rectification requirements. The scope of skills for EMS personnel are defined by the mandatory curricula.

The process, as it currently exists, does not adequately address circumstances for revocation. The DEHS is currently powerless to revoke certification in certain situations in which it is clear that revocation should occur.

Controversy has occurred regarding EMS providers functioning in hospital settings. EMS providers are viewed by other licensed hospital personnel as unlicensed care givers. EMS providers functioning in this environment prefer to be licensed rather than certified.

Implementation Strategy:

Step One: The DEHS should expand the current administrative rules to require medical direction for all ambulance services.

Step Two: Medical directors should ensure that all current regulations and policies are followed. Medical direction should be arranged on a regional basis when possible by establishing protocols and procedures for off-line medical direction and utilizing State Radio communications for on-line medical direction.

Step Three: The DEHS should conduct research to determine if existing statutory authority allows for the development of an EMS practice act or if statutory changes need to occur.

Step Four: The necessary administrative rule or statutory changes need to be drafted by the DEHS through the cooperative efforts of affected medical stakeholder organizations.

Step Five: The administrative or statutory changes need to be introduced and adopted.

RESOURCE MANAGEMENT

STANDARD

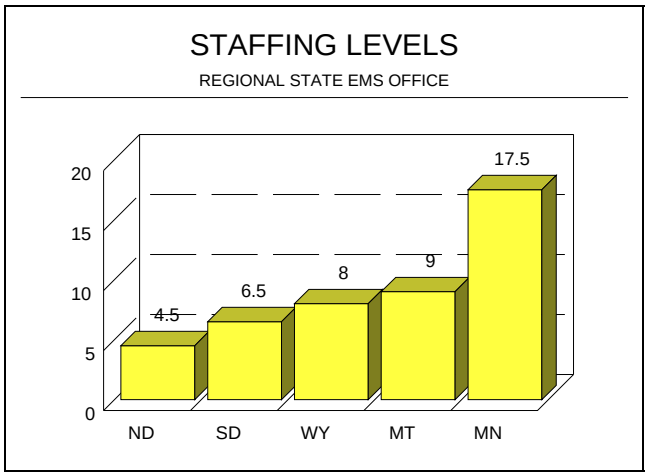
The provision of centralized coordination to identify and categorize the resources necessary for the overall system implementation and operation is essential to an effective EMS System. This is required to maintain a coordinated response and appropriate resource utilization throughout the state. It is essential that victims of medical or traumatic emergencies have equal access to basic emergency care, including the triage and transport of all victims by appropriately certified personnel (at a minimum, trained to the EMT-Basic level) and a licensed and equipped ambulance to a facility that is appropriately equipped and staffed and ready to administer to the needs of the patient.

CURRENT STATUS

North Dakota does not have a current state EMS plan. The last plan was completed and disseminated for the period from 1981 through 1985. In 1992 DEHS initiated the process of creating a new state EMS plan by coordinating an assessment of North Dakota's EMS System. The National Highway Traffic Safety Administration (NHTSA) completed their assessment and presented a list of recommendations. The DEHS has been utilizing the NHTSA Assessment as a de-facto North Dakota EMS plan in the absence of a state planning process. Many of NHTSA's recommendations have been realized but there still remains a need for an EMS plan. DEHS believes North Dakotans should have access to high quality emergency medical care from the initial call for assistance through discharge from appropriate definitive care facilities.

LEAD AGENCY

The DEHS is the state agency charged with regulation and implementation of EMS programs in North Dakota. The DEHS has fewer employees than almost all other state EMS agencies in the country. Staffing levels have declined from a high in 1975 of 12 to the current 4.5 full time equivalents (FTEs). In relation to other comparable states North Dakota ranks lowest in actual staff positions. With 73,000 square miles of geographical area to cover, it is extremely difficult for a staff of 4.5 full time positions to carry out all of the resource management tasks associated with a statewide EMS System.



The individual areas of responsibility within the DEHS are listed as follows:

TIM WIEDRICH, DIRECTOR
- Overall administration of the division
- EMS Grant Projects
- Communications
- North Dakota Trauma Plan
- Run report data

LARRY WEBER, ALS TRAINING COORDINATOR
- Training, testing and certification and licensure of EMT-Intermediates and Paramedics
- Defibrillation, Epinephrine, IV maintenance and D-50 Modules
- Licensure of Ground Ambulance Services
- Quick Response Unit Certification

ALAN AARHUS, BASIC LIFE SUPPORT TRAINING COORDINATOR
- Training, testing and certification for First Responder, EMT-Basic, EMS Instructor, Automobile Extrication, and Automobile Extrication Instructor programs.
- Critical Incident Stress Debriefing Program
- Rescue Service Certification
- Emergency Vehicle Operations Program
- Ambulance Inspections
- DEHS Liaison to the American Heart Association, Affiliate Faculty Member

LINDA ZAHN, CLERK (Part Time)
- Data Input

CAROL EISENBEIS, SECRETARY

- All secretarial and clerical functions within the DEHS, including data entry, word processing, and telephone responsibilities

DEHS - APPROXIMATE ANNUAL OUTPUTS

The DEHS achieves a substantial number of outputs annually. The following is a brief overview of the typical outputs the DEHS is responsible for in a 12 month period:

TRAINING, TESTING and CERTIFICATION

- First Responder
  51 courses per year involving new students
  855 currently certified

- EMT-Basic
  50 courses per year involving new students
  2,241 currently certified

- EMT-Intermediate
  12 courses per year involving 140 students
  339 currently certified

- EMT-Paramedic
  5 courses per year involving 55 students
  201 currently certified

- Manual and Auto Defibrillation
  90 courses per year involving 740 students

- IV Maintenance
  65 courses per year involving 470 students

- Epinephrine Administration
  75 courses per year involving 750 students

- Auto Extrication
  47 courses per year involving 470 students

- Coordinate and conduct 12 ALS tests per year at which 85 EMT-I students and 25 EMT-P students are tested

- Coordinate and conduct 6 BLS test sites annually at which 563 EMT-B Students are tested

LICENSING

- License 220 EMT-I and 135 EMT-P Providers Annually

- License 141 Ambulance Services

EMS Grants

- Issue $400,000 in EMS training grants for the Biennium

VOLUNTARY CERTIFICATION PROGRAM

- Certify 13 Quick Response Units Annually
- Certify 35 Rescue Services Annually

CRITICAL INCIDENT STRESS MANAGEMENT

- Conduct 30 debriefings annually
- Coordinate Basic and Advanced training sessions annually

PREHOSPITAL INFORMATION SYSTEM

- Enter 30,000 ambulance reports into the data base each year and generate biannual reports for all ambulance services

TRAUMA PLAN

- Coordinate and staff 4 State and 16 Regional trauma committee meetings
- Establish and maintain a state wide trauma registry
- Conduct quality improvement audits
- Conduct trauma center verification
- Provide EMS technical assistance

EMERGENCY VEHICLE OPERATIONS COURSE

- Conduct 12 courses training 150 students annually in emergency ambulance driving

CURRENT EMS SYSTEM

- 55% of North Dakota's 53 counties utilize 911 dispatch including 11 counties contracted with State Radio and 18 counties with their own dispatch centers.
- 23 Certified Quick Response Units with the First Responder certification as the minimum training level

- 125 Licensed Basic Life Support Ambulance Services with the EMT-Basic or the AFA or AFA-A as the minimum training level

- 16 Licensed Advanced Life Support Ambulance Services

- Approximately 13 unlicensed Air Ambulance Services comprised of 3 rotor wing and 10 fixed wing services.

- 32 Certified Rescue Services comprised of 4 Light Rescue and 28 Heavy Rescue Squads

- North Dakota Critical Incident Stress Management Team comprised of 65 Mental Health and EMS volunteers located in the four EMS regions and accessible 24 hours a day through State Radio.

- Run Report System that collects 30,000 run reports annually and generates biannual reports to ambulance services

NHTSA ASSESSMENT RECOMMENDATIONS

- Develop an EMS Plan for he State of North Dakota, with adequate attention given to the Resource Management aspects of the system.

- Develop a network of emergency medical response units to provide the capability of meeting defined response times in both urban and rural portions of the State (QRUs, ground and air ambulances, and rescue-extrication organizations.) The law enforcement first responder program should be expanded.

- The State of North Dakota should provide sufficient staff and related resources to the DEHS to accomplish the EMS resource management task associated with the development of a comprehensive statewide EMS system.

- Licensure standards should be developed for air ambulance services, rescue-extrication units and QRUs.

- The prehospital aspects of the EMS system should be fully integrated with the hospital care aspects, as part of the effort to develop a comprehensive EMS system in North Dakota. This includes identifying capabilities, and also the designation of centers of excellence for trauma and other categories of patients with critical, life-threatening problems.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Conduct a thorough review of staff functions and increase the DEHS staffing level to a size between 6.5 and 7.5 FTEs. Those functions which can be delegated to entities outside of the DEHS should be delegated. This activity should be accomplished by July 1, 2000.

Discussion: The DEHS is not sufficiently staffed to complete it's statutory and contractual responsibilities. It is important that the EMS system maintains the DEHS as an effective lead agency. Some activities that are important to the system do not currently receive adequate attention because of insufficient staff. Some services are not provided in a timely manner.

An environment exists where additional levels of responsibilities are created for the DEHS either through additions to statutory responsibilities or through the pursuit of federal funding sources but no additional human resources are provided. Comparison of North Dakota's staffing level to other rural states reaffirms that staffing levels in DEHS are inadequate.

Implementation Strategy:

Step One: Conduct a study internally or through a consultant regarding the duties and responsibilities of the DEHS and the available human resource to deliver the output.

Step Two: Regionalize those activities that can be done outside of the DEHS into outside resource centers.

Step Three: Increase the staff size identified in the study

Step Four: Create a volunteer task force to conduct specialized projects.

Step Five: Identify a new lead agency for the Critical Incident Stress Management program.

Objective Two: Establish a requirement through the Peace Officer Standards and Training Board which provides for the ongoing certification of law enforcement officers as First Responders by July 1, 1998.

Discussion: Law enforcement officers can play a very important role in the provision of Emergency Medical Services. In many situations they arrive at the scene of medical emergencies prior to the arrival of quick response units or ambulance services. Their provision of first responder care, both prior to and after the arrival of quick response units and ambulance services, can substantially enhance the provision of care.

While law enforcement officers are currently required to obtain initial certification as a first responder as part of their peace officer licensure, many law enforcement agencies do not see the provision of EMS Care as part of their mission and most peace officers do not maintain first responder certification once they have completed basic training.

Law enforcement officers are paid public safety providers. Given the importance of EMS and difficulty in maintaining EMS systems in rural areas where substantial volunteer effort is contributed, it is logical to utilize the public's paid law enforcement personnel in this effort. Law enforcement agencies must recognize the provision of EMS as an important component of their mission and dedicate adequate resources as agencies to fulfill that mission. Law enforcement agencies should recognize their responsibility to recertify their officers as first responders just as they recognize their responsibility to maintain adequate training in enforcement roles.

Implementation Strategy:

Step One: Approach the Peace Office Standards and Training Board to include certification as a First Responder by the DEHS as part of their three year Law Enforcement rectification requirements.

Step Two: Revise the administrative rules through the North Dakota State Health Council for First Responders from the current two year certification period to a three year certification period to coincide with the law enforcement certification time period.

Step Three: Develop a format which encourages local EMS services to contact local law enforcement agencies for the provision of first responder continuing education and encourage their participation in quick response units.

Step Four: Provide funding from the North Dakota EMS grant administered by the DEHS to law enforcement agencies to fund first responder training and provide first responder equipment.

Objective Three: Develop a planned regional approach to the delivery of a tiered response EMS system including 911 dispatch, quick response, basic life support and advance life support ground ambulance services, rotor wing and fixed wing air ambulance service, hospital admission and discharge. The system must include the implementation of quality improvement audits and assure that EMS services are not allowed to be implemented in areas already served which deliver a lower level of care. This objective should be implemented by July 1, 2002.

Discussion: EMS services have historically developed without having any type of an overall planning process. Typically, an individual community will decide it should create a quick response unit or ambulance service. Little attempt is made to coordinate EMS on a county, regional or state level. Without having a specific planning process in place, services are created which overlap in some areas, of the state while other areas find they have no service within close proximity. Without a more regional approach to the delivery of services, levels of the tiered response system do not integrate well with one another.

Concern also exists that lack of a planning process may lead to the degradation of care in areas where higher levels of services may exist. For example, nothing currently prohibits a basic life support ambulance service from becoming licensed to serve a community already served by an advanced life support ambulance service. This situation should be resolved by amending the current ambulance licensure standards.

Currently little quality improvement is being carried out in the EMS system. Some services do ambulance run reviews but overall audit filters for the system have not been created. A more standardized quality improvement system must be created and the process afforded protection from legal discovery.

Implementation Strategy:

Step One: A comprehensive State EMS planning process must be developed which promotes a tiered-response system.

Step Two: Regional resources should be identified to carry out the development and implementation of the tiered response system.

Step Three: Quality improvement systems should be developed after protection mechanisms exist to prevent access to the information for use in litigation.

HUMAN RESOURCES AND TRAINING

Standard

EMS personnel can perform their mission only if adequately trained and available in sufficient numbers throughout the State. At a minimum, all transporting prehospital personnel should be trained to the EMT-Basic level. In addition, each prehospital training program should use a standardized curriculum for each level of EMT personnel. In an effective EMS system, training programs are routinely monitored, instructors must meet certain requirements, and the curriculum is standardized throughout the State. In addition, the state agency must provide a comprehensive plan for stable and consistent EMS training programs with effective local and regional support.

Current Status

The DEHS has statutory authority to act as the certifying agency for all EMS personnel. The statutory authority grants the ability for the North Dakota State Health Council (NDSHC) to establish administrative rules for the training, testing and certification of EMS personnel. The administrative rules also provide for a mechanism to revoke certification.

The administrative rules identify the curricula and textbooks to be used, establish minimum standards for course coordinator, establish the certification testing requirements, indicate the standards for initial certification and define the recertification requirements.

The DEHS coordinates EMS training and compliance with the administrative rules through a course authorization process. Instructors wanting to conduct an EMS training course submit a course authorization request to the DEHS. The course authorization request indicates the type of course to be conducted; the date, time and place of the course; identify who will be instructing the course; indicate if DEHS audio visual materials will be requested and indicate that the course will be conducted in accordance with the established administrative rules.

The course authorization is then reviewed by DEHS staff for compliance with the standards, the course information is added to a list of EMS courses to assist the public in locating training, and a course authorization is issued if the course is in compliance. The DEHS has implemented this system of authorizing individual courses rather than authorizing trainers for blocks of time in order to maintain a central repository of current course locations. This central repository allows the DEHS to make referrals to training programs when requested that would otherwise not be possible.

The training programs are defined as primary certification programs and scope enhancement programs. The primary certification programs provide the core level of skills. There are six primary certification programs. They include First Responder, Emergency Care Technician, Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic and Advanced First Aid Ambulance Attendant. All primary certification programs utilize national standardized curricula as published by the National Highway Traffic Safety Administration except for the Advanced First Aid Ambulance Attendant. Detailed explanations for each of these levels are as follows:

FIRST RESPONDER

Prerequisite: None
Curriculum: National Standardized US Department of Transportation
Course length: 40 hours including CPR.
Course Coordinator: Certified EMS Instructor certified at least to the First Responder level
Certification test: Local skill demonstration and local (or state if requested by the instructor) written.
Certification period: Two years but initially reconciled to a December 31 expiration date resulting in slightly more or less than two years depending on when the testing process was completed.
Recertification requirements: Sixteen hour refresher course with local practical and local (or state if requested by the instructor) written examination.

EMERGENCY CARE TECHNICIAN

Prerequisite: None
Curriculum: National Standardized US Department of Transportation
Course Coordinator: Certified EMS Instructor certified at least to the EMT-Basic level
Course length: 110 hours including CPR.
Certification test: State practical and National Registry written.
Certification period: Two years but initially reconciled to a March 31 expiration date resulting in slightly more or less than two years depending on when the testing process was completed.
Recertification requirements: Twenty-four hour refresher course with local practical and state written examination and 48 hours of continuing education.

EMERGENCY MEDICAL TECHNICIAN-BASIC

Prerequisite: None
Curriculum: National Standardized US Department of Transportation
Course length: 110 hours including CPR.
Course Coordinator: Certified EMS Instructor certified at least to the EMT-Basic level

Certification test: State practical and National Registry written.
Certification period: Two years but initially reconciled to a March 31 expiration date resulting in slightly more or less than two years depending on when the testing process was completed.
Recertification requirements: Twenty-four hour refresher course with local practical and state written examination and 48 hours of continuing education.

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE

Prerequisite: Current Emergency Care Technician or Emergency Medical Technician-Basic Certification
Curriculum: National Standardized US Department of Transportation
Course length: 100 hours
Course Coordinator: Certified EMS Instructor certified at least to the EMT-Intermediate level
Certification test: National Registry practical and written
Certification period: Two years but initially reconciled to a March 31 expiration date resulting in slightly more or less than two years depending on when the testing process was completed.
Recertification requirements: Twenty-four hour EMT-Basic refresher course with local practical and state written examination, 12 hour EMT-Intermediate refresher and 36 hours of continuing education.

EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC

Prerequisite: Current Emergency Care Technician or Emergency Medical Technician-Basic Certification
Curriculum: National Standardized US Department of Transportation
Course length: 1000 hours
Course Coordinator: Certified EMS Instructor certified at least to the EMT-Paramedic level
Certification test: National Registry written and practical.
Certification period: Two years but initially reconciled to a March 31 expiration date resulting in slightly more or less than two years depending on when the testing process was completed.
Recertification requirements: Twenty-four hour Paramedic refresher course, 48 hours of continuing education, ACLS Certification

ADVANCED FIRST AID AMBULANCE ATTENDANT

The Advanced First Aid Ambulance Attendant certification was created as a mechanism to allow persons who had been trained by the American Red Cross as Advanced First Aid providers to continue to function as ambulance attendants. When ambulance standards were first established in North Dakota, the American Red Cross Advanced First Aid certification was defined as the minimum level of training for an ambulance attendant. When the Red Cross discontinued their training course in 1994, the DEHS began offering to certify persons at this level

as a way to grandfather these Red Cross providers and allow them to continue functioning as ambulance attendants.

The result of this action is that those persons who were certified by the American Red Cross can continue to function as ambulance attendants under certification by the DEHS but that no new Advanced First Aid providers are being created. The DEHS believes that new ambulance attendants should be trained at least to the EMT-Basic level.

Prerequisite: Advanced First Aid certification by the American Red Cross, two years of ambulance experience, completion of an EMT-Basic refresher course
Certification period: Three years
Recertification requirements: Twenty-four hour refresher course with local practical and state written examination

Scope enhancement programs are programs which add skills beyond those found in the primary certification program or refresh the student in the content of the primary certification program curriculum. There are 13 scope enhancement programs. They are as follows:

EMERGENCY MEDICAL SERVICES INSTRUCTOR

Prerequisite: None
Curriculum: National Standardized US Department of Transportation
Course length: 32 hours
Course Instructor: Provided by the DEHS
Certification test: None
Certification period: Two years
Recertification requirements: Eight hour refresher

AUTOMATIC DEFIBRILLATION

Prerequisite: Current First Responder (or higher) certification
Curriculum: National Standardized US Department of Transportation EMT-Basic Automatic Defibrillation
Course length: 4 hours
Course Instructor: EMT-Paramedic, Registered Nurse or Physician; ACLS certification
Certification test: State written and practical
Certification period: One year
Recertification requirements: 1 hour

MANUAL DEFIBRILLATION

Prerequisite: Current First Responder (or higher) certification
Curriculum: National Standardized US Department of Transportation EMT-Basic Automatic Defibrillation

Course length: 26 hours
Course Instructor: EMT-Paramedic, Registered Nurse or Physician; ACLS certification
Certification test: State written and practical
Certification period: One year
Recertification requirements: 1 hour

INTRAVENOUS MAINTENANCE

Prerequisite: EMT-Basic
Curriculum: DEHS
Course length: 4 hours
Course Instructor: EMT-Paramedic, Registered Nurse or Physician
Certification test: State written and practical
Certification period: One year
Recertification requirements: One hour refresher

FLIGHT MEDICAL CREW

Prerequisite: EMT-Basic
Curriculum: Air Medical Crew National Standard Curriculum - Advanced, US Department of Transportation
Course length: 16 hours
Course Instructor: DEHS Approved
Certification test: State written
Certification period: Two years
Recertification requirements: 4 hours

AUTOMOBILE EXTRICATION

Prerequisite: None
Curriculum: Car-buster
Course length: 16 hours
Course Instructor: Certified Extrication Instructor
Certification test: State written and practical
Certification period: Two years
Recertification requirements: Six hour refresher

AUTOMOBILE EXTRICATION INSTRUCTOR

Prerequisite: Current Automobile Extrication certification
Curriculum: Car-buster
Course length: 16 hours
Course Instructor: DEHS approved
Certification test: None
Certification period: Two years
Recertification requirements: Conduct an Automobile Extrication course or audit eight hours of an Automobile Extrication Instructor course

EPINEPHRINE ADMINISTRATION

Prerequisite: Current ECT or EMT-Basic Certification
Curriculum: DEHS
Course length: One hour
Course Instructor: EMT-Paramedic, Registered Nurse or Physician
Recertification test: State written and practical

DEXTROSE ADMINISTRATION

Prerequisite: Current EMT-Intermediate Certification
Curriculum: DEHS
Course length: One hour
Course Instructor: EMT-Paramedic, Registered Nurse or Physician
Recertification test: State written and practical

FIRST RESPONDER REFRESHER

Prerequisite: Current First Responder Certification
Curriculum: National Standardized US Department of Transportation
Course length: 16 hours
Course Instructor: Certified EMS Instructor certified at least to the First Responder level
Recertification test: Local skill demonstration and local (or state if requested by the instructor) written.

EMT-BASIC REFRESHER

Prerequisite: Current ECT or EMT-Basic Certification
Curriculum: National Standardized US Department of Transportation
Course length: 24 hours
Course Instructor: Certified EMS Instructor certified at least to the EMT-Basic level
Recertification test: State written and local practical

EMT-INTERMEDIATE REFRESHER

Prerequisite: Current EMT-Intermediate Certification
Curriculum: National Standardized US Department of Transportation
Course length: 12 hours
Course Instructor: Certified EMS Instructor certified at least to the EMT-Intermediate level
Recertification test: None

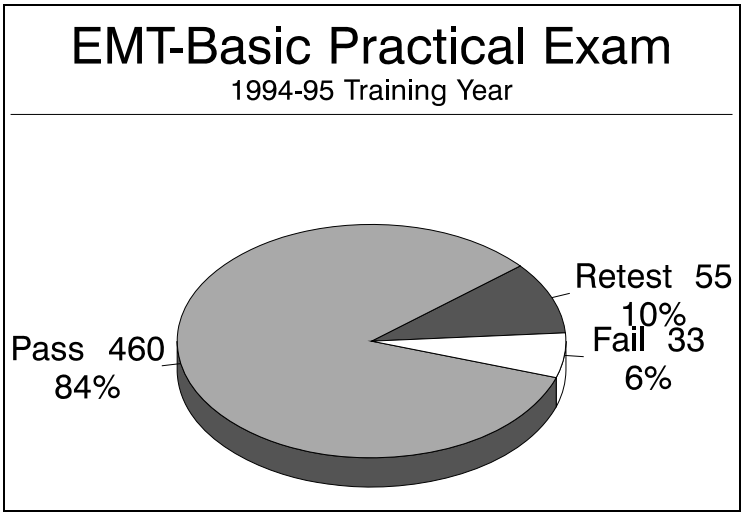
EMT-PARAMEDIC REFRESHER

Prerequisite: Current EMT-Paramedic Certification
Curriculum: National Standardized US Department of Transportation
Course length: 24 hours
Course Instructor: Certified EMS Instructor certified at least to the EMT-Paramedic level
Recertification test: None

Following the completion of a course, the course coordinator or instructor sends a course roster to the DEHS. The DEHS reviews the course roster, assures minimum prerequisites were met, then enters the course information into a computer database. The computer database maintains demographic information about the EMS provider, their squad affiliation, certification information and certain test scores. The DEHS then forwards certification documents directly to the student for the majority of the training programs.

Most EMS instruction is delivered by persons who are volunteering their services or receiving only nominal payment. Seven training institutions employ full time EMS instructors and market their services. They are the Northwest Technical College, East Grand Forks, MN and the Northwest Technical College, Moorhead, MN (while these are Minnesota institutions they market to and train a significant number of North Dakotans) FM Ambulance Service, Fargo, ND; St. Alexius Meducal Center, Medcenter One, Bismarck, ND; Trinity Medical Center, and Unimed Medical Center, Minot, ND.

Practical testing for EMT-Basic, EMT-Intermediate and EMT-Paramedic students is accomplished at a centralized test site in Bismarck. Practical testing is conducted every other month. While the DEHS is responsible for the operation and supervision of the test site, testing personnel are provided by the North Dakota EMS Association.



The DEHS maintains a database of EMS test team personnel. Applications are sent to the test team asking if they are interested in assisting at a particular test site. Students are required to register for test sites before a deadline established four weeks before the practical exam. Students register by submitting an application form and a $50 non-refundable payment.

After the registration deadline, the DEHS determines the number of test team members required for the test site and then mails applications to the EMS test team. EMS test team members who are available and interested in assisting return their applications and the DEHS selects personnel for the test site. Personnel are selected without consideration of their proximity to Bismarck.

Practical test station assignments are mailed to the test team members instructing them to be present at an orientation session held on the evening before the test site. Notices are sent to students advising of their assigned practical test time, date and location.

First Responder and EMT-Basic written examinations are conducted at the course location proctored by a DEHS contracted proctor for those courses with more than 10 students. The written exam also can be taken in Bismarck on the evening prior to each practical examination and at many North Dakota Highway Patrol District Offices.

EMT-Intermediate and Paramedic written examinations are conducted six times a year in the offices of DEHS and an additional six times a year on the evening prior to a practical examination.

Written tests for all other courses are sent directly to the course coordinator for administration.

The primary course quality improvement tool has been certification examination results. While the DEHS believes this is an inadequate approach to course quality improvement, it lacks the personnel resources to conduct on site EMS course quality improvement activities.

The administrative rules for EMS personnel training, testing and certification do provide for the revocation of certification by the DEHS in compliance with due process rights, under five circumstances. Those circumstances include the following:

1. Representation to others as a physician, nurse or health care provider other than the highest level for which they are certified.

2. Being incapable of properly performing the skills for which the person is certified.

3. Performing skills which exceed those allowed by the individual's certification.

4. Conviction of a felony for an offense which has a direct bearing upon the persons' ability to serve the public.

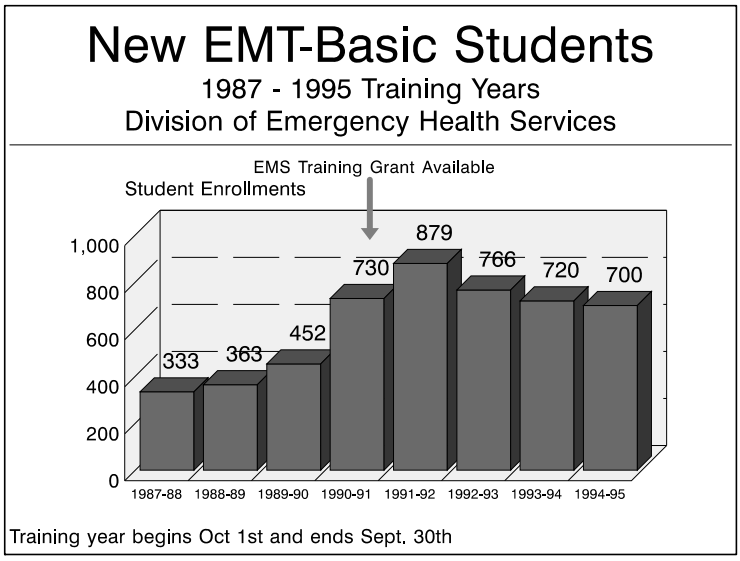
5. Declaration by a court of law that the person is mentally incompetent.

Numerous situations have recently occurred in which the DEHS felt that action should be taken to revoke a certification but these situations fell outside of the five defined reasons for revocations. For example, the DEHS detected that an EMS instructor had compromised a written examination by duplicating the test.

When confronted the instructor acknowledged the breach of security but stated that the students need all the help they can get. Consultation with legal council revealed we were unable to revoke this instructor's credentials.

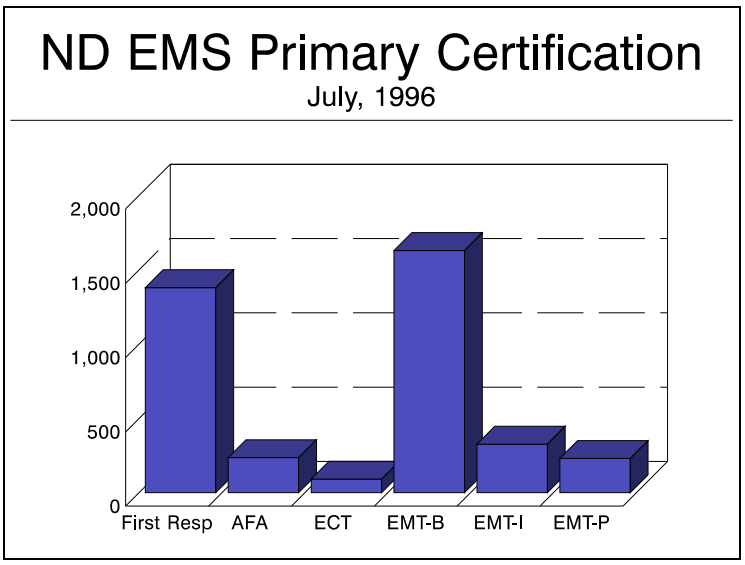
The DEHS administers a grant program in which $250 is reimbursed to each new EMT who agrees to serve on an ambulance service for six months or longer. Additionally, $1,100 is provided to each ambulance service annually for use in defraying continuing education costs. Legislation passed in 1995 expanded eligibility for the grants from just licensed ambulance services to include quick response units and rescue services. Because of a loss of anticipated federal funds, distributions were not made to quick response units or rescue services for the current biennium.

Implementation of the EMS training grants has had a positive impact on the number of EMT-Basic students enrolling in the course. A substantial increase was noted in the number of enrolled students during the first full year of the grant availability.



A substantial number of personnel are involved in North Dakota EMS certification programs. Currently we have 1,380 persons certified as First Responders, 236 as Advanced First Aid, 92 as Emergency Care Technicians, 1,630 as Emergency Medical Technician-Basics, 327 as Emergency Medical Technician-Intermediates, 231 Emergency Medical Technician-Paramedics.

The expanded scope certifications include 1,213 Automatic Defibrillation, 89 Manual Defibrillation, 349 IV Maintenance, 49 Flight Medical Crew, 1,566 Auto Extrication, 276 EMS Instructors, 162 Auto Extrication Instructor and 666 Epinephrine Administration.



Criminal background checks are not performed on persons applying for EMS certification. Persons applying for EMT-Basic, EMT-Intermediate and EMT-Paramedic complete an National Registry application which asks if the applicant has been convicted of a felony, but no record check is done independently of this self reporting.

1992 NHTSA RECOMMENDATIONS

- Establish minimum prerequisites for all Instructor/Coordinator candidates. Special attention should be given to the candidates EMS experience prior to being selected.

- Establish an evaluation program for EMS course instruction. Status: Not implemented.

- Identify resources to supplement current training staff at DEHS. Status: Not implemented. An attempt was made last legislative session to increase the staff size of DEHS by two FTEs as part of the Trauma/EMS legislative package. The increase was eliminated in the House budget committee.

- Consider consolidation of the individual training programs into current certification programs upon receipt of the revised DOT EMT curriculum.

- Establish the EMT-Basic as the minimum requirement level for BLS ambulance services (for QRU and Rescue Units). Establish First Responder certification as the minimum requirement for QRU and Rescue Units.

- Assure appropriate use of training funds by determining where training courses are needed.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: The objective identified reflects the same objective found in Regulation and Policy Objective Three.

Objective Two: Supplement the EMS Instructor certification standards to include a two year practical experience prerequisite, instructor performance requirements, on site evaluation by another certified instructor, completion of student evaluations twice each class and completion of 12 hours continuing instructor education every certification period. This objective should be implemented by July 1, 1998.

Discussion: Current certification standards inadequately address necessary minimum standards for EMS instructors. While standards do exist which define the initial instructor training and recertification training, the standards need to be expanded. Instructors should have experience implementing the skills contained in the course in a field setting prior to instructing courses. The practical experience will familiarize the instructor to the type of environments and circumstances in which the students will be functioning.

Instructors need to have feedback regarding their instruction beyond relying on the results of certification examinations. Specifically, instructors should be audited by another certified instructor using a standardized evaluation instrument to assist the instructor in teaching technique improvement.

Instructors currently do not routinely obtain written course evaluations from their students. The DEHS should implement a standardized course evaluation instrument which should be completed by students at the midway and completion points of the course.

Recertification of EMS instructors can currently can be accomplished by completing continuing education materials or completing a review of a portion of the original training. Repeated exposure to the original training material is of marginal benefit.

Implementation Strategy:

Step One: Define the additional EMS certification requirements to include prerequisite experience, implementation of student evaluations, inclusion of periodic auditing by another certified instructor, establishment of teaching performance standards and continuing education.

Step Two: Draft the administrative rule revisions and introduce to the North Dakota State Health Council for implementation.

Objective Three: Integrate advanced technologies into the provision of EMS training, including but not limited to interactive computer software, and distance learning through satellite and interactive television networks. This should be implemented by July 1, 1999.

Discussion: Current training consists primarily of didactic presentations and practical skill labs conducted by local instructors. The primary audio visuals utilized are slides, chalk or white boards and flip charts. Some limited utilization is made of video tapes.

Nationally, a very limited number of advanced technology training materials exist for EMS topics. North Dakota does have several advanced technology training resources in place which have been used on a very limited basis. Some of those advanced technologies include the MedStar programs, the Interactive Television Network, and some electronic bulletin boards.

Additional resources need to be developed to provide training which is more interesting and effective. These resources need to be widely available to EMS services and adequate funding needs to be secured to implement these technologies.

Implementation Strategies:

Step One: Identify which advanced technologies are most effective and their associated costs.

Step Two: Develop educational programs which integrate the advanced technologies.

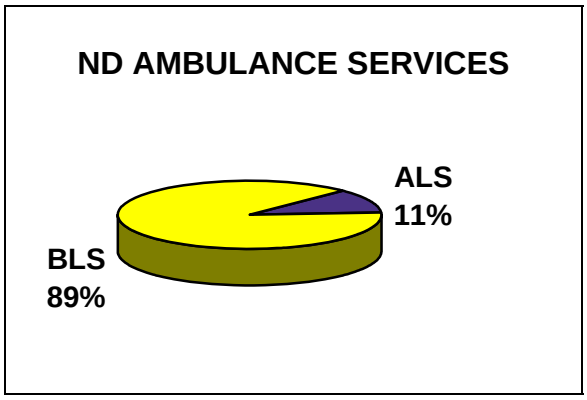
Step Three: Identify and secure the necessary funding to support the programs.

TRANSPORTATION

STANDARD

Safe, reliable ambulance transportation is a critical component of an effective EMS System. Most patients can be effectively transported in a ground ambulance staffed by qualified EMS personnel. Other patients with more serious injuries or illnesses, particularly in remote areas, require rapid transportation provided by rotor wing or fixed wing air medical services. Routine standardized methods for inspection and licensing of all EMS transport vehicles is essential to maintain a constant state of readiness throughout the state.

CURRENT STATUS



North Dakota Licenses a total of 141 surface ambulance services annually. There are 16 licensed at the Advanced Life Support (ALS) level, and 125 licensed at the Basic Life Support (BLS) level. Five of these services are from out of state, 2 in Minnesota 1 BLS and 1 ALS, and 3 in South Dakota all BLS. In addition 5 of the BLS services are industrial services, in which they only answer calls that occur on the industrial sites, and do not come off their respective property except to transport a patient to the hospital. The 16 communities that have ALS licensed services are: Minot, Devils Lake, Grand Forks, Carrington, Dickinson, Mandan, Bismarck, Jamestown, Valley City, Fargo, Hettinger, Linton, Wishek, Lisbon, Cavalier, and Ada MN.

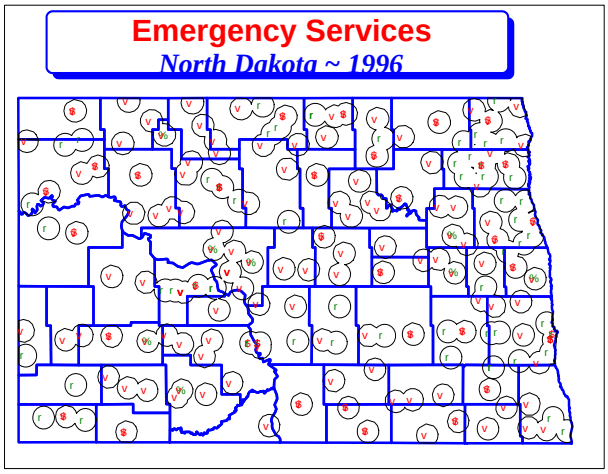
All surface ambulance services are inspected by DEHS staff for equipment compliance on a biennial basis. In the beginning ambulance services were inspected on an annual basis, that changed in 1984 as a result of staff reductions within the office. At that time inspection was accomplished at times when DEHS staff was in the area performing training related functions. In late 1991 a new inspection plan was instituted were the services are inspected every other year, and DEHS staff dedicates time solely to this process. In the time frame of August 1, 1995 to August 1, 1996, there were 64 ambulance services inspected with the following results: 10 services in full compliance, 41 services with 3 or less deficiencies, 13 services with 4 to 10 deficiencies. Those services that had deficiencies have either corrected these deficiencies or are in the process of correcting them.

There are 261 ambulance vehicles in service in North Dakota. The oldest primary vehicle is a 1973, the oldest backup vehicle is a 1971, so the range in the age of vehicles is 1971 to 1996. The number of primary vehicles and their age indicated by model year are as follows:

1970-1974 - 4

1975-1979 - 11
1980-1984 - 36
1985-1989 - 48
1990-1994 - 67
1995-1996 - 26

Standards for ambulances operated by the Federal Government call for replacement of primary ambulance vehicles after 6 years or 60,000 miles.



The DEHS established a response time goal for EMS to reach the citizens of North Dakota, which was endorsed by the Health Task Force. That goal was that emergency medical services be available within five minutes to 90% of the urban population and within 10 minutes to 90% of the rural population. In this goal EMS is defined as either a Quick Response Unit or an Ambulance Service. The following information is based on a 10 minute time frame for both QRUs and Ambulance Services individually and in combination and only deals with population percentage. The population served by those ambulance services that can respond and be on scene in 10 minutes or less is, 45.95%. The population served by those quick response units that can respond and be on scene in 10 minutes or less is, 30.47%. The combination of both types of services responding in 10 minutes or less is 56.29%.

North Dakota has no standards for, or licensing of, rotor wing or fixed wing ambulance services. In the late 80s and early 90s the Division had a voluntary certification program that set standards for both equipment and personnel on air ambulance services. During that period there were 10 fixed wing and 2 rotor wing services that took part in that program. A bill was introduced during the 1991 legislative session for the licensure of air ambulance services. The bill passed the House almost unanimously but was defeated in the Senate. At that time it was decided to drop the voluntary certification program because of the staff time spent on a program that was not legislated. No attempt was made to introduce the bill again in the 1993 session, however in the 95 session licensure of air ambulance services was a part of the Trauma legislation package. That portion of the bill was removed by committee and so there is still no regulation of air ambulances from a medical standpoint.

There are three rotor wing services that currently operate in North Dakota, all three are operated by and based out of hospitals. They are Merit Care in Fargo,

Trinity in Minot, and Medcenter One and St. Alexius which share a helicopter in Bismarck. All three services carry standard ALS equipment and have communication capabilities compatible with State Radio, hospitals, ground ambulance services, law enforcement, and aviation. They fly with a two member medical team and a single pilot. All three services are dispatched by a phone number that is answered at there respective hospitals.

All three services have a dedicated staff in-house. Two are staffed with an RN/Paramedic team, and the other is staffed with an MD (anesthesiologist)/RN team. Each service has a specialty team for neonatal transport. There are 80 to 100 helicopter responses each month with the vast majority being interfacility transports, about 20 to 25% are trauma related. All of the services provide education to ground ambulance services about interfacing with the air services.

The North Dakota State Department of Transportation, the North Dakota State Department of Health, and the North Dakota State Aeronautics Commission have developed a project which promotes the establishment of mediports in rural communities. Mediports are rotor wing landing areas that meet designated construction standards, have been surveyed for landing and take off safely, and are kept free from obstructions such as snow or tall grass or weeds. Mediports will be utilized as pre-designated intercept points between advanced life support helicopters located in Fargo, Minot and Bismarck, and basic life support surface ambulance services. Training programs are available which consist of written materials for use in constructing the mediports as well as a video tape which is utilized in convincing local communities and ambulance services to engage in this project.

As stated earlier 10 fixed wing ambulance services participated in the voluntary certification program which was discontinued in 1991. Those ten continue to offer patient transports. We are aware anecdotally that many other air carriers provide air ambulance service other than the ten who took part in the certification program.

1992 NHTSA RECOMMENDATIONS

- Develop licensure and inspection standards for all EMS services and vehicles to include QRUs, light and heavy rescue units.

- Develop licensure and inspection standards for all rotary and fixed wing aircraft.

- Establish minimum ground ambulance vehicle design standards. Establish as minimum staffing requirement:

    - BLS Ambulances = EMT certification
    - QRU = First Responder certification

- In coordination with the Highway Patrol, continue to train ambulance drivers with the "Emergency Vehicle Operators Course" to attain statewide coverage.

- Develop ambulance placement strategies to assure timely response to all citizens within the State.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Develop standards which address requirements for the ambulance vehicle including vehicle design, lighting and interior compartment specifications and road worthiness. This objective should be completed by July 1, 1998.

Discussion: While current ambulance licensure standards address minimum equipment, staffing and availability requirements, no standards exist which pertain to the ambulance vehicle. Ambulance vehicles have been used in the past as primary response vehicles which compromised the delivery of emergency medical services. In one instance a converted bread truck with a raw plywood floor was used as an primary response ambulance vehicle.

Vehicle inspection programs exist in North Dakota for some forms of commercial transportation (i.e. school buses). The inspection program carried out by the DEHS does not attempt to address the road worthiness of the vehicle. The DEHS only starts the vehicle and checks the emergency and non-emergency signaling equipment as part of their inspection. This inspection is not sufficient to assure road worthiness of the vehicle. Ambulance road worthiness inspections could be conducted by the North Dakota Highway Patrol in a similar fashion to the school bus inspection program.

The KKK specifications used by the federal government in creating bid specifications for the ambulances it purchases could be used as a starting point for the creation of ambulance vehicle requirements but it should not be relied upon as the standard. The KKK specifications are too prescriptive in many areas (i.e. exterior vehicle color) and are not updated frequently enough to represent current standards.

Many North Dakota ambulance services are not following a schedule of vehicle preventative maintenance. Recommendations should be developed for a preventative maintenance schedule and distributed to all ambulance services.

DEHS inspections should be conducted every two years as they currently are, however, services which have deficiencies should be subjected to annual inspection.

Implementation Strategy:

Step One: Obtain the necessary legislative and or administrative authority to add vehicle design standards to the licensure requirements.

Step Two: Evaluate the KKK specifications and develop design standards for North Dakota.

Step Three: Formulate a preventive maintenance program.

Objective Two: Establish licensure requirements for air ambulance services which create minimum standards for equipment, staffing, training, and availability. This objective should be completed by July 1, 2000.

Discussion: While a substantial number of regulations exist pertaining to the flight operations of air ambulance services, very little exists pertaining to the medical component of air ambulance service operation. The medical component should establish minimum standards for the quantity and training of medical personnel, the type of medical equipment to be carried and the availability of the service .

Historically, providers who regularly engage in the provision of air ambulance services have supported licensure. Support also exists from most medical personnel. Opposition to air ambulance licensure has primarily come from air taxi operators who infrequently engage in air ambulance service.

Licensure standards should exist for both rotary and fixed wing ambulance services. The public erroneously assumes that licensure standards exist for air ambulance service providers since the standards do exist for ground ambulance services.

Implementation Strategies:

Step One: Educate the current providers and the legislature regarding the importance of air ambulance service licensure including reimbursement issues.

Step Two: Educate the ND Medical Association, ND Hospital Association, ND Nurses Association and ND Social Services Association regarding the importance of air ambulance service licensure.

Step Three: Introduce a bill which would remove the word “surface” from the ambulance service licensure law.

Step Four: Develop administrative rules which detail the standards for air ambulance licensure and inspection.

Objective Three: Develop and implement ambulance and quick response unit placement and response strategies so that the delivery of emergency medical services can be delivered in accordance with established response time goals. This objective should be completed by July 1, 2001.

Discussion: Delivery of emergency medical services is very time sensitive. In many emergency situations there is a direct link between the length of response time and the outcome of the patient. Placement of ambulance services and quick response units has occurred in North Dakota without consideration of the overall impact on the system. Typically, an individual community will decide it would like to have an ambulance service or quick response unit and create the service without examining if the service is strategically located within a county or region of the state.

The result of this approach is the establishment of ambulance services which have large portions of duplicate primary areas of coverage while other areas of the state have no ambulance service claiming to provide primary coverage. In areas where no ambulance service provides primary coverage, ambulance services will still respond but they are at such a distance from the ambulance service that it does not consider it an appropriate area to cover.

Quick response units have evolved in much the same manner. Some quick response units are not affiliated with a specific ambulance service making it more difficult to determine how and when the service should be dispatched and to what areas they respond.

Failing to target specific areas for the development of ambulance and quick response units results in a system that is less efficient than if planning would occur. A plan which identifies areas which need coverage and areas where duplicative coverage exists could assist in allocating state EMS grants and other resources.

Implementation Strategy:

Step One: Review the voluntary Quick Response Unit standards and remove any requirements which lead to the use of a specialized vehicle rather than an individual response.

Step Two: Create administrative or if necessary legislative authority for the DEHS to accept or deny ambulance service applications.

Step Three: Encourage the development of Quick Response Units.

Step Four: Create an overall plan which maps the best placement of ambulance services and quick response units based upon the populations needs.

Step Five: Legislatively establish minimum requirements for staffing QRUs to include the Department of Transportation First Responder course and Automatic Defibrillation.

Step Six: Establish standards requiring electronic dispatch (i.e. pagers, two way radios) and call schedules.

HOSPITAL FACILITIES

STANDARD

It is imperative that the seriously ill patient be delivered in a timely manner to the closest appropriate facility. This determination needs to consider stabilization and definitive care. This determination should be free of political considerations and require that the capabilities of the facilities are clearly understood by prehospital personnel. Hospital resource capabilities must be known in advance so that the appropriate primary and secondary decisions can be made.

CURRENT STATUS

There are 46 hospitals in North Dakota. All licensed hospitals in North Dakota have emergency services. According to the Licensing Rules For Hospitals in North Dakota hospitals are not required to have emergency departments to be licensed. 33-07-01.1 states that each general acute hospital shall provide emergency services to its inpatients. If the hospital does not provide emergency services to the public, it shall be prepared to provide immediate lifesaving measures to persons who may appear for emergency care and arrange for their transfer to another hospital that does provide a public emergency service. Hospitals without emergency service for the public must have written policies and procedures governing the handling of emergencies.

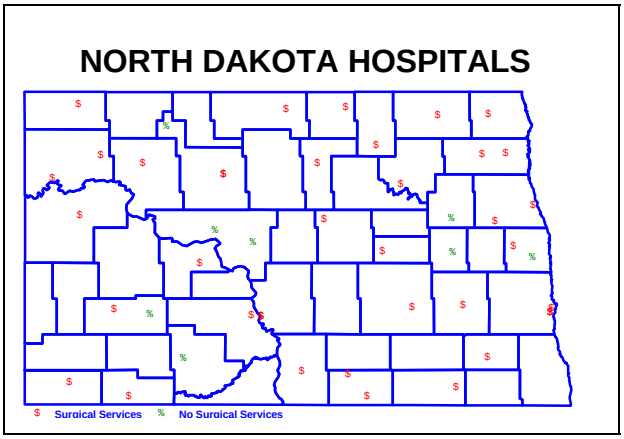
A hospital providing emergency services must have one or more licensed health care practitioners qualified by training and experience in care of emergency patients on duty or call at all times and available to respond to emergencies within thirty minutes. The staffing of nursing or allied health personnel must be consistent with the scope and complexity of the emergency services provided. At least one licensed person who is qualified by training and experience in emergency care must be assigned to the emergency department at all times.

The emergency service in a hospital must have necessary supportive services available on a 24 hour basis. These services must include on site clinical laboratory service plasma expanders, provision for blood or blood products; pharmaceutical services; on site radiology service including protocol to govern the interpretation by a radiologist of diagnostic images produced by x-ray, or other modalities if provided, including a procedure for the prompt communication of the radiologist's interpretation; and surgical and anesthesia service or referral process for surgical and anesthesia service.

At a minimum, the following special supplies and equipment must be available in a complete set of adult and pediatric sizes for the provision of emergency services:

1. Oxygen.
2. Pulse oximeter.
3. Complete set of bag/valve/mask ventilation devices.
4. Complete set of oral & nasal airways.
5. Suction equipment.
6. Endotracheal intubation, pericardiocentesis throacotomy, & cricotracheotomy trays.
7. Electrocardiograph.
8. Cardiac monitor & defibrillator with battery pack.
9. Moveable equipment cart for use as a crash cart.
10. AHA-ACLS recommended drug inventory.
11. IV fluids including lactated ringers & dextrose 5% in water.
12. Infusion pump.
13. Pressure infuser.
14. Gastric lavage equipment.
15. Urinary catheter kits.
16. Emergency obstetrical pack.
17. Spine board.
18. Rigid cervical collars.
19. Fracture splints.
20. Sterile dressings and bandages.
21. Sterile burn sheets.
22. Gurney or exam table.

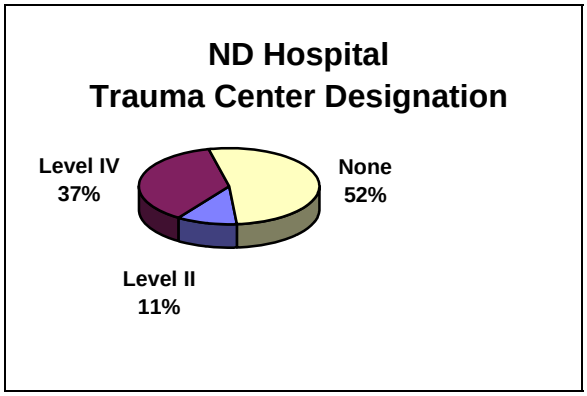
Of the 46 hospitals in North Dakota 8 do not have surgery capabilities. Hospitals that provide surgical services must have effective policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation of the surgical patient.



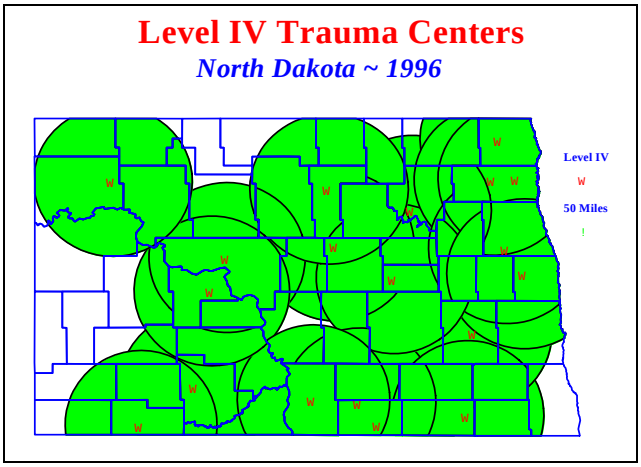
Surgical services must be directed by a physician who is qualified by training and experience and approved by the medical staff and governing body. Operating rooms must be supervised by a qualified registered nurse.

The following equipment must be available for use in the surgical services area: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, tracheotomy tray, and such other instruments or equipment available for lifesaving measures.

In North Dakota, non-trauma emergencies are transported to the nearest facility or to the facility of the patient's choice if travel to that facility does not require longer transport times. There are no statewide protocols for non-trauma calls and EMS personnel have a poor understanding of the capabilities of the facilities to which patients are transported. This situation is even more acute in rural areas where hospitals are encountering substantial financial strains. Some rural hospitals have closed, and others are incapable of providing any surgical intervention. Most rural hospitals will have a substantial time delay before the arrival of a physician at the emergency room.



North Dakota has in place a statewide trauma plan that includes trauma designation for hospitals, destination and transfer protocols and a trauma registry. Twenty-two, or 48% of the hospitals in North Dakota are designated as Level II or Level IV Trauma Centers. In order to be designated a Level II Trauma Center, a hospital must complete an American College of Surgeons application process. Once a hospital is verified as a Level II Trauma Center by the American College of Surgeons, The Health Department designates the hospital as a Level II Trauma Center. Level II Trauma Centers are "urban" hospitals and must have 24-hour in-house surgery, anesthesia and emergency services available. There are four identifiable regions within the State with larger hospitals that have achieved ACS verification as Level II Trauma Centers.



Hospitals seeking Level IV Trauma Center Designation must apply through the Health Department and are usually located in rural areas. It is desirable that they have general surgery, anesthesia and emergency services on call and promptly available.

Both levels require the hospitals to meet specified criteria as well as complete an application process, participate in a verification visit and

be reviewed periodically to maintain their designation.

Fifty mile radii are used to approximate a 60 minute travel time to depict the "Golden Hour." The area and population served by the trauma centers are as follows:

Level II	19,911 sq. miles 300,811 people	28.43% of the state covered 47.09% of the population covered
Level IV	60,365 sq. miles 544,334 people	86.19% of the state covered 85.21% of the population covered
Combined	63,914 sq. miles 602,196 people	91.26% of the state covered 94.27% of the population covered

1992 NHTSA RECOMMENDATIONS

- Development of a statewide EMS plan including destination and transfer protocols.
- Hospital capabilities should be evaluated and determined according to national standards.
- Patients should be transported, by protocol, to the nearest **APPROPRIATE** facility. This process needs to be dynamic as hospital status changes.
- The DEHS should continue to work with the North Dakota Hospital Association to ensure that facility issues impacting emergency medical services are addressed.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Hospital capabilities should be categorized for medical emergency patients in a manner similar to the categorization that has occurred for trauma capabilities. This objective should be completed by July 1, 2001.

Discussion: The trauma system has served as a model for the development of hospital categorization. The trauma system has developed hospital criteria pertaining to minimum levels of equipment, clinical capabilities and quality improvement programs for a variety of trauma service levels. The system is inclusive allowing all hospitals that want to participate the opportunity to do so

and clearly articulates the trauma capabilities to the EMS community. No such system currently exists for medical emergencies. In addition to trauma, categorization should occur which clearly articulates the medical emergency capabilities of hospitals. No such system currently exists for medical emergencies.

While all hospitals currently offer emergency department services, concern was expressed that current hospital administrative rules do not required hospitals which do not offer emergency department services to disclose that fact through signage and other means. Hospitals which do offer emergency department services are not required to disclose if a physician is present in the emergency department or on call.

Implementation Strategies:

Step One: Develop the capability for all ambulance services to have contact with on line medical direction. Medical direction could then be contacted when indecision occurs regarding patient destination decisions.

Step Two: Utilize the local trauma transport plans as a model and expand their use to include protocol for medical emergency transportation decisions.

Objective Two: A state wide plan should be developed for ambulance and other EMS services which creates destination and transfer protocols for medical emergencies similar to those created for trauma. This objective should be completed by July 1, 2001.

Discussion: Ambulance services have not typically developed written protocols which pre-plan transportation decisions within their primary areas of coverage. In many situations, the transportation decisions are obvious. In other situations, time of day and distance considerations, types of transportation modalities, and intercept services available make transportation decisions less obvious and in some cases contentious.

It is not unusual for an ambulance service in rural areas to have patients request to bypass the nearest hospital and request transport to a hospital located at a greater distance. Ambulance services in rural areas typically transport patients to the closest hospital where the patient can be evaluated and if appropriate transfer the patient to a distant hospital at a later time. The development of local transport plans for medical emergencies must be driven locally through discussion with local hospital administration, medical direction and EMS service managers.

Implementation Strategy:

Step One: Create an adhoc committee to define the transport and transfer protocol. The task force should consist of at least the North Dakota Hospital Association and the DEHS, but should ideally include physician, nursing and EMT provider representation.

Step Two: The program should be implemented by distribution of the protocol and requesting the voluntary creation of the transport plans in a fashion similar to the trauma transport plans.

Step Three: Education materials should be developed and distributed to EMS and hospital providers regarding the use of the medical emergency protocols.

Objective Three: Improve the educational component of care providers within hospital settings to assure familiarity with equipment and contemporary medical emergency protocols such as those contained in Advanced Cardiac Life Support and Pediatric Advanced Life Support courses. This objective should be completed by July 1, 2000.

Discussion: The provision of advanced life support resuscitation services are infrequently utilized in some rural hospitals. Some hospital personnel are unfamiliar with prehospital and hospital equipment and protocols.

Personnel from the prehospital and hospital environments would be able to gain higher levels of efficiency and function as a better team if persons from both were uniformly trained in the provisions of advanced life support skills such as those contained in the Advanced Cardiac Life Support and Pediatric Advanced Life Support courses. The courses need to have a higher degree of availability and some prehospital and hospital services need to make a stronger commitment in providing this training to their personnel.

Implementation Strategy:

Step One: Establish minimum training and equipment standards to include training such as Advanced Cardiac Life Support and Pediatric Advanced Life Support courses.

Step Two: Provide the education to assure the availability of the courses.

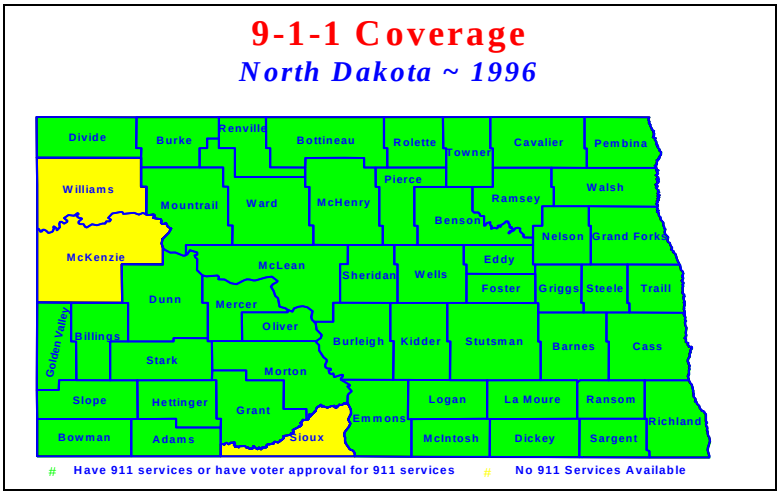
Step Three: Include the training requirements as part of the hospital categorization process for medical emergencies. Patients would still be transported to the closest facility but patient care would generally be improved.

COMMUNICATIONS

STANDARD

An effective communications subsystem is an essential component of an overall EMS System. Beginning with the universal access number, such as 9-1-1, the communications network should provide for a prioritized dispatch, dispatch to ambulance communication, ambulance to ambulance communication, ambulance to public safety agencies communication, ambulance to hospital communication, and hospital to hospital communication to ensure the receiving facility is ready and able to accept the patient.

CURRENT STATUS

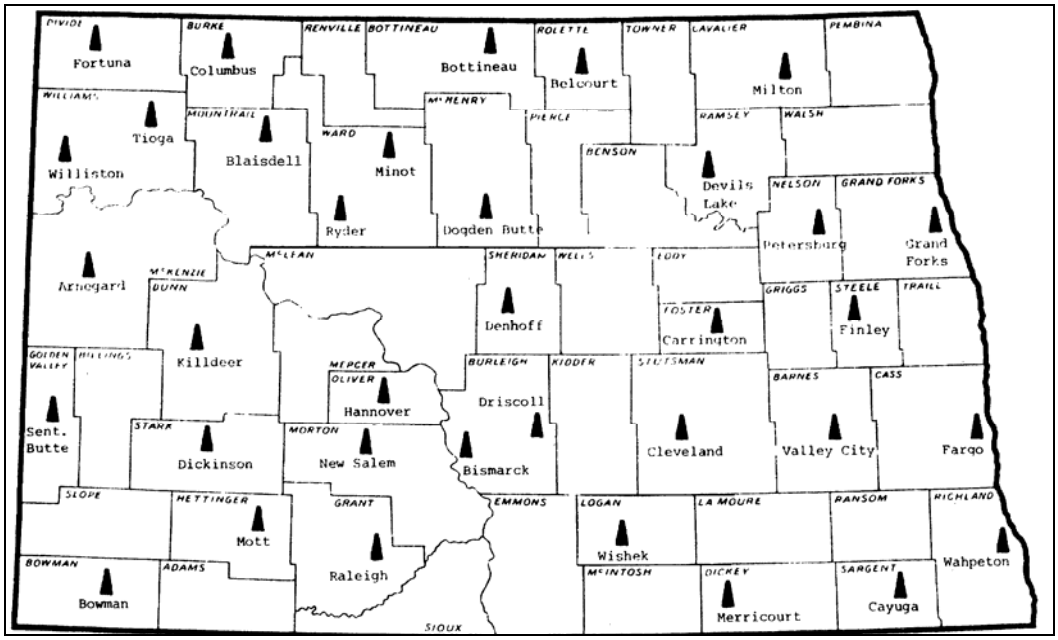


Coverage by 9-1-1 currently exists in 38 of the state's 53 counties. 11 of these counties are serviced by the State Radio Communications Department at this time, and 9 more are coming on line in the near future, for a total of 20. In the 1995 legislative session there was a move by some legislators to remove State Radio completely from performing 9-1-1 duties for counties, and that State Radio should become part of the North Dakota National Guard. A committee was formed to study both issues, and came to the conclusion published in their report that State Radio should remain under the office of management and budget and providing 9-1-1 services for counties that wanted them to, was most appropriate. In addition there are 18 counties with their own dispatch centers. Seventy % of the population in North Dakota is covered by a 9-1-1 system. Based on the voting process, on the 9-1-1 issue, by the summer of 1997, 51 of the 53 counties will have 9-1-1 in place.

A 9-1-1 advisory committee had been established by statute for the approval of 9-1-1 communications plans, the director of the Division of Emergency Health Services had a seat on that advisory committee. The advisory committee was charged with establishing standards for 9-1-1 systems and for approving 9-1-1

communications plans. State law was created which enables communities to assess a surcharge on telephone lines for the support of 9-1-1 systems. Any system utilizing a surcharge must have had its plan approved by the 9-1-1 committee. When that committee was formed it had a sunset date of June 30, 1996 to complete its work. The committee asked the state legislature in the 1995 session for an extension of that date, however the legislature denied that request, and the committee disbanded on the above mentioned date. When the committee was disbanded the standards for 9-1-1 systems also went out of existence, and are no longer in effect. In reality an entity wanting to start a 9-1-1 communications center, can operate that system any way they see fit. One of the major components of the standards, for those 9-1-1 systems needing approval from the advisory committee, that most affected EMS was that the communication system had to offer pre-arrival care instructions, by having their dispatchers trained in Emergency Medical Dispatch. Except for a few dispatch centers in the state, pre-arrival care instructions was not initially well received.

The State Radio Communications System is comprised of a centralized dispatch point located in Bismarck, which controls 35 radio towers dispersed throughout the state. These 35 towers provide 100 percent coverage of the state.



In the mid 1970s a communications grant placed radio equipment in every ambulance vehicle and in all hospitals. The states communication plan is very old having been authored in 1977. Ambulance licensure requirements mandate the installation of a radio system in the ambulance vehicles which conforms with the State Radio Communications standards. Additionally, each hospital has a radio base station which enables communications directly with the ambulances or between the hospitals. The radio systems that were placed in each of the hospitals have the capacity for only two channels and they are 4 and 5 which are mentioned below. Ambulance vehicles are required through the ambulance

licensure standards to have radios which have a minimum of six channels. Those channels must be configured as follows:

Channel 1 - Local law enforcement
Channel 2 - State Radio
Channel 3 - National mutual aid use
Channel 4 - All hospitals
Channel 5 - Ambulance service's primary care hospital
Channel 6 - County civil defense units

All communications on the system are coordinated through the State Radio Communications Department. At this time State Radio cannot provide telephone patches. A number of ambulances have updated their radio equipment in their vehicles on their own and with their own funds, however there are some services that are still using the same radios provided by the original communications grant.

1992 NHTSA RECOMMENDATIONS

- All counties in the State should establish 9-1-1 systems to serve the public with universal emergency telephone access. The implementation of enhanced (vs. basic) 9-1-1 systems should be encouraged in all areas of the State in order to provide automatic location identification (ALI) and automatic number identification (ANI) capabilities.

- State standards should be established for all dispatchers handling emergency medical calls, i.e. for training and certification in use of priority dispatch concepts and to give pre-arrival instructions. All dispatchers providing emergency medical dispatch (EMD) services should be certified and should have liability protection under state law. EMD programs should function under physician medical direction and should include quality assurance review of the pre-arrival instructions given to callers.

- The potential should be explored to have EMS calls that come into local public safety answering points (PSAPs) transferred to the State radio communications center where highly qualified personnel exist to give quality pre-arrival instructions.

- EMS organizations throughout the State should more fully utilize the significant communications capabilities of the existing statewide system.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Re-implement standards for 9-1-1 dispatch centers which establish appropriate training requirements for dispatcher to assure that medical emergency calls are handled appropriately. The standards must include the provision of pre-arrival care instructions. This objective should be completed by July 1, 1999.

Discussion: The loss of 9-1-1 standards through the sunsetting of the 9-1-1 Communications Advisory board may have a devastating impact on emergency medical services dispatching. Some dispatch centers which were compelled to offer pre-arrival instructions are not completing the training now that the mandate is no longer in effect. In some situations, 9-1-1 dispatch centers see their primary area of responsibility to be service to law enforcement and medical emergency services dispatch becomes an area of less emphasis.

A 9-1-1 standard setting body must be re-established. This body must have representation from the emergency medical services community to assure that standards for handling medical calls are appropriately established.

Rural counties should continue to have the option of contracting with State Radio for the provision of 9-1-1 services. Counties should be able to determine the most efficient means of establishing 9-1-1 services including the creation of a single county dispatch center, a regional dispatch center including several counties or the use of State Radio.

Implementation Strategy:

Step One: Support the conclusions of the Interim Legislative 9-1-1 Study Committee Report.

Step Two: Legislatively create a 9-1-1 standard setting body.

Step Three: Create standards which address emergency medical dispatch including a requirement that pre-arrival care instructions be made available by the 9-1-1 dispatch center.

Step Four: Create educational materials which define the importance of 9-1-1 systems and pre-arrival care instructions.

Objective Two: Upgrade pre-hospital and hospital communications equipment to include digital communications capabilities. This objective should be completed by July 1, 2002.

Discussion: Much of the radio equipment in use today by hospitals and ambulance services was purchased in the 1970s. The antiquated equipment is being replaced sporadically by ambulance services and hospitals without an overall coordinating effort. Hospitals, for example, which used to be able to

perform telephone patches with the old equipment are purchasing new equipment which does not provide this capability. Hospitals may also be replacing their old equipment with new equipment which does not support hospital to hospital communications.

Ambulance services are also replacing their equipment and in some situations they are acquiring radios which do not meet standards established for the State Radio communications system. Some ambulance services, for example, have purchased radios which do not meet the 100 watt requirement. As technology becomes more sophisticated and more choices are available for purchase, the likelihood of individual radios becoming incompatible on the system increases if there is not a high level of coordination.

Implementation Strategy:

Step One: Develop a task force to create standards for the purchase of communications systems.

Step Two: Implement the standards through the 9-1-1 Communications Committee if it is re-established.

Step Three: Obtain a frequency on the system dedicated for use by EMS which has repeater capabilities.

Objective Three: Develop a separate channel on the State Radio system which is dedicated to EMS communications, has repeater capabilities and has access to both pre-hospital mobile units and hospital base stations. This objective should be completed by July 1, 2002.

Discussion: Ambulance to hospital and ambulance to ambulance radio communications are increasing in frequency. Higher levels of care delivered in the pre-hospital setting and increased utilization of ambulance intercepts constitute some of the reasons that EMS is making greater use of the radio airwaves. This increased utilization has become problematic as multiple public safety agencies such as law enforcement and fire services compete for air time on the State Radio channels. Common channels for all public safety services need to continue to exist but a separate channel needs to be available for EMS use other than the existing EMS/hospital channels.

The existing EMS/hospital channels are inadequate because they do not provide repeater capabilities. Additionally, hospitals currently do not have any way to access the existing State Radio system. A new EMS/hospital channel should be added to the State Radio system which has the capability to activate and de-activate repeaters and provides EMS mobile to mobile and mobile to hospital communication. Additionally, direct phone patches should be available on the system to establish contact with medical control located outside of the hospital.

While cell phones are used in North Dakota EMS radio communications, they should not be relied upon as the sole means of communications. Problems associated with cell phone utilization include substantial areas where coverage does not exist and the fact that cell phones work off of cell sites with a limited number of telephone lines to access. Historically, telephone cell sites become clogged with calls during disasters and emergency medical services and other public safety officials are unable to complete their calls.

Implementation Strategies:

Step One: Complete a comprehensive statewide communications study which includes law enforcement, fire services and emergency medical services.

Step Two: Secure necessary funding sources for the study.

Step Three: Secure necessary funding sources for the system upgrade.

MEDICAL DIRECTION

STANDARD

EMS is a medical care system that includes medical practices delegated by physicians to nonphysician providers who manage patient care outside the traditional confines of office or hospital. As befits this delegation of authority, it is the obligation of the physician to be involved in all aspects of the patient care system. Specific areas of involvement include the following:

* Planning and protocols
* On-line medical direction and consultation
* Audit and evaluation of patient care

CURRENT STATUS

Medical Direction is mandated for all surface ambulance services that are licensed at the Advanced Life Support level. While advanced life support procedures or licensing at the ALS level require the use of medical direction, no such requirements exists for basic life support surface ambulance services.

The ideal would be for on-line medical direction, meaning that the service is actually talking to the physician, in reality most medical direction in North Dakota is accomplished by written protocols or standing orders. These are documents that delineate what can be done for a specific medical or trauma related problem, depending on the certification level of a care provider. These standing orders are usually drawn up at the physician discretion and will vary from service to service. Under the North Dakota trauma system, there are state wide trauma treatment protocols that the medical directors helped to develop. These protocols are set up to be used from the First Responder level on through to EMT-Paramedic. No such state wide treatment protocols exist for medical emergencies at this time.

Another very important component of medical direction is ongoing QA/QI activities relative to patient care. Some of the medical directors will physically attend squad meetings and go over selected run reports to look at the quality of

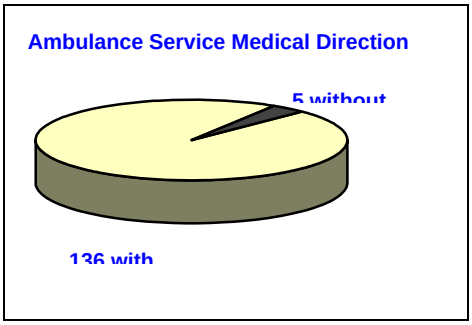
patient care. Other physicians will have the squad send trip tickets to them, and they will go over them and send back written comments on the patient care delivered. However there are some squads and physicians who do not do any sort of auditing of the patient care rendered.

The 1994 Department of Transportation National Standard EMT-Basic Curricula mandates that each course must have a medical director, because some of the skills taught are considered advanced life support. Those ALS skills in the curricula are: Automated External Defibrillation, Pharmacology in the context of assisting a patient to take their own prescription for the following medications: Epinephrine in the form of an Epi-pen which is an automatic injection system, aerosol inhalers, and Nitroglycerin. The curricula calls for the EMT to give with a physician order, oral glucose and activated charcoal that by law must be carried in all ambulance vehicles.

All EMT-Intermediates and EMT-Paramedics have medical direction established through a Physician Preceptor system. Physician preceptor forms are filed with the DEHS, this office checks to make sure that the person is certified to the level in which they are applying for licensure and then forwards them to the North Dakota State Board of Medical Examiners. These individual preceptor-ships expire on March 31 of each year.

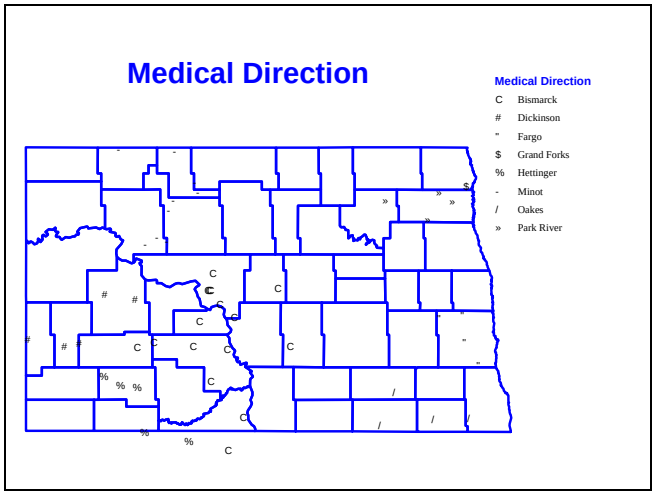
Medical Direction must also be established through a Physician Preceptor system, on an annual basis, for certain skills that are considered Advanced Life Support, but have had curricula designed to teach these skills to First Responders, Advanced First Aid-Ambulance, EMT-Basics and EMT-Intermediates. These ALS skills allow the individual to render this care as a physician extender and thus are subject to only those skills which have curricula that has been approved by the DEHS. These skills are: Automatic External Defibrillation for First Responders and up, Manual Defibrillation for EMT-Basics and up, IV Maintenance for EMT-Basics, Epinephrine Administration for EMT-Basics and up, and 50% Dextrose Administration for EMT-Intermediates. Physician preceptor forms are filed with the DEHS, this office inputs the information into the database and then forwards them to the North Dakota State Board of Medical Examiners. These preceptor-ships expire on December 31 of each year for all, except the two defibrillation skills, which expire a calendar year from the date of the Physician signature on the form.

There are at present 83 physicians who function as medical directors for 136 ambulance services across the state. Of these 136 services, 52 have medical directors from their community, and 84 have medical directors from other communities.



It is a common thought that the four largest cities provide medical direction to those services that do not have physicians within their communities. That assumption is incorrect.

There are 16 services that use physicians from Bismarck, 9 from Minot, 4 from Fargo, 1 from Grand Forks, 5 from Dickinson, 5 from Hettinger, 4 from Oakes, and 4 from Park River. The vast majority of the physicians provide this service on a volunteer basis.



The DEHS consults physicians who serve as medical directors whenever there is a move to expand a certain ALS skill from one certification level to a lesser one. For example when Epinephrine administration was first being talked about, the physician medical directors were surveyed for their thoughts on the subject. This group is a very valuable resource to DEHS and the EMS system in general

In 1985 the DEHS instituted medical director training programs. However, those programs were discontinued as a result of poor attendance. There is a Medical Directors Society as part of the North Dakota EMS Association. The DEHS takes a big role in the annual meeting of this particular society every April during the spring conference. There are training sessions held on various topics of interest or concern to medical directors, as well as presentations on what is in the future in EMS, how that relates to the North Dakota EMS system, and the impact it may have on medical direction. In addition the DEHS takes this opportunity to present its vision of EMS in North Dakota, and to inform the medical directors, what has been accomplished over the past year, and what is coming up in the next year. This meeting is attended by five to ten physicians each year.

The DEHS undertook the project of producing a medical directors manual for the purposes of providing information to the current medical directors, and to provide a guide of sorts for any physician who was thinking of becoming a medical director for a service. The document is formatted in a 3 ring binder so that as specific information may change, it is easy to replace only those pages that need to be. There are five general headings in the binder and they are as follows: EMS SYSTEM OVERVIEW, REGULATION, EMERGENCY HEALTH SERVICES (DEHS), EMS SERVICES, and MEDICAL DIRECTOR ROLE.

1992 NHTSA RECOMMENDATIONS

- Anticipate the revised EMT-Basic curriculum and require medical direction for all basic life support services that are a part of the North Dakota EMS System.

- Enhance medical director recruitment by providing educational materials about the job (e.g., an orientation videotape, medical directors course) and soliciting input and assistance from the University of North Dakota Medical school and representatives from local ACEP, ACS, and NAEMSP organizations.

- Develop training requirements for medical directors and a program for assessing the quality of medical direction.

- Develop a process for facilitating both state and local medical direction. This will require a commitment of staff and funding resources from the State.

- Propose legislation that provides legal immunity for those physicians that provide medical direction.

Objectives and Implementation Strategies

The objectives appear in their order of priority

Objective One: Medical Direction must be required for all ambulance services, as part of the licensure process, to include a formal Quality Improvement (QI) program. This objective should be implemented by July 1, 1998.

Discussion: The role of medical direction is very important to the overall patient care that is provided by an EMS agency. For those services that do not currently have a medical director, the DEHS medical advisor could possibly fill in an a short term basis. The state medical advisor would not act as a squad specific medical director on an ongoing basis, only short term.

Without proper medical oversight in the form of a good QI program, the chances seem to be high, that patient care may be stagnant or deteriorating without any hope of improving how that care is delivered. Medical direction however, is much more than a physician providing QI to a specific service. The physician must be involved in all aspects of the EMS system. It is deemed necessary that the medical director be involved with training issues, protocol development and revision, etc. In addition it is very important for the medical director to know what is going on at the state and federal level as well. So that as technology and education change, the medical director is on the cutting edge of EMS evolution

Implementation Strategy:

Step One: Utilize state (DEHS) medical advisor as an interim medical director for any service unable to find local medical direction.

Step Two: Implementation of this process should be accomplished through Administrative Rules developed by the ND State Health Council.

Objective Two: Develop statewide medical protocols for use by all services in North Dakota, that are updated periodically, and will be used if local protocols have not been developed by the medical director. In addition each service is required to have medical protocols in place in order to be eligible for licensure as an ambulance service. This objective should be implemented by July 1, 1999.

Discussion: The preferred form of medical protocols would be statewide protocols for all levels of certification from First Responder to EMT-Paramedic, and mandated for every service. This course of action would make care of the medical patient uniform across the state of North Dakota. In addition it would provide for a continuum of care from one certification level to the next.

It is known that some local physicians have developed very good working protocols for their service(s), and no one wants to impinge on their freedom for medical direction. The one person that should be heavily involved in the process of developing the state medical protocols is the DEHS medical advisor. The state medical advisor could act as a very effective liaison between the different physician groups that are involved in this process.

Implementation Strategy:

Step One: Establish a statewide committee to develop medical protocols. Member of this committee to include but not limited to: physicians, ALS/BLS providers, nurses, DEHS, and the DEHS medical Advisor.

Step Two: The DEHS makes a proposal to State Health Council to adopt state medial protocols, and mandate protocols (local or state) as a condition for licensure as an ambulance service.

Objective three: Develop a comprehensive recruitment and training program for EMS medical directors. This objective should be implemented by October 1, 1999.

Discussion: Since medical direction is such an integral part of an effective EMS system, recruiting and training of medical directors is very important to our system. The first thing to be accomplished in this whole process is to educate the EMS services of the importance of quality medical direction. They have to be convinced of this most important part of the system. Their are other stake holders in this process as well, namely the Hospital Association, and the Medical Association. By bringing organizations like these and others on board may make

this an easier process. There is also the thought of working with the UND School of Medicine, to possibly teach med students and residents about the need for EMS medical directors in North Dakota.

One of the major impediments to all of this is how to accomplish the training components, without too much disruption to the physicians. Naturally the thought of retreats, where the physicians could get away from their communities for a day, be educated on medical direction with fancy multimedia presentations, and be pampered a little bit, is appealing but not practical. The more logical choice seems to be some form of Distance Learning process. Some ideas in this vein that stand out are using an Interactive Video Network, or the UND Medstar satellite system. The Medstar system is already in almost all of the hospitals in the state, and providing training programs for EMS, nursing, and physicians on an ongoing basis.

Implementation Strategy:

Step One: Investigate other states medical director training and recruitment programs for initial development of a North Dakota program.

Step Two: Educate physicians and EMS services regarding benefits of Medical Oversight, i.e. QI, continuing education, etc.

Step Three: Utilize current organizations (ACEP; NAEMSP; ACS; ND Medical Association; ND Hospital Association; ND Medical Society; ND Medical Directors Society of the ND EMS Association; UND) for training and recruitment/retention of physician medical directors.

PUBLIC INFORMATION AND EDUCATION STANDARD

Public awareness and education about the EMS system is essential to a quality system and is often neglected. Public information and education efforts must serve to enhance the public's role in the system, its ability to access the system, and the prevention of injuries. In many areas, EMS personnel provide system access information and present injury prevention programs which ultimately lead to better utilization of EMS resources and improved patient outcome.

CURRENT STATUS

There is no coordinated or effective public information and education program in North Dakota. Until recently there have been no staff members assigned this responsibility. The last major undertaking involved the creation of radio and television public service announcements, billboards advertising, posters and brochures. This activity was undertaken in 1985. Since that time, however, the only other activity undertaken by the DEHS has been the annual distribution of the ACEP Emergency Medical Services Week Kit to North Dakota ambulance services.

In May of 1996 a DEHS staff member attended an EMS Public Information, Education, and Relations (PIER) Train-the-Trainer Workshop sponsored by the National Highway Traffic Safety Administration (NHTSA). The purpose of this workshop was to provide members from State EMS Agencies and EMS leaders from the private sector with a standard curriculum on PIER and the training to go back to their respective states and begin the implementation of PIER programs. The DEHS has received a training grant from DOT for the implementation of the PIER training program. The DEHS will train approximately 40 individuals from 40 ambulance services as PIER providers. The training will be conducted in two 8 hour training sessions. The implementation of the PIER program will begin after October 1, 1996.

The North Dakota Emergency Medical Services Association (NDEMSA) publishes a newsletter, but this form of outreach is not currently used as a vehicle for conveying PIER information to EMS providers. Each year at their annual conference the NDEMSA presents a Media Award. Recipients of this award are recognized for their outstanding efforts in promotion of EMS in North Dakota. The types of media recognized include radio, television and newspaper. The NDEMSA also coordinates with the each city's Convention Visitor's Bureau for media coverage of the Annual EMS Conference and the Fall EMS Conference. The NDEMSA also has produced two videos entitled "EMS: THE CRITICAL DIFFERENCE" and "TODAY'S HEROES." These videos promote

EMS in North Dakota and are available through the NDEMSA and DEHS for use in PIER activities.

Promotion of PIER from the provider's standpoint varies widely in North Dakota. The major hospitals and their respective EMS Education departments generally do a range of activities for the public and EMS providers. Training courses are held for providers and programs such as injury prevention, CPR, farm injury and public first aid are directed at the general public.

The ambulance services vary drastically in their involvement with PIER. Although the ambulance services in the major cities could be considered generally more active, city size and service area is not a specific factor relative to PIER in North Dakota. There are ambulance services in North Dakota that, regardless of the size of their communities, are very active in PIER related activities. These services generally do activities such as fund drives, EMS week activities, ambulance coverage for local sporting events and recruiting drives. These services try, on an ongoing basis, to keep their services in the public eye. Many North Dakota services are struggling with recruitment problems, funding problems, aging populations and young people leaving. Some services are unwilling to commit their overworked personnel to more ambulance activities. Many communities are totally uninformed about what their ambulance service does, the types of services it provides and its needs for survival.

1992 NHTSA RECOMMENDATIONS

- **P. I. & E. should be included as a component of the State EMS Plan. The financial and staff resources needed to support this component should be identified.**

- The DEHS should investigate the feasibility of using the safety belt task force as an ongoing group to coordinate EMS related P.I.& E. efforts among all of the involved agencies.

- The DEHS should identify an annual theme as the primary focus for P. I. & E. initiatives.

- Ongoing efforts by hospitals, EMS organizations, communities, schools and others should continue and where possible expand.

Objectives and Implementation Strategies

The objectives appear in their order of priority.

Objective One: Utilize any and all agencies, organizations and entities to promote EMS education and awareness to the general public by January 1, 1999.

Discussion: There is no coordinated effort focused on the education of the general public relative to EMS. There are a number of organizations in North Dakota that could be utilized to form a statewide coalition aimed directly at public information, education and injury prevention. These agencies include the North Dakota EMS Association, the Division of Emergency Health Services, the Emergency Nurses Association, the North Dakota Nurses Association, the North Dakota Medical Association, the North Dakota Hospital Association, all Law Enforcement agencies and the North Dakota Injury Control Advisory Board.

There are currently many programs in other states that could be adapted to North Dakota. There are large national corporations that address injury prevention and EMS awareness in their advertizing campaigns that could be utilized in North Dakota. There are many EMS promotions and general information available now on the Internet. North Dakota does not have an EMS Public Information and Information Coodinator at the state level to organize and coordinate such efforts.

Implementation Strategies

Step One: Utilize trained PIER specialist and the North Dakota EMS Association's Instructor/Coordinator Society to form an EMS Speaker's Bureau available for public and private speaking engagements with coordination done by NDEMSA.

Step Two: Identify agencies and organizations available for Public Information and Education in North Dakota.

Step Three: Urge the North Dakota EMS Association to promote EMS through Public Service Announcements, EMS Week promotions, newspaper and magazine articles and the Internet.

Objective Two: Develop and implement a comprehensive EMS Public Information and Education Plan.

Discussion: EMS public information and education is seldom thought of in the overall EMS picture. Usually little or no funding or labor is dedicated to this particular segment of a statewide EMS system. Public information and Education should be installed as an ongoing function in the implemenation of a

statewide EMS plan. Resources geared toward recruitment and retention of volunteers in all areas of EMS should be available to EMS agencies as a routine function of P. I. & E. in the statewide EMS plan.

Step One: Research what NHTSA has available along with other P.I. & E. programs and further customize these programs for North Dakota.

Step Two: Identify staff and funding sources for the development, implementation and maintenance of an annual P.I. & E. program.

Step Three: Educate EMS and other public safety agencies in an hour long video or MedStar presentation as a pro-active introduction to Public Information, Education and Relations training.

Step Four: Implement a media relations program to dispurse information in North Dakota appropriately.

Objective Three: Provide for the standardization of P.I. & E. should include standardized training for EMS providers. This training approach would dictate that all training be of a specific quality. There should be some type of reporting form that participating EMS services would utilize to be eligible for P.I. & E. annual awards. This reporting form could also be utilized as an evaluation tool for quality improvement. An assessment of current P.I. & E. programs would let EMS providers know what is available now and a “library” of P.I. & E. programs could be created for use by EMS services state-wide. P.I. & E. programs may need to be created to fit specific community requirements, such as very rural areas with unusually long transport times.

Step One. Develop a simple project report form for use with any P.I. & E. programs.

Step Two: Establish NHTSA’s PIER National Standard Curriculum for the training of EMS providers in North Dakota.

Step Three: Establish an annual P.I. & E. award for EMS services.

EVALUATION

STANDARD

A comprehensive evaluation program is needed to effectively plan and implement a statewide EMS System. Each EMS System must be responsible for evaluating the effectiveness of services provided adult and pediatric victims of medical or trauma related emergencies. A statewide EMS System should be able to state definitively what impact has been made on the patients served by the system. EMS Systems managers must be able to evaluate resource utilization, scope of service, patient outcome, and the effectiveness of operational policies, procedures and protocols. An effective EMS System evaluates itself against pre-established standards and objectives so that improvements in service, particularly direct patient care, can occur. These requirements are part of an ongoing quality assurance system to review system performance. The evaluation process should be educational and ongoing. QA reviews should occur at all phases of EMS Systems management so that needed policy changes or treatment protocol revisions can be made.

CURRENT STATUS

The three primary sources of information for profiling North Dakota's EMS System, consist of the DEHS registry, the ambulance run report data collection system, and the trauma registry. The DEHS registry contains information regarding services and personnel. For the services, the registry keeps such information as the service contact person, number of employees or volunteers, and information on the service vehicles. On the personnel side, the registry has such information as, all training levels, including current, expired, or superseded levels, demographic information, and service affiliation of each individual. The types of information that is kept in the trauma registry includes but is not limited to, types of injuries, mortality rates, time spent in level IV trauma centers before being transferred to a level II facility if needed, injury severity scores for patients, etc.

In late 1992 the DEHS implemented a new ambulance run report data collection system, which utilizes mark sense report forms. The information from the forms is entered into the computer by utilizing an optical scanning process. This data is reviewed by the computer using pre-defined error checking methodologies. If the computer senses an error, that trip ticket is rejected and the information is not placed into the data base. All rejected forms are sent back to the services with an explanation of what is missing, the services than fix the mistakes and

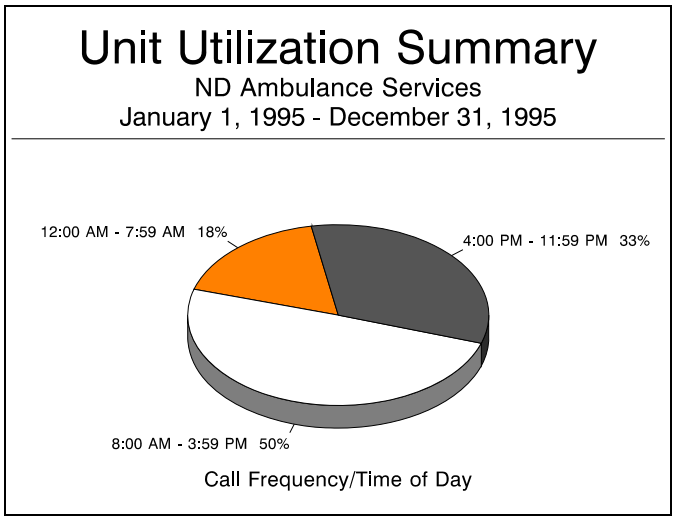
resubmit the forms. Obviously if there are no problems, the information goes into the computer, and can be used immediately. For the calendar year of 1995 the overall acceptance rate of scanned trip tickets was 69%. Some ambulance services are submitting their run reports electronically to DEHS, that is they fill out the information needed by DEHS on a computer and then send us the disks for processing. The major advantage to this type of submission is that the computer program that the services have will not allow inputting the type of mistakes that are rejected on the paper submission, consequently the disks are error free upon arrival at the DEHS. Reports can be generated which identify unit utilization, response times, call dispositions, incident type and locations, patient demographics, treatments, hospital admissions, as well as a host of other reports.

The data that the run report system generates, is sent out to the ambulance services on a biannual basis. Although some of the services use this knowledge to improve their patient care, there are no requirements for a service to have a QA/QI program in place, or to use the known facts to that end.

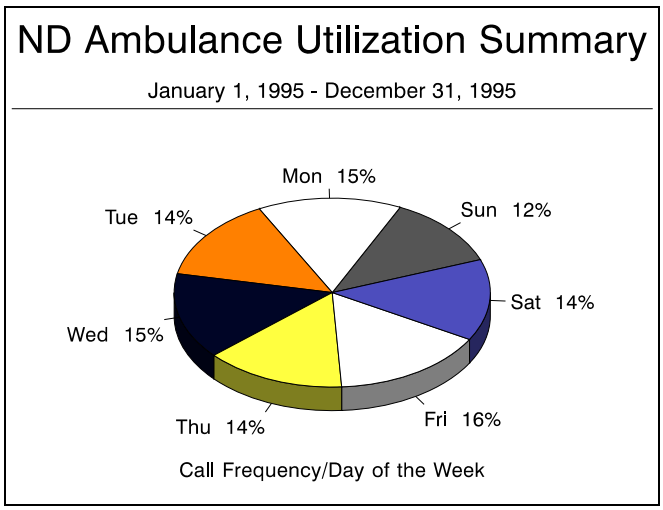
The data was generated and reported using a combination of EMSCAN and Harvard Graphics software packages. Harvard Graphics does not resolve rounding errors to equal 100% when calculating percentages. For this reason, total percentages reported at times will be within one percent of 100%. The ambulance run report data base for the calendar year 1995 is as follows:

There were 23,892 calls entered into the database.

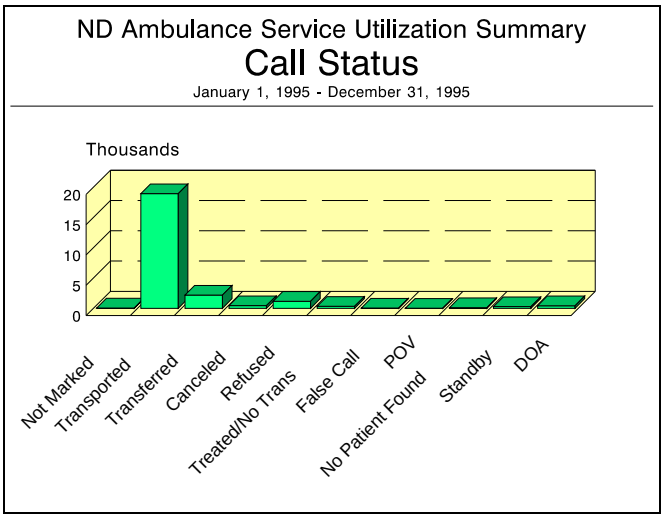
The most prevalent time of day that ambulance calls occur are between 8:00 AM and 3:59 PM. Fifty percent of the ambulance calls occur during this time period. Thirty three percent of the calls occur between 4:00 PM and 11:59 PM. Calls occurring between 12:00 AM and 7:59 AM accounted for 18% of the ambulance runs.



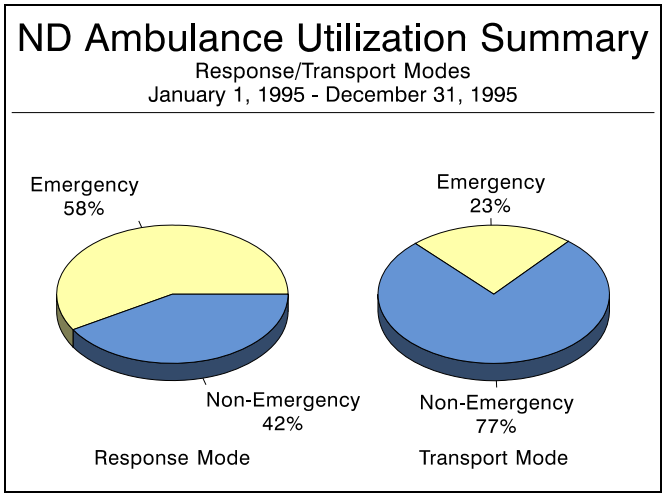
The day of the week in which ambulance services engage in runs is fairly evenly distributed. Friday has a slightly higher level of prevalence at 16% of the runs but it is closely followed by Monday and Wednesday with each at 15% and Tuesday, Thursday and Saturday with each at 14%. The day of the week with the least number of runs is Sunday at 12%.



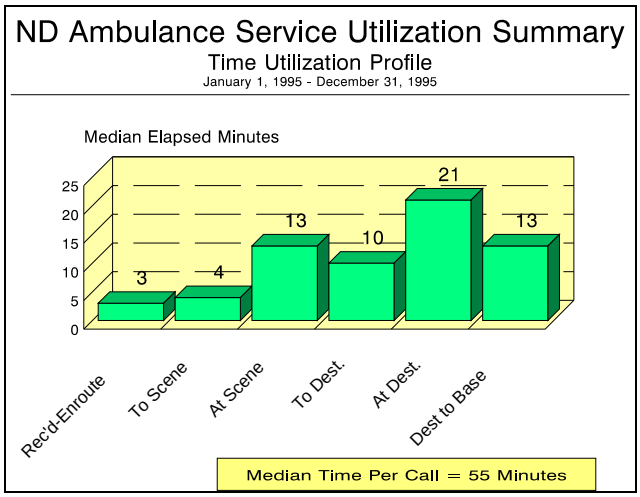
By far the greatest percentage of ambulance calls results in transportation. Seventy nine percent of the calls resulted in the patient being transported. Five percent of the patients refused treatment or transportation. Unlike our urban counterparts, no significant problem exists with false calls in North Dakota. Only 47 false calls or 0.1%.



Calls in which the ambulance services responded to the scene in an emergency mode numbered 13,975 or 58%. Calls in which the ambulance services responded to the scene in a non-emergency mode numbered 9,917 or 42%. In the transport mode for the same number of calls, 5,481 or 23% were transported with lights and siren, and 18,411 or 77% were transported in the non-emergency mode.

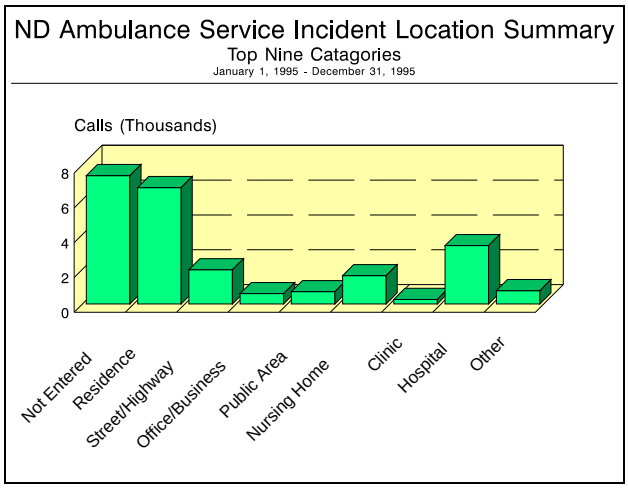


The median time per call was 55 minutes. Rural ambulance services had substantially higher median times per call than their urban counterparts. Communities with populations between 20,000 and 5,000 had a median time per call of 80 minutes. For those communities with populations between 5,000 and 1,000 the median time per call was 120 minutes and communities with populations less than 1,000 had a median time per call of 137 minutes.

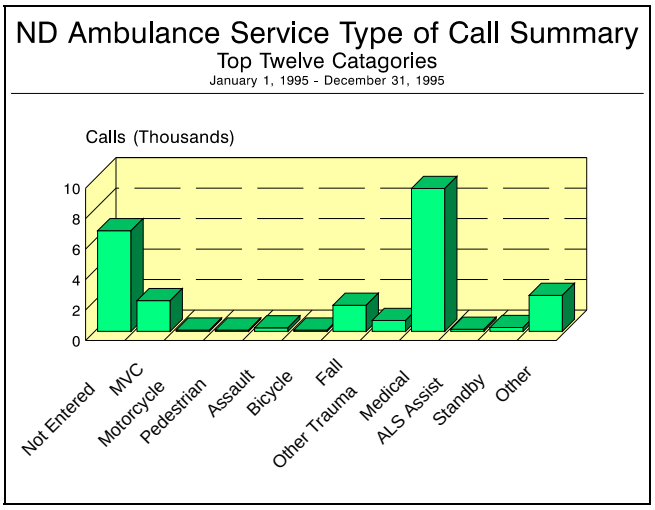


The median response time for all ambulance services was three minutes from the time a call was received until the vehicle was enroute and 4 minutes from the time the vehicle was enroute until the ambulance reached the scene. Median times for all ambulance services at the scene was 13 minutes. Median ambulance transport times from the scene to the facility was 21 minutes. The return trip from the facility to the base station that the ambulance was located involved a median of 13 minutes.

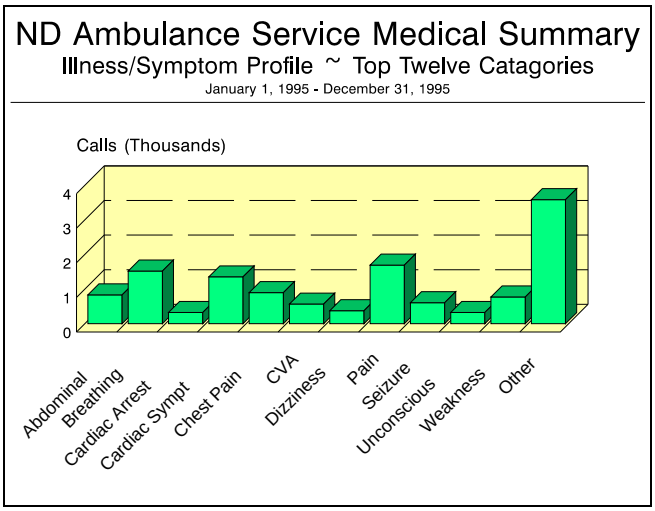
The two highest areas of incident location were in the residence with 6,691 calls or 28% followed by 3,358 or 14.1% for the hospital. The third highest category involved calls to streets, highways or other traffic ways. This category involved 1,968 calls or 12.3%. A substantial number of run reports did not enter incident location information.



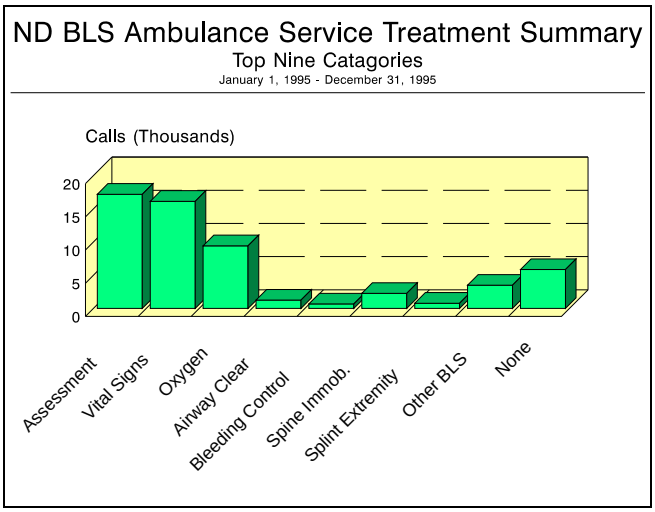
The most prevalent types of calls involved medical/ illness with 9,378 calls or 55% followed by motor vehicle crashes at 2,015 calls or 12%. The third most prevalent type of calls were falls with 1,712 runs or 10%. A substantial number of runs were marked as other meaning that none of the existing choices fit the type of run the ambulance service encountered.



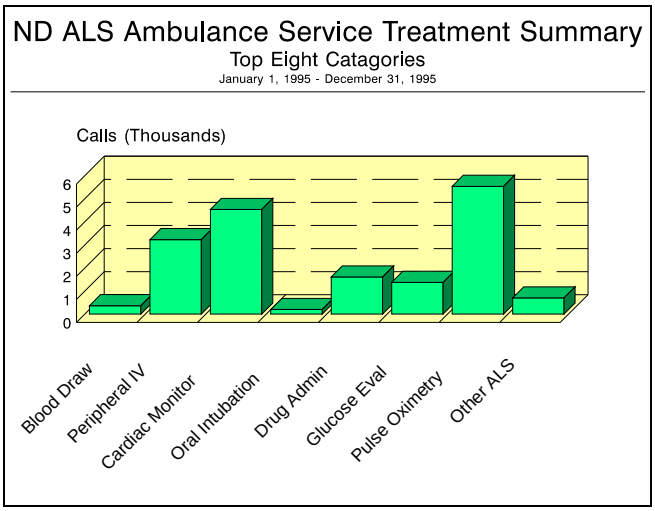
Excluding the category of other, the most prevalent medical emergency or illness symptoms were for pain with 1,692 calls or 12%. Breathing difficulty was the second highest medical emergency symptom with 1,523 calls or 11%. Cardiac symptoms ranked third with 1,353 calls or 10% and chest pain ranked fourth with 899 calls or 7%. If the categories of chest pain, cardiac symptoms and cardiac arrest are combined, these symptoms rank first with 2,577 calls or 20%.



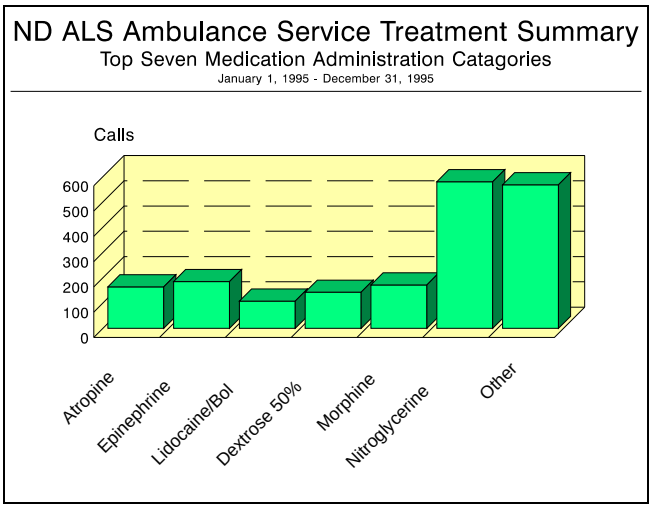
The most prevalent BLS treatment procedures is patient assessment. The data indicates that patient assessments were conducted on 72% of calls. Taking vital signs was the second activity conducted most often. Vital signs were taken on 68% of the calls. Oxygen therapy ranked third in frequency. Oxygen therapy was provided on 40% of calls. No BLS procedures were conducted on 10% of the calls.



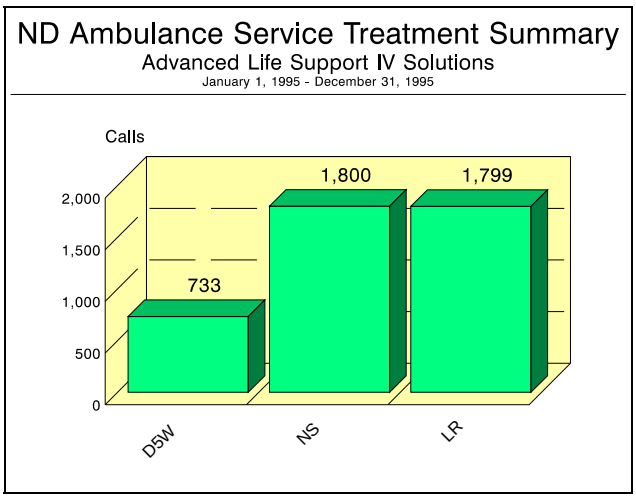
Pulse oximetry was the most common ALS procedure performed. Pulse oximetry was conducted on 23% of the runs. Cardiac monitoring followed as the second most prevalent ALS procedure being conducted on 19% of the calls. The third most common ALS procedure the starting of peripheral IVs. This procedure was performed on 14% of the calls.



Nitroglycerin is the most common drug administered by ambulance services. Nitroglycerin was administered on 2% of the calls. The other category also recorded a substantial number of entries. Epinephrine, Morphine and Atropine tied for the next most common drugs with each being administered in about 1% of the runs.



No clear preference is occurring between Lactated Ringers and Normal Saline IV solutions. Each were administered on 8% of the runs. At a distant third was D5W having been administered in 2% of the calls. Eighty two percent of the ambulance calls had no IVs administered.



At this time there is no formal statewide EMS QA/QI program which monitors the effectiveness of the EMS System and uses evaluation data to plan system improvements. The DEHS looks at the data as it develops, and makes some decisions on training, that may be disseminated statewide to improve some aspects of patient care. However this does not constitute a formal QA system.

1992 NHTSA RECOMMENDATIONS

- Develop a comprehensive EMS quality management system that includes standards and protocols for all phases of emergency medical care, in-depth operational policies, linkage of emergency care data to patient outcome information, and mechanisms for making changes in the system as indicated by quality assessments.

- Complete implementation of the ambulance run data collection system and develop a process for analyzing and interpreting run report data.

Objectives and Implementation Strategies

Objective One: Develop educational materials for instruction on the use of the run report bubble form. This will increase compliance and produce more reliable and accurate data. This objective should be completed by July 1, 1998.

Discussion: The ambulance run report bubble forms are used by the state to enter the data into the computer utilizing an optical scanning process. This data is compiled into multiple reports. The bubble forms must be completed accurately to allow the data to be included in the reports. The completion of the run report bubble forms is time consuming and is being done inconsistently. The ambulance

members need to understand the type of information, statistics and reports that can and are generated from the information retrieved from the run report bubble forms. If they were more aware of the data obtain they would understand the need for accuracy.

Implementation Strategies:

Step One: Develop a 30 minute video to be include in the monthly continuing education. This video is to include how to complete the form and also the reports that are being derived from the information on the bubble forms.

Step Two: Conduct monthly updates and reviews for the employees using the bubble form. These updates should include tips to facilitate the completion of the form and also the new reports that are being derived from the run report bubble forms.

Objective Two: Coordinate all the existing databases for ease in data collection and evaluation. This objective should be completed by July 1, 1999.

Discussion: There are Quick Response Units, First Responders, and Rescue Units who are providing care, but those actions are not included in the EMS run report system. Discussion was made that all units should compile there data and submit it to the state. The inclusion of this data would provide more complete and comprehensive reports. There is data that is being collected by DOT research specialists and this should be reviewed to see if it could benefit the current database.

Implementation Strategies:

Step One: Review data obtained from DOT research specialist.

Step Two: Include the data received from the Quick Response Units, First Responders, and Rescue Units to make the EMS run reports system more comprehensive.

Objective Three: Explore a pilot project for ambulance services to use electronic entry at the local hospitals, while continually researching for other more “user friendly” software programs. This objective should be completed by July 1, 2000.

Discussion: The use of electronic input of data dramatically improves the accuracy of the information. The reason for this is the computer will not allow the ambulance member to continue if an area is completed incorrectly or is missed. The placing of a computer with software into a local hospital will allow the ambulance members to input the run report data at the time of transferring the patient to that facility. The data inputted electronically would be cleaner and would probably take less time then filling out the bubble forms. There was

concern about needing to wait for the computer if more than one patient is being transferred to a facility at the same time from different ambulances. It was stated that the average input time for one patient is 4 minutes.

The state currently has the most widely used program available. Ongoing research will insure that if a better program is developed it can be evaluated.

Implementation Strategies:

Step One: Initiate the pilot project by identifying the participating hospitals, acquiring the software and setting up the computer.

Step Two: Continually research for newly developed or improved software.

Step Three: Institute a suggestion box for improvement requests to the current software template.

HUMAN RESOURCES AND TRAINING

EMS personnel can perform their mission only if adequately trained and available in sufficient numbers throughout the state. At a minimum, all transporting prehospital personnel should be trained to the EMT-Basic level. In addition, each prehospital training program should use a standardized curriculum for each level of EMT personnel.

In an effective EMS system, training programs are routinely monitored, instructors must meet certain requirements, and the curriculum is standardized throughout the state. In addition, the state agency must provide a comprehensive plan for stable and consistent EMS training programs with effective local and regional support.

Where We Are Today

Through administrative rulemaking by the authority of state statute, DEMS acts as the licensing/certifying agency for a variety of training programs. DEMS has gone to great effort to address and initiate broad-based programs, as well as individual skills, to meet the needs of local communities within the state.

Of the 3,166 persons providing ambulance services, 508 are at the driver level only, 48 have Red Cross Advanced First Aid, 1,809 are at the EMT-Basic level, 302 are EMT Intermediates, 388 are EMT Paramedics, and 111 are nurses.

Basic life support (BLS), intermediate life support and advanced life support (ALS) personnel are licensed/certified for two years. A number of other individual training courses (Automobile Extrication, Manual Defibrillation, IV Maintenance, Nebulized Medications, Limited Advanced Airway, Epinephrine Administration, EMS Instructor, Dextrose Administration, and Emergency Vehicle Operations) are made available with certification period for two years. Based upon the staffing limitations within the state office, consolidation of the many certification programs and skill levels may become necessary in order to maintain current levels of service. The certification programs follow national standard curricula established by the U.S. Department of Transportation. Individual skills programs are developed and approved by DEMS.

DEMS and the North Dakota EMS Association have established a unique working agreement in the training and practical testing of providers. A formal testing program has been established to provide examinations. The National Registry examination model is currently being utilized for testing and certification at the EMT level. Currently, an instructor must maintain a pass rate of at least 70 percent in order to remain a licensed instructor.

An EMS entity also may choose to be a licensed training institution according to rules established in Article 33-26-02 of North Dakota Administrative Code. The licensed training institution may approve EMS educational courses they conduct themselves, conduct practical testing, and approve continuing education following guidelines established by

DEMS. They also must maintain a pass rate of candidates of 70 percent in order to remain licensed. Currently there are six licensed training institutions in North Dakota.

There are currently six CBT test centers located within the state of North Dakota to facilitate the National Registry's cognitive knowledge examination.

First Responder

North Dakota first responder training programs are required to follow the 40-hour DOT curriculum that includes cognitive and psychomotor instruction. The first responder may become registered through the National Registry of EMTs or complete a local cognitive examination and become state certified.

This level is utilized by quick response units and law enforcement officials as an assistant on scene or to prepare the patient for arrival of more advanced EMS personnel. The First Responder also may complete an epinephrine auto injector module for administration under medical direction.

Recertification for this level includes a 16-hour refresher course authorized by DEMS every two years and requires authorization through DEMS for initial and refresher training.

Emergency Medical Technician

North Dakota EMT training programs are required to adhere to the 110 hour DOT curriculum that includes cognitive and psychomotor instruction. The candidate must be at least 16 years of age to become state licensed and 18 years of age to become nationally registered. All candidates that successfully complete an approved training program are required to successfully complete the cognitive and psychomotor testing following the guidelines of the National Registry of EMTs.

Once the candidate becomes certified, the individual must apply for licensure through DEMS.

Recertification of the EMT may be completed by three different methods:

1. The candidate may complete 48 hours of approved continuing education, a 24-hour approved refresher course and hold a current CPR card every two years, or
2. The candidate may successfully pass the NREMT cognitive examination every two years and hold a current CPR card, or
3. The candidate may successfully complete the psychomotor examination approved by DEMS every two years and possess a current CPR card. At this level the EMT would be state certified only.

The EMT also may complete optional skill-enhancement courses approved and developed by DEMS. These courses include limited advanced airway, nebulized medications, manual defibrillation and IV maintenance.

The EMT is the minimum level of provider that may perform primary care to an individual on a licensed BLS ambulance service and requires medical director oversight by a licensed North Dakota physician.

Emergency Medical Technician – Intermediate 85

North Dakota EMT-I85 training programs are required to adhere to the 1985 DOT 100-hour curriculum that includes 50 hours of cognitive and 50 hours of psychomotor instruction. A candidate must be at least 18 years of age and be current with EMT certification prior to enrollment into this type of education. The candidate must successfully complete both the cognitive and psychomotor examination processes approved by the NREMT.

Once the candidate becomes certified through the NREMT, he or she may apply for licensure in order to practice at this level and must have a physician preceptor. An enhancement skill called "dextrose 50 percent administration" is available.

Recertification for this level must follow the guidelines of the NREMT that includes a 36-hour refresher course and 36 hours of approved continuing education.

Emergency Medical Technician – Paramedic

North Dakota Paramedic training programs adhere to the National Standard Curriculum. The training program must apply for conduct of the class through an application process to DEMS. All EMT-Paramedic training programs must be nationally accredited by Jan. 1, 2010.

Like other levels, the paramedic may provide care specific to written protocols set forth by his or her medical director. Many medical directors include a large number of medications, 12 lead EKG and advanced airways.

Recertification for this level must follow the guidelines of the NREMT that includes a 48-hour refresher and 24 hours of continuing education. The paramedic also may recertify by examination by the NREMT policy and procedures.

Instructor Coordinator

North Dakota uses the 2002 National Guidelines for Educating EMS Instructors published by the National Association of EMS Educators and the U.S. Department of Transportation. The instructor must be licensed through DEMS and attend an approved instructor refresher course every two years.

Specialty Course Instructor

North Dakota has specialized licensed instructors for emergency vehicle operations, emergency medical dispatch and auto extrication courses that follow DOT guidelines. These instructors follow same guidelines as EMS instructor coordinators.

Other Training Requirements

Advanced life support training (Intermediate and Paramedic) requires a physician medical director who is responsible for course content, instructor supervision and student supervision. All ALS practical examinations are administered by DEMS training staff under guidelines set by the National Registry of EMTs. Cognitive examinations are administered by Pearson Vue test sites located throughout the state.

Recertification in North Dakota is accomplished at the BLS levels (First Responder, Emergency Medical Technician) under the direction of a licensed EMS

instructor/coordinator who administers both a written and practical examination. Recertification at the advanced level is accomplished under the direction of a physician medical director. ALS providers are required to maintain continual National Registry certification.

Grants

DEMS administers an Initial Training Grant program in which $750 is reimbursed to each new EMT who agrees to serve on a volunteer ambulance service for at least six months. Practical testing fees for EMT candidates are subsidized by DEMS. The out-of-pocket expense to the first-time practical test taker is reduced $175, leaving $25 as a candidate obligation. Subsequent test attempts are not subsidized by state funds.

New paramedics may qualify for a Rural Paramedic Training Assistance Grant of $4,000. To be eligible, an individual must complete a state-authorized program and become nationally registered. Additionally, the paramedic must serve on an ALS ambulance service for two years. The population of the ambulance service's base city must be less than 15,000 and the city must have a hospital.

A North Dakota licensed volunteer ambulance service is also eligible for a $2,000 continuing education grant each year; quick response units are eligible for a $1,500 grant and rescue squads are eligible for a $500 grant.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• Identify resources to supplement current Training Staff at DEMS.	Additional training staff has not been added in the State EMS Office.
• Consider consolidation of the individual training programs into current certification programs upon receipt of the revised DOT EMT curriculum.	North Dakota mandates the use of the DOT curricula for all levels of EMS provider. We continue to offer scope enhancement courses that are beyond the core training curricula.
• Establish minimum prerequisites for all Instructor/Coordinator candidates. Special attention should be given to the candidates EMS experience prior to being	In 2005 requirements were added in administrative rules requiring at least two years of experience in a given EMS provider level before an instructor may teach at that level.

selected.	
• Establish the EMT-Basic as the minimum requirement level for BLS ambulance services (for QRU and Rescue Units). Establish First Responder certification as the minimum requirement for QRU and Rescue Units.	BLS staffing requires at least an EMT as the primary care provider. QRU staffing requires at least a first responder as the primary care provider. Rescue squads are not required to have personnel medically trained.
• DEMS should establish an evaluation program for EMS course instruction.	Regulations adopted in 2005 and 2007 require a minimum pass rate of 70% for primary training courses; EMT, EMT-I, and Paramedic.
• Assure appropriate use of training funds by determining where training courses are needed.	Nearly all EMS agencies are eligible for training grant from DEMS. A new grant has been available since 2005 for services that have less than 10 EMT's on their roster.

HUMAN RESOURCES AND TRAINING SUPPORTING DOCUMENTS

ARTICLE 33-36

EMERGENCY MEDICAL SERVICES PERSONNEL

Chapter

33-36-01 Emergency Medical Services Personnel Training, Testing, Certification, and Licensure

33-36-02 Licensing of Emergency Medical Services Training Institutions

33-36-03 Scope of Practice for Unlicensed Emergency Medical Services Personnel

33-36-04 Scope of Practice for Emergency Medical Services Professionals

CHAPTER 33-36-01
EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING, TESTING, CERTIFICATION, AND LICENSURE

Section

33-36-01-01 Definitions

33-36-01-02 Emergency Medical Services Training Courses

33-36-01-03 Training, Testing, Certification, and Licensure Standards for Primary Certification Courses

33-36-01-03.1 Limited Temporary Certification or Licensure of Emergency Medical Services Training Course Graduates

33-36-01-04 Training, Testing, and Certification Standards for Certification Scope Enhancement Courses

33-36-01-04.1 Training, Testing, and Certification Standards for Certification Refresher Courses

33-36-01-05 Denial or Revocation of Certification or Licensure

33-36-01-05.1 Criminal History Background Checks

33-36-01-06 Revocation Process

33-36-01-07 Hearing

33-36-01-08 Waivers

33-36-01-01. Definitions. Words defined in North Dakota Century Code chapter 23-27 have the same meaning in this chapter.

1. "Cardiopulmonary resuscitation", initial and refresher, means the American heart association health care provider standards or its equivalent which includes the following skills: adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

2. "Certification scope enhancement programs" means those certification programs which add additional skills to or refresh existing skills obtained from the primary certification programs.

3. "Department" means the state department of health.

4. "Equivalent" means training of equal or greater value which accomplishes the same results as determined by the department.

5. "Field internship preceptor" means a qualified person designated by an emergency medical services instructor to supervise a student during field internship training.

6. "National registry" means the national registry of emergency medical technicians located in Columbus, Ohio.

7. "Prehospital emergency medical services personnel" are those persons certified or licensed under the programs defined in this chapter.

8. "Primary certification programs" means those certification programs which integrate a broad base of skills necessary to perform within a level of the emergency medical services system as determined by the department.

History: Effective April 1, 1992; amended effective August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-02. Emergency medical services training courses. The department shall establish training, testing, and certification requirements for the following emergency medical services courses:

1. Primary certification courses:

   a. First responder;

   b. Emergency medical technician;

   c. Emergency medical technician-intermediate/85;

   d. Emergency medical technician-intermediate/99;

   e. Advanced first-aid ambulance attendant;

   f. Emergency vehicle operations;

   g. Emergency medical dispatch; and

   h. Automobile extrication.

2. Certification scope enhancement courses:

   a. Manual defibrillation;

b. Intravenous maintenance;

c. Automobile extrication instructor;

d. Emergency medical services instructor;

e. Epinephrine administration;

f. Dextrose administration;

g. Bronchodilator/nebulizer administration;

h. Limited advanced airway insertion; and

i. Emergency vehicle operations instructor.

3. Certification refresher courses:

a. First responder-refresher;

b. Emergency medical technician-basic refresher;

c. Emergency medical technician-intermediate/85 refresher;

d. Emergency medical technician-intermediate/99 refresher; and

e. Paramedic refresher.

History: Effective April 1, 1992; amended effective October 1, 1992; August 1, 1994; August 1, 2003; August 1, 2004; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-03. Training, testing, certification, and licensure standards for primary certification courses. The department shall authorize the conduct of courses, the testing of students, and the certification or licensure of personnel when application has been made on forms requested from and provided by the department prior to conducting the course and in the manner specified by the department contingent on the following requirements:

1. First responder:

a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

b. Textbooks. The department shall approve textbooks.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently certified as a first responder or its equivalent.

d. A first responder student may practice all of the skills defined in the core scope of practice for first responder while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as a first responder student.

e. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department or the national registry cognitive knowledge examination and pass all stations of a practical examination conducted by the course coordinator. The practical examination must consist of no less than one medical, one cardiopulmonary resuscitation, and one trauma station.

f. Initial certification. The department shall issue initial certification to persons who meet the physical requirements described in the functional job analysis for first responder as published by the national highway traffic safety administration and have completed an authorized course and passed the testing process, or are certified as a first responder by the national registry. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year, or ninety days past their national registry expiration date if they are nationally registered. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year, or ninety days past their national registry expiration date if they are nationally registered.

g. Recertification. The department shall recertify for a two-year period expiring on June thirtieth, or ninety days past their national registry expiration date if they are nationally registered, to those persons that meet the physical requirements described in the functional job analysis for first responder as published by the national highway traffic safety administration and who have met one of the following requirements:

(1) Completion of a sixteen-hour North Dakota first responder refresher course.

(2) Completion of a twenty-four hour emergency medical technician-basic refresher course.

2. Emergency medical technician:

a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

b. Textbooks. The department shall approve textbooks.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician or its equivalent.

d. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician or its equivalent.

e. An emergency medical technician student may practice all of the skills defined in the core scope of practice for emergency medical technician while in the classroom and during field internship while under direct supervision of an instructor or the field internship preceptor and if registered with the department as an emergency medical technician student.

f. Testing. Students must pass the national registry cognitive knowledge examination and a practical examination specified by the department which meets the national registry's standards or its equivalent in order to be eligible for licensure. The content of the practical examination must be determined by the department, and the department shall establish policies regarding retesting of failed written and practical examinations.

g. Emergency medical technician initial licensure. The department shall issue initial licensure as an emergency medical technician to persons that meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and are over the age of sixteen who have completed an authorized course and passed the testing process or those who have requested reciprocity from another state with equivalent training. Persons passing the testing process between January first and June thirtieth shall be licensed until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be licensed until June thirtieth of the third year.

h. Relicensure of emergency medical technicians. The department shall relicense for a two-year period expiring June thirtieth those persons that meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who have met the following requirements:

(1) Completion of a twenty-four hour emergency medical technician-basic refresher course which includes a cardiopulmonary resuscitation health care provider refresher, answering correctly at least seventy percent of the questions on a written examination specified by the department and passing a local practical examination meeting the department's requirements; and

(2) Completion of forty-eight hours of continuing education as approved by the department or the national registry; or

(3) If currently licensed as an emergency medical technician, successful completion of the practical examination for emergency medical technician as established by the department. The practical examination must be administered by a licensed emergency medical services training institution in accordance with section 33-36-02-10 or by the department.

3. Emergency medical technician-intermediate/85:

a. Student prerequisite certification. Students must be licensed as an emergency medical technician or its equivalent prior to testing.

b. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

c. Textbooks. The department shall approve textbooks.

d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent.

e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician intermediate/85 or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician intermediate/85 or its equivalent.

f. An emergency medical technician-intermediate/85 student may practice all of the skills defined in the core scope of practice for emergency medical technician-intermediate/85 while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as an emergency medical technician-intermediate/85 student.

g. Testing. Students must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.

h. Emergency medical technician-intermediate/85 initial licensure. A person eighteen years of age or older that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring ninety days after their national registry expiration date.

i. Relicensure of emergency medical technician-intermediate/85. Emergency medical technician-intermediate/85 must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring ninety days after their national registry expiration date.

4. Emergency medical technician-intermediate/99:

a. Student prerequisite certification or license. A student must be licensed as an emergency medical technician or its equivalent prior to testing.

b. Curriculum. The course curriculum shall be that issued by the United States department of transportation, national highway traffic safety administration, in the addition specified by the department.

c. Textbooks. The department shall approve textbooks.

d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent.

e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician intermediate/99 or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as an emergency medical technician intermediate/99 or its equivalent.

f. An emergency medical technician-intermediate/99 student may practice all of the skills defined in the core scope of practice for emergency medical technician-intermediate/99 while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as an emergency medical technician-intermediate/99 student.

g. Testing. Students must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.

h. Emergency medical technician-intermediate/99 initial licensure. A person eighteen years of age or older that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring ninety days after their national registry expiration date.

i. Relicensure of emergency medical technician-intermediate/99. An emergency medical technician-intermediate/99 must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring ninety days after their national registry expiration date.

5. Paramedic:

a. Student prerequisite certification. Students must be certified or licensed as an emergency medical technician or its equivalent prior to testing.

b. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

c. Textbooks. The department shall approve textbooks.

d. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent.

e. Course instructors. The primary course instructor must be licensed by the department as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent. The primary instructor must teach at least fifty percent of the lecture portion of the course. Secondary instructors must be currently licensed as a paramedic or its equivalent.

f. A paramedic student may practice all of the skills defined in the core scope of practice for paramedic while in the classroom and during field internship while under direct supervision of an instructor or field internship preceptor and if registered with the department as a paramedic student.

g. Field internship. Courses must provide field internship experience based on the curriculum requirements for patient contacts with a paramedic preceptor.

h. Testing. A student must pass the cognitive knowledge and practical examinations as provided by the national registry and approved by the department in order to be eligible for licensure.

i. Paramedic initial licensure. A person eighteen years of age or older that meets the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and who has completed an authorized course and passed the testing process shall obtain certification from the national registry. Persons obtaining national registry certification and in compliance with chapter 50-03-03 will be licensed by the department expiring ninety days after their national registry expiration date.

j. Relicensure of paramedic. A paramedic must be recertified by the national registry recertification policies and meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration. Persons recertified by the national registry and in compliance with chapter 50-03-03 will be relicensed by the department for a two-year period expiring ninety days after their national registry expiration date.

6. Advanced first aid ambulance attendant:

   a. Advanced first aid ambulance attendant initial certification. The department shall issue initial certification to persons currently certified in American national red cross advanced first aid and who demonstrate a minimum of two years experience with a North Dakota licensed ambulance service as evidenced by North Dakota ambulance service license application personnel rosters.

   b. Recertification of advanced first aid ambulance attendants. The department shall recertify for a three-year period, expiring on June thirtieth, those persons who meet the physical requirements described in the functional job analysis for emergency medical technician as published by the national highway traffic safety administration and have completed a twenty-four hour emergency medical technician-basic refresher course, which includes a cardiopulmonary resuscitation refresher, answering correctly at least seventy percent of the questions on a written examination specified by the department and passing a local practical examination meeting the department's requirements.

7. Emergency vehicle operations:

   a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

   b. Course coordinator. The course coordinator must be certified by the department as an emergency vehicle operation instructor.

   c. Testing. The students must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

   d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.

8. Emergency medical dispatch:

   a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

b. Course coordinator. The course coordinator must be approved by the department as an emergency medical dispatch instructor.

c. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.

d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.

9. Automobile extrication:

a. Curriculum. The course curriculum must be approved by the department.

b. Course coordinator. The course coordinator must be certified by the department as an automobile extrication instructor.

c. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.

d. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth must be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first must be certified until June thirtieth of the third year.

History: Effective April 1, 1992; amended effective August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-03.1. Limited temporary certification or licensure of emergency medical services training course graduates.

1. An individual that has graduated from a department-authorized emergency medical services training course as an emergency medical technician, emergency medical technician - intermediate, or paramedic and has submitted a completed application signed by a physician and an official transcript verifying program completion may be issued a limited certification or license one time. A limited temporary certification

or licensure allows the graduate to be employed while awaiting results of the graduate's national registry examination. The limited temporary certification or licensure expires ninety days after the date of issue.

2. The graduate must practice under the direct supervision of a person certified or licensed at an equal or greater level. Direct supervision means close physical and visual proximity. The graduate may not be the primary care provider.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-04. Training, testing, and certification standards for certification scope enhancement courses. The department shall authorize the conduct of courses, the testing of students, and the certification or licensure of personnel when application has been made on forms provided prior to conducting the course and in the manner specified by the department contingent on the following requirements:

1. Manual defibrillation:

   a. Student prerequisite certification. A student must be licensed as an emergency medical technician or its equivalent.

   b. Curriculum. The course curriculum must be that issued by the department entitled "Manual Defibrillator/Monitor Curriculum".

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently certified by the American heart association in advanced cardiac life support or its equivalent.

   d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of the manual defibrillation of a simulated cardiac arrest patient and correctly identify eleven out of thirteen static cardiac strips.

   e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

2. Intravenous therapy maintenance:

   a. Student prerequisite certification. A student must be licensed as an emergency medical technician or its equivalent.

   b. Curriculum. The course curriculum must be that issued by the department entitled "EMT IV Maintenance Module".

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor, and currently certified in intravenous therapy maintenance, or its equivalent.

   d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of performing intravenous maintenance skills on a mannequin.

   e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

3. Automobile extrication instructor:

   a. Curriculum. The course curriculum must be approved by the department.

   b. Student prerequisite. The candidate for this course must be currently certified in automobile extrication with at least two years of certified automobile extrication experience.

   c. Course coordinator. The department shall designate the course coordinator.

   d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department.

   e. Initial certification. The department shall issue initial certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of

the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

f. Recertification. The department shall recertify for a two-year period those persons who have satisfactorily conducted an automobile extrication course or have audited eight hours of an automobile extrication instructor course before the expiration date of their certification.

4. Emergency medical services instructor:

a. Student prerequisite. An individual must be at least eighteen years of age and certified or licensed for at least two years as a patient care provider at the level the individual will instruct at, in order to be licensed.

b. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department or its equivalent.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor.

d. Initial licensure. The department shall issue initial licensure to persons who have completed an authorized course. Persons completing the course between January first and June thirtieth shall be licensed until June thirtieth of the second year. Persons completing the course between July first and December thirty-first shall be licensed until June thirtieth of the third year.

e. Relicensure. The department shall relicense for a two-year period those persons who have:

(1) Completed the department's eight-hour relicensure course;

(2) Those persons that are employed or affiliated with a licensed training institution, may submit documentation of eight hours of adult education training to satisfy the relicensure requirements;

(3) Within the current two-year licensure period the instructor has had at least a seventy percent pass rate for the following primary certification courses; emergency medical technician, emergency medical technician - intermediate/85, emergency medical technician - intermediate/99, or paramedic; and

(4) In addition, failure to achieve a seventy percent pass rate for these courses would require the instructor to retake the entire initial licensure process for emergency medical services instructor.

5. Epinephrine administration:

a. Student prerequisite certification. A student must be certified as a first responder or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled " Epinephrine Administration Module".

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently certified in epinephrine administration or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of performing subcutaneous injection of epinephrine with the use of a preloaded, self-injecting device such as the epipen trainer.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

6. Dextrose administration:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician-intermediate or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "EMT-I – 50% Dextrose Administration Module".

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all portions of a practical examination specified by the department. The practical examination must consist of administration of the drug by aseptic injection into intravenous administration tubing.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

7. Bronchodilator/nebulizer administration:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician or its equivalent.

b. Curriculum. The course curriculum must be the general pharmacology and the respiratory emergencies sections of the curriculum issued by the United States department of transportation, national highway traffic safety administration, for emergency medical technicians-basic, in the edition specified by the department, or its equivalent.

c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and be licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

8. Limited advanced airway insertion:

a. Student prerequisite licensure. A student must be licensed as an emergency medical technician or its equivalent.

b. Curriculum. The course curriculum must be that issued by the department entitled "Limited Advanced Airway Module".

c. Course coordinator. The course coordinator must be licensed as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent.

d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

e. Certification. The department shall issue a certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

9. Emergency vehicle operations instructor:

a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

b. Course instructor. The department shall designate the course instructor.

c. Testing. The students must correctly answer at least seventy percent of the questions on a written examination and pass a practical examination specified by the department.

d. Initial certification. The department shall issue initial certification to persons who have completed an authorized course and passed the testing process. Persons passing the testing process between January first and June thirtieth shall be certified until June thirtieth of the second year. Persons passing the testing process between July first and December thirty-first shall be certified until June thirtieth of the third year.

e. Recertification. The department shall recertify for a two-year period those persons who have satisfactorily conducted an emergency

vehicle operations course or have audited eight hours of an emergency vehicle operator's course.

History: Effective April 1, 1992; amended effective October 1, 1992; August 1, 1994; August 1, 2003; August 1, 2004; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-04.1. Training, testing, and certification standards for certification refresher courses. The department shall authorize the conduct of courses, the testing of students, and the certification of personnel when application has been made on forms requested from and provided by the department prior to conducting the course and in the manner specified by the department contingent on the following requirements:

1. First responder refresher:

   a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

   b. Textbooks. The department shall approve textbooks.

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently certified as a first responder or its equivalent.

   d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by the department and pass all stations of a practical examination conducted by the course coordinator. The practical examination must consist of no less than one medical, one cardiopulmonary resuscitation, and one trauma station.

2. Emergency medical technician refresher:

   a. Curriculum. The course curriculum must be that issued by the United States department of transportation, national highway traffic safety administration, in the edition specified by the department.

   b. Textbooks. The department shall approve textbooks.

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician or its equivalent.

   d. Testing. The student must correctly answer at least seventy percent of the questions on a written examination specified by

the department and pass all stations of a practical examination conducted by the course coordinator.

3. Emergency medical technician-intermediate/85 refresher:

   a. Curriculum. The course coordinator shall select topics consistent with the reregistration requirements of the national registry.

   b. Textbooks. The department shall approve textbooks.

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/85 or its equivalent.

4. Emergency medical technician-intermediate/99 refresher:

   a. Curriculum. The course coordinator shall select topics consistent with the reregistration requirements of the national registry.

   b. Textbooks. The department shall approve textbooks.

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as an emergency medical technician-intermediate/99 or its equivalent.

5. Paramedic refresher:

   a. Curriculum. The course curriculum must be consistent with the reregistration requirements of the national registry.

   b. Textbooks. The department shall approve textbooks.

   c. Course coordinator. The course coordinator must be licensed by the department as an emergency medical services instructor and must be currently licensed as a paramedic or its equivalent.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-05. Denial or revocation of certification or licensure. The department may deny or revoke the certification or licensure of a person who:

1. Has misrepresented to others that the person is a physician, nurse, or health care provider other than the highest level for which they are certified or licensed.

2. Is incapable of properly performing the skills for which the individual has been certified or licensed.

3. Performs a skill which exceeds those allowed by the individual's level of certification or licensure.

4. Has been charged or convicted of a felony which has a direct bearing upon the person's ability to serve the public in a capacity certified or licensed by this chapter. Persons certified or licensed who have been charged or convicted of a felony must report the information to the department.

5. Has been found by a court of law to be mentally incompetent.

6. Failure to follow examination policies as a student, instructor, or course coordinator.

7. Diversion of drugs for personal or unauthorized use.

8. Performance of care in a manner inconsistent with acceptable standards or protocols.

9. Has attempted to obtain by fraud or deceit a certification or license or has submitted to the department any information that is fraudulent, deceitful, or false.

10. Has had the person's national registry or other health care certification or license encumbered for any reason. Persons certified or licensed as described in this chapter must report any encumbrance of their national registry or other health care certification or licensure to the department.

11. Has misrepresented to others that the person is an employee, volunteer, or agent of an ambulance service, quick response unit, or rescue squad to offer emergency medical services.

12. Unprofessional conduct, which may give a negative impression of the emergency medical services system to the public, as determined by the department.

13. As an instructor has failed to have emergency medical services training authorized as required in section 33-36-01-03, 33-36-01-04, or 33-36-01-04.1.

14. Providing emergency medical services without authorization from a physician.

History: Effective April 1, 1992; amended effective August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-05.1. Criminal history background checks. The department may perform criminal history background checks on any applicant requesting a certification or license or a person requesting to be listed on an ambulance service or quick response unit's roster as a driver. A driver may be denied participation in any emergency medical services operation based on the driver's criminal background history or any occurrence listed in section 33-36-01-05.

History: Effective January 1, 2008.
General Authority: NDCC 12-60-24.2, 23-27-04.3
Law Implemented: NDCC 12-60-24.2, 23-27-04.3

33-36-01-06. Revocation process. The department may revoke an individual's certification or license after making a diligent effort to:

1. Inform the individual by the department of the allegations.

2. Inform the individual of the department's investigation results.

3. Inform the individual of the department's intent to revoke and provide a notice of right to request hearing.

4. Provide the individual opportunity to request a hearing and rebut the allegations.

History: Effective April 1, 1992; amended effective August 1, 2003; January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-07. Hearing. A request for hearing must be received by the department no later than twenty days following the individual's receipt of the allegations against the individual. If a hearing is requested, the department will apply to the office of administrative hearings for appointment of a hearing officer. The department will notify any complainants and the accused of the date set for the hearing. The hearing officer will conduct the hearing and prepare recommended findings of fact and conclusions of law as well as a recommended order for the department. The department shall notify the individual of its findings

in writing after receiving the attorney general's finding of fact, conclusion of law, and recommended order.

History: Effective April 1, 1992.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-01-08. Waivers. Based on each individual case, the department may waive any provisions of this chapter that may result in unreasonable hardship upon the individual or the individual's emergency medical service agency, provided such a waiver does not adversely affect the health and safety of patients. The department will consider waivers for the following situations and conditions:

1. A person had completed all the requirements for recertification or relicensure and a good-faith effort was made by that person to recertify with the national registry and by no fault of the person recertification was not granted.

2. A person who was current in the person's certification or license was called to active duty in the United States armed forces and deployed to an area without the resources to maintain the person's certification or license resulting in a lapse of the person's certification or license.

3. A waiver may be granted for a specific period of time not to exceed one year and shall expire on June thirtieth of each year.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

CHAPTER 33-36-02
LICENSING OF EMERGENCY MEDICAL SERVICES TRAINING INSTITUTIONS

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33-36-02-01. Definitions. Words defined in North Dakota Century Code chapter 23-27 have the same meaning in this chapter.

1. "Acceptable criminal background requirements" means that a student's criminal background is acceptable by the department and the national registry for entry into the profession.

2. "Accrediting agency" means the commission on accreditation on allied health education programs or its equivalent.

3. "Candidate" means a person that has completed a primary training course and is in the testing process.

4. "Certifying examination" means a national registry test.

5. "Department" means the North Dakota state department of health.

6. "Emergency medical services equipment" means automated external defibrillator, long back board, Kendrick extrication device, oxygen delivery equipment, rigid splints, traction splint, suction equipment, bandages, and other equipment needed to accomplish training.

7. "National registry" means the national registry of emergency medical technicians located in Columbus, Ohio.

8. "Physician" means a person licensed by the North Dakota board of medical examiners to practice medicine.

9. "Student" means a person that is actively in a primary training course and has not yet completed the course.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-02. License required - Fees.

1. No North Dakota emergency medical services training institution, as defined in North Dakota Century Code chapter 23-27, shall be advertised or offered to the public or any person as a licensed training institution unless the operator of such service is licensed by the department.

2. The license shall expire midnight on October thirty-first of the third year following issuance. License renewal shall be on a three-year basis.

3. A license is valid only for the training institution for which it is issued. A license may not be sold, assigned, or transferred.

4. The license shall be displayed in a conspicuous place.

5. The three-year license fee shall be seventy-five dollars which is nonrefundable.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-03. Application for license. An application for licensure as an emergency medical services training institution may be submitted on a form provided by the department or an alternate format which includes the following information:

1. Applicant information:

   a. Name of the training institution;

   b. Mailing address;

   c. Telephone number;

   d. Name of program coordinator;

   e. Name of training institution medical director; and

   f. E-mail address of contact person;

2. A copy of the written agreement with the physician medical director;

3. A copy of the written agreement with the hospitals, clinics, ambulance services, and physicians' offices that will provide field internship training;

4. A listing of the names of the persons or organizations that have financial interest in the institution;

5. A copy of the student handbook for the institution; and

6. A signed statement attesting to the accuracy of the application and all of its attachments.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-04. Issuance and renewal of licenses.

1. The department or its authorized agent shall inspect the training institution. If minimum standards are met, the department shall issue a license.

2. A training institution may request that the department consider it in compliance with this chapter if it is fully accredited by the commission on accreditation of allied health education programs or its equivalent. The training institution must provide any additional information to the department that is required of licensed emergency medical services training institutions but not evaluated in the accreditation process.

3. Training institutions requesting their compliance with this chapter to be verified through an accrediting agency shall submit to the department appropriate documentation to include the site visit survey report and official letter from the accrediting agency citing any deficiencies. Subsequent accreditation or revisit documentation must be submitted prior to license renewal.

4. Training institutions that offer paramedic training shall have the paramedic course accredited by an accrediting agency by January 1, 2010.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-05. Training institution director requirements. Each licensed training institution must have a director who serves as the administrator of the training institution and who is responsible for:

1. Planning, conducting, and evaluating the program;

2. Selecting students and instructors;

3. Documenting and maintaining records;

4. Developing a curriculum; and

5. Acting as or appointing the test site coordinator for practical examinations if applicable.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-06. Training institution medical director requirements. Each licensed training institution shall have an agreement on file at the department with a physician whose responsibilities include:

1. Ensuring an accurate and thorough presentation of the medical content of each training program;

2. Certifying that each candidate has successfully completed the training course;

3. In conjunction with the training program director, planning the clinical training;

4. Being available for practical test site consultations; and

5. Acting as a liaison between the training institution and the medical community.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-07. Course instructors. Primary course instructors must be licensed as an instructor coordinator as defined in section 33-36-01-04 and hold a certificate or license in or above the discipline that they are teaching and teach at least fifty percent of the course content. The remaining fifty percent may be taught by guest lecturers approved by the training institution director or medical director.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-08. Training institution policies, records, and quality assurance. North Dakota licensed emergency medical services training institutions must:

1. Publish a student handbook which includes at least the following information:

   a. The full name and address of the school;

   b. Names of owners and officers, including governing boards;

   c. A description of each educational service offered, including tuition, fees, and length of courses;

   d. Enrollment procedures and entrance requirements, including late enrollment if permitted;

   e. A description of the institution's tuition assistance. If no assistance is offered, the institution must state this fact;

   f. Attendance policy, including minimum attendance requirements;

   g. A policy explaining satisfactory student progress which includes:

      (1) How progress is measured and evaluated, including an explanation of any system of grading used;

      (2) The conditions under which the student may be readmitted if terminated for unsatisfactory progress; and

      (3) Explanation of any probation policy;

   h. A description of the system used to make progress reports to students; and

   i. An explanation of the refund policy which also includes the training agency's method of determining the official date of termination.

2. Maintain as a minimum, the following records for emergency medical services courses taught:

   a. Student records that include:

      (1) Name and address for each student enrolled in an emergency medical services course;

      (2) Grades for each written examination;

(3) Copies of each student's documentation of entrance requirements to each course, including a copy of the individual's cardiopulmonary resuscitation certification and criminal history statement; and

(4) Field internship student evaluation forms from each field or clinical internship session. The form must include the evaluator's printed name, contact information, and signature.

Student records must be maintained for five years.

b. Instructor and course records that include:

(1) Names and qualifications of the primary instructors;

(2) Names and qualification of guest instructors;

(3) Instructor evaluation records completed by students and training institution personnel; and

(4) Names of the practical examination evaluators.

3. Have at least seventy percent of the candidates who successfully complete a primary training course certified or licensed by the department or certified by the national registry within two years of course completion.

4. Develop and implement a quality assurance program for instruction. The quality assurance program must:

a. Establish and implement policies and procedures for periodic evaluation of all instructors, field internship sites, equipment, and other training resources;

b. Establish and implement a mentoring program for each new instructor. Each new instructor will be assigned a mentor who has a background in the course being taught or in teaching. The assigned mentor will complete an evaluation of the assignee at least once;

c. Establish and have completed student evaluations during and after each course taught; and

d. Establish and implement a remediation plan for all noted instructor deficiencies. Documentation of remediation shall be maintained for five years.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-09. Other training institution requirements. North Dakota licensed emergency medical services training institutions must:

1. Have adequate classroom and laboratory space to conduct emergency medical services training.

2. Have appropriate dedicated emergency medical services equipment for training.

3. Determine the eligibility of prospective students in regard to age, minimum prior training requirements, and acceptable criminal background requirements.

4. Maintain a written agreement with a licensed medical facility and licensed ambulance service designating a field internship site.

5. After each primary training class is complete, notify the department of the starting date and number of students initially enrolled and the number of students fully completing the course.

6. Provide proof of liability insurance that covers the training institution and primary instructors.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-10. Practical examination administration. A licensed training institution may conduct practical examinations under the following conditions:

1. The institution must be designated by the department to conduct practical examinations.

2. The facility must have adequate room to accommodate a test. Each test station must be well away from others so that the privacy of the candidate and the security of the test are maintained. There must be a separate monitored room for candidates to wait. The designated department representative may shut down or cancel a test because of inadequate facilities.

3. Test site dates must be approved by the department. For an advanced life support test site, the test site coordinator must notify the department eight weeks prior to the test date and submit a roster of probable candidates for the practical test. For a basic life support test site, the test site coordinator must notify the department two weeks prior to the test date and submit a roster of probable candidates for the practical test. The test site coordinator may accept candidates from other licensed training institutions or department-authorized courses or qualified candidates from other states if the test site coordinator has verified the eligibility of the candidate.

4. The test site coordinator is responsible for all logistics of the test site. The test site coordinator must remain at the test site for the duration of the test.

5. A national registry representative approved by the department or a designated department representative must oversee the test site. The national registry or department representative's only duties are to ensure the integrity of the test site and submit results to the national registry or the department. The designated department representative may not have an affiliation with the training institution.

6. The training institution must provide an adequate number of qualified evaluators for the number of students to be tested. For every eight candidates there must be at least one evaluator. The evaluators may not evaluate a candidate in a practical station for which the evaluator had been a guest lecturer, or had been the training institution coordinator or the primary instructors of the candidates. Evaluators must use and adhere to the department's testing evaluation forms.

7. An emergency medical technician candidate must pass all stations of a practical test site within two years of course completion. The required practical stations are:

   a. Patient assessment management - trauma;

   b. Patient assessment management - medical;

   c. Cardiac arrest management/automated external defibrillator;

   d. Spinal immobilization, seated or supine;

   e. Bag valve mask, apneic patient with a pulse; and

   f. One of the following random skills chosen by the department:

      (1) Long bone immobilization;

      (2) Joint dislocation immobilization;

(3) Traction splinting;

(4) Bleeding control and shock management;

(5) Upper airway adjuncts and suction;

(6) Mouth to mask with supplemental oxygen; or

(7) Supplemental oxygen administration.

8. A candidate may fail no more than three stations at any one test site. The candidate may retest those failed stations one time on the same day at the discretion of the test site coordinator. If a candidate fails four or more stations, the candidate must retest all stations at a later date.

9. All emergency medical technician practical test results must be reported to the department within one week of the practical test by the department representative. The department will determine the eligibility of the candidates to retest according to department policy.

10. Retesting candidates that have failed all or part of the emergency medical technician practical test will be done in accordance with department policy. The number of times a candidate may retest all or part of the emergency medical technician practical test is determined by department policy.

11. An advanced level practical test site must be approved by the department and comply with national registry rules and policies.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-11. Continuing education. Continuing education courses for emergency medical services personnel must be approved by the department, licensed training institution, the national registry, or physician medical director. A licensed training institution may conduct continuing education courses, utilizing appropriate instructors, under the following conditions:

1. A number is assigned for each continuing education course. The numbering system must be approved by the department;

2. Continuing education units will be awarded for actual time rounded to the nearest quarter hour;

3. A certificate must be awarded or available upon request by the participant or the department. The certificate must list the title of the course, course number, date, hours awarded, location, instructor, and training institution name; and

4. The licensed training institution must keep records of the continuing education for two years. The records must include the course name, number, date, hours awarded, location, instructor, attendees, and attendee's state-issued license numbers.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-12. Revocation of licensure. The department may revoke the license of a training institution or license of an individual to instruct or practice under the following circumstances:

1. Negligence in performing or instructing emergency medical care.

2. Fraud, forgery, or misrepresentation of facts in procuring or attempting to procure licensure as an emergency medical service training institution.

3. Violation of this chapter promulgated to regulate emergency medical services training institutions.

4. Falsely passing candidates or discrimination of candidates at a practical test site.

5. Grossly immoral or dishonorable conduct.

6. Diversion of drugs for personal or unauthorized use.

7. The licensed training institution receives adverse accreditation action from a national accrediting agency.

8. Failing to submit required course documentation to the department either prior to the conduct of the course, for those courses that require prior authorization, or within a reasonable amount of time after the course is complete, for those courses that require course completion documentation submission.

History: Effective January 1, 2006; amended effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-13. Revocation process. The department may revoke a training institution's or individual's license after making a diligent effort to:

1. Inform the training institution or individual by the department of the allegations.

2. Inform the training institution or individual of the department's investigation results.

3. Inform the training institution or individual of the department's intent to revoke and provide a notice of right to request hearing.

4. Provide the training institution or individual opportunity to request a hearing and rebut the allegations.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-14. Hearing. A request for hearing must be received by the department no later than twenty days following the training institution's or individual's receipt of the allegations. If a hearing is requested, the department will apply to the office of administrative hearings for appointment of a hearing officer. The department will notify any complainants and the accused of the date set for the hearing. The hearing officer will conduct the hearing and prepare recommended findings of fact and conclusions of law as well as a recommended order for the department. The department shall notify the training institution or individual of its findings in writing after receiving the hearing officer's finding of fact, conclusion of law, and recommended order.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-02-15. Waivers. Based on each individual case, the department may waive any provisions of this chapter.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

CHAPTER 33-36-03
SCOPE OF PRACTICE FOR UNLICENSED EMERGENCY MEDICAL SERVICES PERSONNEL

Section
33-36-03-01 Definitions
33-36-03-02 Scopes of Practice

33-36-03-01. Definitions. Words defined in chapter 23-27 of the North Dakota Century Code have the same meaning in this chapter. For purposes of this chapter:

1. "Advanced first-aid ambulance attendant" means a person that has fulfilled the training, testing, and certification process for advanced first-aid ambulance attendant as required in chapter 33-36-01.

2. "Airway adjuncts" means oxygen and oxygen delivery equipment, oropharyngeal airways, nasopharyngeal airways, bag-valve-mask ventilator, or any other mechanical ventilator or respiratory care equipment.

3. "Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent which includes the skills adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

4. "Driver" means a person that is registered with the department as an uncertified crew member of a basic life support ambulance.

5. "First responder" means a person that has fulfilled the training, testing, and certification process for first responder as required in chapter 33-36-01.

6. "Primary care provider" means a qualified individual responsible for the care of the patient and supervision of all ambulance personnel while on the ambulance run.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-03-02. Scopes of practice. Each level of emergency medical services provider has a scope of practice that includes the scopes of practice of all subordinate emergency medical services providers. The hierarchy of emergency medical services providers is listed sequentially in this section.

1. Driver.

   a. Scope. The driver's minimum scope of practice primarily focuses on driving the basic life support ambulance and assisting the other emergency medical services personnel on the ambulance crew with nonpatient care issues. The driver's maximum scope of practice is limited to providing cardiopulmonary resuscitation without mechanical resuscitation equipment or airway adjuncts but including the use of an automated external defibrillator if the driver is certified in cardiopulmonary resuscitation. A major difference between the layperson and the driver is the "duty to act" as part of an organized emergency medical services response.

   b. Curriculum. The driver must hold a valid operator's license under chapter 39-06 of the North Dakota Century Code.

   c. Occupational setting. Drivers may only participate in the emergency medical services system as part of a crew of a basic life support ambulance service or quick response unit. At no time may a driver respond without other higher level emergency medical services personnel.

   d. Medical oversight. Because transport is an important part of the patient care continuum, a driver functions with physician oversight through protocol.

   e. Supervision. A driver is supervised by the primary care provider.

2. First responder.

   a. Scope. The first responder's core scope of practice includes simple, noninvasive skills focused on lifesaving interventions for critical patients based on assessment findings. The first responder renders onscene emergency care while awaiting additional emergency medical services response and may serve as part of the transporting crew, but not as the primary care provider. A first responder is not prepared to make decisions independently regarding the appropriate disposition of patients. A first responder must function with an emergency medical technician or higher level personnel during the transportation of patients. The first responder's scope includes all of the skills included in the driver's scope. A major difference between a driver and a first responder is the training and skills to provide immediate lifesaving interventions.

   b. Curriculum. The educational requirements include successful completion of a state-authorized first responder training program and continued educational requirements as defined in chapter 33-36-01.

c. Scope enhancements. First responders may provide enhanced treatments beyond the core scope if they have successfully completed training as defined in section 33-36-01-04 and have authorization to perform those skills from their medical director.

d. Skills. Specific skills for the first responder are defined by the department. Local medical directors may limit the specific skills that a first responder may provide and they may not exceed those specific skills defined by the department.

e. Occupational setting. First responders may participate in the emergency medical services system as a sole responder in a quick response unit or as part of the crew of a basic life support ambulance service but not as the primary care provider. First responders may also provide services to a private company or organization as part of a response team that is not offered to the public.

f. Medical oversight. A first responder provides medical care with physician oversight. A physician credentials the first responder and establishes patient care standards through protocol.

g. Supervision. A first responder may be the highest trained person on a quick response unit and may supervise other first responders or drivers. As part of a basic life support ambulance crew, a first responder is supervised by the primary care provider.

3. Advanced first-aid ambulance attendant.

a. Scope. The advanced first-aid ambulance attendant's scope of practice is equal to the emergency medical technician's as defined in section 33-36-04-02.1. The advanced first-aid ambulance attendant's scope includes the skills in the first responder's scope and the driver's scope. The major difference between an advanced first-aid ambulance attendant and first responder is the knowledge and skills necessary to provide medical transportation of emergency patients.

b. Curriculum. The curriculum for advanced first-aid ambulance attendant is no longer supported. Therefore, no new advanced first-aid ambulance attendants can be trained. Continued educational requirements are defined in chapter 33-36-01.

c. Scope enhancements. Advanced first-aid ambulance attendants may provide enhanced treatments beyond the core scope if they have completed training as defined in section 33-36-01-04 and have the authorization to perform those skills from their medical director.

d. Skills. Specific skills for the advanced first-aid ambulance attendant are defined by the department. Local medical directors may limit the specific skills that an advanced first-aid ambulance attendant may provide and they may not exceed those specific skills defined by the department.

e. Occupational setting. Advanced first-aid ambulance attendants may participate in the emergency medical services system as a sole responder in a quick response unit or as a primary care provider on a basic life support ambulance service. Advanced first-aid ambulance attendants may also provide services to a private company or organization as part of a response team that is not offered to the public.

f. Medical oversight. An advanced first-aid ambulance attendant provides medical care with physician oversight. A physician credentials the advanced first-aid ambulance attendant and establishes patient care standards through protocol.

g. Supervision. An advanced first-aid ambulance attendant may be the primary care provider on a quick response unit or basic life support ambulance and may supervise other advanced first-aid ambulance attendants, first responders, or drivers.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

CHAPTER 33-36-04
SCOPE OF PRACTICE FOR EMERGENCY MEDICAL SERVICES PROFESSIONALS

Section
33-36-04-01 Definitions
33-33-04-02 Scopes of Practice

33-36-04-01. Definitions. Words defined in chapter 23-27 of the North Dakota Century Code have the same meaning in this chapter. For purposes of this chapter:

1. "Emergency medical technician" means a person that has fulfilled the training, testing, certification, and licensure process for emergency medical technician as required in chapter 33-36-01.

2. "Emergency medical technician - intermediate/85" means a person that has fulfilled the training, testing, certification, and licensure process for emergency medical technician - intermediate/85 as required in chapter 33-36-01.

3. "Emergency medical technician - intermediate/99" means a person that has fulfilled the training, testing, certification, and licensure process for emergency medical technician - intermediate/99 as required in chapter 33-36-01.

4. "Paramedic" means a person that has fulfilled the training, testing, certification, and licensure process for paramedic as required in chapter 33-36-01.

5. "Primary care provider" means a qualified individual responsible for the care of the patient and supervision of all ambulance personnel while on the ambulance run.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

33-36-04-02. Scopes of practice. Each level of emergency medical services professional has a scope of practice that includes the scopes of practice of all subordinate emergency medical services professionals and the scopes of all emergency medical services providers listed in chapter 33-36-03. The hierarchy of emergency medical services professionals is listed sequentially in this section.

1. Emergency medical technician.

   a. Scope. The emergency medical technician's core scope of practice includes basic, noninvasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and

traumatic emergencies. Emergency care is based on assessment findings. An emergency medical technician is not prepared to make decisions independently regarding the appropriate disposition of patients. The emergency medical technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility. The primary differences between an advanced first-aid ambulance attendant and emergency medical technician are the educational and testing requirements required for licensure as an emergency medical technician.

b. Curriculum. The educational requirements include successful completion of a state-authorized emergency medical technician training program and continued educational requirements as defined in chapter 33-36-01.

c. Scope enhancements. Emergency medical technicians may provide enhanced treatments beyond the core scope if they have completed training as defined in section 33-36-01-04 and have authorization to perform those skills from their medical director.

d. Skills. Specific skills for the emergency medical technician are defined by the department. Local medical directors may limit the specific skills that an emergency medical technician may provide and they may not exceed those specific skills defined by the department.

e. Occupational setting. Emergency medical technicians may participate in the emergency medical services system as a sole responder in a quick response unit, as the primary care provider of a basic life support air or ground ambulance service, or as part of the crew of an advanced life support air or ground ambulance service. Emergency medical technicians may also provide services to a private company or organization as part of a response team that is not offered to the general public.

f. Medical oversight. An emergency medical technician provides medical care with physician oversight. A physician credentials the emergency medical technician and establishes patient care standards through protocol.

g. Supervision. An emergency medical technician may be the highest trained person on a quick response unit and as the primary care provider may supervise other emergency medical technicians, first responders, or drivers. As part of a basic life support ambulance crew, an emergency medical technician may supervise subordinate emergency medical services personnel. As part of an advanced

life support ambulance service, an emergency medical technician is supervised by a paramedic.

2. Emergency medical technician - intermediate/85.

   a. Scope. The emergency medical technician's - intermediate/85 scope of practice includes basic, limited advanced interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. An emergency medical technician - intermediate/85 is not prepared to make decisions independently regarding the appropriate disposition of patients. The emergency medical technician - intermediate/85 may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility. The primary differences between an emergency medical technician and emergency medical technician - intermediate/85 are the basic, limited advanced interventions that an emergency medical technician - intermediate/85 may provide.

   b. Curriculum. The core educational requirements include successful completion of a state-authorized emergency medical technician - intermediate/85 training program and continued educational requirements as defined in chapter 33-36-01.

   c. Scope enhancements. Emergency medical technicians - intermediate/85 may provide enhanced treatments beyond the core scope if they have completed training as defined in section 33-36-01-04 and have the authorization to perform those skills from their medical director.

   d. Skills. Specific skills for the emergency medical technician - intermediate/85 are defined by department policy. Local medical directors, or hospitals if working in the hospital setting may limit the specific skills that an emergency medical technician - intermediate/85 may provide. They may not exceed those specific skills defined by department policy.

   e. Occupational setting. Emergency medical technicians - intermediate/85 may participate in the emergency medical services system as a sole responder in a quick response unit, as the primary care provider of a basic life support air or ground ambulance service, or as part of the crew of an advanced life support air or ground ambulance service. Emergency medical technicians - intermediate/85 may work for a hospital in a nonemergency setting or provide services to a private company or organization as part of a response team that is not offered to the general public.

f. Medical oversight. An emergency medical technician - intermediate/85 working in a prehospital setting provides medical care with physician oversight. In this circumstance a physician credentials the emergency medical technician - intermediate/85 and establishes patient care standards through protocol. An emergency medical technician - intermediate/85 working in a hospital setting is credentialed by the hospital.

g. Supervision. An emergency medical technician - intermediate/85 may be the highest trained person on a quick response unit and as the primary care provider may supervise other emergency medical technicians - intermediate/85, emergency medical technicians, first responders, or drivers. As part of a basic life support ambulance crew, an emergency medical technician - intermediate/85 may supervise subordinate emergency medical services personnel. As part of an advanced life support ambulance service an emergency medical technician - intermediate/85 is supervised by a paramedic. Emergency medical technicians - intermediate/85 working in a hospital setting are supervised by nursing staff.

3. Emergency medical technician - intermediate/99.

a. Scope. The emergency medical technician's - intermediate/99 scope of practice includes basic, limited advanced and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. An emergency medical technician - intermediate/99 is not prepared to make decisions independently regarding the appropriate disposition of patients. The emergency medical technician - intermediate/99 may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility. The primary differences between an emergency medical technician - intermediate/85 and emergency medical technician - intermediate/99 are the limited pharmacological interventions that an emergency medical technician - intermediate/99 may provide.

b. Curriculum. The core educational requirements include successful completion of a state-authorized emergency medical technician - intermediate/99 training program and continued educational requirements as defined in chapter 33-36-01.

c. Scope enhancements. Emergency medical technicians - intermediate/99 may provide enhanced treatments beyond the core scope if they have completed training as defined in section 33-36-01-04 and have the authorization to perform those skills from their medical director.

d. Skills. Specific skills for the emergency medical technician - intermediate/99 are defined by department policy. Local medical directors, or hospitals if working in the hospital setting, may limit the specific skills that an emergency medical technician - intermediate/99 may provide. They may not exceed those specific skills defined by department policy.

e. Occupational setting. Emergency medical technicians - intermediate/99 may participate in the emergency medical services system as a sole responder in a quick response unit, as the primary care provider of a basic life support air or ground ambulance service, or as part of the crew of an advanced life support air or ground ambulance service. Emergency medical technicians - intermediate/99 may work for a hospital in a nonemergency setting or provide services to a private company or organization as part of a response team that is not offered to the general public.

f. Medical oversight. An emergency medical technician - intermediate/99 working in a prehospital setting provides medical care with physician oversight. In this circumstance a physician credentials the emergency medical technician - intermediate/99 and establishes patient care standards through protocol. An emergency medical technician - intermediate/99 working in a hospital setting is credentialed by the hospital.

g. Supervision. An emergency medical technician - intermediate ’99 may be the highest trained person on a quick response unit and as the primary care provider may supervise other emergency medical technicians - intermediate/99, emergency medical technicians - intermediate/85, emergency medical technicians, first responders, or drivers. As part of a basic life support ambulance crew, an emergency medical technician - intermediate/99 may supervise subordinate emergency medical services personnel. As part of an advanced life support ambulance service an emergency medical technician - intermediate/99 is supervised by a paramedic. Emergency medical technicians - intermediate/99 working in a hospital setting are supervised by nursing staff.

4. Paramedic.

a. Scope. The paramedic’s scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on an advanced assessment and the formulation of a field impression. The paramedic may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an

acute care facility. The major difference between the paramedic and the emergency medical technician - intermediate/99 is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.

b. Curriculum. The core educational requirements include successful completion of a state-authorized paramedic training program and continued educational requirements as defined in chapter 33-36-01.

c. Skills. Specific skills for the paramedic are defined by department policy. Local medical directors, or hospitals if working in the hospital setting, may limit the specific skills that a paramedic may provide and they may not exceed those specific skills defined by department policy.

d. Occupational setting. Paramedics may participate in the emergency medical services system as a sole responder in a quick response unit, as the primary care provider of a basic life support air or ground ambulance service, as the primary care provider of an advanced life support air or ground ambulance service, or as the primary care provider of a critical care air ambulance service. Paramedics may work for a hospital in an emergency or nonemergency setting or provide services to a private company or organization as part of a response team that is not offered to the general public.

e. Medical oversight. A paramedic working in a prehospital setting provides medical care with physician oversight. In this circumstance a physician credentials the paramedic and establishes patient care standards through protocol. A paramedic employed by and working in a hospital setting is credentialed by the hospital.

f. Supervision. A paramedic may supervise all subordinate levels of emergency medical services personnel. Paramedics working in a hospital setting are supervised by the hospital's nurse executive.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04.3
Law Implemented: NDCC 23-27-04.3

North Dakota State Health Department
Division of Emergency Medical Services
Accepted Skills for EMS Providers

Airway/Ventilation/Oxygenation

Certification Levels

Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Airway - Nasal									
Airway -Oral									
Airway - Multi Lumen									
Bag-Valve-Mask (BVM)									
BiPAP									
Chest Decompression - Needle									
Chest Tube Placement - Initiation									
Chest Tube - Monitoring & Management									
CPAP									
Cricoid Pressure (Sellick)									
Cricothyroidotomy - Needle									
Cricothyroidotomy - Surgical									
End Tidal CO_2 Monitoring/Capnometry									
Gastric Decompression - NG Tube									
Gastric Decompression - OG Tube									
Head-tilt/chin-lift									
Intubation - Digital									
Intubation - Lighted Stylet									
Intubation - Medication Assisted									
Intubation - Paralytic (RSI)									
Intubation - Nasotracheal									
Intubation - Orotracheal									
Intubation - Retrograde									
Jaw-thrust									
Jaw Thrust - Modified (trauma)									
Mouth-to-Barrier									
Mouth-to-Mask									
Mouth-to-Mouth									
Mouth-to-Nose									
Mouth-to-Stoma									
Obstruction - Manual									
Obstruction - Direct Laryngoscopy									
Oxygen Therapy - Humidifiers									

Revised (02/06), (07/07)

North Dakota State Health Department
Division of Emergency Medical Services
Accepted Skills for EMS Providers

Airway/Ventilation/Oxygenation (cont)

Certification Levels

Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Oxygen Therapy - Nasal Cannula									
Oxygen Therapy - Partial Rebreather Mask									
Oxygen Therapy - Non-Rebreather Mask									
Oxygen Therapy - Simple Face mask									
Oxygen Therapy - Venturi Mask									
Oxygen Therapy - Regulators									
PEEP - Therapeutic (>5cm H_2O pressure)									
Pulse Oximetry									
Suctioning - Upper Airway									
Suctioning - Tracheobronchial									
Ventilators - Automated									

CARDIOVASCULAR/CIRCULATION

Certification Level

Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Cardiopulmonary Resuscitation (CPR)									
Defibrillation - Automated/Semi-Automated (AED)									
Defibrillation - Manual									
Hemorrhage Control - Direct Pressure									
Hemorrhage Control - Pressure Point									
Hemorrhage Control - Tourniquet									
Cardiac Monitoring - Single Lead (non-interpretive)									
Cardiac Monitoring - Single Lead (interpretive)									
Cardiac Monitoring - Multi Lead (non-interpretive)									
Cardiac Monitoring - Multi Lead (interpretive)									
Carotid Massage									
Cardioversion - Electrical									
Transcutaneous Pacing - Automatic									
Transcutaneous Pacing - Manual									
Mechanical CPR Device									

Revised (02/06), (07/07)

North Dakota State Health Department
Division of Emergency Medical Services
Accepted Skills for EMS Providers

MAST/PASG									
CARDIOVASCULAR/CIRCULATION		**Certification Level**							
Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Internal Cardiac Pacing - Monitoring Only									

MEDICATIONS		**Certification Level**							
Skill	First Responder	First Responder w/ specilaized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Activated Charcoal									
Auto-Injected Epinephrine									
Medicated Inhaler									
Nitroglycerin									
Oral Glucose									

IMMOBILIZATION		**Certification Level**							
Skill		First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Spinal Immobilization - Cervical Collar									
Spinal Immobilization - Long Board									
Spinal Immobilization - Manual Stabilization									
Spinal Immobilization - Seated (KED, etc.)									
Splinting - Manual									
Splinting - Rigid									
Splinting - Soft									
Splinting - Traction									
Splinting - Vacuum									

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North Dakota State Health Department
Division of Emergency Medical Services
Accepted Skills for EMS Providers

Miscellaneous		Certification Level							
Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
ICP Monitoring									
Hemodynamic Monitoring									
Venous Blood Sampling - Obtaining									
Urinary Catheterization									
Assisted Delivery (Childbirth)									
Blood Glucose Monitoring									
Blood Pressure - Manual/Automated									
Epi-Pen - Carrying/Administration									

IV Initiation/Maintenance/Fluids		Certification Level							
Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Arterial Line - Monitoring									
Arterial Line - Access									
Arterial Line - Initiation ***									
Peripheral - Initiation									
Intraosseous - Initiation									
Central Line - Monitoring & Access									
Crystalloids (D_5W, R/L, NS)									
Colloids - (Albumin, Dextran)									
Blood/Blood By-Products									
Maintenance - Medicated IV Fluids									
Peripheral Inserted Central Catheter (PICC) ***									
Central Line - Initiation ***									
Maintenance - Non-Medicated IV Fluids									
Implanted Artificial Venous Access Device (Access Only)***									

Revised (02/06), (07/07)

North Dakota State Health Department
Division of Emergency Medical Services
Accepted Skills for EMS Providers

Medication Administration - Routes		Certification Level							
Skill	First Responder	First Responder w/ specialized training	EMT-B	EMT-B w/enhanced skills	EMT-I85	EMT-I85 w/enhanced skills	EMT-I99	EMT-P	EMT-P w/specialized training
Aerosolized/Nebulized									
Buccal									
Endotracheal Tube									
Intramuscular									
Intravenous (IV) Piggyback									
Intravenous (IV) Push									
Nasogastric									
Oral									
Rectal									
Subcutaneous									
Sub-Lingual									
Dextrose 50%									
Thrombolytic Therapy - Initiation									
Thrombolytic Therapy - Monitoring									

Revised (02/06), (07/07)

North Dakota Department of Health

EMS Instructor / Coordinator

Handbook

North Dakota Department of Health
Division of Emergency Medical Services
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1/2008

INTRODUCTION

This manual has been prepared by the North Dakota Department of Health, Division of Emergency Medical Services (DEMS). It is intended to serve as a resource for Emergency Medical Services course instructor / coordinators. It describes the administrative details associated with conducting an EMS provider course. This Coordinator Handbook is intended to be used in conjunction with the EMT Student Handbook, which contains additional program information.

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The National Highway Traffic Safety Administration

Through a grant administered by:

The North Dakota Department of Transportation Drivers License & Traffic Safety Division

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REGISTERING A PROGRAM

In order to conduct initial training (First Responder, EM-B, -I, or –P) you will need to register your program on the National Registry of EMT's website. This process only needs to be completed one time, not for each course.

To register your program you must go to the National Registry of EMT's website and follow the instructions on the website. The program ID number requested is the six digit state ID/license number assigned to you by DEMS. This is very important. If you use the incorrect number, your program will not be approved. It is suggested that you register your program immediately in order to prevent delays in candidate testing.

Once you obtain approval of your program you must remember your login information. If you lose or forget your password, you will need to contact the National Registry of EMT's in order to obtain a new one.

Candidates that attend your initial training courses also need to register on the National Registry website in order to complete the testing process. They will register under your program number that contains your six digit state ID number. Prior to testing you will need to login to your program and approve these candidates for testing. A candidate will not be allowed to take the cognitive examination without your approval. It is the instructor's discretion whether or not a candidate is ready for testing – you should not authorize a student if you feel they are not qualified to test.

Once you have approved the candidate for testing and all fees have been paid, the candidate will receive an "authorization to test number" by email or postal mail (as chosen by the student). The candidate will then be required to call the toll free number listed on the authorization in order to schedule the exam. The candidate may access the Pearson Vue website to check available test sites and choose what city to take the examination. It is not required to take the exam in North Dakota. The examination will be scheduled at the candidate's time preference, but the candidate must arrive promptly to testing.

The candidate will have the ability to check their results through the National Registry's website after 24 hours of taking the exam. The results will be reported to the candidate as a "pass or fail". No percentages will be given. If the candidate fails the exam, they will receive instruction on areas to study as well as how to schedule another exam. The candidate will be required to wait two weeks before registering for another exam.

The candidate is allowed three attempts at the examination before a refresher is required. If the candidate fails the examination three times, the instructor must login and approve the candidate again upon completion of a refresher course. A total of six attempts is allowed at any level before the candidate is required to attend another complete course.

COURSE CURRICULUM

The curriculum shall be the most recent edition of the EMT National standard Curriculum as published by the US Department of Transportation, National Highway Traffic Safety Administration, Washington DC. Textbooks must be approved by DEMS.

Initial Primary Certifications – Course Length

First Responder	40 hours
EMT-Basic*	110 hours
Patient contacts (minimum)	5
EMT-Intermediate 85 (minimum*)	100 hours
Didactic	50 hours
Clinical	30 hours
ALS Ambulance Experience	20 hours
EMT-Paramedic (minimum*)	1200 hours
Contact DEMS for further information	
* Total hours including didactic and clinical	

Refresher and Enhancement Courses – Course Length

First Responder Refresher	16 hours
EMT-Basic Refresher	24 hours
EMT-I85 Refresher	36 hours*
*May consist of 24-hour EMT-B refresher and 12 hours of advanced	
EMT-P Refresher	48 hours
Limited Advanced Airway	6 hours
Nebulized Medications	4 hours
Dextrose 50%	4 hours
Manual Defibrillation	24 hours
IV Maintenance	4 hours
Epinephrine	3 hours
Note: Enhancement course hours are recommendations	

CERTIFICATION LEVELS

FIRST RESPONDER

State Certified First Responder: There is no age limit to become a state certified First Responder. However, consideration should be given to the maturity of the underage person with the understanding that he or she may be called upon to make difficult decisions in the field.

The First Responder student must:

- Attend a state-approved 40-hour First Responder course.
- Pass a local practical and written test. The written test can either be provided by DEMS, or designed by the course coordinator. Passing for the written test is a minimum of 70%.
- Be current in the American Heart Association's Healthcare Provider Cardiopulmonary Resuscitation (CPR) with Automated External Defibrillator (AED) or its equivalent.

Certification of State Certified First Responders is good for two years and expires on June 30.

Recertification: A recertification letter will be sent from DEMS prior to expiration.

A State Certified First Responder must:

- Complete either a 16-hour First Responder refresher course, or a 24-hour EMT-B refresher course. One refresher course must be completed during every certification period.
- Be current in the American Heart Association's Healthcare Provider Cardiopulmonary Resuscitation (CPR) with Automated External Defibrillator (AED) or its equivalent. The instructor must verify the status of the candidate's CPR certification prior to completion of the refresher course. A candidate that is not current in CPR with AED must not be issued a certificate of completion nor identified on a roster as having completed the refresher course.

No further continuing education is required at the First Responder level.

As course coordinator, if conducting a First Responder refresher course in conjunction with an EMT-B refresher course, the only paperwork required is a course authorization request and roster for the EMT-B refresher. Be sure to include the First Responders on the roster with the appropriate level of certification listed, and include an EMS Registration form for each student. The refresher course must be completed within the current two-year certification period.

Nationally Registered First Responder: There is no age limit to become a Nationally Registered First Responder. However, consideration should be given to the maturity of the underage person with the understanding that he or she may be called upon to make difficult decisions in the field. Becoming Nationally Registered as a First Responder is voluntary in North Dakota.

The First Responder student must:

- Attend a state-approved 40-hour First Responder course.
- Pass a local practical exam.

- Pass a National Registry First Responder cognitive exam. Passing for this test is rated as a "pass or fail", not percentage.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

The proper paperwork should be requested from DEMS by marking the appropriate boxes on the course authorization request form. The cognitive examination given by the National Registry is conducted through Pearson Vue Test Centers.

The North Dakota certification expiration date for Nationally Registered First Responders is December 31.

Recertification: The Nationally Registered First Responder will receive a recertification packet from the National Registry as well as a reminder letter from DEMS prior to their expiration date.

The Nationally Registered First Responder must:

- Complete either a 16-hour First Responder refresher course or a 24-hour EMT-B refresher course. One refresher course must be completed during every certification period.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent. The instructor must verify the status of the candidate's CPR certification prior to completion of the refresher course. A candidate that is not current in CPR with AED must not be issued a certificate of completion nor identified on a roster as having completed the refresher course.

No further continuing education is required at the Nationally Registered First Responder level.
As course coordinator, if conducting a First Responder refresher course in conjunction with an EMT-B refresher course, the only paperwork required is a course authorization request and roster for the EMT-B refresher. Be sure to include the First Responders on the roster with the appropriate level of certification listed, and include an EMS Registration form for each student. The refresher course must be completed within the current two-year certification period. Upon completion of the required refresher course, completion of the National Registry paperwork, and receipt of a new National Registry card, the First Responder is responsible for sending a copy of their new National Registry card to DEMS to receive State Certification.

Enhancement module available for State Certified First Responders and Nationally Registered First Responders:

- Epinephrine module (No other enhancement module is allowed at the First Responder level).

AFA-A, EMT, and EMT-B

Advanced First Aid – Ambulance (AFA-A): American Red Cross Advanced First Aid Courses are no longer accepted for primary training courses. However, anyone certified at the AFA-A level prior to January 1, 1992 is qualified as a primary care provider in a Basic Life Support (BLS) Ambulance.

Recertification: AFA-As must recertify every three years. They will receive a recertification letter from DEMS prior to their expiration date.

Those certified at the AFA-A level must:

- Complete an EMT-B refresher course every three years.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

No other continuing education hours are required, although it is recommended.

State EMT: Licensure as a State EMT is available to candidates under the age of 18 or to persons requesting reciprocity from another state. A North Dakota certified EMT may be no younger than sixteen years of age at the time of initial certification.

The EMT student must:

- Complete a 110-hour EMT-B Initial course with a minimum of five patient contacts.
- Pass a State Practical exam.
- Pass the National Registry EMT-B cognitive assessment exam.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

A student can test as a Nationally Registered EMT anytime after their 18th birthday. If a State EMT turns 18 within a year of passing the cognitive and practical tests, they must simply complete a National Registry application online and submit the $35 fee (payable to NREMT). If it has been longer than a year since passing either of these tests, they must complete the testing process again.

State EMT certification is good for two years and expires on June 30.

Re-licensure: EMTs will receive a recertification letter from DEMS prior to their expiration date.

A State EMT must complete all of the following:

- Complete a 24-hour EMT-B refresher course.
- Complete an additional 48 hours of continuing education.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

OR:

- Take the state approved practical exam (in lieu of the 24 hour refresher course and 48 hours of continuing education). The practical exam may be taken at any DEMS approved practical test site and may be completed starting six months prior to the EMT's expiration date.

- The EMT must still maintain a current American Heart Association's Healthcare Provider CPR with AED or its equivalent.

OR:

- Take the National Registry cognitive assessment exam as well as maintain a current American Heart Association's Healthcare Provider CPR with AED or its equivalent.

EMT-B: Certification as a Nationally Registered EMT-Basic is available to candidates 18 and older.

The EMT-B student must:

- Complete a state approved-110 hour EMT-B Initial course with a minimum of five patient contacts.
- Pass a State Practical exam.
- Pass the National Registry EMT-B cognitive exam.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

Upon successful certification by the National Registry of EMT's an EMT may apply for state licensure. Licensure is obtained by completing an EMS Registration form and submitting it to DEMS along with a copy of their current NREMT card.

EMT-B licensure is good for a two year period and expires on June 30 of the year of their NREMT expiration.

Re-licensure: An EMT-B will receive a recertification packet from the National Registry as well as a re-licensure letter from DEMS prior to their expiration date.

The EMT-B must:

- Complete a state approved 24-hour EMT-B refresher course.
- Complete an additional 48 hours of continuing education.
- Be current in the American Heart Association's Healthcare Provider CPR with AED or its equivalent.

Upon completion of the required refresher course, continuing education, completion of the National Registry paperwork and receipt of a new National Registry card, the EMT-B is responsible for sending a copy of their new National Registry card and a newly completed EMS Registration form to DEMS to receive State Licensure.

Recertification by Examination: Within six months of their expiration date a Nationally Registered EMT-Basic may choose to forego the continuing education requirements and take the cognitive examination offered by the National Registry. This option is available for one attempt per certification period. If the candidate fails the attempt, he/she will be required to complete all training requirements before the deadline of March 31 of their expiration year.

Enhancement modules available for AFA-A, EMT, and EMT-B:

- Bronchodialator / Nebulizer Administration
- Limited Advanced Airway
- Manual Defibrillation
- IV Maintenance

EMT-Intermediate / 85

Certification as a Nationally Registered EMT-I / 85 is available to candidates 18 and older who are currently a State EMT or a Nationally Registered EMT-B.

The EMT-I / 85 candidate must:

- Complete a state approved 100-hour EMT-I / 85 Initial course, including;
  - 50 hours of didactic,
  - 30 hours of clinical, and
  - 20 hours of Advanced Life Support (ALS) Ambulance Experience.
- Pass a National Registry Practical exam.
- Pass the National Registry EMT-I / 85 cognitive exam. The passing score for this test is given as a "pass or fail" not by percentage.

To become licensed to work in North Dakota as an EMT-I / 85, the candidate must:

- Complete an EMT-I / 85 License Application. This must be signed by each Medical Director under which the EMT-I / 85 will be working. More than one form may be required if the provider works for more than one service.
- Submit the license application along with a copy of their National Registry card to DEMS.

EMT-I / 85 licensure is good for two years and expires on June 30 of the year of their National Registry expiration.

Re-licensure: A Nationally Registered EMT-I / 85 will receive a recertification packet from the National Registry as well as a re-licensure letter from DEMS prior to their expiration date. The EMT-I / 85 must remain Nationally Registered in order to be licensed in North Dakota.

The EMT-I / 85 must:

- Complete a 36-hour refresher course or a 24-hour EMT-B refresher course along with an additional 12 hours of advanced training.
- Complete an additional 36 hours of continuing education.

Upon completion of the required refresher course, continuing education, completion of the National Registry paperwork, and receipt of a new National Registry card, the EMT-I / 85 is responsible for sending a copy of their new National Registry card and a newly completed License Application form to DEMS to receive State Licensure.

Recertification by Examination: Within six months of their expiration date a Nationally Registered EMT-I / 85 may choose to forego the continuing education requirements and take the cognitive examination offered by the National Registry. This option is available for one attempt per certification period. If the candidate fails the attempt, he/she will be required to complete all training requirements before the deadline of March 31 of their expiration year.

Enhancement module available for EMT-I / 85:

- Dextrose 50% (AFA-A, EMT, and EMT-B's are **NOT ALLOWED** to perform this skill. Any providers at these levels who attend the course will not be granted licensure by DEMS.)

EMT-P

Licensure as a Nationally Registered EMT-P is available to candidates 18 and older who are currently a State EMT or a Nationally Registered EMT-B or EMT-I / 85.

The EMT-P candidate must complete:

- Complete a state approved 1200-hour EMT-P Initial course.
- Pass a National Registry Practical exam.
- Pass the National Registry EMT-P cognitive exam. The passing score for this test is given as a "pass or fail" not by percentage.

To become licensed to work in North Dakota as an EMT-P, the candidate must :

- Complete an EMT-P License Application. This must be signed by each Medical Director under which the EMT-P will be working. More than one form may be required if the provider works for more than one service.
- Submit the license application along with a copy of their National Registry card to DEMS.

Licensure is good for two years and expires on June 30 of the year of their National Registry expiration.

Re-licensure: A Nationally Registered EMT-P will receive a recertification packet from the National Registry as well as a re-licensure letter from DEMS prior to their expiration date. The EMT-P must remain Nationally Registered in order to be licensed in North Dakota.

The EMT-P must:

- Complete a 48-hour refresher course along with
- Complete an additional 24 hours of continuing education.
- Maintain approved CPR Healthcare provider training requirements'
- Maintain Advanced Cardiac Life Support training

Recertification by Examination: Within six months of their expiration date a Nationally Registered EMT-P may choose to forego the continuing education requirements and take the cognitive examination offered by the National Registry. This option is available for one attempt per

certification period. If the candidate fails the attempt, he/she will be required to complete all training requirements before the deadline of March 31 of their expiration year.

Upon completion of the required refresher course, continuing education, completion of the National Registry paperwork, and receipt of a new National Registry card, the EMT-P is responsible for sending a copy of their new National Registry card and a newly completed License Application form to DEMS to receive State Licensure.

COURSE AUTHORIZATION

Prior to conducting any of the courses listed on page 4, a course authorization request must be completed in its entirety and submitted to DEMS at least two weeks prior to the scheduled start date of the class. If this is not done, the class will not be recognized by the State of North Dakota. Incorrect or incomplete forms will be returned to the Coordinator for correction. Upon receipt by DEMS, the request will be reviewed, the course will then be approved or denied, and authorization and / or requested supplies will be sent to the Instructor / Coordinator listed. DEMS will assign a course authorization number to all primary training courses (initial and refresher). This course authorization number will be required on all paperwork related to this class, including test applications and rosters. Without the course authorization number, the candidate will not be allowed to test and the roster will not be processed.

A completed roster is required to be submitted within five business days of course completion for the following courses: Auto Extrication, Auto Extrication Refresher, EVOC, EVOC Refresher, Instructor / Coordinator, Instructor / Coordinator Refresher, Emergency Medical Dispatch, Emergency Medical Dispatch Refresher, First Responder, First Responder Refresher, and EMT-B Refresher. Instructors that consistently submit their class rosters late may have disciplinary actions taken against their licensure.

A completed roster and physician preceptor form are required within five business days of course completion for the enhanced skills, which includes the following courses: Limited Advanced Airway, Nebulized Medications, Dextrose 50%, Manual Defibrillation, Epinephrine, and IV Maintenance. Instructors that consistently submit their class rosters and physician preceptor forms late may have disciplinary actions taken against their licensure.

A completed EMS Registration form must be submitted to DEMS in the following situations:

1. Within the first week of a primary training course. (First Responder, EMT-B, EMT-I, EMT-P). The Instructor / Coordinator is responsible for making sure the forms are complete and include the correct course authorization number. All student EMS registration forms should be submitted as a class. DEMS will then provide a list of state ID #s to be used for testing applications and rosters.
    a) If a student affirms a felony charge or conviction, or an encumbrance of another health care certification or license, specifics concerning the situation must be submitted to DEMS for evaluation. A student in this situation may not be eligible to

take the National Registry exam or gain state licensure or certification. It is the responsibility of the instructor to ask for this information from the students early in the process.

2. To re-license at the EMT level (including AFA-A). The person must also submit a copy of their NREMT card if applicable.
3. To re-certify at the First Responder level. An EMS Registration form from each candidate must accompany the roster or a certificate of completion.
4. The person has a change of address or any other personal information.

Since rules and policies change, it is recommended that an instructor download the most current forms from the DEMS website or call the department and request the form(s) by mail or fax.

Course authorization requests for select courses may be submitted online through the DEMS website. In order to submit a course authorization request online, the coordinator must have a valid email address. Course authorization will be forwarded to the course coordinator by Postal Mail upon approval by DEMS. Submission of course authorization request by email does not mean automatic approval of a course. **Authorization from DEMS for the course to be conducted must still be received prior to beginning the course.**
Online course authorizations **are not** available for EMT-I / 85 and EMT-P initial training courses as these are considered contracts and require signatures.

Licensed Training Institutions should consult the *EMS Training Institution Guidebook.*

COURSE TEXTBOOKS

There are many publishers that print quality EMS textbooks. The course coordinator is responsible for choosing the appropriate textbook that follows the DOT curriculum for the class being instructed. Textbooks need to be approved by DEMS.

Each course authorization request contains a checklist of available supplies for that particular course. **One** copy of each checked item will be sent to the course coordinator. If nothing is checked on this list, no supplies will be sent to.

FORMS AND TERMINOLOGY

COURSE AUTHORIZATION REQUEST:
Course Authorization Request forms must be completed and submitted to DEMS a minimum of two weeks prior to the scheduled start date of the class. Be aware that there are different request forms for different classes. To be sure to always use the most current form, it is recommended to print the current form from the DEMS website each time.

COURSE AUTHORIZATION:
This is the letter that that will be sent from DEMS upon authorization of your course. This will be accompanied by the supplies requested on the Course Authorization Request for teaching the course. This will also contain your **Course Authorization Number**. This number MUST be on all correspondence for that class, including rosters and testing applications.

ROSTER:
This form must be submitted to DEMS within five business days of course completion for the following courses: Auto Extrication, Auto Extrication Refresher, EVOC, EVOC Refresher, Instructor / Coordinator, Instructor / Coordinator Refresher, Emergency Medical Dispatch, Emergency Medical Dispatch Refresher, First Responder, First Responder Refresher, and EMT-B Refresher. This form lists the students attending the course, their state ID number and other pertinent information for updating their certifications. This form must be signed by the instructor and MUST have the Course Authorization Number listed. A roster must be sent for each class completed; do not combine multiple classes on one roster, i.e. enhanced skills.

EMS REGISTRATION FORM:
A completed EMS Registration form must be submitted to DEMS in the following situations:

1. Within the first week of a primary training course. (First Responder, EMT-B, EMT-I, EMT-P). The Instructor / Coordinator is responsible for making sure the forms are complete and include the correct course authorization number. All student EMS registration forms should be submitted as a class. DEMS will then provide a list of state ID #s to be used for testing applications and rosters.
    a) If a student affirms a felony charge or conviction, or an encumbrance of another health care certification or license, specifics concerning the situation must be submitted to DEMS for evaluation. A student in this situation may not be eligible to take the National Registry exam or gain state licensure or certification. It is the responsibility of the instructor to ask for this information from the students early in the process.
2. To re-license at the EMT level (including AFA-A). The person must also submit a copy of their NREMT card if applicable.
3. To re-certify at the First Responder level. An EMS Registration form from each candidate must accompany the roster or a certificate of completion.
4. The person has a change of address or any other personal information.
5. Any current EMT-I / 85 or EMT-P is not required to submit this form. They are required to submit an ALS licensure application.

LICENSE APPLICATION (EMT-I / 85 AND EMT-P)
This form must be completed by the EMT-I / 85 or EMT-P and signed by the medical director that the EMT-I / 85 or Paramedic will be working under. This form must be received by DEMS in order for an EMT-I / 85 or EMT-P to receive North Dakota licensure to work. A different license application is required for each EMS agency the person works for.

PHYSICIAN PRECEPTOR FORM:
This form lists EMTs who have completed enhanced skill courses and are approved to do this skill in the field. This form must be signed by the person's medical director to be valid. The enhanced skill allowed must be initialed by the medical director. (See individual provider level information for allowed enhanced skills.) If an individual attends a course and is signed off by the medical director, they will not be granted certification if not allowed by DEMS. Separate forms must be completed and signed for each specific skill trained. The physician preceptor form must be sent to DEMS along with the roster for each individual class.

TESTING APPLICATIONS (EMT-B OR ALS):
This form must be completed and received by North Dakota EMS Association prior to the deadline for each test site. This form is used for initial practical and practical retests. Appropriate practical fees must be sent with this form to NDEMSA. Cognitive examination fees are collected by the National Registry of Emergency Medical Technicians directly through their website: www.nremt.org.

MEDICAL DIRECTOR:
This identifies the physician medical director that is responsible for course content, instructor supervision, and student supervision.

COURSE COORDINATOR:
This identifies a person to be responsible for assuring that material covered is within the Core Curricula by instructors whether guest or primary. This person is also responsible for submission of all paperwork and signatures. The course coordinator must be a licensed Instructor / Coordinator through DEMS.

PRIMARY INSTRUCTOR:
This identifies the main instructor of the course. This person must instruct at least 50% of the class and must be a licensed Instructor / Coordinator through DEMS.

HOSPITAL ADMINISTRATIVE SUPPORT CONTRACT (Advanced Level Only):
This contract assures that arrangements have been made with a hospital or clinic to conduct the clinical rotation portion of the course. Hospital or clinical rotations are optional at the BLS level.

ALS AMBULANCE SERVICE SUPPORT CONTRACT (Advanced Level Only):
This contract assures that arrangements have been made with an ALS ambulance service for this portion of the training. This is required in advanced level EMT training only. In the EMT-Basic course, a BLS Licensed ambulance may be used.

PRACTICAL EXAM SITES

National Registry and State practical exams will be conducted five times each year at test sites located in Bismarck. These test sites are conducted by the North Dakota EMS Association and sponsored by DEMS. Only those persons completing a state or licensed training institution authorized EMS Course will be eligible for the testing and certification process. **All requests for testing and associated practical fees MUST BE at the NDEMSA office by the deadline date or the candidate will not be allowed to test on the requested date.** Practical test fees may be in the form of a check or money order payable to the North Dakota EMS Association. Written (cognitive) examinations are not offered at the practical test sites and applications must be completed on the NREMT website.

BLS Testing (EMT-Basic)
The Application for Basic Life Support Testing must be completed prior to testing as an EMT-B. Mark all appropriate boxes on the form for full practical or retest practical. All registration forms and appropriate fees must be submitted and received by the deadline date. No faxes will be accepted. To ensure use of the most current forms, it is suggested to download the registration form from the NDEMSA website (www.ndemsa.org) at the time of application. Appropriate practical testing fees must accompany the application. North Dakota cannot accept EMT-Basic candidates for practical testing that attended a course that was not authorized by DEMS (ex. out of state).

Appropriate practical testing fees must accompany the application. Cognitive examinations are not offered at the practical test sites. All cognitive examinations are completed through a Pearson Vue Test Center. Please contact DEMS for most current locations.

The candidate will be notified by mail of their practical exam time. This usually occurs approximately one week after the deadline date. Testing fees are **NON-REFUNDABLE** under any circumstances.

ALS Testing (Intermediate and Paramedic)
The Application for Advanced Life Support Testing must be completed prior to testing as an EMT-I / 85 or EMT-P. Mark all appropriate boxes on the form full practical or retest practical. All registration forms and appropriate fees must be submitted and received by the deadline date. No faxes will be accepted. To ensure use of the most current forms, it is suggested to download the registration form from the NDEMSA website (www.ndemsa.org) at the time of application. Candidates that attended a program not authorized by DEMS will be allowed to attend practical testing under the discretion of NDEMSA.

Appropriate practical testing fees must accompany the application. Cognitive examinations are not offered at the practical test sites. All cognitive examinations are completed through a Pearson Vue Test Center. Please contact DEMS for most current locations.

The candidate will be notified by mail of their practical exam time. This usually occurs

approximately one week after the deadline date. Testing fees are **NON-REFUNDABLE** under any circumstances.

Licensed Training Institutions
Licensed Training Institutions have the option of conducting their own practical exams following the guidelines set forth in the *EMS Training Institution Guidebook*. They also have the option of accepting candidates from outside programs to test at their test site. However, this is not a requirement and it is suggested to contact the individual Training Institution for further information.

INSTRUCTOR QUALIFICATIONS

Each course is required to have a State Licensed EMS instructor that is certified or licensed at or above the level they are instructing and have been certified or licensed at that level for at least two years. The course coordinator and the physician medical director shall obtain instructors who are qualified as indicated in the curriculum. However, a state licensed EMS Instructor must be present for at least 50% of the class time, and the Coordinator must review the lesson plans being presented for the remaining 50% of classes to assure that the National Standard Curriculum is being followed. The instructor must maintain a pass rate of candidates of at least seventy percent.

STUDENT QUALIFICATIONS

- The student must be at least 18 years of age in order to become Nationally Registered. The student may take the EMT-B course and become State Certified if under 18 years of age and older than 16 at time of certification. The student may become Nationally Registered at anytime after their 18th birthday.
- If the student has been charged or convicted of a felony, prior approval must be obtained from DEMS to admit the student to class. Please contact DEMS for further information.
- An EMS Registration **MUST BE COMPLETED** as soon as the student begins the class. DEMS will assign a 6 digit state identification number to the student once registration is received.
- A student must meet the physical requirements of being an EMT and be able to perform all skills required.
- The student must be able to attend all classes as scheduled by the course coordinator.
- The student must be able to read and write the English language and communicate effectively.
- Advanced Level EMT's **MUST** be either a State EMT or Nationally Registered EMT-Basic prior to attending class or clinical rotations at the advanced level.
- Any test result, cognitive or practical, is valid for a period of 12 months from the date of successful completion of the exam.

- A candidate has 2 years from the date of course completion to complete all testing requirements. After this deadline has occurred, the candidate will be required to attend another entire course.

COURSE MANAGEMENT & ADMINISTRATION

The following is a suggested guideline for the course coordinator to follow in conducting a state authorized EMT course.

TIME FRAME	ACTIVITY
12 weeks prior to class	Determine the level of local interest by contacting local physicians, hospital administrators, ambulance service squad leaders, and other appropriate persons.
	Identify an approximate number of potential students.
	Select a tentative date to begin course.
	Estimate expenses associated with conducting a course, such as postage, handouts, textbooks, workbooks, DOT curriculum, flip charts, projection equipment, training equipment, costs associated with the use of classrooms, costs associated with clinical experience, costs associated with ambulance field internship.
	Arrange for course financing.
	Identify and contact potential instructors.
10 weeks prior to class	Obtain any necessary signatures on the course authorization application, including the Medical Training Director, Course Coordinator Agreement, Clinical Experience, and Ambulance Service Training
	Agreement. Once completed, the request must be submitted to DEMS for course authorization.

TIME FRAME (Cont.)	**ACTIVITY** (Cont.)
	Jointly draw up a course schedule with the medical training director.
	Order textbooks and workbooks.
6 weeks prior to class	Arrange for the use of classroom facilities.
4 weeks prior to class	Obtain final commitments from instructors and provide teaching assignments to instructors.
2 weeks prior to class	All course authorization requests must be submitted to DEMS by this date.
First class session	Distribute the DEMS EMT Student Handbook to students. Have students complete the EMS Registration form and forward to DEMS as a class. A candidate's registration for testing will not be accepted without a current EMS Registration. At the appropriate time, **remembering the strict registration deadlines,** the coordinator should submit the testing applications for the practical exam to NDEMSA with appropriate fees. ✓ Candidates at all levels should register with the National Registry of EMT's at least two weeks prior to scheduling cognitive exam.

Keep in mind that the fees for practical testing are **NON-REFUNDABLE.**

COURSE COMPLETION

It is the instructor / coordinator's responsibility to submit all completed rosters to DEMS within 5 days of course completion. Make sure that the roster is printed clearly and the proper areas are filled out. Instructors that consistently submit their class rosters late may have disciplinary action taken against their licensure.

Please send the material to:

North Dakota Department of Health
Division of Emergency Medical Services
600 E. Boulevard Ave. - Dept 301
Bismarck, ND 58505-0200
Phone: 701-328-2388
Fax: 701-328-1890
dems@nd.gov

Please direct any questions on training to:

Ed Gregoire, NREMT-P
State EMS Training Coordinator
Primary Training Courses, Enhancement courses, ALS courses, Continuing Education
egregoire@nd.gov

Stuart Hammer, NREMT-P
EMS Specialist
Auto Extrication, EMD/Dispatch, EVOC, CISM
shammer@nd.gov

Tim Meyer, NREMT-P, Director
Division of Emergency Medical Services
tmmeyer@nd.gov

Most forms are available on our website:
http://www.ndhealth.gov/EMS

TRANSPORTATION

Safe, reliable ambulance transportation is a critical component of an effective EMS system. Most patients can be effectively transported in a ground ambulance staffed by qualified emergency medical personnel. Other patients with more serious injuries or illnesses, particularly in remote areas, require rapid transportation provided by rotor craft or fixed wing air medical services. Routine, standardized methods for inspection and licensing of all emergency medical transport services is essential to maintain a constant state of readiness throughout the state.

Where We Are Today

Transporting EMS Agencies

In North Dakota, an EMS agency must hold an ambulance service license to transport patients. There are two types of ground ambulance licensure; basic life support and advanced life support. There are three types of air ambulance licensure: BLS, ALS, and Critical Care.

There are a total of 137 ground ambulance services. Eighteen are ALS and 119 are BLS. Currently, 57 percent of the population of the state lives in a city that has an ALS service. There are four licensed air ambulance services that operate three rotary-wing and two fixed-wing aircraft. BLS ambulance services may “flex up” to provide ALS level care if the personnel are properly licensed at an ALS level, the medical director has given them the authority to provide ALS level care, and all the equipment needed to provide ALS care is available on the ambulance.

Typically, each licensed ambulance service is a stand-alone operation that may or may not have formal relationships with other transporting agencies for ALS ground or air intercepts, and although we have a formalized trauma system that requires major trauma patients to be transported to a trauma center, some volunteer ambulance services will not bypass a non-trauma designated hospital to transport to another hospital that is trauma designated.

Recognizing that some ambulance services in North Dakota are not using the resources that are available to them, DEMS recently promulgated rules that require BLS services to make use of ALS intercepts when appropriate and require all ambulance services to transport certain types of patients to facilities with specific capabilities. The resistance to develop true EMS systems or to engage in a regional approach to patient care is a shortcoming in North Dakota. Statewide standards for performance or quality assurance have not been developed.

Inspections of ambulance services are done by DEMS personnel with the goal of inspecting each service every other year. Inspection is not required by statute, and, with limited personnel, DEMS does not complete inspections on a regular basis. The fees for

licensure are capped by statute at $25 per year. This nominal amount by no means covers the expense of conducting an inspection.

Due to the remote nature of our state, ambulance services face challenges in traveling long distances to calls, at times under severe weather conditions. There is no requirement for the drivers of the vehicles to complete emergency vehicle operator (EVOC) courses, although the course is available from specialized instructors throughout the state.

North Dakota has no designated ambulance service areas, resulting in overlaps in coverage. Theoretically, all areas in the state are covered by at least one ambulance service, eliminating any gaps. A 2002 North Dakota Attorney General's opinion requires that the closest ambulance be dispatched to the scene of a medical emergency. This must be accomplished regardless of any existing geographic or political boundaries. A licensed ambulance must respond if dispatched by a public safety answering point (PSAP). Regulations regarding response time standards have not been developed.

With the rural population decreasing and fewer individuals willing to volunteer as EMTs, a problem has developed for many rural ambulances. In 2007, the state legislature appropriated $1.25 million for DEMS to provide staffing grants to "access critical" ambulance services: those ambulance services that are struggling to maintain adequate staffing and are strategically important for the state to maintain. The maximum award is $45,000 per year. We are in year one of this project, and the impact is not yet known.

Ambulance Licensure Level	Minimum Staffing Requirement
Basic Life Support – Ground	EMT, Driver trained in CPR
Advanced Life Support – Ground	Paramedic, EMT
Basic Life Support – Air	EMT
Advanced Life Support – Air	Paramedic
Critical Care Air Ambulance	2 Paramedics

Non-Transporting EMS Agencies

There are two types of non-transporting EMS Agencies; quick response units (QRUs) and rescue squads. QRUs are medical first responder units and may provide any level of care, from First Responder level to Paramedic ALS care. There are 49 licensed QRUs in the state. Rescue Squads provide auto-extrication services and are required to have licensed EMTs on their responding units to provide patient care until extrication. Currently, there are 53 heavy rescue services and six light rescue services certified.

In North Dakota, QRUs are licensed and rescue squads are certified. In statute, QRU licensure is explicitly described as optional. DEMS lacks statutory authority to regulate rescue squads, so, in essence, this certification is optional as well. There are many more unlicensed QRUs and noncertified rescue squads throughout the state that provide emergency response but choose to not become state certified chiefly because of the 24/7 coverage requirements for licensure or certification.

Progress on meeting 1992 recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• Develop licensure and inspection standards for all rotary and fixed-wing aircraft.	Chapter 33-11-04 of the N.D.A.C. has been developed and implemented regulating air ambulance services
• Establish minimum ground ambulance vehicle design standard.	Chapter 33-11-01.2-13 of the N.D.A.C. has been implemented stating vehicle must be manufactured as an ambulance.
• Establish as minimum staffing requirement: BLS ambulances = EMT certification QRU = First Responder certification	N.D.A.C. § 33-11-02 of has been developed and implemented stating that an EMT is required on BLS ambulance. N.D.A.C. § 33-11-01.2 has been developed and implemented stating that First Responder is the minimum staffing on a QRU.
• In coordination with Highway Patrol, continue to train ambulance drivers with the "Emergency Vehicle Operators Course" to attain statewide coverage.	No mandatory certification/completion has been implemented. However, 29 EVOC instructors are currently trained.
• Develop ambulance placement strategies to assure timely response to all citizens within the state.	No ambulance "districts" have been formed.

TRANSPORTATION SUPPORTING DOCUMENTATION

LETTER OPINION
2002-L-27

May 8, 2002

Terry L. Dwelle, MD, MPHTM
State Health Officer
Department of Health
600 E Boulevard Ave Dept 301
Bismarck, ND 58505-0200

Dear Dr. Dwelle:

You asked my opinion regarding the implementation of N.D.C.C. § 57-40.6-10(1)(k). Section 57-40.6-10(1)(k), N.D.C.C., enacted by the 2001 Legislature, provides:

> 1. The governing body of the local governmental unit with jurisdiction over an emergency 911 telephone system shall be or shall designate a governing committee of the emergency 911 telephone system which shall [among other things]:
>
> * * * *
>
> k. Beginning June 1, 2002, ensure that the closest available emergency medical service is dispatched to the scene of medical emergencies regardless of city, county, or district boundaries. The state department of health shall provide emergency 911 telephone systems with necessary geographical information to assist in the implementation of this subdivision.

The North Dakota Department of Health (Department) licenses emergency medical services (EMS), which includes basic life support ambulance services, advance life support ambulance services, air ambulance services and quick-response unit services. N.D.C.C. §§ 23-27-01(1), 23-27-02. Currently the Department only licenses surface basic life support and advanced life support ambulance services. N.D.A.C. § 33-11-01-03, chs. 33-11-02, 33-11-03. Section 57-40.6-10(1)(k) puts the onus on the governing body of a local governmental unit such as a city or county that has a 911 telephone system to

implement that section and ensure that the closest EMS is dispatched by a 911 telephone system or emergency call center "regardless of city, county, or district boundaries."

Your initial question is whether dispatching an EMS that will arrive at the emergency scene sooner than an EMS that is physically closer to the scene of the emergency is in compliance with N.D.C.C. §57-40.6-10(1)(k). The underlying question is what is the meaning of the "closest" EMS. A statute is construed to ascertain the intent of the legislature. Kim-Go v. J.P. Furlong Enterprises, Inc., 460 N.W.2d 694, 696 (N.D. 1990). Intent must be sought from the language of a statute. Id. Unless defined in the code, words are to be given their plain, ordinary and commonly understood meaning. Id. Furthermore, construction of any statute must effect its objects and promote justice. N.D.C.C. § 1-02-01. "Closest" means "[n]ear in time or space." The American Heritage Dictionary 282 (2d coll. ed. 1991). Thus, the fact that an ambulance service is physically closer but cannot respond as quickly as another EMS, would justify the dispatcher in sending the EMS that can respond more quickly. This interpretation is not only consistent with the meaning of the word "closest" which allows a dispatcher to evaluate the time a response will take before dispatching an EMS, but is consistent with the testimony before the Legislature in support of HB 1409 which enacted N.D.C.C. §57-40.6-10(1)(k). For example, the sponsor and author of HB 1397, which contained a similar provision and which was incorporated in HB 1409[1], Representative Audrey Cleary, explained its purpose at a hearing before the House Political Subdivisions Committee. She stated, "This bill seeks to make certain . . . that the person needing assistance receives the quickest possible response." Hearing on H.B. 1397 Before the House Political Subdivisions Comm. 2001 N.D. Leg. (Feb. 2) (Statement of Rep. Cleary). The director of the Division of Emergency Health Services for the Department, Timothy Wiedrich, testified that "it is important that [the] closest emergency medical service (EMS) unit respond to an emergency regardless of city, county or district boundaries. EMS response time is critical when a medical emergency occurs." Hearing on H.B. 1409 Before the Senate Political Subdivisions Comm. 2001 N.D. Leg. (Mar. 1) (Statement of Timothy Wiedrich). In my opinion a 911 telephone system dispatcher is in the best position to determine which EMS is closest in terms of time as well as space or distance. It would be unreasonable, for example, to dispatch an EMS which is on the other side of a river only two miles from the emergency scene, if it would have to drive 100 miles to cross the river and reach the scene, when another EMS may be 10 miles away from the emergency scene but on the same side of the river. Such a result would be an absurdity and flies in the face of the plain meaning of the words in the statute which requires the quickest response. Statutes must be construed logically so as not to produce an absurd result. In Interest of M.Z., 472 N.W.2d 222, 223 (N.D. 1991).

[1] See Hearing on H.B. 1409 Before the House Political Subdivisions Comm., 2001 N.D. Leg. (Feb. 2) (Statement of Rep. Severson).

Your request also questions whether a 911 dispatch center would be in compliance with the law if it dispatched the closest quick-response unit to the scene of the emergency, but dispatched an ambulance service that is affiliated with the quick-response unit through business or organizational ties even if it is not the closest ambulance service to the emergency. Section 57-40.6-10(1)(k), N.D.C.C., requires the "closest available" EMS be dispatched to the scene of medical emergencies. The law does not modify its requirement for the "closest" EMS based on organizational or corporate affiliation with a quick-response unit, or any other entity, that may also be responding to the emergency. The manifest purpose of this statute is to insure quick response times. To send an ambulance service that is not the closest ambulance service simply because of common ownership with a quick-response unit already at the scene cannot be justified under N.D.C.C. § 57-40.6-10(1)(k) and would unreasonably delay the provision of necessary emergency services in contradiction to the intent of this statute.

A member of your staff contacted this office to supplement your request for an opinion concerning issues arising when dispatching different types of EMS services to a particular emergency. The statutes governing dispatch leave a great deal of discretion with the emergency 911 dispatch centers, but the very nature of the various types of EMS available will impact the dispatcher's judgment. For example, a quick-response unit is considered to be a stop gap measure for communities without an ambulance and does not have the capability of transporting persons.[2] Therefore, if a basic life support or advanced life support ambulance is needed but a quick-response unit is not needed, N.D.C.C. § 57-40.6-10(1)(k) does not require the 911 dispatch center to dispatch both an ambulance and the quick-response unit. Your staff member also mentioned that an ambulance jurisdiction was planning to implement a policy where one of its ambulances would meet an ambulance dispatched from another jurisdiction and transport the patient from that point. Not only would such a policy clearly violate the underlying principal in N.D.C.C. § 57-40.6-10(1)(k) concerning dispatching the closest EMS "regardless of city, county or district boundaries," but would also result in unreasonable delay in transporting a patient to a hospital or trauma center. Any unreasonable and unnecessary delay may result in civil liability if it causes harm to the patient.

While local governing bodies and their 911 telephone systems are required to implement N.D.C.C. § 57-40.6-10(1)(k), the Department is to provide those systems with necessary geographical information to assist in the implementation. I am advised that the Department has furnished a list of contact personnel for licensed ambulance services and quick-response units together with state maps designating the locations of the ambulance services and the quick response units. It would be helpful to the 911 telephone systems if

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[2] These units "are trained to provide care while an ambulance is enroute [sic] to the scene." Hearings on H.B. 1409 Before the Senate Political Subdivisions Comm. 2001 N.D. Leg. (Mar. 9) (Statement of Timothy Wiedrich). They are not trained for transporting patients. Id.

the Department provided uniform circles of time and distance around each location. This concept was discussed during the legislative hearing by Mr. Wiedrich, the director of the Department's EMS Division. In response to a question, he indicated the Department was plotting EMS areas of coverage on a mapping system. Hearing on H.B. 1409 Before the Senate Political Subdivisions Comm. 2001 N.D. Leg. (Mar. 9) (Statement of Timothy Wiedrich). This would assist the local 911 dispatch centers in determining which EMS can most quickly respond, and facilitate the local 911 dispatcher's ability to judge various factors influencing the time it takes to respond, including variables such as a road being out or under construction and a detour in place.

Sincerely,

Wayne Stenehjem
Attorney General

tam/vkk

CHAPTER 33-11-01.1
NORTH DAKOTA QUICK RESPONSE UNITS

Section	
33-11-01.1-01	Definitions
33-11-01.1-02	License Required
33-11-01.1-03	Application for License
33-11-01.1-04	Issuance and Renewal of Licenses
33-11-01.1-05	Availability of Quick Response Unit
33-11-01.1-06	Driver's License Required
33-11-01.1-07	Number of Personnel Required
33-11-01.1-08	Minimum Equipment Requirements
33-11-01.1-09	Other Requirements
33-11-01.1-10	Quick Response Units Performing Advanced Life Support Interventions
33-11-01.1-11	Transporting of Patients

33-11-01.1-01. Definitions. Words defined in North Dakota Century Code chapter 23-27 shall have the same meaning in this chapter. For purposes of this chapter:

1. "Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent which includes the skills adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

2. "Department" means the state department of health as defined in chapter 23-01 of the North Dakota Century Code.

3. "Driver" means an individual who operates a quick response unit vehicle.

4. "Driver's license" means the license as required under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

5. "Emergency medical technician" means a person who is licensed as an emergency medical technician by the department.

6. "Equivalent" means training of equal or greater value which accomplishes the same results as determined by the department.

7. "Personnel" means qualified primary care providers, or drivers, or both, within a quick response unit service.

8. "Primary care provider" means a qualified individual on the quick response unit crew responsible for the care of the patient.

9. "Quick response unit run" means the response of a quick response unit vehicle and personnel to an emergency or nonemergency for the purpose of rendering medical care to someone sick or incapacitated, including canceled calls, no transports, and standby events where medical care may be rendered.

10. "State health council" means the council as defined in title 23 of the North Dakota Century Code.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-02. License required.

1, Quick response unit licensure, as defined in chapter 23-27 of the North Dakota Century Code, is optional.

2. The license shall expire midnight on June thirtieth of the odd year following issuance. License renewal shall be on a biennial basis.

3. A license is valid only for the service for which it is issued. A license may not be sold, assigned, or transferred.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-02
Law Implemented: NDCC 23-27-02

33-11-01.1-03. Application for license. Application for the license shall be made in the manner prescribed by the department.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-04. Issuance and renewal of licenses.

1. The department or its authorized agent may inspect the service. If minimum standards are met, the department shall issue a license.

2. If minimum standards are not met, the department will allow the quick response unit thirty days to comply with the standards. The department will work with the quick response unit to obtain compliance.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-05. Availability of quick response unit. A quick response unit shall be available twenty-four hours per day and seven days per week, except as exempted through waiver by the department.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-06. Driver's license required. All drivers of quick response unit vehicles shall have a current valid driver's license pursuant to requirements under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-07. Number of personnel required. The minimum personnel required on each quick response unit run shall be one primary care provider who may function as the driver and is certified as a first responder or its equivalent.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-08. Minimum equipment requirements. The quick response unit shall have the following:

1. Automated external defibrillator.

2. Blood pressure manometer, cuff in child, adult, and large adult sizes; and stethoscope.

3. Disposable gloves - four pair of each size small, medium, and large.

4. One blunt shears.

5. One portable suction device with catheter.

6. One portable oxygen unit size "D" with variable flowmeter.

7. Two nasal cannulas and two nonrebreather masks with supply tubing.

8. Nasopharyngeal airways in adult and child sizes.

9. Oropharyngeal airways in adult, child, and infant sizes.

10. Two cold packs.

11. Four hot packs.

12. Two space blankets.

13. Twelve four-by-four sterile gauze pads.

14. Three sterile soft roller self-adhering bandages.

15. Four rolls of tape.

16. Two sterile occlusive dressings.

17. One sterile multitrauma dressing approximately ten inches [25.4 centimeters] by thirty-six inches [91.44 centimeters].

18. One sterile burn sheet or its equivalent.

19. Equipment case.

20. Equipment storage - readily accessible and safe from the elements.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-09. Other requirements.

1. Personnel must be able to identify and locate all equipment items required to be carried in a quick response unit.

2. All licensed quick response unit agencies shall keep the quick response unit vehicle and other equipment clean and in proper working order.

3. All linens, airways, oxygen masks, nasal cannulas, and other equipment coming in direct contact with the patient must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

4. All licensed quick response units must be affiliated with a licensed ambulance service, as defined in chapter 33-11-02.1, that provides medical oversight for the quick response unit.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-10. Quick response units performing advanced life support interventions. Quick response units may provide advanced life support interventions on an as-needed basis if the following requirements are met:

1. The primary care provider is licensed to provide the level of care required.

2. The service complies with the equipment list as set forth by its medical director.

3. A North Dakota licensed physician has authorized advanced life support interventions by verbal or written order.

4. The transporting ambulance's primary care provider is licensed to provide or maintain any advanced life support intervention provided by the quick response unit.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.1-11. Transporting of patients.

1. Except as otherwise provided in subsection 2, quick response units may not transport patients.

2. Notwithstanding subsection 1, quick response units may transport patients during a major catastrophe or mass casualty incident if all of the following conditions are met:

   a. The ambulance services that normally provide service or mutual aid in the area of the catastrophe or mass casualty incident are insufficient or unavailable to transport.

   b. The primary care provider on the quick response unit must be an emergency medical technician or its equivalent.

   c. The quick response unit must rendezvous with a licensed ambulance service if one becomes available during transport.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-01.2
NORTH DAKOTA GROUND AMBULANCE SERVICES

Section	
33-11-01.2-01	Definitions
33-11-01.2-02	License Required - Fees
33-11-01.2-03	Application for License
33-11-01.2-04	Issuance and Renewal of Licenses
33-11-01.2-05	Special Licenses and Waivers
33-11-01.2-06	Other Requirements for Substation Ambulance Operation
33-11-01.2-07	Availability of Ground Ambulance Service
33-11-01.2-08	Driver's License Required
33-11-01.2-09	Number of Personnel Required
33-11-01.2-10	Other Requirements
33-11-01.2-11	Out-of-State Operators
33-11-01.2-12	Specialty Care Transport
33-11-01.2-13	Ground Ambulance Service Vehicle Requirements
33-11-01.2-14	Transporting of Patients
33-11-01.2-15	Required Advanced Life Support Care

33-11-01.2-01. Definitions. Words defined in chapter 23-27 of the North Dakota Century Code shall have the same meaning in this chapter. For purposes of this chapter:

1. "Advanced first-aid ambulance attendant" means a person who meets the requirements of the advanced first-aid ambulance attendant program and is certified by the department.

2. "Advanced life support ambulance service" means an emergency medical services operation licensed under and meeting all requirements of chapter 33-11-03.

3. "Ambulance driver" means an individual who operates an ambulance vehicle.

4. "Ambulance run" means the response of an ambulance vehicle and personnel to an emergency or nonemergency for the purpose of rendering medical care or transportation, or both, to someone sick or incapacitated, including canceled calls, no transports, and standby events where medical care may be rendered.

5. "Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent which includes the skills adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

6. "Commission on accreditation of ambulance services" means the commission on accreditation of ambulance services located in Glenview, Illinois.

7. "Department" means the state department of health as defined in chapter 23-01 of the North Dakota Century Code.

8. "Designated trauma center" means a licensed hospital with a trauma designation as defined in section 33-38-01-06.

9. "Driver's license" means the license as required under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

10. "Emergency medical technician" means a person who is licensed as an emergency medical technician by the department.

11. "Equivalent" means training of equal or greater value which accomplishes the same results as determined by the department.

12. "Headquarters ambulance service" means the base of operations for an ambulance service that operates subordinate substation ambulances.

13. "Industrial site ambulance service" means an ambulance service that primarily serves an organization and may or may not offer service to the general public.

14. "Licensed health care facilities" means facilities licensed under chapter 23-16 of the North Dakota Century Code.

15. "Major trauma patient" means any patient that fits the trauma triage algorithm as defined in chapter 33-38-01.

16. "Nonemergency health transportation" means health care transportation not provided by a licensed ambulance service that takes place on a scheduled basis by licensed health care facilities to their own patients or residents whose impaired health condition requires special transportation considerations, supervision, or handling but does not indicate a need for medical treatment during transit or emergency medical treatment upon arrival at the final destination.

17. "Paramedic" means a person who is certified as an emergency medical technician-paramedic by the national registry of emergency medical technicians and licensed by the department.

18. "Paramedic with additional training" means evidence of successful completion of additional training and appropriate periodic skills verification in such topics as management of patients on ventilators, twelve-lead electrocardiograms or other critical care monitoring devices, drug infusion pumps, and cardiac or other critical care

medications, or any other specialized procedures or devices determined at the discretion of the paramedic's medical director.

19. "Personnel" means qualified primary care providers, or drivers, or both, within an ambulance service.

20. "Primary care provider" means a qualified individual on the ambulance crew responsible for the care of the patient and supervision of all ambulance personnel while on the ambulance run.

21. "Scheduled basic life support transfer" means transfers provided on a scheduled basis by an advanced life support service to patients who need no advanced life support procedures en route.

22. "Specialty care transport" means interfacility transportation, including transfers from a hospital to an aeromedical intercept site, of a critically injured or ill patient by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician-paramedic.

23. "State health council" means the council as defined in title 23 of the North Dakota Century Code.

24. "Substation ambulance service" means a subordinate operation of a headquarters ambulance service located in a separate municipality.

25. "System status management" means strategically positioning ambulances in geographic locations during various times of the day based on historical data that can aid in predicting operational demands.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-02. License required - Fees.

1. No ground ambulance services, as defined in chapter 23-27 of the North Dakota Century Code, shall be advertised or offered to the public or any person unless the operator of such service is licensed by the department.

2. The license shall expire midnight on October thirty-first of the even year following issuance. License renewal shall be on a biennial basis.

3. A license is valid only for the service for which it is issued. A license may not be sold, assigned, or transferred.

4. The license shall be displayed in a conspicuous place inside the patient compartment of the ambulance vehicle. An operator operating more than one ambulance unit out of a town, city, or municipality will be issued duplicate licenses for each unit at no additional charge.

5. The biennial license fee, including special licenses, shall be fifty dollars for each headquarters ambulance service location and fifty dollars for each substation location.

6. Entities solely providing nonemergency health transportation services are not required to obtain a license under chapter 23-27 of the North Dakota Century Code as long as they do not advertise or offer services to the general public.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-03. Application for license.

1. Application for the license shall be made in the manner prescribed by the department.

2. The application must be for a headquarters ambulance service or substation ambulance service at either the basic life support level as defined in chapter 33-11-02.2, or for the advanced life support level as defined in chapter 33-11-02.3.

3. New operators applying for an ambulance service license for an operation that will be based in a city already served by a licensed advanced life support ambulance service must apply for advanced life support ambulance licensure.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-04. Issuance and renewal of licenses.

1. The department or its authorized agent may inspect the service. If minimum standards for either basic life support ground ambulance services or advanced life support ground ambulance services are met, the department shall issue a license.

2. A service may request that the department consider it in compliance with this chapter if it is fully accredited by the commission on accreditation of ambulance services or its equivalent.

3. Services requesting their compliance with this chapter to be verified through an accrediting agency shall submit to the department a copy of the entire accrediting agency survey report. Subsequent accreditation or revisit documentation must be submitted prior to license renewal.

4. If minimum standards for either basic life support ambulance services or advanced life support ambulance services are not met, the department will allow the ambulance service thirty days to comply with the standards. The department will work with the ambulance service to obtain compliance.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-05. Special licenses and waivers.

1. An operator of a ground ambulance service intended for industrial site use may be issued a special license by the department.

2. Based on each individual case, the department may waive any provisions of this chapter.

3. The waiver provision shall only be used for a specific period in specific instances provided such a waiver does not adversely affect the health and safety of the person transported, and then only if a nonwaiver would result in unreasonable hardship upon the ambulance service.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-06. Other requirements for substation ambulance operation.

1. A substation ambulance operation and all of its assets must be fully owned and operated by a headquarters ambulance service. A substation ambulance may not establish a separate business structure independent of the headquarters service.

2. A substation ambulance service may not have its own governing board separate from a governing board of the headquarters ambulance service.

3. All logos, vehicle lettering, personnel uniforms, and signage on any substation building must reflect the name of the headquarters ambulance service. However, a logo, vehicle lettering, personnel uniforms, or signage on a substation building may include the name of the substation.

4. A licensed advanced life support ambulance service meeting the requirements of chapter 33-11-03 may operate a substation ambulance that meets the basic life support ambulance standards outlined in chapter 33-11-02.

5. A substation ambulance service may not be established in a city that has a licensed ambulance service based in that city.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-07. Availability of ground ambulance service.

1. A headquarters ambulance service shall be available twenty-four hours per day and seven days per week, except as exempted through waiver by the department.

2. A substation ambulance service may be available intermittently. When the substation ambulance is not available it is the responsibility of the headquarters service to respond to calls within that area if no closer ambulance can respond. The headquarters ambulance service must inform its dispatching entity as to the time of availability of its substation ambulance service.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-08. Driver's license required. All drivers of ambulance service vehicles shall have a current valid driver's license pursuant to requirements under sections 39-06-01 and 39-06-02 of the North Dakota Century Code.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-09. Number of personnel required. The minimum personnel required on each ambulance run shall be one driver and one primary care provider.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-10. Other requirements.

1. Personnel must be able to identify and locate all equipment items required to be carried in an ambulance.

2. All licensed ambulance services shall keep the ambulance vehicle and other equipment clean and in proper working order.

3. All linens, airways, oxygen masks, nasal cannulas, and other equipment coming in direct contact with the patient must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

4. When a vehicle has been utilized to transport a patient known to have a communicable disease other than a common cold, the vehicle and all exposed equipment shall be disinfected before the transport of another patient.

5. Each ambulance run must be reported to the department in the manner and in the form determined by the department.

6. All ambulance services must give the receiving licensed health care facility a copy of the run report.

7. All equipment must be stowed in cabinets or securely fastened when not in use.

8. All ambulance services must submit a trauma transport plan to the department upon request.

9. All licensed ambulance services must keep either an electronic or paper copy of each run report on file for a minimum of seven years.

10. All licensed ambulance services must have current written protocols developed and signed by their medical director. The current version of the protocols must be kept on file with ambulance service management. The ambulance service manager must keep inactive protocols for a period of seven years after deactivating the protocol.

11. All ambulance services must report any collision involving an ambulance that results in property damage of one thousand dollars or greater, or personal injury. The report must be made within thirty days of the event and on a form provided by the department.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-11. Out-of-state operators.

1. Operators licensed in another state may pick up patients within this state for transportation to locations within this state under the following circumstances:

a. When there is a natural disaster, such as a tornado, earthquake, or other disaster, which may require all available ambulances to transport the injured; or

b. When an out-of-state ambulance is traveling through the state for whatever purpose comes upon an accident where immediate emergency ambulance services are necessary.

2. Out-of-state ambulance services who expect to pick up patients from within this state and transport to locations within this state must meet the North Dakota state standards and become licensed under chapter 23-27 of the North Dakota Century Code and this chapter.

3. Out-of-state fire units responding to North Dakota for the purposes of forest fire or grassland fire suppression may bring their own emergency medical personnel to provide emergency medical treatment to their own staff. The emergency medical personnel must be certified by the national registry of emergency medical technicians and have physician oversight.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-01
Law Implemented: NDCC 23-27-01

33-11-01.2-12. Specialty care transport.

1. Specialty care transport is necessary when a patient's condition requires ongoing care that must be provided by one or more health care professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or paramedic with additional training.

2. Qualifying interventions for specialty care transports are patients with:

a. One of the following:

(1) Intravenous infusions;

(2) Vasopressors;

(3) Vasoactive compounds;

(4) Antiarrhythmics;

(5) Fibrinolytics;

(6) Paralytics; or

(7) Any other pharmaceutical unique to the patient's special health care needs; and

b. One or more of the following special monitors or procedures:

(1) Mechanical ventilation;

(2) Multiple monitors;

(3) Infusion pumps;

(4) Cardiac balloon pump;

(5) External cardiac support such as a ventricular assist device;

(6) Rapid sequence intubation;

(7) Surgical airways; or

(8) Any other specialized devices or procedures unique to the patient's health care needs.

3. Minimum required staffing shall be one emergency medical technician or its equivalent and at least one of the following: physician, physician assistant, nurse practitioner, registered nurse with special knowledge of the patient's needs, paramedic with additional training, respiratory therapist, or any licensed health care professional designated by the transferring physician.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-13. Ground ambulance service vehicle requirements.

1. All ground ambulances must have a vehicle manufactured to be an ambulance.

2. All ground ambulance service vehicles must be equipped with a siren and flashing lights as described for class A emergency vehicles in subsection 2 of section 39-10-03 of the North Dakota Century Code.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-14. Transporting of patients. Ambulance services must transport patients to the nearest appropriate licensed health care facility according to their hospital transport plan except for:

1. Interfacility transports shall be made in accordance with the referring or accepting physician's orders.

2. In the following specific instances transport must be made to a licensed health care facility with specific capabilities or designations. This may result in bypassing a closer licensed health care facility for another located farther away. An ambulance service may deviate from these rules contained in this section on a case-by-case basis if online medical control is consulted and concurs.

   a. Major trauma patients must be transported to a designated trauma center as per article 33-38.

   b. A patient suffering acute chest pain that is believed to be cardiac in nature or an acute myocardial infarction determined by a twelve-lead electrocardiograph must be transported to a licensed health care facility capable of performing percutaneous catheter insertion or thrombolytic therapy.

   c. In cities with multiple hospitals an ambulance service may bypass one hospital to go to another hospital with equal or greater services if the additional transport time does not exceed ten minutes.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-01.2-15. Required advanced life support care. When it would not delay transport time, basic life support ambulance services must call for a rendezvous with an advanced life support ground ambulance, or an advanced life support or critical care air ambulance if the basic life support ambulance is unable to provide the advanced life support interventions needed to fully treat a patient exhibiting:

1. Major trauma.

2. Cardiac chest pain or acute myocardial infarction.

3. Cardiac arrest.

4. Severe respiratory distress or respiratory arrest.

History: Effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-02
BASIC LIFE SUPPORT GROUND AMBULANCE LICENSE

Section
33-11-02-01 Training Standards for Ambulance Driver
33-11-02-02 Training Standards for Primary Care Provider
33-11-02-03 Minimum Equipment Requirements
33-11-02-04 Medical Director
33-11-02-05 Basic Life Support Ambulance Performing Advanced Life Support Interventions

33-11-02-01. Training standards for ambulance driver. The driver shall have a current cardiopulmonary resuscitation certification, unless there are two primary care providers as defined in section 33-11-02-02 or one primary care provider plus one other person with a current cardiopulmonary resuscitation certification providing care to the patient.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-02. Training standards for primary care provider. The primary care provider must have current emergency medical technician license or its equivalent and must have current cardiopulmonary resuscitation certification.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-03. Minimum equipment requirements. In addition to a vehicle as described in section 33-11-01-15, the ambulance shall have the following:

1. Mounted ambulance cot with retaining straps.

2. Stretchers with retaining straps. Vehicle design dictates quantity.

3. Piped oxygen system - with appropriate regulator and flow meter, or two "E" size bottles for minimum oxygen supply with regulator and flowmeter.

4. Portable oxygen unit with carrying case. To include one "D" size bottle with another "D" bottle in reserve.

5. Three nasal cannulas, three nonrebreather oxygen masks in adult and pediatric sizes, and three sets of oxygen supply tubing.

6. Suction - wall-mounted and portable - capable of achieving 400 mmhg/4 seconds or less.

7. Bag valve mask resuscitation units in infant child and adult sizes with appropriate-sized face masks or pocket masks with oxygen inlet in pediatric and adult sizes.

8. Spine boards - one full-size and one seated spinal immobilization device, with retaining straps.

9. Commercial fracture splints usable for open and closed fractures, or padded boards usable for pediatric and adult patients.

10. Cold packs - four minimum.

11. Fire extinguisher - dry chemical, mounted, five pound [2.27 kilogram] minimum.

12. Head-to-board immobilization device.

13. Obstetrical kit - disposable or sterilizable.

14. Activated charcoal.

15. Two sterile burn sheets or equivalent.

16. Three triangular bandages or commercial slings.

17. Two trauma dressings - approximately ten inches [25.4 centimeters] by thirty-six inches [91.44 centimeters].

18. Twenty-five sterile gauze pads - four inches [10.16 centimeters] by four inches [10.16 centimeters].

19. Twelve soft roller self-adhering type bandages - five yards [4.57 meters] long.

20. One set of nasopharyngeal airways in adult and child sizes.

21. One set of oropharyngeal airways in adult, child, and infant sizes.

22. Two sterile occlusive dressings approximately three inches [76.2 millimeters] by nine inches [228.6 millimeters].

23. Four rolls of tape - assorted sizes.

24. Shears - blunt - two minimum.

25. Bedpan, emesis basin, urinal.

26. One gallon [3.79 liters] of distilled water or saline solution.

27. Intravenous fluid holder - cot mounted or ceiling hooks.

28. Flashlights - two minimum.

29. One sharps container less than half full.

30. Three red biohazard bags.

31. Cervical collars in adult, child, and infant sizes.

32. Two blankets, four sheets, two pillows, four towels.

33. Phenol disinfectant product, such as lystophene or amphyl.

34. Reflectorized flares for securing scene - set of three minimum.

35. Automatic defibrillator.

36. Blood pressure manometer, cuff in child, adult, and large adult sizes, and stethoscope.

37. Lower extremity traction splint.

38. Radio with the capability of meeting state emergency medical services standards as determined by the department.

39. Glutose or glucose - one dose for oral use.

40. Disposable gloves - one box each of small, medium, and large sizes.

41. Four disposable hot packs.

42. Personal protection equipment such as mask, nonabsorbent gown, protective eyeware - minimum of four.

43. Biological fluid cleanup kit.

44. Twenty-five triage tags.

History: 33-11-01-11; redesignated effective March 1, 1985; amended effective February 1, 1989; August 1, 1994; August 1, 2003; January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-04. Medical director. Each ground ambulance service shall have a signed agreement on file with the department with a North Dakota licensed physician who shall serve as official medical director and whose duties

include establishing written medical protocols, recommending optional equipment, oversight of a quality assurance program, and maintaining current training requirements for personnel.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-02-05. Basic life support ambulance performing advanced life support interventions. Basic life support ambulance services may provide advanced life support interventions on an as-needed basis if the following requirements are met:

1. The primary care provider is licensed to provide the level of care required.

2. The service complies with the equipment list as set forth by its medical director.

3. A North Dakota licensed physician has authorized advanced life support interventions by verbal or written order.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-03
ADVANCED LIFE SUPPORT GROUND AMBULANCE LICENSE

Section	
33-11-03-01	Minimum Standards for Personnel
33-11-03-02	Minimum Equipment Standards
33-11-03-03	Minimum Medication Requirements
33-11-03-04	Medical Director
33-11-03-05	Number of Ambulances Staffed
33-11-03-06	Advertising Restrictions

33-11-03-01. Minimum standards for personnel.

1. The driver must be a licensed emergency medical technician or its equivalent.

2. The primary care provider, whose duties include an assessment of each patient, must be a licensed paramedic or its equivalent, or be a licensed registered nurse currently licensed as an emergency medical technician or its equivalent who has a current American heart association advanced cardiac life support certification or its equivalent, with the following exceptions:

   a. If, based on the paramedic's, or its equivalent's, assessment findings, a patient's condition requires only basic life support, an emergency medical technician or its equivalent may assume primary care of the patient.

   b. For scheduled basic life support transfers, the driver and the primary care provider must be at least licensed emergency medical technicians or its equivalent.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-02. Minimum equipment standards. The ambulance must contain all the equipment requirements as found in section 33-11-02-03, except oral glutose or glucose, plus the following:

1. Manual cardiac monitor defibrillator with pediatric capabilities.

2. Portable radio. Rechargeable battery operated capable of reaching law enforcement and hospitals.

3. Nebulizer with tubing.

4. Endotracheal airway equipment in pediatric and adult sizes.

5. Intravenous therapy equipment. Catheters, intraosseouss needles, tubing solutions, for both pediatric and adult patients as approved by medical director.

6. Glucose measuring device.

7. Syringes and needles.

8. Alcohol swabs. Betadine swabs.

9. Electrocardiogram supplies. Rolls of electrocardiogram paper, monitor electrodes and defibrillator pads.

10. Pediatric weight and length based drug dosage chart or tape.

History: Effective March 1, 1985; amended effective August 1, 1994; August 1, 2003; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-03. Minimum medication requirements. The ambulance must carry the following functional classification of medications in pediatric and adult dosages:

1. Alkalinizer.

2. Bronchodilator - adrenergic intravenous or subcutaneous.

3. Antidysrhythmic.

4. Anticholinergen parasympatholitic.

5. Opioid antagonist.

6. Coronary vasodilator, antianginal.

7. Antianxiety.

8. Caloric.

9. Anticonvulsant.

10. Bronchodilator.

11. Narcotic.

History: Effective March 1, 1985; amended effective August 1, 1994; August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-04. Medical director. Each ground ambulance service shall have a signed agreement on file with the department with a North Dakota licensed physician who shall serve as official medical director and whose duties include establishing written medical protocols, recommending optional equipment, oversight of a quality assurance program, and maintaining current training requirements for personnel.

History: Effective March 1, 1985; amended effective August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-05. Number of ambulances staffed. Unless the advanced life support ambulance service has a system status management program as defined in this chapter in place that is approved by the department, the number of advanced life support ambulances staffed, either by on call or in-house staff, by the licensed ambulance service is dependent upon the population of the city in which the ambulance is based.

1. For cities with a population less than fifteen thousand, one advanced life support ambulance must be staffed. Additional ambulances may be staffed and equipped at the basic life support level.

2. For cities with populations between fifteen thousand one and fifty-five thousand, two advanced life support ambulances must be staffed. Additional ambulances may be staffed and equipped at the basic life support level.

3. For cities with populations greater than fifty-five thousand, three advanced life support ambulances must be staffed. Additional ambulances may be staffed and equipped at the basic life support level.

History: Effective March 1, 1985; amended effective January 1, 1986; August 1, 1994; August 1, 2003; January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-03-06. Advertising restrictions. No ambulance service may advertise itself as an advanced life support ambulance service unless it is so licensed.

History: Effective March 1, 1985.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-04
NORTH DAKOTA AIR AMBULANCE SERVICES

Section	
33-11-04-01	Definitions
33-11-04-02	License Required - Fees
33-11-04-03	Application for License
33-11-04-04	Issuance and Renewal of Licenses
33-11-04-05	Availability of Air Ambulance Services
33-11-04-06	Number of Personnel Required
33-11-04-07	Out-of-State Operators
33-11-04-08	Required Certificate of Airworthiness
33-11-04-09	Securing of Equipment
33-11-04-10	Aircraft Doors
33-11-04-11	Required Lighting
33-11-04-12	Required Power Source
33-11-04-13	Required Radio Communication
33-11-04-14	Medical Director
33-11-04-15	Other Requirements

33-11-04-01. Definitions.

1. "Air ambulance run" means the response of an aircraft and personnel to an emergency or nonemergency for the purpose of rendering medical care or transportation or both to someone who is sick or injured. Includes canceled calls, no transports, and standby events where medical care may be rendered.

2. "Aircraft" means either an airplane also known as a fixed-wing, or a helicopter also known as a rotor-wing.

3. "Cardiopulmonary resuscitation" means the American heart association health care provider standards or its equivalent, which includes the following skills: adult one-person and two-person cardiopulmonary resuscitation, adult obstructed airway, child one-person and two-person cardiopulmonary resuscitation, child obstructed airway, infant cardiopulmonary resuscitation, infant obstructed airway, and automated external defibrillator.

4. "Commission on accreditation of medical transport systems" means the commission on accreditation of medical transport systems located in Anderson, South Carolina.

5. "Department" means the state department of health as defined in North Dakota Century Code chapter 23-01.

6. "Emergency medical technician" means a person who meets the requirements of the state emergency medical technician program and is licensed by the department.

7. "Equivalent" means training or equipment of equal or greater value which accomplishes the same results as determined by the department.

8. "Paramedic" means a person who is certified by the national registry of emergency medical technicians and licensed by the department as a paramedic.

9. "Personnel" means qualified primary care providers within an air ambulance service.

10. "Primary care provider" means a qualified individual responsible for care of the patient while on an air ambulance run.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-02. License required - Fees.

1. No air ambulance service as defined in North Dakota Century Code chapter 23-27 shall be advertised or offered to the public or any person unless the operator of such air ambulance service is licensed by the department.

2. The license shall expire midnight on October thirty-first of the even year following issuance. License renewal shall be on a biennial basis.

3. A license is valid only for the service for which it is issued. A license may not be sold, assigned, or transferred.

4. The license shall be displayed in a conspicuous place inside the patient compartment of the aircraft. An operator operating more than one aircraft out of a town, city, or municipality will be issued duplicate licenses for each aircraft at no additional charge.

5. The biennial license fee shall be fifty dollars for each air ambulance service operated.

History: Effective August 1, 2003; amended effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-03. Application for license.

1. Application for the license shall be made in the manner prescribed by the department.

2. The application must be made for either basic life support air ambulance service as defined in chapter 33-11-05, advanced life support air ambulance service as defined in chapter 33-11-06, or for critical care air ambulance service as defined in chapter 33-11-07.

History: Effective August 1, 2003; amended effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-04. Issuance and renewal of licenses.

1. The department or its authorized agent may inspect the air ambulance service. If minimum standards for either basic life support air ambulance services, advanced life support air ambulance services, or critical care air ambulance services are met, the department shall issue a license.

2. A service may request that the department consider it in compliance with this chapter if it is fully accredited by the commission on accreditation of medical transport systems or its equivalent.

3. Services requesting their compliance with this chapter be verified through an accrediting agency shall submit to the department a copy of the entire accrediting agency survey report. Subsequent accreditation or revisit documentation must be submitted prior to license renewal.

History: Effective August 1, 2003; amended effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-05. Availability of air ambulance services. Basic life support air ambulance services may be available as needed per licensee's discretion. Advanced life support air ambulance services and critical care air ambulance services shall be available twenty-four hours per day and seven days per week, except as limited by weather or aircraft maintenance or by unscheduled pilot duty limitations in accordance with federal aviation administration regulations.

History: Effective August 1, 2003; amended effective March 24, 2004; January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-06. Number of personnel required. For a licensed basic life support air ambulance service, the minimum number of personnel required is one primary care provider as defined in chapter 33-11-05. For a licensed advanced

life support air ambulance service, the minimum number of personnel required is one primary care provider as defined in chapter 33-11-06, except when either the transferring or receiving physician believes the patient's status requires a minimum of two providers. For a licensed critical care air ambulance service, the minimum number of personnel required is two providers as defined in chapter 33-11-07.

History: Effective August 1, 2003; amended effective March 24, 2004; January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-07. Out-of-state operators.

1. Operators from another state may pick up patients within this state for transportation to locations within this state when there is a natural disaster such as a tornado, flood, or other disaster which may require available air ambulances to transport the injured.

2. Out-of-state air ambulance services that expect to pick up patients from within this state and transport to locations within this state shall meet the North Dakota standards and become licensed under North Dakota Century Code chapter 23-27 and this chapter.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-08. Required certificate of airworthiness. An air ambulance service must have a certificate of airworthiness from the federal aviation administration for each aircraft it uses as an air ambulance, which is maintained current by compliance with all required federal aviation administration inspections as defined by federal aviation administration regulation 14 CFR 135.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-09. Securing of equipment. All equipment and materials used in an air ambulance must be secured in accordance with federal aviation administration regulation title 14 Code of Federal Regulations.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-10. Aircraft doors. Aircraft doors must accommodate passage of a patient lying on a stretcher with no more than thirty degrees rotation or forty-five degrees pitch.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-11. Required lighting. Lighting of at least forty foot-candles of illumination must be available in the patient care area to afford observation by medical personnel. Lighting must be shielded from the pilot of the aircraft so as not to interfere with operation of the aircraft.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-12. Required power source. The aircraft will be equipped with a federal aviation administration approved electrical power source that will accommodate commonly carried medical equipment, both AC and DC powered, and that is not dependent upon a portable battery.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-13. Required radio communication. The aircraft must have a radio communication system that will allow the communications between the aircraft and medical facilities, between the medical crew and the pilot, and between the medical crew on board the aircraft.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-14. Medical director. Each air ambulance service shall have a signed agreement on file with the department with a North Dakota licensed physician who shall serve as official medical director and whose duties include establishing written medical protocols, recommending optional equipment, oversight of a quality assurance program, and maintaining current training requirements for personnel.

History: Effective August 1, 2003; amended effective January 1, 2006; January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-04-15. Other requirements.

1. The aircraft shall have sufficient space to accommodate at least one patient on a stretcher, two medical personnel, and the medical equipment required.

2. The aircraft must be configured to allow medical personnel to have a good patient view and access to equipment and supplies in order to initiate both basic and advanced life support.

3. All licensed air ambulance services shall keep the aircraft and other equipment clean and in proper working order.

4. All linens, and all equipment and supplies coming in direct contact with the patient, must be either a single-use disposable type or cleaned, laundered, or disinfected after each use.

5. When an aircraft has been utilized to transport a patient known to have a communicable disease other than a common cold, the aircraft and all exposed equipment shall be disinfected before the transport of another patient.

6. Each air ambulance run must be reported to the department in the manner and in the form determined by the department.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-05
BASIC LIFE SUPPORT AIR AMBULANCE LICENSE

Section
33-11-05-01 Training Standards for Primary Care Provider
33-11-05-02 Minimum Equipment Requirements

33-11-05-01. Training standards for primary care provider. The primary care provider must have current emergency medical technician license or its equivalent and must have current cardiopulmonary resuscitation certification.

History: Effective August 1, 2003; amended effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-05-02. Minimum equipment requirements.

1. Patient litter or stretcher.

2. One stethoscope.

3. One blood pressure cuff with aneroid gauge.

4. Manual suction device with catheter.

5. One set of oropharyngeal airways including six sizes, from infant through adult.

6. One set of nasopharyngeal airways.

7. Oxygen administration system, including a protective pressure gauge, a nongravity dependent flowmeter, supply tubing, a nonrebreather mask, and a nasal cannula. The unit must be capable of achieving an oxygen delivery flow rate of at least fifteen liters per minute for one hour.

8. Mouth-to-mask artificial ventilation device, with a supplemental oxygen inlet port such as a pocket mask, suitable for use on infant through adult patients. This may be replaced with bag valve mask devices with masks for infant, child, and adult patients.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-06
ADVANCED LIFE SUPPORT AIR AMBULANCE LICENSE

Section
33-11-06-01 Training Standards for Primary Care Provider
33-11-06-02 Minimum Equipment Requirements
33-11-06-03 Advertising Restrictions

33-11-06-01. Training standards for primary care provider. One of the crew members must be a licensed paramedic or its equivalent.

History: Effective August 1, 2003; amended effective January 1, 2008.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-06-02. Minimum equipment requirements. All equipment required for a basic life support air ambulance as found in section 33-11-05-02, plus the following:

1. A suction unit capable of providing a free airflow of at least twenty liters per minute and achieving a minimum of three hundred millimeters of mercury vacuum within four seconds after clamping the suction tube.

2. Intravenous equipment and supplies for both pediatric and adult patients.

3. Two intravenous bag holders with straps.

4. Endotracheal intubation equipment and supplies for both pediatric and adult patients.

5. Cardiac monitor-defibrillator and supplies with pediatric and adult capabilities.

6. A drug box that contains drugs that have been ordered by the medical director of the air ambulance service.

History: Effective August 1, 2003.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-06-03. Advertising restrictions. No basic life support air ambulance service may advertise itself as an advanced life support air ambulance service.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

CHAPTER 33-11-07
CRITICAL CARE AIR AMBULANCE LICENSE

Section
33-11-07-01 Training Standards for Care Providers
33-11-07-02 Minimum Equipment Requirements
33-11-07-03 Advertising Restrictions

33-11-07-01. Training standards for care providers. Both care providers' training shall be consistent with the definition of specialty care transport in section 33-11-01-14.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-07-02. Minimum equipment requirements. All equipment required for a basic life support air ambulance as found in section 33-11-05-02 and all equipment required for an advanced life support air ambulance found in section 33-11-06-02 plus the following equipment must be available at the base station:

1. Ventilator.

2. Intravenous infusion pumps.

3. Any specialized equipment ordered by a physician.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

33-11-07-03. Advertising restrictions. No air ambulance service may advertise itself as a critical care air ambulance service unless it has been issued a critical care air ambulance license by the department.

History: Effective January 1, 2006.
General Authority: NDCC 23-27-04
Law Implemented: NDCC 23-27-04

PUBLIC INFORMATION, EDUCATION AND PREVENTION

To effectively serve the public, each state must develop and implement an EMS public information and education (PI&E) program. The PI&E component of the state EMS plan ensures that consistent, structured PI&E programs are in place that enhance the public's knowledge of the EMS system, support appropriate EMS system access, demonstrate essential self-help and appropriate bystander care actions, and encourage injury prevention. The PI&E plan is based on a needs assessment of the population to be served and an identification of actual or potential problem areas (i.e., demographics and health status variable, public perceptions and knowledge of EMS, type and scope of existing PI&E programs).

There is an established mechanism for the provision of appropriate and timely release of information on EMS-related events, issues and public relations (damage control). The lead agency dedicates staffing and funding for these programs, which are directed at both the general public and EMS providers. The lead agency enlists the cooperation of other public service agencies in the development and distribution of these programs and serves as an advocate for legislation that potentially results in injury/illness prevention.

Public awareness and education about the EMS system is essential to a quality system and is often neglected. Public information and education efforts must serve to enhance the public's role in the system, its ability to access the system and the prevention of injuries. In many areas, EMS personnel provide system access information and present injury prevention programs which ultimately lead to better utilization of EMS resources and improved patient outcomes.

Where We Are Today

During the 1992 assessment, it was stated that there was no coordinated or effective EMS public information and education program in North Dakota and that the last major undertaking involved the creation of radio and television public service announcements, billboard advertising, posters and brochures (1985). Since that time, however, the DEMS distributes the ACEP Emergency Medical Services Week kit to North Dakota ambulance services on an annual basis. The DEMS also coordinates the Public Information Education and Relations (PIER) program. PIER's goal is to promote the development of proactive EMS PIER programs that raise public awareness, understanding, and participation in the EMS system. Some of the PIER program benefits include:

- Increases public knowledge of your EMS system.
- Enhances better use of EMS resources – less misuse.
- Improves recruitment and retention.
- Increases financial and political support.
- Enhances patient outcome.

Progress on Meeting 1992 Recommendations

NHTSA Recommendations	Action
The State EMS Office Should:	
• PI&E should be included as a component of the state EMS plan.	There is no PI&E component in the state EMS plan.
• The DEMS should investigate the feasibility of using the safety belt task force as an ongoing group to coordinate EMS-related PI&E efforts among all of the involved agencies.	The DEMS was involved with the safety belt coalition in trying to get the primary seat belt law passed through legislation.
• The DEMS should identify an annual theme as the primary focus for PI&E initiatives.	There is no PI&E annual theme from DEMS.
• Ongoing efforts by hospitals, EMS organizations, communities, schools and others should continue and where possible expand.	DEMS has some involvement with outside PI&E programs; however, there is no information that comes directly from this office.

FACILITIES

It is imperative that the seriously ill patient be delivered in a timely manner to the closest appropriate facility. The lead agency has a system for categorizing the functional capabilities of all health-care facilities that receive patients from the out-of-hospital emergency medical care setting.

There is a process for verification of the categorization. This information is disseminated to EMS providers so that the capabilities of the facilities are known in advance and appropriate primary and secondary transport decisions are made.

The lead agency also develops and implements triage and destination polices based upon the functional assessment of facilities.

Criteria are identified to guide interfacility transport patients.

Diversion polices are developed and utilized to match system resources with patient needs; standards are clearly identified for placing a facility on bypass or diverting an ambulance to another facility. The lead agency has a method for monitoring if patients are directed to appropriate facilities.

Where We Are Today

There are 43 hospitals with an emergency room capabilities licensed in North Dakota and two IHS hospitals. Thirty-three of these hospitals are critical access hospitals.

Ambulance services are required to transport patients to the nearest appropriate licensed healthcare facility according to their hospital transport plan, with the following exceptions:

- Major trauma patients must be transported to the nearest designated trauma center.
- A patient suffering acute chest pain that is believed to be cardiac in nature or an acute myocardial infarction determined by a twelve-lead electrocardiograph must be transported to a licensed healthcare facility capable of performing percutaneous catheter insertion or thrombolytic therapy.
- In cities with multiple hospitals, an ambulance service may bypass one hospital to go to another with equal or greater services if the additional transport time does not exceed 10 minutes.

North Dakota does have a trauma system in place and has authority to designate trauma centers. Ambulance services are required to have transport plans in place for triaging

major trauma patients and are included in the trauma system regulations. A criterion for triaging a trauma patient is taken from ACS triage scheme and is included in the EMS protocols. Ambulance services are notified when hospitals receive or lose their trauma designation so they can adjust their transport plans accordingly.

Hospitals are required to have trauma transport agreements with their referring tertiary hospitals. There are not any specific transfer protocols required by the state. Each facility develops its own set of protocols according to its policies.

There are no state diversion policies in place. Each individual hospital develops its own policies/procedures for notifying ambulance services and other facilities that the hospital is unable to accept patients.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	**Action**
Facilities	
• Develop of a statewide EMS plan including destination and transfer protocols.	Transfer protocols are in place within the EMS regulations.
• Hospital capabilities should be evaluated and determined according to national standards.	North Dakota does have a trauma system in place with authority to designate trauma centers.
• Patients should be transported, by protocol, to the nearest APPROPRIATE facility. This process needs to be dynamic as hospital status changes.	There are protocols in place within the EMS regulations for transporting patient to the nearest appropriate facility.
• The DEMS should continue to work with the North Dakota Healthcare Association to ensure that facility issues impacting emergency medical serves are addressed.	The DEMS has good collaboration with the NDHA. An NDHA representative serves on both the EMS and State Trauma Advisory Committees.

TRAUMA SYSTEM

To provide a quality, effective system of trauma care, each state must have in place a fully functional EMS system; trauma care components must be clearly integrated with the overall EMS system. Enabling legislation should be in place for the development and implementation of the trauma care component of the EMS system. This should include trauma center designation (using ACS-COT, APSA-COT and other national standards as guidelines), triage and transfer guidelines for trauma patients, data collection and trauma registry definitions and mechanisms, mandatory autopsies and quality improvement for trauma patients. Information and trends from the trauma registry should be reflected in PIER and injury prevention programs. Rehabilitation is an essential component of any statewide trauma system and hence these services should also be considered as part of the designation process. The statewide trauma system (or trauma system plan) reflects the essential elements of the model Trauma Care System Plan.

Where We Are Today

The North Dakota Department of Health – Division of Emergency Medical Services is the lead agency for the North Dakota Trauma system. In 1993, the State Trauma Advisory Committee was formed, and a state trauma plan was developed. Additional legislation and administrative rules were adopted in 1995 and 1997 that began the formation and development of a fully integrated, inclusive, statewide trauma system.

The State Health Council establishes the standards and regulations for the state trauma system, and the North Dakota Department of Health – Division of Emergency Medical Services maintains and enforces them within system. The state trauma coordinator, State Trauma Committee**,** and state site review teams continuously monitor standards and rules when doing designation visits and regional trauma meetings. Any issues are discussed at quarterly State Trauma Committee meetings**,** and rule changes go through the State Health Council and public hearings.

A steady funding mechanism has been a continuing problem for the trauma system since the HRSA grant was discontinued. Currently, salary and benefits for the state trauma coordinator are funded by state general funds, and operations is supported by general funds allocated in the amount of $30,000/year specifically towards the trauma system.

The North Dakota Department of Transportation 408 grant funds the Research Analyst position including salary and operations. Training courses such as Advanced Trauma Life Support (ATLS) and Trauma Nursing Core Course (TNCC) are funded in part from a general fund grant administered by DEMS. DEMS also provides an honorarium to the Level II hospitals for trauma designation site visits conducted by the trauma program managers. Trauma surgeons are not compensated for their participation in the site visit process.

The State Trauma Committee along with the Level II and III trauma centers have been the driving force for our trauma system development and enhancements. The State Trauma Committee is comprised of 19 appointed members with the following representation: North Dakota Medical Association, University of North Dakota School of Medicine, American College of Emergency Physicians, North Dakota American College of Surgeons committee on trauma, accredited rehabilitation facilities, four Regional Trauma Committee chairs, American Academy of Pediatrics, Indian Health Service, American Health Care Association, ND EMS Association – ALS, ND EMS Association–BLS, North Dakota Emergency Nurses Association, Emergency Preparedness and Response Section, legislative representative, North Dakota Nurses Association, and the North Dakota Trauma Coordinator Committee chair.

The State Trauma Committee is responsible for activities of the state trauma system and works in conjunction with the director of the Division of Emergency Medical Services and the state trauma coordinator. State Trauma Committee responsibilities include:

6. Monitoring the standard of care of the trauma system as defined by requirements.
   - Prehospital triage of the major trauma victim
   - EMS transport plans
   - Emergency department, hospital care, rehabilitation

7. Addressing systems issues, such as:
   - Quality of care.
   - Patient outcomes.
   - Education needs.
   - Prehospital issues.
   - Trauma injury prevention.

8. Providing a forum for:
   - Establishing policy/guidelines.
   - Problem solving.
   - Identification of issues.

4. Reviewing designation of trauma centers.
   - Reviews applications and site visit reports for Level IV and V trauma centers.
   - Recommends approval or denial of trauma center designation based on trauma system criteria provided by North Dakota Administrative Code 33-38-01-13 and -14. Trauma center designation is provided by North Dakota Department of Health.
   - Evaluates and conducts provisional designation site visits for Level I, II, or III trauma centers.
   - Reviews any “plan of correction” submitted by a facility to recommend an appropriate course of action.

5. Monitoring the effectiveness of the trauma system through:
   - A periodic review of ongoing quality improvement.
   - Quality outcomes based on the data submitted to the state trauma registry.

6. Supporting public education and trauma prevention programs and being involved in legislative activities affecting the trauma plan.

7. Defines four trauma regions of the state and overseeing the functions of the regional trauma committees.

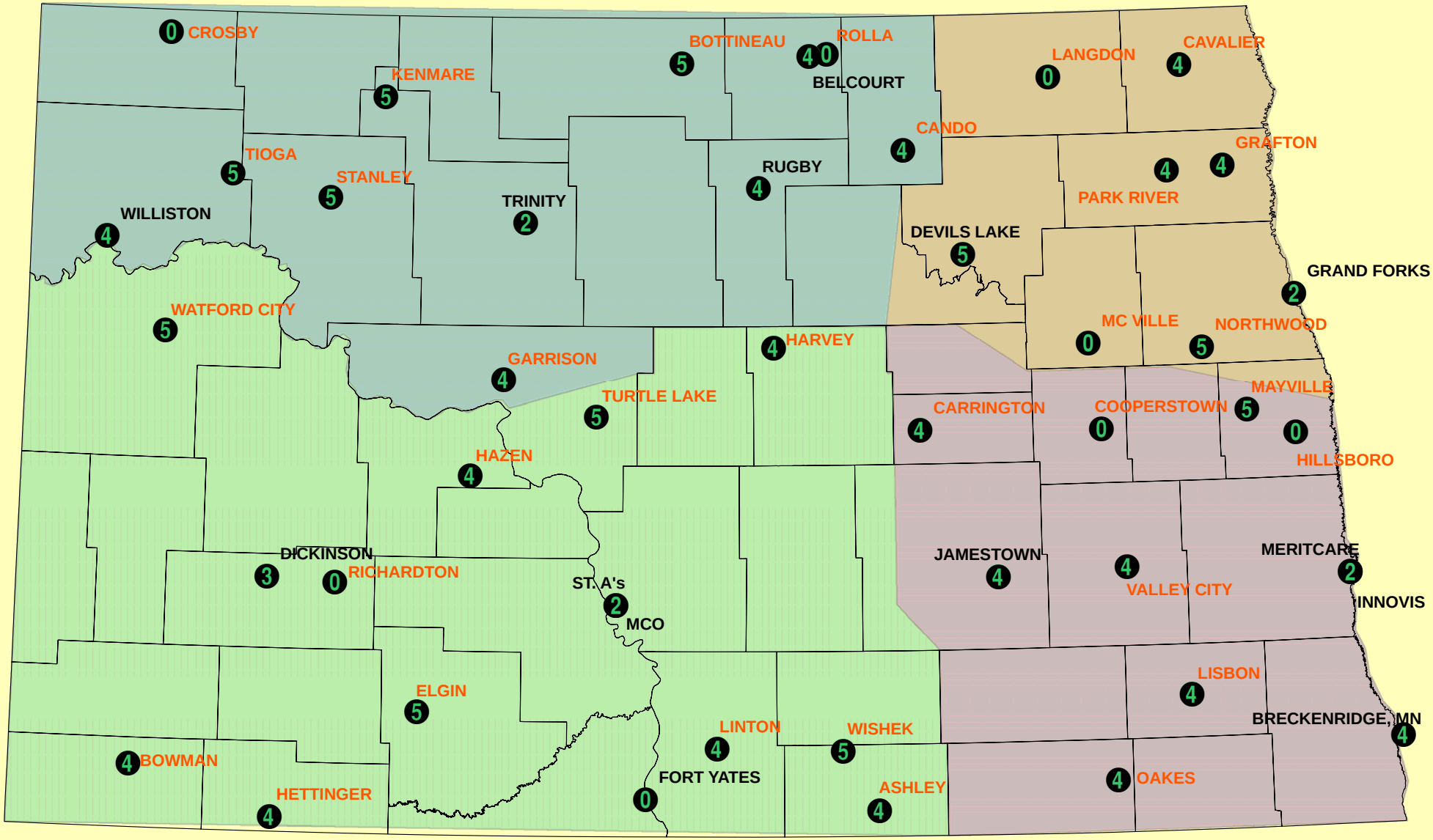
Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
Trauma System	
• Develop a statewide trauma system, using the objective outlined for the trauma care plan.	The state trauma plan was drafted in 1993. Along with the State Trauma Advisory Committee, the Rural EMS Institute of the Lincoln Medical Education Foundation in Nebraska was consulted to help with the trauma system plan. The State Health Council establishes the standards and regulations for the state trauma system and the North Dakota Department of Health – Division of Emergency Medical Services has the authority to maintain and enforce them within system.
• Draft enabling legislation.	Legislation and administrative rules were adopted in 1995 and 1997 that began the formation and development of a fully integrated, inclusive statewide trauma system.
• Establish a trauma system advisory committee (including representatives from ACEP and ACS-COT).	In 1993, the State Trauma Advisory Committee was formed. Multiple organizations are represented, including ACS-COT and ACEP.

• Establish prehospital and hospital triage and transfer guidelines (i.e., bypass the nearest hospital for the nearest appropriate facility).	Triage and transfer protocols have been developed and are in administrative rules.
• Designate trauma centers in the four geographic regions.	Trauma Designations include: Level II = 6 Level III = 1 Level IV = 21 Level V = 10 Not designated = 8
• Develop methodology for implementation of the system.	This was done and can be found in the North Dakota Trauma Care System Plan.
• Establish a statewide, standardized trauma registry for monitoring and evaluation	We have a statewide trauma registry using Trauma Base/Basic with Clinical Data Management as our vendor. It has been a struggle to get consistent and quality data. We are still working on these issues with our hospitals and vendor.
• Establish a quality management process including evaluation of prehospital, resuscitative, operative, critical care, convalescent and rehabilitative phases of trauma care.	We do not have formal process in place due to inconsistent data from our registry. When system issues arise they are taken to the State Trauma Committee for discussion and actions.
• Mandate post-mortem examinations on all trauma deaths.	As a state, we do not mandate this. Most of our Level II trauma centers do have policies/procedures for examinations after a trauma death.
• Identify inpatient and outpatient rehabilitation resources	All but one Level II trauma center have a CARF-accredited rehabilitation unit within their hospitals. The Level II trauma centers also utilize rehabilitation facilities in Minnesota and Colorado.
• Provide for public education and public service announcements on trauma including system access and injury prevention	The trauma system has not done a great deal with public education. The state does issue news releases when hospitals receive trauma designations.

TRAUMA SUPPORTING DOCUMENTATION

Trauma Designation and Critical Access Hospitals



Trauma Designation

- 0 — 0
- 2 — II
- 3 — III
- 4 — IV
- 5 — V

Critical Access Hospitals

NORTH DAKOTA DEPARTMENT of HEALTH

CHAPTER 23-01.2
TRAUMA AND EMERGENCY MEDICAL SYSTEM

23-01.2-01. Trauma system established - Duties of health council. The health council, in conjunction with the state department of health, may establish and maintain a comprehensive trauma system for the state. The trauma system may include standards for the following components:

1. A system plan.

2. Prehospital emergency medical services.

3. Hospitals, for which the standards must include:

   a. Standards for designation, redesignation, and dedesignation of trauma centers.

   b. Standards for evaluation and quality improvement programs for designated trauma centers. The standards must require each trauma center to collect quality improvement data and to provide specified portions to the department for use in state and regional trauma quality improvement programs.

   c. Qualifications for trauma center personnel.

4. A trauma registry. Data in the trauma registry is not subject to subpoena or discovery or introduction into evidence in any civil action. Designated trauma centers must participate in the trauma registry. A hospital not designated as a trauma center must provide to the registry a minimum set of data elements for all trauma patients as determined by the health council.

5. A trauma quality improvement program to monitor the performance of the trauma system. The proceedings and records of the program are not subject to subpoena or discovery or introduction into evidence in any civil action arising out of any matter that is the subject of consideration by the program.

23-01.2-02. Physician immunity for voluntary medical direction. A physician is immune from liability while providing voluntary medical direction.

ARTICLE 33-38

STATE TRAUMA SYSTEM

Chapter
33-38-01 Trauma System Regulation

CHAPTER 33-38-01
TRAUMA SYSTEM REGULATION

Section
33-38-01-01 Definitions
33-38-01-02 Trauma System
33-38-01-03 Activation of Trauma Codes For Major Trauma Patients
33-38-01-04 Emergency Medical Services
33-38-01-05 Local Emergency Medical Services Transport Plans
33-38-01-06 Trauma Center Designation
33-38-01-07 Trauma Center Revocation of Designation
33-38-01-08 State Trauma Registry
33-38-01-09 Quality Improvement Process
33-38-01-10 State Truama Committee Membership
33-38-01-11 Trauma Regions - Regional Trauma Committee
33-38-01-12 Trauma Center Name Restriction
33-38-01-13 Level IV Trauma Center Designation Standards
33-38-01-14 Level V Trauma Center Designation Standards

33-38-01-01. Definitions. Words defined in North Dakota Century Code chapter 23-01.2 have the same meaning in this chapter. As used in this chapter:

1. "Advanced prehospital trauma life support" means the most current edition of the course as developed by the national association of emergency medical technicians in cooperation with the American college of surgeons - committee on trauma, or its equivalent, as determined by the department.

2. "Advanced trauma life support" means the most current edition of the course as developed by the American college of surgeons - committee on trauma, or its equivalent, as determined by the department.

3. "Department" means the state department of health.

4. "Emergency medical services" means the system of personnel who provide medical care from the time of injury to hospital admission.

5. "Local emergency medical services transport plans" means plans developed by emergency medical services, medical directors, and hospital officials which establish the most efficient method to transport trauma patients.

6. "Major trauma patient" means any patient that fits the trauma triage algorithm adopted by American college of surgeons, committee on trauma, Resources for Optimal Care of the Injured Patient: 1999, page 14.

7. "Provisional designation" means a state process of designating a facility as a level I, II, or III trauma center based on American college of surgeons standards for a period of up to twenty-four months, until an American college of surgeons verification visit is completed.

8. "Trauma" means tissue damage caused by the transfer of thermal, mechanical, electrical, or chemical energy, or by the absence of heat or oxygen.

9. "Trauma center" means a facility that has made a commitment to serve the trauma patient, has met the standards of the trauma system, and has obtained designation as a trauma center.

10. "Trauma code" includes the activation and assembly of the trauma team to provide care to the major trauma patient.

11. "Trauma nursing core course" means the most current edition of the course as developed by the emergency nurses association, or its equivalent, as determined by the department.

12. "Trauma quality improvement program" means a system of evaluating the prehospital, trauma center, and rehabilitative care of trauma patients.

13. "Trauma registry" includes the collection and analysis of trauma data from the trauma system.

14. "Trauma team" includes a group of health care professionals organized to provide care to the trauma patient.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-02. Trauma system. A statewide trauma system shall be adopted by the state health council. The trauma system shall consist of the following:

1. Standardized definition of major trauma patient.

2. Trauma code activation protocols.

3. Local emergency medical services transport plans.

4. Trauma center designation process.

5. Revocation of trauma center designation process.

6. Statewide trauma registry.

7. Quality improvement process.

8. State trauma committee.

9. Four regional trauma committees.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-03. Activation of trauma codes for major trauma patients. Emergency medical services and trauma centers shall assess patients and activate a trauma code if the patient meets the major trauma definition.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-04. Emergency medical services. All emergency medical services licensed or certified by the department shall establish each of the following:

1. Trauma code activation protocols.

2. Trauma patient care protocols that have been reviewed and approved by a medical director.

3. Local emergency medical services transport plans.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-05. Local emergency medical services transport plans. Emergency medical services shall develop local emergency medical services transport plans for the transport of major trauma patients by appropriate means to the nearest designated trauma center. Emergency medical services may bypass the nearest designated trauma center for a higher level trauma center provided that it does not result in an additional thirty minutes or more of transport time. If there are multiple trauma centers in the community, the major trauma patient meeting the criteria in steps one or two of the field triage decision scheme, provided by the American college of surgeons Resources for Optimal Care of the Injured Patient: 1999, page 14, should be taken to the trauma center with the highest level of designation. Theplans are subject to approval by all the participating health care entities named in the plan, then submitted for review and approval to the regional

trauma committee. Following approval, the local emergency medical services transport plans must be filed with the department and distributed to participating dispatch centers.

After activation of a trauma code, a dispatch center shall notify the necessary facilities and the emergency medical service unit shall transport the patient according to its local emergency medical services transport plan.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-06. Trauma center designation.

1. Five levels of hospital designation must be established.

2. Hospitals applying for level I, level II, or level III designation shall present evidence of having current trauma center verification from the American college of surgeons. The department shall issue designation with an expiration date consistent with the American college of surgeons verification expiration date.

3. Hospitals applying for level IV and V trauma center designation must submit an application to the department. Once the application is approved by the department, an onsite verification visit shall be conducted by the department or its designee. The verification team shall compile a report. The application and report will be reviewed by the state trauma committee. If approved, the department shall issue the designation to the facility.

4. Hospitals without trauma center designation applying for a provisional designation must submit an application to the department. Once the application is approved by the department an onsite visit shall be conducted by a team designated by the state trauma committee. The team shall compile a report. The application and report will be reviewed by the state trauma committee. If approved, the department shall issue a provisional designation for a maximum of twenty-four months. During these twenty-four months the facility must complete an American college of surgeons verification visit.

5. The health council, in establishing a comprehensive trauma system, may designate an out-of-state hospital within fifty miles of any border of this state.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-07. Trauma center revocation of designation. The department may revoke designation of a trauma center if evidence exists that the facility does not meet the required trauma center standards. The department or its designee may inspect any trauma center or applicant for trauma center designation at any time for compliance with the standards. Designation must be revoked if a facility denies or refuses inspection.

A trauma center that fails to maintain the standards, or voluntarily relinquishes its designation, may submit a plan for correction. Once the plan is approved by the department, the trauma center may be reinstated as a designated trauma center. Failure to follow an approved plan of correction results in revocation of the trauma center's designation.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-08. State trauma registry. The department shall establish a trauma registry including the minimum data elements. All hospitals must report the minimum data elements to the department for patients who have an international classification of diseases, ninth revision (ICD-9) code of 800-959.9 and one of the following criteria:

1. Trauma deaths.

2. Hospital admission greater than forty-eight hours.

3. Patients admitted that go to the intensive care unit or operating room.

4. Patients transferred into or out of the hospital.

Reporting may occur electronically by downloading computer files or through completion of the North Dakota transfer form or other form approved by the department. Information may not be released from the state trauma registry except as permitted by North Dakota Century Code sections 23-01-15 and 23-01-02.1.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-09. Quality improvement process. A quality improvement process shall be established by the state trauma committee. The process must include evaluation criteria that will provide guidelines for acceptable standards of care.

The regional committees shall evaluate the trauma system within their regions based upon the evaluation criteria. The regional trauma committee shall

make recommendations to emergency medical services and trauma centers in the development of plans to improve the system.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-10. State trauma committee membership. The state trauma committee membership must include the following:

1. One member from the North Dakota committee on trauma - American college of surgeons, appointed by the committee.

2. One member from the American college of emergency physicians - North Dakota chapter, appointed by the chapter.

3. One member from the North Dakota health care association, appointed by the association.

4. One member from the North Dakota medical association, appointed by the association.

5. One member from the North Dakota EMS association - basic life support, appointed by the association.

6. One member from the North Dakota EMS association - advanced life support, appointed by the association.

7. One member from the North Dakota nurses association, appointed by the association.

8. One member on the faculty of the university of North Dakota school of medicine and health sciences, appointed by the dean of the medical school.

9. One member from the North Dakota emergency nurses association, appointed by the association.

10. One member from Indian health service, appointed by the Aberdeen area director of the service.

11. One member from accredited trauma rehabilitation facilities, appointed by the state health council.

12. One member who is a hospital trauma coordinator, appointed by the trauma coordinators committee.

13. The medical director of the division of emergency health services of the department.

14. The regional trauma committee chair from each region, if not representing an association.

15. Four additional members, appointed by the state health council.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-11. Trauma regions - Regional trauma committee. The state trauma committee shall establish four trauma regions. The regions must be designated northwest, northeast, southeast, and southwest. An emergency medical service or trauma center that is located within fifteen miles [24.14 kilometers] of a regional boundary may request to function within another region. This request shall be reviewed and is subject to approval by the state trauma committee.

The state trauma committee shall appoint a regional trauma committee to serve each trauma region. The regional committees may consist of members representing the following:

1. North Dakota committee on trauma - American college of surgeons.

2. North Dakota chapter of American college of emergency physicians.

3. Physician of a level IV trauma center.

4. Level IV or V hospital representative.

5. Hospital trauma coordinator.

6. Accredited rehabilitation facility representative.

7. Indian health service or tribal government representative.

8. North Dakota EMS association.

9. Other members, chosen by the state trauma committee.

History: Effective July 1, 1997; amended effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-12. Trauma center name restriction. No health care facility in North Dakota may use the title "trauma center" or otherwise hold itself out as a

trauma center unless the facility is designated by the department as a trauma center.

History: Effective July 1, 1997.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-13. Level IV trauma center designation standards. The following standards must be met to achieve level IV designation:

1. Trauma team activation plan.

2. Trauma team leader must be a current advanced trauma life support certified physician, who is on call and available within twenty minutes and has experience in resuscitation and care of trauma patients.

3. Transfer agreements as the transferring facility to a level II trauma center for major trauma care, burn care, rehabilitation service for long-term care, acute spinal cord and head injury management, and pediatric trauma management.

4. Equipment for resuscitation and life support of all ages must include:

   a. Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, including pediatrics, bag mask resuscitator, pocket masks, and oxygen.

   b. Pulse oximetry.

   c. End tidal CO_2 determination.

   d. Suction devices.

   e. Electrocardiograph, oscilloscope, and defibrillator.

   f. Standard intravenous fluids and administration devices, including large bore intravenous catheters.

   g. Sterile surgical sets for airway control, cricothyrotomy, vascular access, and chest decompression.

   h. Gastric decompression.

   i. Drugs necessary for emergency care.

   j. Communication with emergency medical services vehicles.

   k. Spinal stabilization equipment.

l. Thermal control equipment for patients.

m. Broselow tape.

5. Quality improvement programs, to include:

a. Focused audit of selected filters.

b. Trauma registry in accordance with section 33-38-01-08.

c. Focused audit for all trauma deaths.

d. Morbidity and mortality review.

e. Medical nursing audit, utilization review, and tissue review.

6. Trauma transfer protocol to include:

a. Triage decision scheme.

b. Trauma transport plan.

History: Effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

33-38-01-14. Level V trauma designation standards. The following standards must be met to achieve level V designation:

1. Trauma team activation plan.

2. Trauma team leader must be on call and available within twenty minutes, who has experience in resuscitation and care of trauma patients. The trauma team leader must be one of the following:

a. A physician who is current in advanced trauma life support.

b. A physician assistant, whose supervising physician has delegated to the physician assistant the authority to provide care to trauma patients and who has taken the trauma nursing core course, and is current in advanced prehospital trauma life support and advanced trauma life support.

c. A nurse practitioner whose scope of practice entails the care of trauma patients, has taken the trauma nursing core course, is current in advanced prehospital trauma life support and advanced trauma life support, and whose scope of practice is approved by the North Dakota board of nursing.

3. Transfer agreements as the transferring facility to a level II trauma center for major trauma care, burn care, rehabilitation service for long-term care, acute spinal cord and head injury management, and pediatric trauma management.

4. Equipment for resuscitation and life support of all ages must include:

   a. Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, including pediatrics, bag mask resuscitator, pocket masks, and oxygen.

   b. Pulse oximetry.

   c. End tidal CO_2 determination.

   d. Suction devices.

   e. Electrocardiograph, oscilloscope, and defibrillator.

   f. Standard intravenous fluids and administration devices, including large bore intravenous catheters.

   g. Sterile surgical sets for airway control, cricothyrotomy, vascular access, and chest decompression.

   h. Gastric decompression.

   i. Drugs necessary for emergency care.

   j. Communication with emergency medical services vehicles.

   k. Spinal stabilization equipment.

   l. Thermal control equipment for patients.

   m. Broselow tape.

5. Quality improvement programs to include:

   a. Focused audit of selected filters.

   b. Trauma registry in accordance with section 33-38-01-08.

   c. Focused audit for all trauma deaths.

   d. Morbidity and mortality review.

   e. Medical nursing audit, utilization review, and tissue review.

f. Current advanced trauma life support certified physician review of all trauma codes managed by a physician assistant or advanced nurse practitioner within forty-eight hours. This may be either the consulting or transfer receiving physician.

6. Trauma transfer protocol to include:

a. Triage decision scheme.

b. Trauma transport plan.

c. Call schedule for physician, if available.

d. Immediate telephone contact with a level II trauma center.

History: Effective June 1, 2001.
General Authority: NDCC 23-01.2-01
Law Implemented: NDCC 23-01.2-01

COMMUNICATIONS

An effective communications subsystem is an essential component of an overall EMS system. Beginning with the universal system access number, the communications network should provide for prioritized-dispatch, dispatch-to-ambulance, ambulance-to-ambulance, ambulance-to-hospital, and hospital-to-hospital communications to ensure adequate EMS system response and coordination.

Where We Are Today

Communications in North Dakota are continuously evolving and improving. State Radio, which continues to be a one-of-a-kind statewide radio communication center, has updated its equipment to be P25 compliant. The current is system is analog and digital capable, although it continues to transmit and receive messages via the analog circuit due to the fact that approximately half of the required digital equipment is fielded. Costs to place digital equipment in the remaining half is estimated to be $25,000,000.

State Radio has all of its 36 towers equipped with mobile data terminals. This allows statewide mobile data coverage for all law enforcement agencies within the state to communicate via text data. State Radio currently is fielding a CAD (computer-aided dispatch) that will aid in the location and dispatching of first responders. This initiative will be used primarily by the Highway Patrol and State Radio during the implementation phase and will be opened up to all responders in the State within a few years. The capability of a CAD system is Automatic Vehicle Locator (AVL), mapping, prioritizing response, and interoperability with other CAD systems already in use in the state.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• All counties in the State should establish 9-1-1 systems to serve the public with universal emergency telephone access. The implementation of enhanced (vs. basic) 9-1-1 systems should be encouraged in all areas of the state in order to provide automatic location identification (ALI) and automatic number identification (ANI) capabilities.	As of February 2008, only one county in North Dakota does not currently have a 9-1-1 system in place. Rolette County has the necessary equipment ordered and expects to be operational sometime in the spring of this year.

• State standards should be established for all dispatchers handling emergency medical calls; i.e., for training and certification in use of priority dispatch concepts and to give prearrival instructions. All dispatchers providing EMD services should be certified and should have liability protection under state law. EMD programs should function under physician medical direction and should include quality assurance review of the prearrival instructions given to callers.	North Dakota now requires that all dispatchers must complete and subsequently become certified as emergency medical dispatchers. North Dakota will guarantee liability protection only if the EMD criteria is met. North Dakota uses the course curriculum issued by NHTSA. Dispatchers must re-certify every two years by attending a refresher course that is an abbreviated version of the initial.
• The potential should be explored to have EMS calls that come into local public safety answering points (PSAPs) transferred to the State Radio communications center where highly qualified personnel exist to give quality prearrival instructions.	To date, all PSAPs require their dispatchers to be trained and certified as emergency medical dispatchers in accordance with The Association of Public-Safety Communications Officers (APCO) rules that state they must complete a 40-hour APCO training and the 24-hour North Dakota EMD certification.
• EMS organizations throughout the state should more fully utilize the significant communications capabilities of the existing statewide system	The State Radio communications center is widely used as the primary dispatch center for several police, fire, and ambulance services. Organizations that do not utilize State Radio as a primary dispatch center have their own PSAP, which employs dispatchers that are trained to the APCO standards mentioned above.

COMMUNICATIONS SUPPORTING DOCUMENTATION

CHAPTER 57-40.6
EMERGENCY SERVICES COMMUNICATION SYSTEMS

57-40.6-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Active prepaid wireless service" means a prepaid wireless service that has been used by the customer during the month to complete a telephone call for which the customer's card or balance was decremented.

2. "Assessed communications service" means a software service, communication connection, cable or broadband transport facilities, or a combination of these facilities, between a billed retail end user and a service provider's network that provides the end user, upon dialing 911, access to a public safety answering point through a permissible interconnection to the dedicated 911 network. The term includes telephone exchange access service, wireless service, active prepaid wireless service, and voice over internet protocol service.

3. "Automated notification system" means that portion of a telecommunications system that provides rapid notice of emergency situations to the public.

4. "Communication connection" means a telephone access line, wireless access line, unique voice over internet protocol service connection, or functional equivalent uniquely identifiable by a number, internet address, or other designation.

5. "Emergency services communication system" means a statewide, countywide, or citywide radio system, land lines communication network, wireless service network, or enhanced 911 (E911) telephone system, which provides rapid public access for coordinated dispatching of services, personnel, equipment, and facilities for law enforcement, fire, medical, or other emergency services.

6. "FCC order" means federal communications commission order 94-102 [961 Federal Register 40348] and any other FCC order that affects the provision of wireless enhanced 911 service.

7. "Prepaid wireless service" means wireless service that is activated in advance by payment for a finite dollar amount of service or for a finite set of minutes that terminates either upon use by a customer and delivery by the wireless provider of an agreed-upon amount of service corresponding to the total dollar amount paid in advance or within a certain period of time following the initial purchase or activation, unless the customer makes additional payments.

8. "Public safety answering point" or "PSAP" means a communications facility or combination of facilities operated on a twenty-four-hour basis which first receives 911 calls from persons in a 911 service area and which, as appropriate, may directly dispatch public safety services or extend, transfer, or relay 911 calls to appropriate public safety agencies.

9. "Subscriber service address" means, for purposes of wire line subscribers, the address where the telephone subscriber's wire line telephone device is used and, for purposes of wireless subscribers, the place of primary use, as that term is defined in section 57-34.1-02.

10. "Telephone access line" means the principal access to the telephone company's switched network, including an outward dialed trunk or access register.

11. "Telephone exchange access service" means service to any wire line telephone access line identified by a unique telephone number that provides local wire line

access to the telecommunications network to a service subscriber and which enables the subscriber to access the emergency services communications system by dialing the digits 9-1-1 on the subscriber's telephone device.

12. "Unpublished" means information that is not published or available from directory assistance.

13. "Voice over internet protocol service" means a service that enables real-time two-way voice communications; requires a broadband connection from the user's location; requires internet protocol-compatible customer premises equipment; and permits users generally to receive calls that originate on the public switched telephone network and to terminate calls to the public switched telephone network.

14. "Wireless access line" means each active wireless and prepaid wireless telephone number assigned to a commercial mobile radio service subscriber, including end users of resellers.

15. "Wireless enhanced 911 service" means the service required to be provided by wireless service providers pursuant to the FCC order.

16. "Wireless service" means commercial mobile radio service as defined in 47 U.S.C. 332(d)(1) and includes:

    a. Services commonly referred to as wireless; and

    b. Services provided by any wireless real-time two-way voice communication device, including radio-telephone communications used in:

        (1) Cellular telephone service;

        (2) Personal communications service; or

        (3) The functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, personal communications service, or a network radio access line.

17. "Wireless service provider" means any entity authorized by the federal communications commission to provide wireless service within the state of North Dakota.

57-40.6-02. Authority of counties or cities to impose fee on assessed communications service - Procedure. The governing body of a county or city may impose a fee on all assessed communications services in accordance with the following requirements:

1. The governing body shall adopt a resolution that proposes the adoption of the fee permitted under this section. The resolution must specify an effective date for the fee which is no more than two years before the expected implementation date of the emergency services communication system to be funded by the fee. The resolution must include a provision for submitting the proposed fee to the electors of the county or city before the imposition of the fee is effective. The resolution must specify a fee that does not exceed one dollar per month per communication connection and must be applied equally upon all assessed communications services.

2. The question of the adoption of the fee must be submitted on a ballot on which the ballot title of the proposition includes the maximum monthly rate of the proposed fee authorized under subsection 1. The question of the adoption of the fee may be submitted to electors at a general, primary, or special election or at a school district election if the boundaries of the school district are coterminous with the boundaries of the governing body adopting the resolution proposing the adoption of the fee. The

fee is not effective unless it is approved by a majority of the electors voting on the proposition. The ballot must be worded so that a "yes" vote authorizes imposition of the fee for an initial six-year period.

3. If the electors have approved imposition of a fee under this section before July 1, 2005, and the governing body of the city or county has not implemented that fee by June 30, 2005, the approval by the electors remains valid until the fee is implemented and, upon implementation, the fee may be imposed for a six-year period and is subject to reimposition under subsection 4.

4. Any political subdivision that desires to increase the fee, subject to the limitations in subsection 1, before the end of the six-year term, must use the same ballot procedure originally used to authorize the fee. The new ballot question may apply to only the proposed increase and not to the original amount or the original term. If the increase is approved, the new amount may be collected for the balance of the original six-year term. If the fee authorized by this section is approved by the electors, the fee may be reimposed for six additional years without resubmitting the question to the electors.

5. In any geographic area, only one political subdivision may impose the fee and imposition must be based on the subscriber service address.

6. In the interest of public safety, where the subscriber's telephone exchange access service boundary and the boundary of the political subdivision imposing the fee do not coincide, and where all of the political subdivisions within the subscriber's telephone exchange access service boundary have not complied with subsection 1, and where a majority of the E911 subscribers within the subscriber's telephone exchange access service boundary have voted for the fee, a telephone exchange access service subscriber whose subscriber service address is outside the political subdivision may receive E911 services by signing a contract agreement with the political subdivision providing the emergency services communication system. The telephone exchange access service provider may collect an additional fee, equal in amount to the basic fee on those subscribers within the exchange boundary. The additional fee amounts collected must be remitted as provided in this chapter.

7. A fee imposed under this section before August 1, 2007, on telephone exchange access service is extended to all assessed communications services.

57-40.6-03. Payment of fee by assessed communications service subscriber or customer. The assessed communications service provider shall collect the fee from the subscriber or customer of the service.

1. For prepaid wireless service, the provider shall remit the monthly fee authorized by section 57-40.6-02 based either upon each active prepaid wireless telephone associated with this state for each active prepaid wireless telephone customer that has a sufficient positive balance as of the last day of each month or upon a two percent assessment on the gross revenue received from the sale of prepaid wireless services each month. The provider shall remit the fee in a manner consistent with the provider's existing operating or technological abilities, including by customer address, location associated with the wireless telephone number, or reasonable allocation method based upon other relevant data. The fee amount or an equivalent number of minutes may be reduced from the prepaid customer's account. However, collection of the fee in the manner of a reduction of value or minutes from the prepaid customer's account does not constitute a reduction in the sales price for purposes of taxes that are collected at the point of sale.

2. For assessed communications service that involves a monthly billing, in the billing statement or invoice to the subscriber, the provider shall state the amount of the fee separately.

57-40.6-03.1. Enhanced 911 data base management charges. Any telephone exchange access service provider charges for enhanced 911 data base management must be on a per telephone exchange access service basis.

57-40.6-04. Fee collection procedure. An assessed communications service provider may retain the actual costs of administration in collection of the fee, not to exceed five percent of the fee collected. The fee proceeds must be paid by the assessed communications service provider within thirty days after it is collected from the subscriber or customer unless the provider has fewer than ten subscribers or customers in a jurisdiction, in which case the provider may pay the proceeds quarterly.

57-40.6-05. Restriction on use of fee proceeds. The governing body may use the proceeds of the fee imposed under section 57-40.6-02 solely for implementing, maintaining, or operating the emergency services communication system and may enter into agreements to effectuate the same. The governing body or its designee shall deposit the fee proceeds in a separate fund and keep records to show all expenditures from the fee proceeds.

57-40.6-06. Data base. Any telephone exchange access service provider providing emergency 911 service shall provide current customer names, addresses, and telephone numbers to each 911 coordinator, the coordinator's designee, or public safety answering point within each 911 system. Information provided under this section must be provided in accordance with the transactional record disclosure requirements of the federal Electronics Communications Privacy Act of 1986, 18 U.S.C. 2703(c)(1)(B)(iii), and in a manner that identifies the names and telephone numbers that are unpublished. The provider shall report data base information regarding new service or a change of service within two business days of the actual service change unless a longer period is permitted by the jurisdiction. The provider shall report data base information regarding dropped service at least monthly.

57-40.6-07. Use of the furnished information. Unpublished names and telephone numbers generated by a 911 coordinator or 911 public safety answering point or provided to a 911 coordinator or public safety answering point under section 57-40.6-06 are confidential and may be used only for verifying the location or identity, or both, for response purposes, of a person calling a 911 answering point for emergency help or by the 911 coordinator or public safety answering point for the purpose of a public safety agency notifying a person of an emergency. Published names and telephone numbers maintained by a 911 coordinator or public safety answering point are exempt records as defined in section 44-04-17.1 but must be provided upon request to the treasurer and auditor of the county served by the 911 coordinator for the purpose of verifying and correcting names and addresses used for official purposes. A record obtained for the purpose of providing services in an emergency and which reveals the address of a person requesting emergency service or reporting an emergency by accessing an emergency telephone number 911 system is exempt from section 44-04-18 and may be redacted from the record before it is released.

57-40.6-08. Emergency services communication system, automated notification system, or emergency instructions - Liability.

1. A public agency, public safety agency, assessed communications service provider, or person that provides access to an emergency services communication system or an automated notification system, or any officer, agent, or employee of any public agency, public safety agency, assessed communications service provider, or person is not liable for any civil damages as a result of any act or omission except willful and wanton misconduct or gross negligence in connection with developing, adopting, operating, or implementing any plan or system as provided under this chapter.

2. A person who gives emergency instructions through a system as provided under this chapter, to persons rendering services in an emergency at another location, or any person following such instructions in rendering such services, is not liable for any civil damages as a result of issuing or following the instructions, unless issuing or

following the instructions constitutes willful and wanton misconduct or gross negligence.

3. This section does not waive, limit, or modify any existing immunity or other defense of the state or any political subdivision, or any of its agencies, departments, commissions, boards, officers, or employees, nor does it create any claim for relief against any of these entities.

57-40.6-09. Governor to appoint an emergency services communication system advisory committee - Standards and guidelines - Report. Expired under S.L. 1987, ch. 720, § 3; S.L. 1991, ch. 686, § 6; and S.L. 1993, ch. 570, § 1.

57-40.6-10. Standards and guidelines.

1. The governing body of the local governmental unit with jurisdiction over an emergency 911 telephone system shall be or shall designate a governing committee of the emergency 911 telephone system which shall:

   a. Designate a 911 coordinator.

   b. Enter written agreements with participating organizations and agencies.

   c. Designate lines of authority.

   d. Provide for a written plan for rural addressing, if applicable, which has been coordinated with the local postal authorities. After January 1, 1993, a rural plan must conform to the modified burkle addressing plan. A plan in use before this date does not have to conform with the modified burkle addressing plan. If implemented, all rural addressing signs must comply with the manual on uniform traffic control devices standards.

   e. Provide for an update of the emergency 911 telephone system's data base annually by obtaining current records from the appropriate telecommunications company.

   f. Define a records retention plan for all printed and recorded records in accordance with jurisdictional requirements.

   g. Encourage that coin-free dialing is available for 911 calls.

   h. Define a mechanism to differentiate between emergency 911 telephone calls from other calls.

   i. Provide for written operating procedures.

   j. Require the public safety answering point that initially receives an emergency call to be responsible for handling that call. If a transfer of an emergency call is made to a secondary public safety answering point, the initial public safety answering point may not disconnect from the three-way call unless mutually agreed upon by the two public safety answering point dispatchers. Upon this agreement, the secondary public safety answering point becomes responsible for the call.

   k. Beginning June 1, 2002, ensure that the closest available emergency medical service is dispatched to the scene of medical emergencies regardless of city, county, or district boundaries. The state department of health shall provide emergency 911 telephone systems with necessary geographical information to assist in the implementation of this subdivision.

l. Ensure that fee proceeds collected under this chapter are expended in accordance with guidelines developed pursuant to section 57-40.6-12 and implement an accounting system sufficient to meet the requirements of section 57-40.6-05.

2. The governing committee may:

   a. Require appropriate liability protection.

   b. Create a user advisory board.

   c. Conduct an annual statistical evaluation of services.

   d. Publish an annual financial report in the official county newspaper.

3. An emergency 911 telephone system must access and dispatch the following services:

   a. Law enforcement.

   b. Fire service.

   c. Emergency medical service.

4. An emergency 911 telephone system may access and dispatch the following services:

   a. Poison control.

   b. Suicide prevention.

   c. Emergency management.

   d. Any other related service in subsection 3 or this subsection.

5. The governing committee of an emergency 911 telephone system shall provide that that system:

   a. Provides twenty-four-hour, seven-day-a-week coverage.

   b. Dispatches and communicates with service identified in subsection 3.

   c. Records all incoming 911 calls and related radio and telephone communications.

   d. Provides alternate measures in the event of an emergency 911 telephone system failure, including an alternate public safety answering point seven-digit number.

   e. Ensures an adequate grade of service that is statistically based by population to assure access to an emergency 911 telephone system.

   f. Does not accept one-way call-in alarms or devices.

   g. Provides access to an emergency 911 telephone system through specialized telecommunications equipment as defined under section 54-44.8-01.

6. An emergency 911 telephone system may:

a. Locate the emergency caller utilizing electronic equipment.

b. Provide a mechanism for investigating false or prank calls.

7. An emergency 911 telephone system must include at least one public safety answering point.

8. A cellular 911 call must be routed to the appropriate 911 public safety answering point.

9. An emergency 911 telephone call must be answered by a dispatcher who has completed training through an association of public safety communications officials course or equivalent course. An emergency 911 dispatch center is required to offer emergency medical dispatch instructions on all emergency medical calls. Prearrival instructions must be offered by a dispatcher who has completed an emergency medical dispatch course approved by the division of emergency health services. Prearrival medical instructions may be given through a mutual aid agreement.

57-40.6-11. Annual report to legislative council. Repealed by S.L. 2007, ch. 535, § 10.

57-40.6-12. Emergency services communications coordinating committee - Membership - Duties.

1. The governing body of a city or county, which adopted a fee on assessed communications services under this chapter, shall make an annual report of the income, expenditures, and status of its emergency services communication system. The annual report must be submitted to the emergency services communications coordinating committee. The committee is composed of three members, one appointed by the North Dakota 911 association, one appointed by the North Dakota association of counties, and one appointed by the adjutant general to represent the division of state radio.

2. The committee shall:

   a. Recommend to the legislative council changes to the operating standards for emergency services communications, including training or certification standards for dispatchers;

   b. Develop guidelines regarding the allowable uses of the fee revenue collected under this chapter;

   c. Request, receive, and compile reports from each governing body on the use of the proceeds of the fee imposed under this chapter, analyze the reports with respect to the guidelines, file its report with the legislative council by November first of each even-numbered year regarding the use of the fee revenue, and recommend to the legislative assembly the appropriate maximum fee allowed by section 57-40.6-02; and

   d. Periodically evaluate chapter 57-40.6 and recommend changes to the legislative council.

3. The committee may initiate and administer statewide agreements among the governing bodies of the local governmental units with jurisdiction over an emergency 911 telephone system to coordinate the procurement of equipment and services, fund the research, administration, and activities of the committee, and contract for the necessary staff support for committee activities.

North Dakota State Radio Frequency Migration Requirements and Guidelines for VHF Mobiles, Portables, and Base Stations

January 23, 2006

The information in this document contains guidelines and requirements for programming of radios for use during State Radio's migration to new frequencies.

This migration does not necessarily require replacement of radios at this time. Existing radios that meet the requirements in this document may be used during this transition period and thereafter. The scan priority requirements are identical to the present requirements.

At this time and for the foreseeable future State Radio ***will continue to operate in the analog mode. It is for this reason that digital mode programming information is not being provided at this time.*** State Radio will only broadcast in the analog mode.

After State Radio has migrated equipment at all sites to the new frequencies, old Channel 1 and Channel 2 information may be removed from radios. Notification will be given when this migration is completed.

If your current State Radio frequency usage is limited to Channel 3 (155.475), no changes are required to the radio.

State Radio will continue use of 154.905 but as a paging only frequency. Channel 1 will continue to transmit voice and paging traffic on 154.935.

Radios that do not meet the migration requirements shall be replaced with radios that are capable of operation on or upgradeable to the P-25 digital platform for future conventional operation on the State Radio system. These radios should also be upgradeable to function on a P-25 trunked VHF radio system. New digital radios <u>must</u> also be capable of analog operation.

NORTH DAKOTA STATE RADIO
LAW ENFORCEMENT VHF MOBILE/PORTABLE
FREQUENCY/SCAN GUIDELINES
January 23, 2006

Mobile/portable units assigned throughout the system shall have a minimum of sixteen channels transmit and receive capability. These shall contain frequency-determining elements and sequential monitoring capability as indicated below. In the sequential monitoring mode, one channel shall have priority over the other; i.e., at any time there is a signal present on both channels, the radio shall be programmed to select the designated priority channel for reception. **The new frequencies, present (old) frequencies, and related priority channels are designated below (priorities being underlined and bolded).**

The following are the frequencies and channel placement for a field subscriber unit (radio) with both the new and old State Radio frequencies.

- The Channel 1 position will transmit on frequency 151.460. Channel 1 position will receive frequency 154.935 and 151.460 with priority on **154.935**.

- The Channel 2 position will transmit on frequency 159.225. Channel 2 position will receive frequency 154.695 and frequency 159.225 with priority on **154.695.**

- The Channel 3 position will transmit and receive on frequency 155.475 (simplex). **COMMON EMERGENCY SYSTEM**

RECOMMENDED LAW ENFORCEMENT CHANNEL CONFIGURATION

CHANNELS	TRANSMIT	RECEIVE	Tx PL	Rx PL
1 SRTWR1	151.460	**154.935**/151.460	192.8	192.8
2 SRTWR2	159.225	**154.695**/159.225	192.8	192.8
3 SRTWR3	155.475	155.475/Simplex	none	CSQ
4				
5				
6				
7 SRMOB1	N/A	151.460 Priority 2 for Ch 1	N/A	192.8
8 SRMOB2	N/A	159.225 Priority 2 for Ch 2	N/A	192.8
9 OLDTW1	155.430	**154.935**/155.430	192.8	CSQ
10 OLDTW2	155.505	**154.905**/155.505	192.8	CSQ
11 OLDMB1	N/A	155.430 Priority 2 for Ch 9		
12 OLDMB2	N/A	155.505 Priority 2 for Ch 10		
13				
14				
15				
16				

* **Frequencies 154.935, 154.695 and 154.905 shall not be programmed as transmit frequencies in mobiles or portables.**

NORTH DAKOTA STATE RADIO
LAW ENFORCEMENT VHF MOBILE/PORTABLE
FREQUENCY/SCAN GUIDELINES
(continued)
January 23, 2006

- All mobile radios should have a minimum of 100 Watts of transmitter power.

- All mobile units are required to have a transmitter time-out timer set for no more than 120 seconds.

- The common emergency system (CHANNEL 3) will be available to every high band mobile radio unit on the state law enforcement system including the large city police departments. The mode of operation will be simplex. The system will be reserved for emergencies and special operations for vehicles normally assigned to other systems. Such operations will be conducted at the discretion of the dispatchers at State Radio or upon request from a department having a valid need.

Note:

The above channel placement recommendations are intended for an older radio with single zone channel placement capability. In newer radios that have multiple channel zone capability the radio may be programmed with the new frequencies/channels in one zone and the old frequencies/channels in another zone. **It is important to understand the potential need or use of both the old or present State Radio frequencies and the new State Radio frequencies.** Both sets of frequencies will be required for radios that roam from one tower coverage area to another during the migration or installation stage of the new radio equipment and related frequencies. This is due to the fact not all equipment and frequencies can be changed simultaneously at each site. The new radio equipment and frequencies will be installed one tower site at a time based on sub networks and related geographic areas.

NORTH DAKOTA STATE RADIO
MOBILE/PORTABLE FIRE TRUCK GUIDELINES
FOR THE USE OF 155.475
January 23, 2006

The State Radio Communications Department approved the official use of 155.475 for all fire trucks in North Dakota. This was done to provide communication interoperable capabilities between State Radio and fire trucks after being dispatched by State Radio to the scene of an emergency such as a serious fire, hazardous materials spill, etc. Fire trucks may also use this frequency to communicate with other emergency services at the scene of an emergency such as an ambulance or police car.

Some of the requirements for the use of this frequency are:

- The radio must have a minimum of four channels.
- All mobile units are required to have a transmitter time-out timer set for no more than 120 seconds.
- That 155.475 be placed in the Channel 3 position of the fire trucks radio. This is a standard requirement for all public safety radios in North Dakota.
- That this frequency be used only in emergencies to communicate with State Radio or other public safety agencies at the scene of the emergency.
- Before installing this frequency in a fire truck, you must first receive a permit from the State Radio Communications Department. For information regarding permits call State Radio Communications at 701-328-8100.
- That the State Radio permit number assigned to the fire truck identifies all radio transmissions. Your state permit is not valid unless the following channel configuration is followed:

CHANNEL 1 - County (LG) Repeater	
CHANNEL 2 – Repeater Bypass	
CHANNEL 3 – 155.475	155.475
CHANNEL 4 – 154.295	154.295

NOTE: Channel 4 is the Statewide Common Fire Frequency

Many fire trucks do not have a home base station and ask for recommendations regarding channel configurations for new fire truck radios. If this is the case, we recommend the above configurations.

155.475 will not be allowed in fire department base stations.

NORTH DAKOTA STATE RADIO
AMBULANCE/RESCUE GUIDELINES
January 23, 2006

- All mobile radios shall have a minimum of 100 Watts transmitter power.
- All mobile units are required to have a transmitter time-out timer set for no more than 120 seconds.
- When programming ambulance radios for use on the State Radio system, keep in mind that the ambulance has a need to communicate with hospitals without any interference from State Radio base stations. The scan priority should follow the selector switch at all times, which means the chosen channel is always the priority.

STATE AMBULANCE/RESCUE CHANNEL CONFIGURATIONS

CHANNELS	TRANSMIT	RECEIVE	Tx PL	Rx PL
1 SRTWR1	151.460	154.935/**151.460P**	192.8	192.8
2 SRTWR2	159.225	**154.695P/**159.225	192.8	192.8
3 SREMG3	155.475	**155.475P/**Simplex	None	CSQ
4 Common EMS	155.340	**155.340P/**	210.7	CSQ
5 Local Hosp.	Local Hosp.	**Local Hosp–P/**	Local	CSQ
6 County LGR	County Channel	**County Channel-P/**	Local	Local
7 SRMOB1	N/A	154.935 Priority 2 for Ch 1		192.8
8 SRMOB2	N/A	159.225 Priority 2 for Ch 2		192.8
9 OLDTW1	155.430	**154.935/**155.430	192.8	CSQ
10 OLDTW2	155.505	**154.905/**155.505	192.8	CSQ
11. OLDMB1	N/A	155.430 Priority 2 for Ch 9		CSQ
12. OLDMB2	N/A	155.505 Priority 2 for Ch 10		CSQ

NORTH DAKOTA STATE RADIO
BASE STATION GUIDELINES
January 23, 2006

Base stations shall be programmed identical to mobiles and portables for State Radio Channels 1, 2 and 3.

Frequencies 154.935, 154.695 and 154.905 shall not be programmed as transmit frequencies in base stations except for the use of 154.905 for paging purposes.

It is important to note that with the addition of PL tones on each transmit frequency, State Radio Dispatch will now hear base station transmissions. Therefore it is important that base stations do not use channel 2 for local traffic.

EVALUATION

A comprehensive evaluation program is needed to effectively plan, implement and monitor a statewide EMS system. The EMS system is responsible for evaluating the effectiveness of services provided victims of medical or trauma-related emergencies; therefore, the EMS agency should be able to state definitively what impact has been made on the patients served by the system. A uniform, statewide out-of-hospital data collection system exists that captures the minimum data necessary to measure compliance with standards (i.e., a mandatory, uniform EMS run report form or a minimum set of data that is provided to the state); data are consistently and routinely provided to the lead agency by all EMS providers and the lead agency performs routine analysis of this data. Pre-established standards, criteria and outcome parameters are used to evaluate resource utilization, scope of services, effectiveness of policies and procedures, and patient outcome. A comprehensive, medically directed statewide quality improvement program is established to assess and evaluate patient care, including a review of process (how EMS system components are functioning) and outcome. The quality improvement program should include an assessment of how the system is currently functioning according to the performance standards, identification of system improvements that are needed to exceed the standards and a mechanism to measure the impact of the improvements once implemented. Patient outcome data is collected and integrated with health system, emergency department and trauma system data; optimally, there is linkage to databases outside of EMS (such as crash reports, FARS, trauma registry, medical examiner reports and discharge data) to fully evaluate quality of care. The evaluation process is educational and quality improvement/system evaluation findings are disseminated to out-of-hospital emergency medical-care providers. The lead agency ensures that all quality improvement activities have legislative confidentiality protection and are non-discoverable.

Where We Are Today

Ambulance Data

North Dakota's licensed ambulances are required to submit data to the state. N.D.A.C § 33-11-01-09.5 requires that all ambulance runs be reported to the North Dakota Department of Health Division of Emergency Medical Services (DEMS) in the manner and form determined by DEMS.

The Division of EMS has collected data in some form for more than thirty years. In July of 2004, the Division of Emergency Medical Services entered into a partnership with Med-Media to have online data submission. Ambulances were given one year to transition from submitting paper trip tickets to online data submission.

In 2007, the Division of EMS worked with Med-Media to transition the State Online Ambulance Reporting (SOAR) data set to NEMSIS Silver + Compliance. The transition is set to take place early 2008.

All ambulances except F-M Ambulance and Metro Ambulance use EmStat/Webcur, both Med-Media products. F-M Ambulance and Metro engineered an export to be uploaded in the Webcur system. Currently, four ambulances are not submitting: Aneta, Marmarth, Lemmon and Goodrich. Ambulances are required to submit data within 30 days of the ambulance call. Submission summaries are run quarterly and noncompliant ambulances are contacted.

Ambulances have the ability to perform QI/QA on all ambulance runs. Ambulance personnel can flag runs to be reviewed by a medical director. The ambulance service has the ability to run a daily audit that provides medications, procedures and provider impression for all calls. The Webcur system has pre-built reports the ambulance can run analyzing unit utilization, unused capacity, skill summary, dispatch complaint and more. In a survey sent to all ambulances in 2007 by the ND EMSC program coordinator, 12 out of 137 respondents reported doing some QI/QA.

More training and education about the tools available are needed. Periodic end-user training is planned for 2008 in order to increase data validity.

Trauma Registry

Some hospitals have been collecting trauma data in some form since 1993. Between 2004-2005, all North Dakota hospitals (and Breckenridge, Minnesota) converted to Trauma Base/Trauma Basic, which are both Clinical Data Management software packages. In 2007, the State Trauma Coordinator, Level II trauma centers, and Clinical Data Management worked to become compliant with the National Trauma Data Standard for the National Trauma Data Bank. The update is planned to come out early 2008. During the update process, a new data dictionary was created to guide hospitals in quality data submission.

All hospitals in the state of North Dakota and those who participate in the state trauma system are required to submit data quarterly to the Department of Health.

All hospitals have the ability to perform QI/QA. All trauma-verified hospitals do some for of QI/QA on trauma calls. Each hospital has the ability to run pre-built reports or to create its own report based on specific needs.

Routine Analysis

All quality improvement activities (including the trauma registry and state online ambulance reporting) have legislative confidentiality protection and are non-discoverable.

The state provides agencies with the software to perform their own routine analysis and quality improvement programs. At this time, the Division of EMS does not have the resources to conduct a statewide quality improvement program for the EMS system.

Progress on Meeting 1992 Recommendations

NHTSA Recommendation	Action
The State EMS Office Should:	
• Develop a comprehensive EMS quality management system that includes standards and protocols for all phases of emergency medical care, in-depth operational policies, linkage of emergency care data to patient outcome information, and mechanisms for making changes in the system as indicated by quality assessments.	All ambulance services were provided with protocols in 2007 that could be modified or edited by the service and medical director. At this time, EMS and trauma data is linked by the trauma registrar's ability to see ambulance calls to their facility using the Webcur system. The information is not yet provided back to the ambulance with the patient's outcome. A feasibility study is set to take place in 2009 on creating linkages.
• Complete implementation of the ambulance run data collection system and develop a process for analyzing and interpreting run report data.	The SOAR is running and a year end report was generated in 2007. Response times are cross referenced with bench marks. Anomalies in the system were reported and ambulances were asked to review these calls.

EVALUATION SUPPORTING DOCUMENTATION PROVIDED AT SITE VISIT TO INCLUDE:

EMS Data Dictionary

Trauma Registry Data Dictionary

Sample EMS Protocols

NORTH DAKOTA
DEPARTMENT of HEALTH

2006-2007

Emergency Medical Services Data Report

North Dakota Department of Health
Division of Emergency Medical Services

Emergency Medical Services Data Report 2006-2007

John Hoeven, Governor
Dr. Terry Dwelle, State Health Officer

NORTH DAKOTA
DEPARTMENT of HEALTH

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North Dakota State Online Ambulance Reporting

History of Data Collection

Every licensed ambulance is required to submit data. N.D.A.C § 33-11-01-09.5 requires that all ambulance runs must be reported to the North Dakota Department of Health, Division of Emergency Medical Services (DEMS) in the manner and form determined by DEMS.

The North Dakota Department of Health has collected ambulance information since the 1970s. Paper copies of trip tickets were received from the various agencies and then a full-time dedicated employee compiled the information. In the early 1990s, the Division of Emergency Health Services started scanning the trip tickets using EMScan. In July 2004, the DEMS entered into a partnership with MedMedia to have online data submission. Ambulances were given one year to transition from submitting paper trip tickets to online data submission.

North Dakota has been part of the national movement for pre-hospital data since the 1970s. The DEMS continues to stay closely aligned with the national dataset set forth by the National Highway Traffic Safety Administration in the National Emergency Medical Services Information System data standard. In 2007, the DEMS worked with MedMedia to transition the SOAR data set to NEMSIS Silver + Compliance. The transition is set to take place early in 2008.

Data Quality Issues

In North Dakota, volunteers compose more than 90 percent of ambulance staffing. A problem with volunteer-based emergency medical services (EMS) is a heavy turnover rate, especially in ambulance managers. Also, ambulance volunteers have dedicated a large amount of time to serve their communities. Data input is perceived as another task that will require more volunteer time, taking volunteers out of the field and putting them into an administrative role.

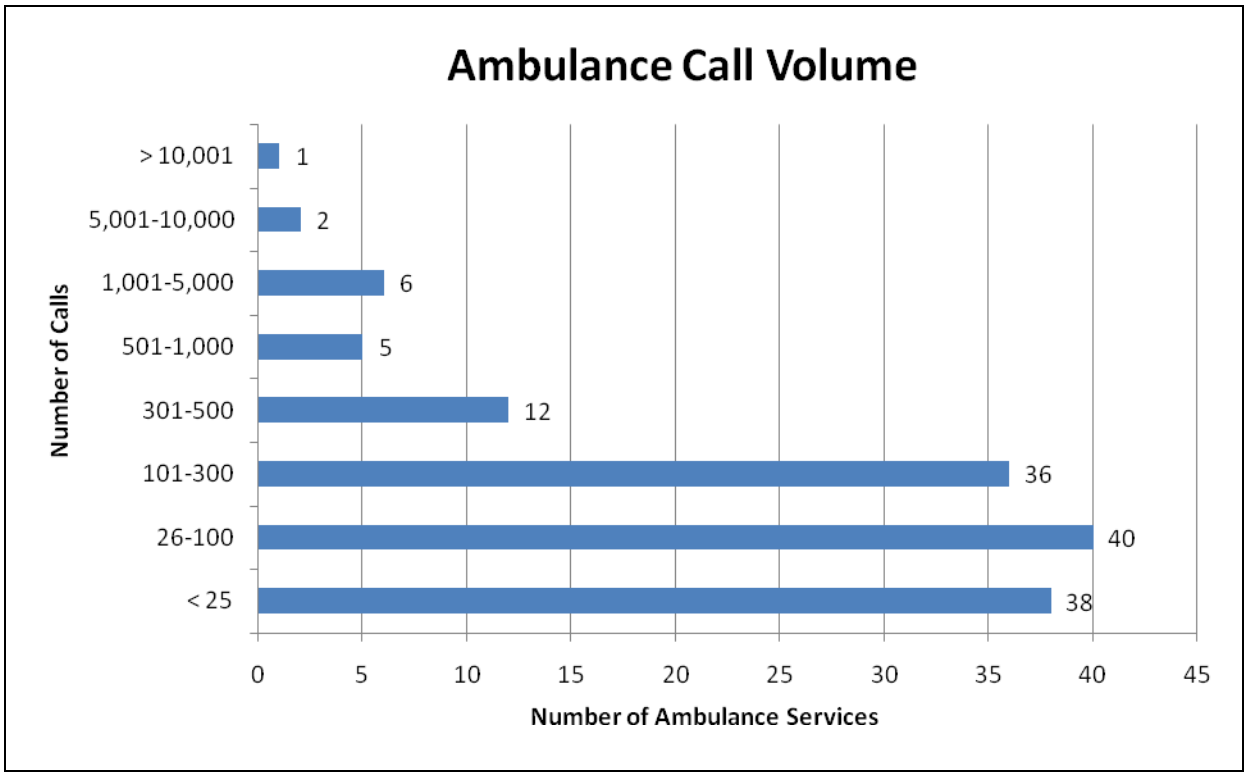
With overtaxed volunteers, a number of ambulance services use billing companies for reimbursement. Approximately 44 percent of North Dakota ambulance services use their respective billing company for data entry to the state system, as well. Out-sourcing of data entry can cause a number of concerns with accuracy and validity of data.

Another data concern is a lack of training. Providers who enter data may not have received any training in the software or proper coding. With the DEMS hiring a research analyst, regional training sessions for SOAR users is planned for 2008.

SOAR data would benefit greatly from medical director quality improvement and quality assurance (QI/QA). Like everything in rural states, doctors are in high demand and overtaxed. QI/QA would benefit not only data, but the entire state EMS system.

State Ambulance Data

From October 1, 2006 through September 30, 2007, North Dakota EMS providers responded to 57,661 calls. Of the 57,661 calls, 97 percent were complete patient care reports. For a patient care report to be complete, all state-required fields must have been answered in an acceptable form. Four ambulance services did not report to the state any runs for the year: Aneta, Marmarth, Lemmon and Goodrich.

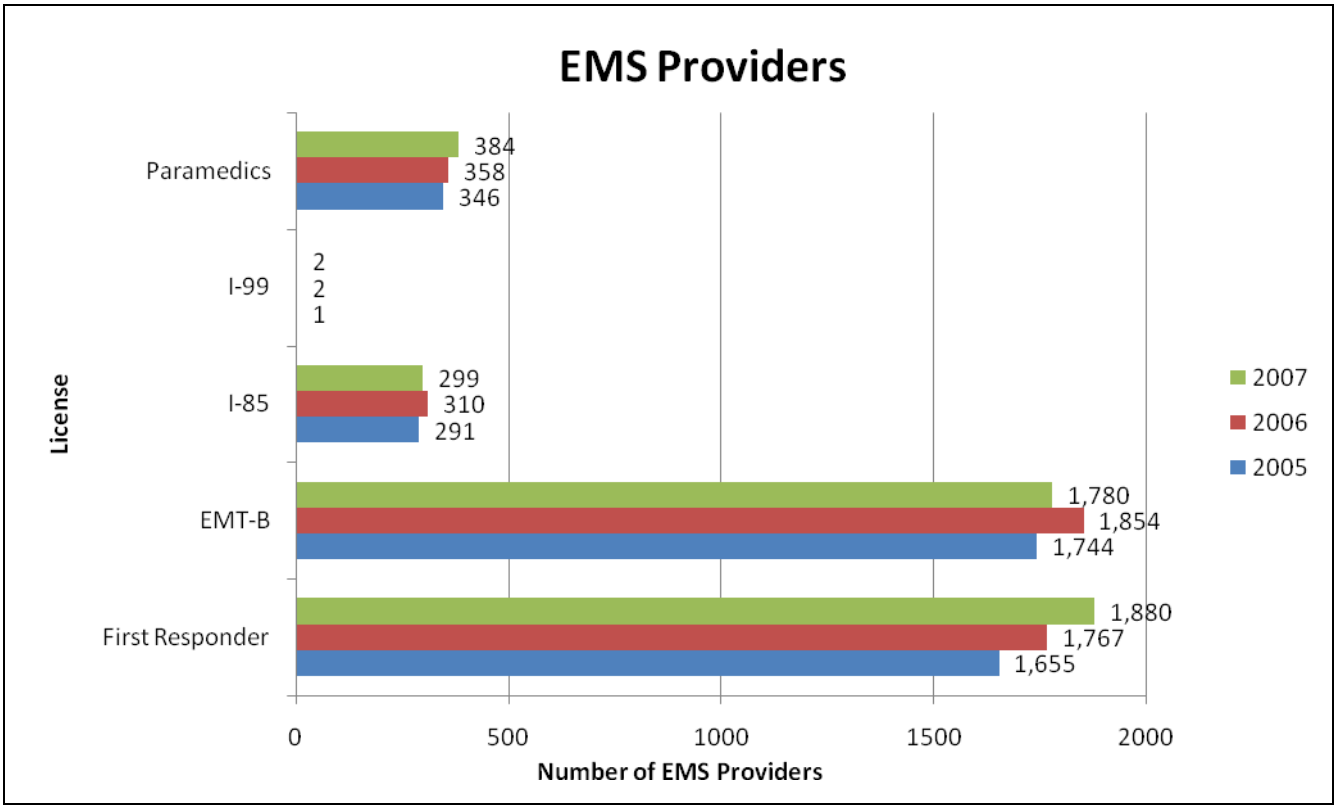


Seventy-eight ambulance services do 100 or fewer ambulance calls per year. DEMS estimates that an ambulance service must do at least 400 ambulance calls per year to be financially self-sustaining through the billing process. Four hundred ambulance calls per year would allow the ambulance to generate enough revenue to have a combination of volunteers and minimally paid staff.

The 10 busiest ambulance services in North Dakota provided service for 71 percent of all ambulance calls for the last year. F-M Ambulance responded to more than 11,000 calls in North Dakota from October 2006 through September 2007.

Above – F-M Ambulance, Fargo, N.D.

Right – Altru Ambulance, Grand Forks, N.D.



Over the past three years, the numbers of EMS providers has shown modest growth. An increase in first responders by 14 percent is very likely due to a training grant opportunity that began in 2005. The number of paramedics has increased by 11 percent in the last three years, most likely due to more employment opportunities and a workforce shortage. EMT-B numbers have gained 2 percent and EMT-I gained 3 percent. These numbers do not correlate to people actually working for an EMS agency. In North Dakota, an EMS provider may be certified or licensed and may never actually work in the field for an ambulance service.

The initial course requirements are as follows: first responders – 40 hours; EMT-B – 120 hours; intermediate – over 120 hours; and paramedic – 1200 hours. To recertify, the following refresher hours are needed: first responders – 16 hours; EMT-B – 24 hours; intermediate – 36 hours; and paramedic – 48 hours. First responders do not need continuing education to recertify. Continuing education is required as follows: EMT-B – 48 hours; intermediate – 36 hours; and paramedic – 24 hours.

In January 2008, DEMS started to collect information about each responder's employment classification. According to state law, a volunteer is someone who earns less than $10,000 per year. On the application for state licensure, the individuals are asked whether they earn more or less than $10,000 per year as an EMT, intermediate or paramedic. In the future, the DEMS will be better able to determine what percentage of ambulance staff volunteer.

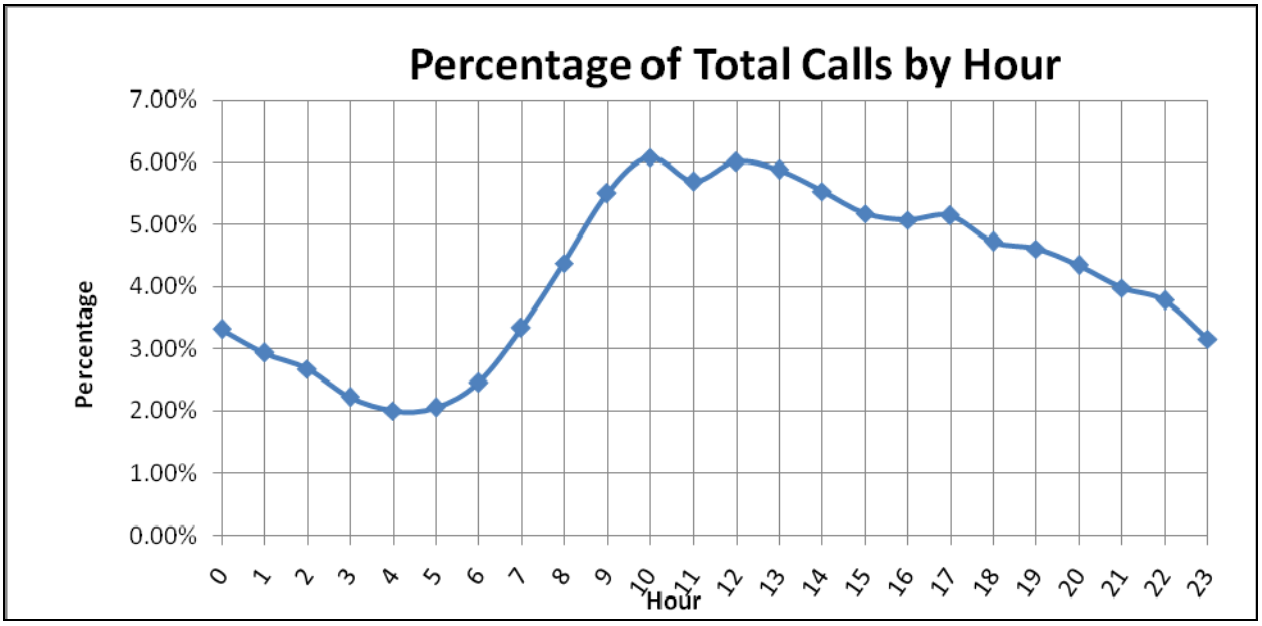
The table to the right depicts the average response time for 911 calls using the following time parameters: 911 dispatch times to scene arrival times. Urban counties include Ward, Burleigh, Grand Forks and Cass. Rural counties include Williams, Stark, Mercer, Morton, Rolette, Ramsey, Walsh, Pembina, Traill, Stutsman, Barnes, Ransom, and Richland. All other counties were classified as frontier. Counties were classified as frontier if the population is fewer than six people per square mile. Calls recorded with a greater than 60-minute response time were assumed to be erroneous and excluded from the average.

	Average in Minutes	Input Error (> 60 minutes)
Frontier	11.48	371
Rural	10.42	74
Urban	7.57	271

Percentage of Calls by Day in the Week

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
13.0%	14.6%	14.5%	14.2%	14.4%	15.3%	13.9%

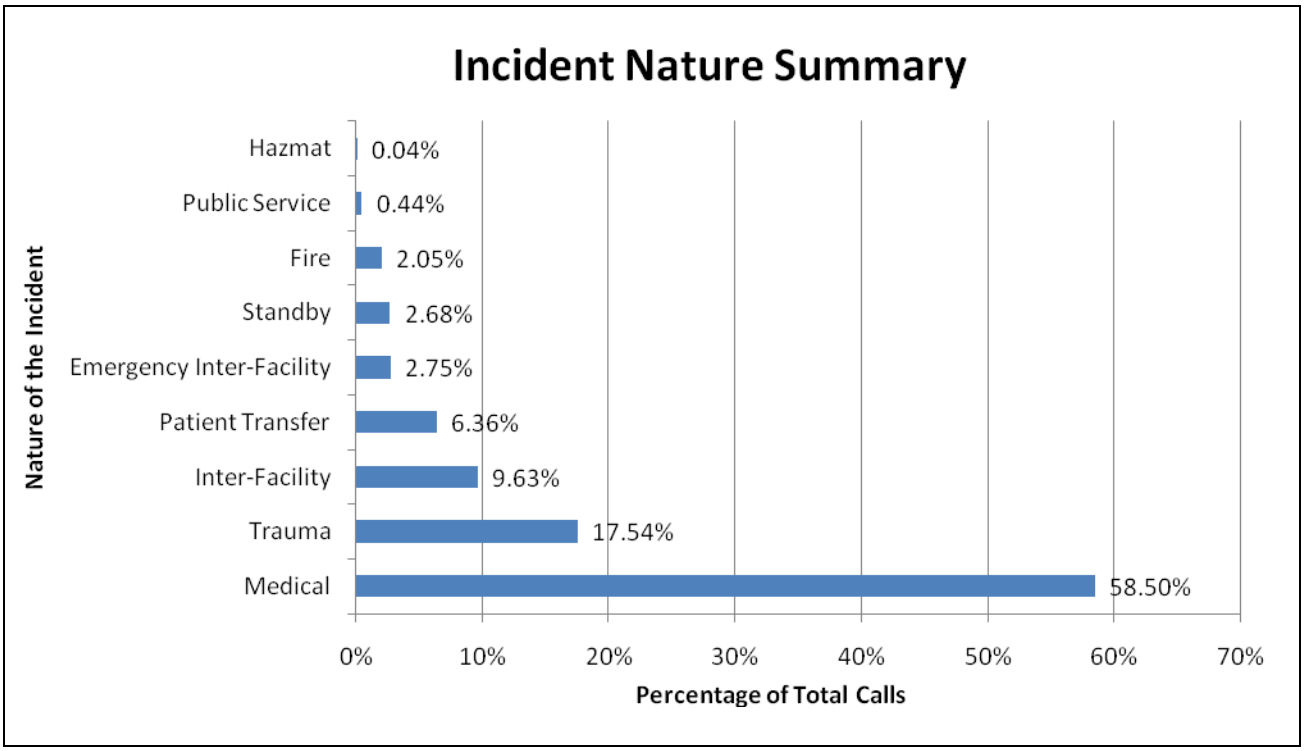
The call volume varies slightly throughout the week. Friday has the highest percentage of calls with 15.3 percent. Sunday has the lowest percentage of calls with 13.0 percent. Ambulance calls are slightly more frequent during midday and taper off throughout the afternoon and evening. Ambulance calls are least frequent during the early morning hours.



Percentage of calls by Hour of the Day

Hour	0	1	2	3	4	5	6	7	8	9	10	11
%	3.31%	2.93%	2.67%	2.22%	2.00%	2.05%	2.45%	3.33%	4.37%	5.50%	6.08%	5.69%
Hour	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**
%	6.01%	5.87%	5.53%	5.18%	5.07%	5.15%	4.72%	4.61%	4.34%	3.98%	3.78%	3.16%

Of the completed reports, the largest percentages were for medical emergencies; followed by trauma incidents. The graph below shows the percentage of calls broken down by the nature of incidents. Medical and trauma incidents make up three-quarters of all ambulance calls for the last year.



The largest percentage of dispatch complaints for the last year is coded as other. Further education and training about the software and the process of documentation should reduce dispatch complaints coded as other. Additional categories may need to be added. Currently, ambulances have 35 choices for dispatch complaint including other and unknown problem. Only the primary complaint reported to or received at dispatch can be submitted. When the ambulance receives multiple complaints, the provider may code the call as other. Further dialogue with providers will be needed to determine how to make this data element more meaningful in the future.

Top 5 - Dispatch Complaint	Percentage
Other	34.66%
Fall victim	7.46%
Traffic accident	6.00%
Unconscious, fainting, syncope	3.57%
Abdominal pain	2.79%

The table to the right shows a correlation of higher age with more frequent use of EMS. Nearly 40 percent of ambulance calls are for patients older than 65.

Ambulance Calls by Age Range

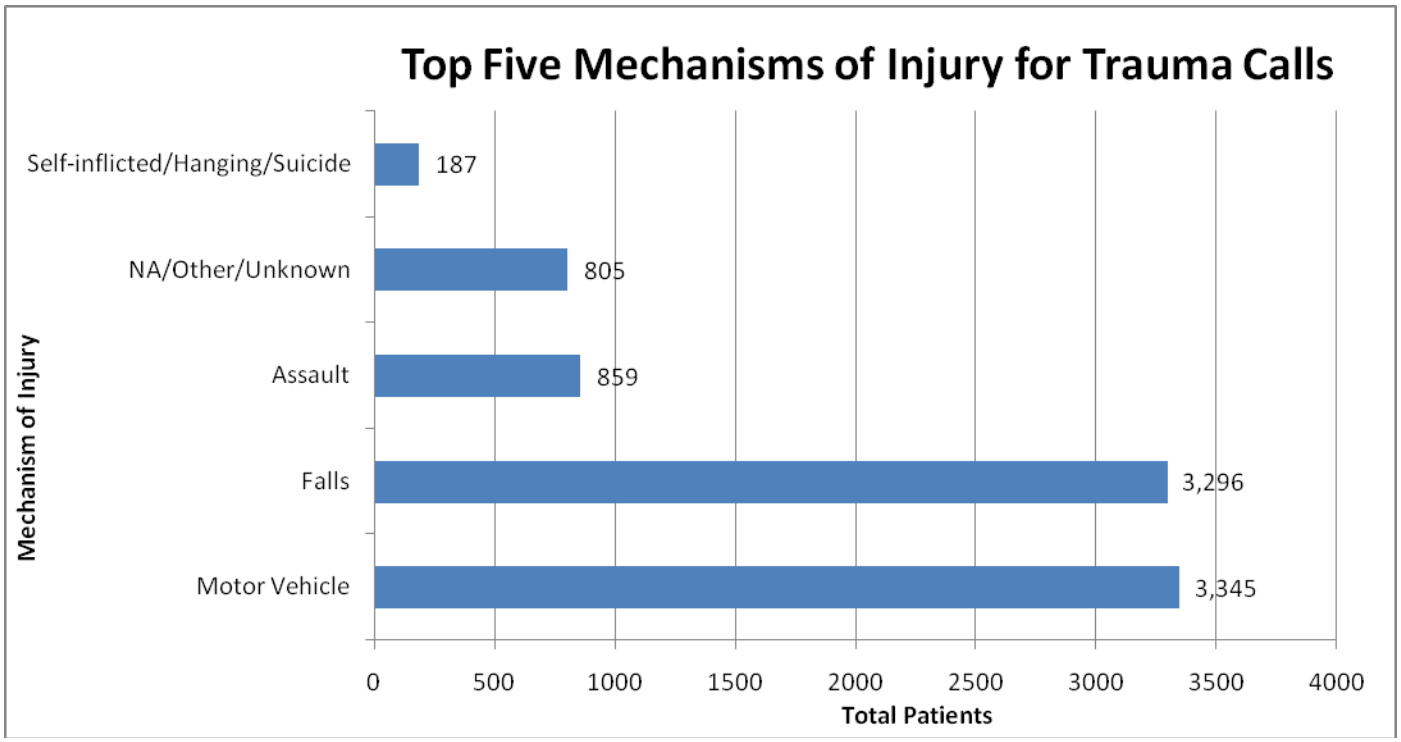
Age Range	Ambulance Calls	Census Data for ND
Under 5 years	1.6%	6.1%
5 to 9 years	1.1%	6.7%
10 to 14 years	1.6%	7.4%
15 to 19 years	4.8%	8.3%
20 to 24 years	5.4%	7.9%
25 to 34 years	7.8%	12.0%
35 to 44 years	9.0%	15.3%
45 to 54 years	11.3%	13.3%
55 to 59 years	5.3%	4.5%
60 to 64 years	5.0%	3.8%
65 to 74 years	11.0%	7.1%
75 to 84 years	15.4%	5.3%
85 years and over	12.4%	2.3%
Missing	8.2%	

Residences are the most common place ambulances respond to. Residence at 39 percent is followed by acute care facility at 25 percent. Together, residences and acute care facilities make up for nearly 65 percent of all incident location types.

Percentage of Ambulance Calls by Location Type

Incident Location	Frequency
Acute care facility	24.76%
Bar/restaurant	0.76%
Clinic/ Dr's office	2.39%
Correctional facility	0.84%
EMS rendezvous	0.23%
Extended-care facility	6.61%
Farm	0.43%
Hotel/motel	0.70%
Industrial	0.47%
Mental health facility	0.05%
Mine	0.01%
Not provided	1.05%
Off-road	0.23%
Office/business	2.73%
Other/ not applicable	1.38%
Other traffic way	4.18%
Public place	7.33%
Recreation area	0.50%
Reservation	0.08%
Residence	39.05%
School/college	0.91%
Specialty care facility	1.00%
Traffic way 55+ mph	4.04%
Unknown	0.19%
Waterway	0.04%
Wilderness	0.08%

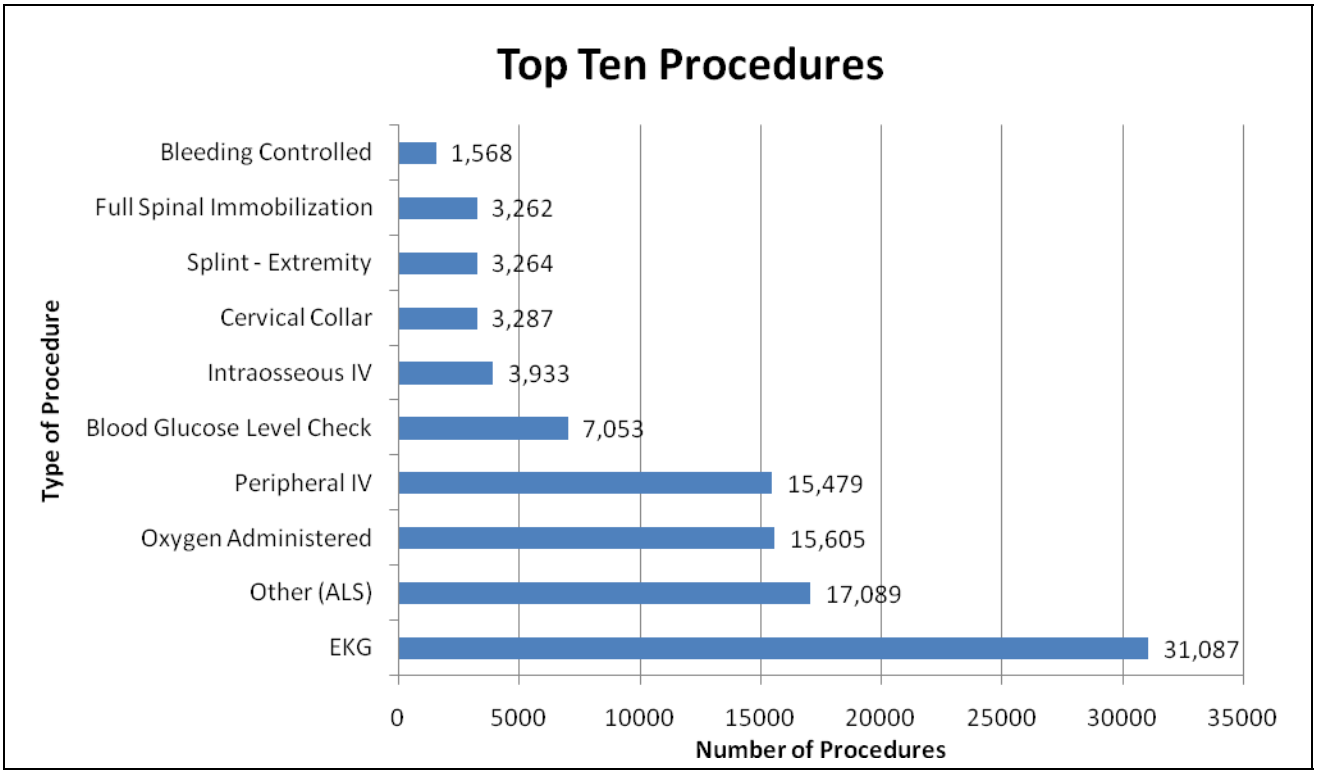
Trauma Incidents



Motor vehicle crashes continue to be the most common cause of trauma to which an ambulance responds; falls are a close second. Together, falls and motor vehicle crashes make up 70 percent of EMS trauma calls. Head trauma makes up the largest percentage for body site trauma, with 23 percent.

Trauma Calls: Site of Injury by Type of Injury

Site	Ampu-tations	Blunt	Burn	Crush	Fracture	Other	GSW	Penetration	Soft Closed	Soft Open	Percentage of Site
Abdomen	0	152	9	7	0	2	3	33	103	52	2.70%
Arm	14	398	41	18	373	0	2	50	386	450	12.96%
Back/spine	0	404	12	8	68	0	3	13	260	53	6.14%
Chest	3	361	19	11	73	0	6	27	194	61	5.65%
Eye	0	97	9	3	8	0	0	10	118	52	2.22%
Face	0	540	36	12	74	0	2	23	389	624	12.72%
Hand	21	101	25	12	37	0	1	31	122	243	4.44%
Head	1	1139	23	15	72	7	14	32	672	1104	23.04%
Leg/foot	33	456	21	26	623	0	7	28	540	294	15.18%
Neck/spine	0	331	15	9	87	0	1	8	200	32	5.11%
Other	0	13	0	1	1	0	0	1	5	1	0.16%
Pelvic/groin	0	249	6	11	298	0	1	7	224	24	6.14%
Thigh	5	125	14	4	132	0	1	14	125	53	3.54%
Totals	0.58%	32.67%	1.72%	1.03%	13.81%	0.07%	0.31%	2.07%	24.98%	22.77%	100.00%



Procedures are somewhat under-reported. Until recently, the state was not receiving procedures from those companies that had their own software or those who hired-out data input. EKG is reported as the most frequent procedure because two readings are required for each EKG and are reported as two separate procedures.

Attachment A of this report includes a map color coded by EMS run incidents per county illustrates where the most incidents occurred in the last year. Attachment B is a map of the ambulance locations. Attachment C is a table of ambulance services listed by license number.

For questions or comments, please contact Tim Meyer or Lindsey Bratvold Narloch at:

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lindseybnarloch@nd.gov

Number of Incidents Requiring an Ambulance per County

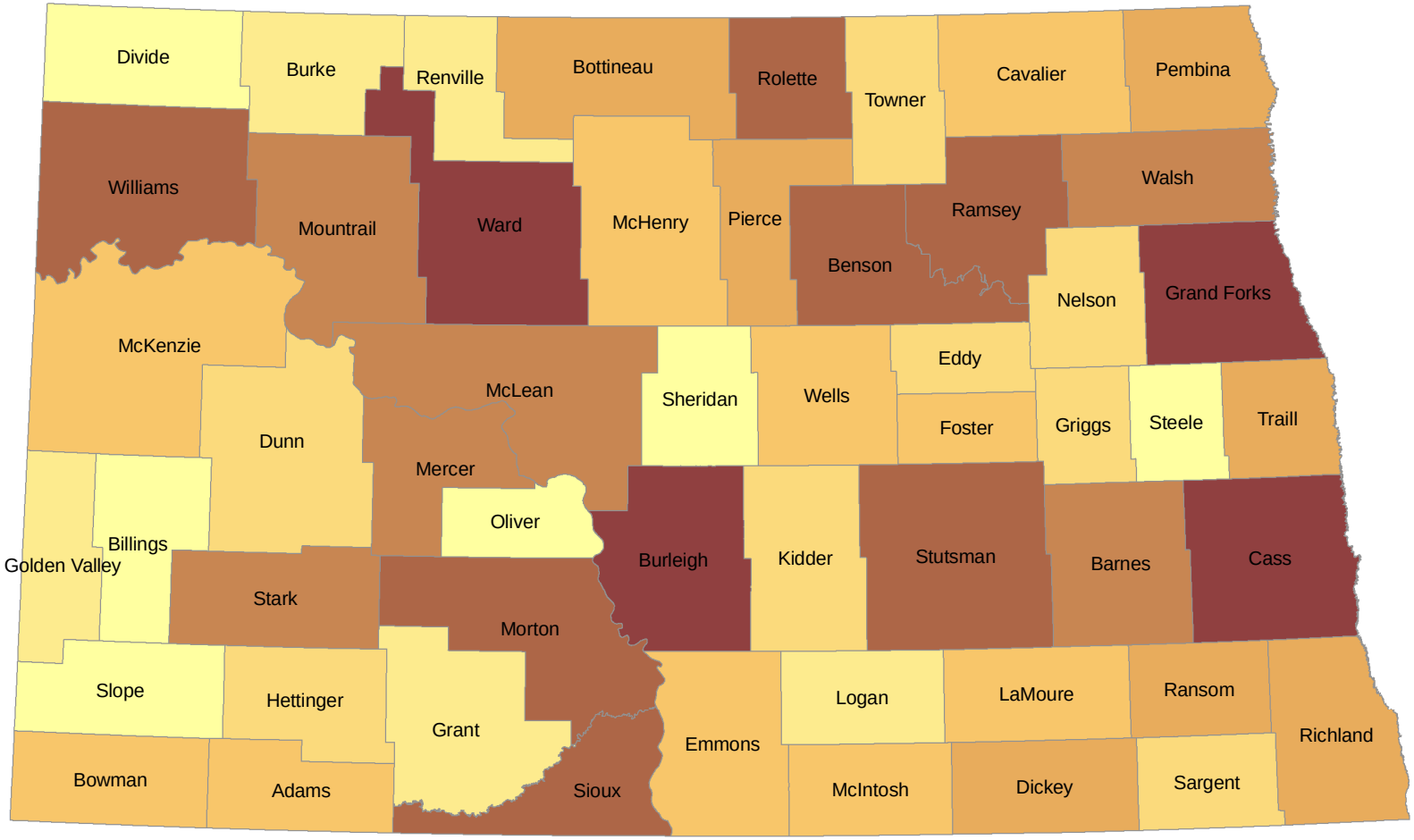
Attachment A

Legend

Total Ambulance Incidents

- 4 - 54
- 55 - 133
- 134 - 215
- 216 - 354
- 355 - 626
- 627 - 1096
- 1097 - 2019
- 2020 - 11537

Minnesota - 2295
South Dakota - 546
Not Listed - 557
Blank - 476

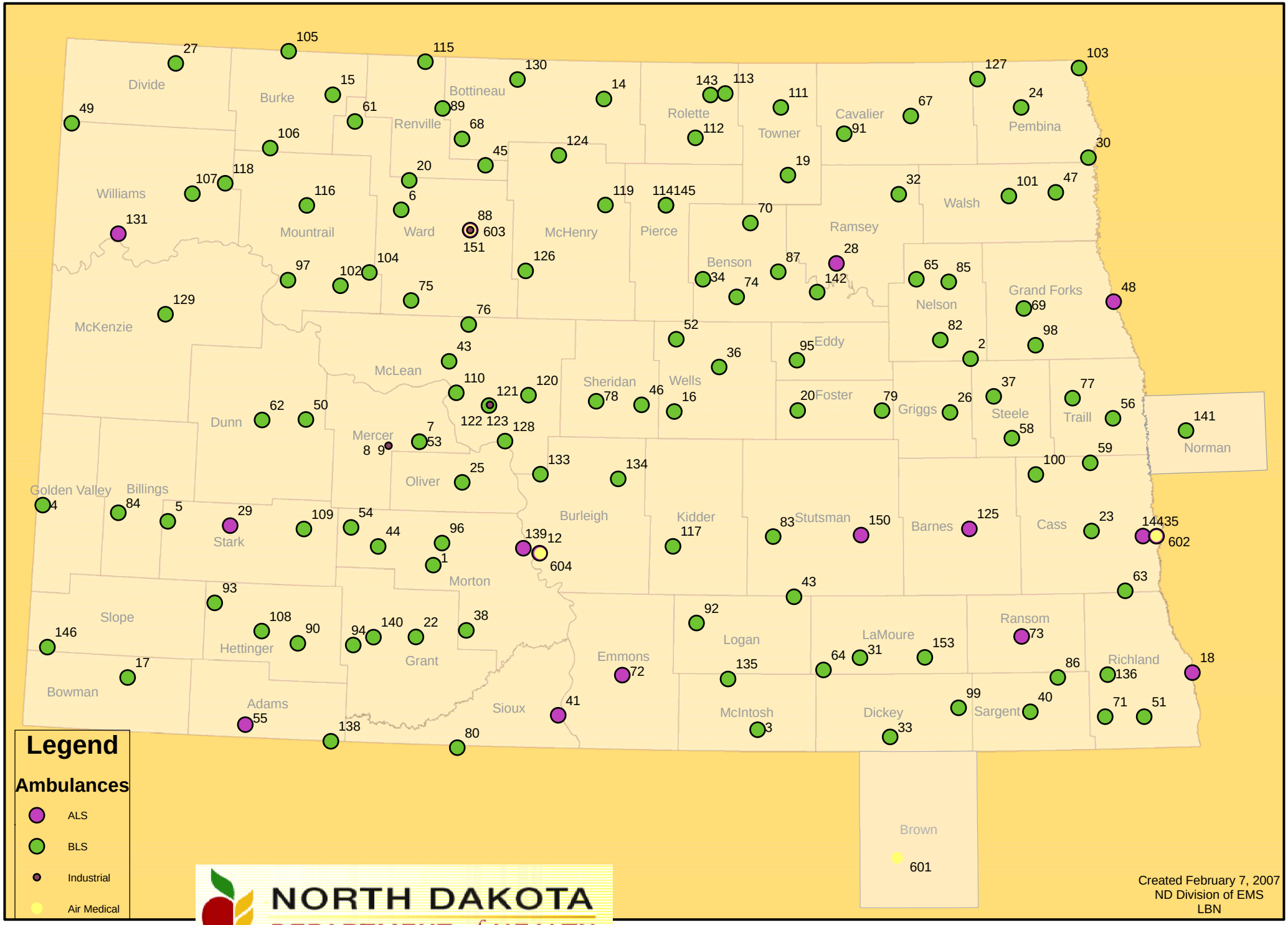


NORTH DAKOTA
DEPARTMENT of HEALTH

From October 1, 2006 - September 30, 2007
Created December 21, 2007
LBN

North Dakota Ambulance Services by License Number

Attachment B



North Dakota Ambulance Services

ID	Company	Address	City	State	Zip	Level
1	Almont Ambulance Service	5247 46th St.	Almont	ND	58520	BLS Ground
2	Aneta Ambulance Service	PO Box 346	Aneta	ND	58212	BLS Ground
3	Ashley Ambulance Service	PO Box 450	Ashley	ND	58413	BLS Ground
4	Community Ambulance Service Inc.	PO Box 803	Beach	ND	58621	BLS Ground
5	Belfield Ambulance Service Inc.	PO Box 906	Belfield	ND	58622	BLS Ground
6	Berthold Ambulance Service Inc.	PO Box 176	Berthold	ND	58718	BLS Ground
7	Mercer County Ambulance Service Inc. -- Beulah	801 4th St. NE	Hazen	ND	58545	BLS Ground
8	The Coteau Properties Co.--Ambulance Service	204 County Rd 15	Beulah	ND	58523	BLS Ground
9	Dakota Gasification Co.--Ambulance Service	420 County Rd 26	Beulah	ND	58523	BLS Ground
12	Metro Area Ambulance Service Inc - Bismarck	PO Box 595	Mandan	ND	58554	ALS Ground
14	Bottineau Ambulance Service	1310 Thompson St. S.	Bottineau	ND	58318	BLS Ground
15	Bowbells Ambulance Service	PO Box 341	Bowbells	ND	58721	BLS Ground
16	Bowdon Ambulance Service	4231 2 St NE	Bowdon	ND	58418	BLS Ground
17	Bowman Ambulance Squad Inc	PO Box C	Bowman	ND	58623	BLS Ground
18	Ambulance Service, Inc.	PO Box 64	Breckenridge	MN	56520	ALS Ground
19	Towner County Ambulance Service Inc. - Cando	P.O. Box 881	Cando	ND	58324	BLS Ground
20	Carpio Ambulance Service	PO Box 83	Carpio	ND	58725	BLS Ground
21	Carrington Health Center Ambulance	PO Box 461	Carrington	ND	58421	BLS Ground
22	Carson Ambulance Service	100 S Main St.	Carson	ND	58529	BLS Ground
23	Casselton Ambulance Service, Inc.	PO Box 826	Casselton	ND	58012	BLS Ground
24	Cavalier Ambulance Service, Inc.	PO Box 231	Cavalier	ND	58220	BLS Ground
25	Oliver County Ambulance Service	PO Box 174	Center	ND	58530	BLS Ground
26	Cooperstown Ambulance Service	1207 Burrel Ave. NE	Cooperstown	ND	58425	BLS Ground
27	Divide County Ambulance Service	PO Box 31	Crosby	ND	58730	BLS Ground
28	Lake Region Ambulance Service	PO Box 893	Devils Lake	ND	58301	ALS Ground
29	Dickinson Area Ambulance Service, Inc.	PO Box 772	Dickinson	ND	58601	ALS Ground
30	Drayton Volunteer Ambulance Association Inc.	507 N 3rd St.	Drayton	ND	58225	BLS Ground
31	Edgeley Ambulance Service	909 4th	Edgeley	ND	58433	BLS Ground
32	Edmore Volunteer Ambulance Service	PO Box 123	Edmore	ND	58330	BLS Ground
33	Ellendale Community Ambulance Service	PO Box 66	Ellendale	ND	58436	BLS Ground
34	Esmond Community Ambulance Service	4332 Hwy 19	Esmond	ND	58332	BLS Ground
35	F-M Ambulance Service, Inc.	2215 18th St S	Fargo	ND	58103	ALS Ground
36	Fessenden Ambulance Service	PO Box 193	Fessenden	ND	58438	BLS Ground
37	Finley Ambulance Service	PO Box 433	Finley	ND	58230	BLS Ground
38	Flasher Ambulance Service	PO Box 243	Flasher	ND	58535	BLS Ground
40	Sargent County Amb Service - Forman	PO Box 316	Forman	ND	58032	BLS Ground

41	Standing Rock Ambulance Service	PO Box D-22	Ft. Yates	ND	58538	ALS Ground
42	Gackle Ambulance Service	PO Box 277	Gackle	ND	58442	BLS Ground
43	Garrison - Max Ambulance District	PO Box 517	Garrison	ND	58540	BLS Ground
44	Glen Ullin Area Ambulance Service	6920 34th St	Glen Ullin	ND	58631	BLS Ground
45	Glenburn Area Ambulance Service Inc	PO Box 95	Glenburn	ND	58740	BLS Ground
46	Goodrich Ambulance Service	141 19th Ave SE	Goodrich	ND	58444	BLS Ground
47	Valley Ambulance & Rescue Serv Inc	164 West 13th St	Grafton	ND	58237	BLS Ground
48	Altru Health System Ambulance Service	PO Box 6002	Grand Forks	ND	58206	ALS Ground
49	Grenora Ambulance Service	PO Box 274	Grenora	ND	58845	BLS Ground
50	Halliday Ambulance Service	215 2nd St. NW	Halliday	ND	58636	BLS Ground
51	Hankinson Vol Ambulance Service	9205 167th Ave. SE	Hankinson	ND	58041	BLS Ground
52	Harvey Ambulance Service, Inc.	318 6th ST W	Harvey	ND	58341	BLS Ground
53	Mercer Co Amb Service Inc -- Hazen	801 4th St NE	Hazen	ND	58545	BLS Ground
54	Hebron Ambulance Service	PO Box 522	Hebron	ND	58638	BLS Ground
55	West River Ambulance Service	1000 Highway 12	Hettinger	ND	58639	ALS Ground
56	Hillsboro Ambulance Service	PO Box 609	Hillsboro	ND	58045	BLS Ground
58	Hope Ambulance Service	PO Box 182	Hope	ND	58046	BLS Ground
59	Hunter Ambulance Service	PO Box 36	Hunter	ND	58048	BLS Ground
61	Kenmare Ambulance Service	PO Box 371	Kenmare	ND	58746	BLS Ground
62	Killdeer Area Ambulance Service Inc	PO Box 33	Killdeer	ND	58640	BLS Ground
63	Kindred Area Ambulance Service	100 1st Ave N.	Kindred	ND	58051	BLS Ground
64	Kulm Ambulance Corps, Inc.	PO Box 189	Kulm	ND	58456	BLS Ground
65	Lakota Ambulance Service	PO Box 338	Lakota	ND	58344	BLS Ground
67	Langdon Ambulance Service	909 2nd ST	Langdon	ND	58249	BLS Ground
68	Lansford Ambulance Service	2589 89th St. NW	Lansford	ND	58750	BLS Ground
69	Larimore Ambulance Service Inc.	PO Box 440	Larimore	ND	58251	BLS Ground
70	Leeds Ambulance Service	PO Box 147	Leeds	ND	58346	BLS Ground
71	Lidgerwood Rural Ambulance Service District	PO Box 416	Lidgerwood	ND	58053	BLS Ground
72	Emmons County Ambulance Service	216 W Spruce Ave	Linton	ND	58552	ALS Ground
73	First Medic Ambulance of Ransom County	PO Box 1007	Lisbon	ND	58054	ALS Ground
74	Maddock Ambulance Service	3042 49th Ave. NE	Maddock	ND	58348	BLS Ground
75	Ryder-Makoti Ambulance Service	PO Box 8	Ryder	ND	58779	BLS Ground
77	West Traill Ambulance Service	42 6th Ave. SE	Mayville	ND	58257	BLS Ground
78	Mcclusky Rural Ambulance District	PO Box 622	McClusky	ND	58463	BLS Ground
79	Mchenry Ambulance Service	9230 Hwy 15	Binford	ND	58416	BLS Ground
80	Mcintosh V.F.D. Ambulance Service	PO Box 413	McIntosh	SD	57641	BLS Ground
82	Mcville Community Ambulance Service	PO Box 343	McVille	ND	58254	BLS Ground
83	Medina Ambulance Service	PO Box 756	Medina	ND	58467	BLS Ground

84	Billings County Ambulance Service	PO Box 104	Medora	ND	58645	BLS Ground
85	Michigan Area Ambulance Service Inc.	PO Box 17	Michigan	ND	58259	BLS Ground
86	Sargent County Ambulance Service	P O Box 98	Milnor	ND	58060	BLS Ground
87	Minnewaukan Ambulance Service	PO Box 43	Minnewaukan	ND	58351	BLS Ground
88	Community Ambulance Service, Inc.	PO Box 2195	Minot	ND	58702	ALS Ground
89	Mohall Ambulance Service	PO Box 685	Mohall	ND	58761	BLS Ground
90	Mott Ambulance Service	PO Box 102	Mott	ND	58646	BLS Ground
91	Munich Rural Ambulance	8422 92nd St. NE	Munich	ND	58352	BLS Ground
92	Napoleon Ambulance Service	515 5th St. E.	Napoleon	ND	58561	BLS Ground
93	New England Ambulance Service	5848 Hwy 22 South	New England	ND	58647	BLS Ground
94	New Leipzig Ambulance Service	PO Box 127	New Leipzig	ND	58562	BLS Ground
95	Community Ambulance Service of New Rockford	PO Box 246	New Rockford	ND	58356	BLS Ground
96	New Salem Ambulance Service	PO Box 87	New Salem	ND	58563	BLS Ground
97	New Town Community Amb. Service District	PO Box 716	New Town	ND	58763	BLS Ground
98	Northwood Ambulance Service	PO Box 139	Northwood	ND	58267	BLS Ground
99	Oakes Volunteer Ambulance Service	615 Ivy Ave	Oakes	ND	58474	BLS Ground
100	Page Ambulance Service	PO Box 106	Page	ND	58064	BLS Ground
101	Park River Volunteer Ambulance Service	PO Box 106	Park River	ND	58270	BLS Ground
102	Parshall Rural Ambulance Service Inc.	PO Box 398	Parshall	ND	58770	BLS Ground
103	Pembina Ambulance Service	PO Box 131	Pembina	ND	58271	BLS Ground
104	Plaza Ambulance Service	PO Box 57	Plaza	ND	58771	BLS Ground
105	Portal Ambulance Service	PO Box 61	Portal	ND	58772	BLS Ground
106	Powers Lake Ambulance Association	PO Box 316	Powers Lake	ND	58773	BLS Ground
107	Ray Community Ambulance District	PO Box 251	Ray	ND	58849	BLS Ground
108	Regent Ambulance Service	PO Box 292	Regent	ND	58650	BLS Ground
109	Richardton-Taylor Ambulance Service	322 C. Street North	Richardton	ND	58652	BLS Ground
110	Riverdale Ambulance Department	PO Box 534	Riverdale	ND	58565	BLS Ground
111	Rock Lake Ambulance Service	54 Elsberry	Rock Lake	ND	58365	BLS Ground
112	Rolette Ambulance Service, Inc	RR 2 Box 92	Rolette	ND	58366	BLS Ground
113	Community Ambulance Service Of Rolla	PO Box 653	Rolla	ND	58367	BLS Ground
114	Rugby Emergency Ambulance Service	800 S Main Ave	Rugby	ND	58368	BLS Ground
115	Sherwood Ambulance Service	PO Box 153	Sherwood	ND	58782	BLS Ground
116	Stanley Ambulance Service	PO Box 546	Stanley	ND	58784	BLS Ground
117	Kidder County Ambulance Service	PO Box 254	Steele	ND	58482	BLS Ground
118	Tioga Ambulance Service	PO Box 451	Tioga	ND	58852	BLS Ground
119	Towner Fire, Ambulance, and Rescue Service, Inc.	PO Box 358	Towner	ND	58788	BLS Ground
120	Turtle Lake Ambulance Service	PO Box 243	Turtle Lake	ND	58575	BLS Ground
121	Underwood Ambulance Service	PO Box 1045	Underwood	ND	58576	BLS Ground
122	GRE--Coal Creek Station Amb Service	2875 3rd St. SW	Underwood	ND	58576	BLS Ground

123	The Falkirk Mine Ambulance Service	PO Box 1087	Underwood	ND	58576	BLS Ground
124	Upham Ambulance Service	PO Box 141	Upham	ND	58789	BLS Ground
125	Barnes County / City Ambulance	914 11th Ave. SW	Valley City	ND	58072	ALS Ground
126	Velva Ambulance Service	PO Box 231	Velva	ND	58790	BLS Ground
127	Walhalla Ambulance Service	PO Box 467	Walhalla	ND	58282	BLS Ground
128	Washburn Volunteer Ambulance Serv	PO Box 164	Washburn	ND	58577	BLS Ground
129	Mckenzie County Ambulance Service	PO BOX 122	Watford City	ND	58854	BLS Ground
130	Westhope Ambulance Service	PO Box 214	Westhope	ND	58793	BLS Ground
131	Williston Ambulance Service	317 11th St W	Williston	ND	58801	ALS Ground
133	Wilton Rural Ambulance Service	PO BOX 163	Wilton	ND	58579	BLS Ground
134	Wing Rural Ambulance	205 2nd Ave W	Wing	ND	58494	BLS Ground
135	Wishek Ambulance Service	1007 4th Ave S.	Wishek	ND	58495	BLS Ground
136	Wyndmere-Barney Rural Amb Dist	PO Box 184	Wyndmere	ND	58081	BLS Ground
138	Lemmon EMT Association	PO Box 3	Lemmon	SD	57638	BLS Ground
139	Metro Area Ambulance Service Inc (M)	PO Box 595	Mandan	ND	58554	ALS Ground
141	Norman County EMS	201 9th St West	Ada	MN	56510	ALS Ground
142	Spirit Lake Emergency Medical Service	PO Box 449	Fort Totten	ND	58335	BLS Ground
143	Belcourt Ambulance Service	PO Box 160	Belcourt	ND	58316	BLS Ground
144	F-M Ambulance Service Inc - West Fargo	PO Box 9058	Fargo	ND	58107	ALS Ground
145	Golden Heart EMS	800 S Main Ave	Rugby	ND	58368	ALS Ground
146	Marmarth Ambulance Service	PO Box 144	Marmarth	ND	58643	BLS Ground
150	Jamestown Area Ambulance	PO Box 641	Fergus Falls	MN	56538	ALS Ground
151	5th Medical Group Ambulance Service	10 Missile Ave	Minot AFB	ND	58705	BLS Ground
153	Community Volunteer EMS of LaMoure	PO Box 234	LaMoure	ND	58458	BLS Ground
601	Avera St. Lukes Careflight	305 S. State St.	Aberdeen	SD	57401	ALS Air (RW)
602	Meritcare Lifeflight	720 4th St. N.	Fargo	ND	58122	CC Air (RW, FW)
603	Northstar Criticair	3100 4th Ave SE	Minot	ND	58701	ALS Air (RW)
604	Bismarck Air Medical LLC	2940 N 19th	Bismarck	ND	58503	CC Air (FW)

MEDICAL DIRECTION

EMS is a medical-care system that involves medical practice as delegated by physicians to non-physician providers who manage patient care outside the traditional confines of the office or hospital. As befits this delegation of authority, the system ensures that physicians are involved in all aspects of the patient-care system. Specific areas of involvement include the following:

- Planning and protocols
- On-line medical direction and consultation
- Audit and evaluation of patient care

The role of the state medical director of EMS is clearly defined, with legislative authority and responsibility for EMS system standards, protocols and evaluation of patient care.

A comprehensive system of medical direction for all out-of-hospital emergency medical-care providers (including BLS) is utilized to evaluate the provision of medical care as it relates to patient outcome, appropriateness of training programs and medical direction.

There are standards for the training and monitoring of direct medical control physicians and statewide standardized treatment protocols.

There is a mechanism for concurrent and retrospective review of out-of-hospital emergency medical care, including indicators for optimal system performance.

Physicians are consistently involved and provide leadership at all levels of quality improvement programs (local, regional, statewide).

Where We Are Today

In North Dakota, physician medical direction is mandated for the licensure of all advanced life support ground ambulance services, basic life support ground ambulance services and air ambulance services. State rules promulgated by the Board of Medical Examiners also requires a written agreement be on file with the Department of Health between a physician and advanced-level EMS provider: EMT-I85, EMT-I99, and paramedic. These rules also require an agreement that allows BLS and ILS providers to provide limited enhanced skills: manual defibrillation, intravenous (IV) fluid maintenance, epinephrine administration, dextrose administration, bronchodilator/nebulizer administration, limited advanced airway insertion (Combitube, King Airway) .

The practice of EMS in North Dakota is rooted in the concept of physician delegation of authority. A physician delegates authority to emergency medical technicians to provide patient care. This happens in two ways: by virtue of employment of an EMT with a licensed or certified EMS agency providing care as outlined in treatment protocols

(Offline Medical Control), and by virtue of a written agreement between a physician and EMT to provide advanced level care. EMS providers in North Dakota also have access to online medical control. Online medical control occurs when the EMT has a conversation with a physician about a patient and receives treatment orders verbally. In the event that online medical control is not available or practical, the EMT shall deliver patient care consistent with the ambulance service's protocols. More information concerning online and offline medical control is provided later in this document.

North Dakota does not have a state medical director. It was reported in the 1992 assessment that the DEMS contracted with a physician. However, this is no longer taking place. There are also no training or education requirements for EMS medical directors, nor is there a process that allows an assessment of the quality of medical direction. However, there has been some strengthening of laws regarding the medical director's authority and liability to EMS providers. See administrative rule 23-27 below:

23-27-04.1. Emergency care or services rendered by officers, employees, or agents of emergency medical services operations - Physician medical direction.

1. An officer, employee, or agent of an emergency medical services operation and a physician licensed in this state who provides medical direction to an emergency medical services operation, who is a volunteer, who in good faith renders emergency care, services, or medical direction, is not liable to the recipient of the emergency care, services, or medical direction for any civil damages resulting from any acts or omissions by the person in rendering the emergency care, services, or medical direction provided the person is properly trained according to law.

2. For the purpose of this section, "volunteer" means an individual who receives no compensation or who is paid expenses, reasonable benefits, nominal fees, or a combination of expenses, reasonable benefits, and nominal fees to perform the services for which the individual volunteered, provided that the fees do not exceed ten thousand dollars in any calendar year.

3. For a volunteer physician providing medical overview to an emergency medical services operation and the operation's personnel, the ten thousand dollar maximum fees amount is calculated separately for each emergency medical services operation for which the physician volunteered medical overview. This section does not relieve a person from liability for damages resulting from the intoxication, willful misconduct, or gross negligence of the person rendering the emergency care or services.

4. An officer, employee, or agent of any emergency medical services operation and a physician licensed in this state who provides medical direction to any emergency medical services operation who in good faith does not render emergency care, service, or medical direction to an individual based on a determination that transport of that individual to a hospital is not medically necessary is not liable to that individual for damages unless the damages resulted from intoxication, willful misconduct, or gross negligence.

Online/Offline Medical Direction

Online medical direction is available to all ambulance services in the state of North Dakota. However, a recent survey conducted by the Emergency Medical Services for Children's program determined that there are some barriers to speaking to a physician while providers are on the scene of an emergency and/or during transport. Surveys were sent to all 141 ambulance services in the state. These ambulance services reported the following (services could answer all that apply):

- Twenty-five ambulance services reported that physicians are not always at the hospital so they have no way to contact them by radio.
- Twelve ambulance services reported that they do not have a way to reach physicians by phone after normal working hours.
- Forty-seven ambulance services reported that in parts of their service area, they are unable to reach the hospital by radio.
- Sixty-eight ambulance services reported that in parts of their service area, they are unable to get cell phone coverage.
- Fifty-nine ambulance services reported that they can reach a physician when they need to.

(The North Dakota Medical Direction survey and results of the data is located in the addendum of this section.)

In 2007, the DEMS developed a sample set of pediatric and adult protocols. These protocols were distributed to all the medical directors and ambulance services in the state. Each medical director then edited or revised the protocols as they saw fit for their ambulance services in their service area.

Progress on Meeting 1992 Recommendations

NHTSA Recommendations	Action
The State EMS Office Should:	
• Anticipate the revised EMT-Basic curriculum and require medical direction for all basic life support services that are a part of the North Dakota EMS system.	In the last 10 years, the administrative rules were revised to include basic life support to require medical direction.
• Enhance medical director recruitment by providing educational materials about the job (e.g., an orientation videotape, medical director's course) and soliciting input and assistance from the UND medical school and representatives from local ACEP, ACS, and NAEMSP organizations.	This has not been addressed.

• Develop training requirements for medical directors and a program for assessing the quality of medical direction.	This has not been addressed.
• Develop a process for facilitating both state and local medical direction.	In the state of North Dakota, every licensed ambulance service must have a medical director.
• Propose legislation that provides legal immunity for those physicians that provide medical direction.	Administrative rule 23-27-04.1 was established. (Listed above table)

MEDICAL DIRECTION SUPPORTING DOCUMENTATION

NORTH DAKOTA EMSC
2007 MEDICAL DIRECTION
AMBULANCE SURVEY RESULTS

Surveys were sent to all 141 ambulance services in the state. At the time this analysis was done, 5 ambulances had not completed the survey. Therefore, data is based on 137 respondents.

On-line Medical Direction

1. Has your EMS agency established some type of formal arrangement or agreement with a medical director or hospital physician to provide on-line (real-time) **pediatric/adult** medical direction to your **BLS** providers at the scene of an emergency? *(Check all that apply)*

99	Yes- pediatric medical direction	72%
101	Yes- adult medical direction	74%
18	No- neither (See responses below table)	13%
5	In Process	4%
4	Not applicable (Due to being an ALS service)	3%

The following reasons were given as to why the service **does not have** either pediatric or adult online medical direction:

- After business hours our medical director is not at the hospital to call
- Have not, because don't know what to do in order to set it up.
- We are using the protocols sent out by the department of health and EMSC
- Is available if needed
- By cell phone or radio
- Always available by phone
- No cell service
- Through our protocols- we call the physician on call and medical direction will be given
- Difficult to reach physician by phone while at scene
- We call the hospital. During the day doctor is available. At night, doctor has to get to the hospital, call ER and have them get a hold of doctor for communication.
- If I can reach with radio
- No formal agreement- we call hospital and let them contact appropriate people
- Standing protocol- contact by radio-only
- No "real time" pediatric/adult agreement- only protocol direction from our medical director

2. Has your EMS agency established some type of formal arrangement or agreement with a medical director or hospital physician to provide real-time (on-line) **pediatric/adult** medical direction to your **ALS** providers at the scene of an emergency if needed? *(Check all that apply)*

73	Yes- pediatric medical direction	53%
74	Yes- adult medical direction	54%
9	No-neither (see responses below table)	7%
5	In Process	4%
41	Not Applicable (Due to being a BLS service)	30%

The following reasons were given as to why the service **does not have** either pediatric or adult online medical direction:

- Difficult to reach physician by phone while at scene
- We call the hospital. During the day doctor is available. At night, doctor has to get to the hospital, call ER and have them get a hold of doctor for communication.
- We don't know how to go about setting up agreement with an ALS provider

Definitions for questions 1 and 2:

- **On-line Pediatric Medical Direction:** real-time medical direction available 24/7 by phone, radio, or email, to EMS providers who require medical direction when transporting a pediatric patient to a hospital.
- **Formal arrangement or agreement:** agreement or instruction, written or otherwise in place, specifying a medical facility (or facilities) or other professional medical personnel to be contacted for direction on how to appropriately treat a pediatric patient.
- **At the scene of an emergency:** time from arrival of providers at the scene of an emergency through arrival of the pediatric patient at the hospital.

3. What are the barriers to speaking to a physician while you are on the scene of an emergency or during transport? (*Check all that apply*)

25	Physicians are not at the hospital so we have no way to get a hold of them by radio.	18%
12	We do not have a way to reach physicians by phone after normal working hours.	9%
47	In parts of our service area, we are unable to reach the hospital by radio.	34%
68	In parts of our service area, we are unable to get cell phone coverage.	50%
59	We can reach a physician when we need to.	43%
14	Other (see responses below table)	10%

"Other" barriers to speaking to a physician while you are on the scene of an emergency or during transport:

- Physicians are not always at the ER
- We call clinic during hours; hospital after clinic hours. A doctor does not always answer our call

- We have gaps in 24 hour coverage
- The ER is minimally staffed at night and our phone calls are sometimes not answered if ER staff is busy.
- The cell coverage is occasionally a concern, but we use radio when needed.
- Typically we can get physician direction, but it may take some time. We contact the hospital and then they inform the doctor and reply to us.
- If we call the hospital and doctor not there- he calls back immediately. On call from nurses.
- We can usually speak to a physician when needed. Other times it is the ER nurse.

Off-line Medical Direction

4. Has your EMS agency adopted for use written or electronic **PEDIATRIC** protocols or guidelines which are accessible at the scene of an emergency (see definitions below)?

123	Yes	90%
12	No	9%

Some "No" responses specified as the following:
- Adopted state of SD protocols
- No defined pediatric protocols
- In the process of reviewing the prepared protocols from DEMS
- In the process of adopting protocols
- They are included with our adult protocols
- No one has written them
- Our service only responds to employees. No pediatric patients

5. Has your EMS agency adopted for use the written adult protocols or guidelines which have been developed by the state?

109	Yes	80%
26	No	19%

Some "No" responses specified as the following:
- Adopted state of SD protocols
- In the process of adopting new protocols
- Have own more comprehensive protocols
- Own protocols approved by medical director

6. Is a set of these written protocols carried by BLS providers or ambulances in your agency, either in paper or electronic form?

115	Yes, all providers/ambulances	84%
8	Yes, most providers/ambulances (>50%)	6%
1	Yes, some providers/ambulances (<50%)	1%
11	No, none	8%

Some "No, none" responses specified as the following:
- ALS service
- Current copy located in ER department. Reviewing the need to carry copies in each ambulance

- They are on file in the office

7. Is a set of these written protocols carried by ALS providers or ambulances in your agency, either in paper or electronic form?

75	Yes, all providers/ambulances	55%
3	Yes, most providers/ambulances (>50%)	2%
1	Yes, some providers/ambulances (<50%)	1%
55	No, none	40%

Some "No, none" responses specified as the following:

- BLS service
- All staff have access to protocols
- Current copy located in ER department. Reviewing the need to carry copies in each ambulance.
- Once ALS intercept, paramedics take care of patient and ALS protocols become obsolete to us basic EMT's

Definitions for questions 4 -7:

- **Off-line Pediatric Medical Direction:** treatment guidelines and protocols used by EMS providers to ensure the provision of appropriate **PEDIATRIC** patient care, available in written or electronic form in the ambulance or with a provider, at the scene of an emergency.
- **At the scene of an emergency:** time from arrival of providers at the scene of an emergency through arrival of the pediatric patient at the hospital.

***Some percentages do not total 100% due to a number of questions left blank on surveys.*