MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES

COMMISSION MEETING MINUTES

DATE:	**February 14, 2014**	
	10:00 A.M.	
LOCATION:	Fishers Town Hall	
	1 Municipal Drive	
	Fishers, IN 46038	
MEMBERS PRESENT:	John Zartman	(Training Institution)
	Charles Valentine	(Municipal Fire)
	G. Lee Turpen II	(Private Ambulance)
	Myron Mackey	(EMTs)
	Terri Hamilton	(Volunteer EMS)
	Mike Garvey	(Indiana State EMS Director)
	Darin Hoggatt	(Paramedics)
	Michael Lockard	(General Public)
	Melanie Jane Craigin	(Hospital EMS)
	Sue Dunham	(Emergency Nurses)
	Stephen Champion	(Medical Doctor)
MEMBERS ABSENT:	Michael Olinger	(Trauma Physicians)
	Ed Gordon	(Volunteer Fire EMS)

OTHERS PRESENT: Elizabeth Fiato, Field Staff (Robin Stump, Don Watson, Steve Gressmire, and Jason Smith), Judge Gary Bippus, IDHS Staff, and members of the EMS Community

CALL TO ORDER AND ROLL CALL

Meeting called to order at 10:02 a.m. Candice Hilton called roll and announced quorum.

No action was needed by the Commission. No action was taken.

Commissioner Mackey introduced the Ivy Tech Columbus Paramedic students that were in the audience.

ADOPTION OF MINUTES

A motion was made by Commissioner Zartman to accept the minutes from the December 20, 2013 meeting. The motion was seconded by Commissioner Mackey. The motion passed.

Lifetime Certifications

Mr. Jason Smith read into record the letter requesting the lifetime honorary Paramedic license for Mr. Gerald "Garry" Hammer (see attachment #1).

A motion was made by Commissioner Lockard to award the honorary Paramedic license to Mr. Hammer. The motion was seconded by Commissioner Hamilton. The motion passed.

Ms. Robin Stump read into record the letter requesting a lifetime honorary EMT certification to Mr. Ralph Dalton and Mrs. Roxie Dalton (see attachment #2).

A motion was made by Commissioner Zartman to award the honorary EMT certifications to both Mr. Ralph Dalton and Mrs. Roxie Dalton. The motion was seconded by Commissioner Hoggatt. The motion passed. The certificates were presented to Mr. and Mrs. Dalton by Ms. Robin Stump and Commissioner Terri Hamilton.

STAFF REPORT

Data Registry

No report submitted. No report given. The new report will be ready to present at the April Commission meeting..

Field Staff

Ms. Robin Stump reported the following information:

Announced the dates for the Provider forums (see attachment #3).

Ms. Stump stated that there is one new paramedic non-transport, 17 new vehicle applications/inspections, and 4 opened investigations.

Individual Certification Report- See attachment #4. Submitted for informational purposes.

Ms. Candice Hilton addressed the Commission regarding the Individual certification. The data that we have been providing is proving to be inconsistent. Ms. Hilton asked several questions to help clarify what the Commission members would like to see on the report. There will be a new report for the April 25th Commission meeting. It was reported that Mr. John Buckman is working on the survey to find out why people are letting their certifications lapse and find out where they are working.

Provider Certification Report- See attachment #5. Submitted for informational purposes.

Training Report

Mrs. Elizabeth Fiato introduced Mr. Billy Brewer from the Indiana State Department of Health. Mr. Brewer spoke about Chempacks. Chempacks are a federal asset from the CDC that contains antidote for an exposure to nerve agents. He would like to hear any feedback from the Commission and would like to keep everyone "in the loop". Commissioner Hoggatt asked what kind of kits are in the packs? Mr. Brewer answered that they are the Mark 1 kits. Mark 1 kits contain 2Pam Chloride and Atropine for organophosphate poisonings.

Mrs. Elizabeth Fiato gave the following brief introduction for IPQIC :

The Indiana Perinatal Quality Improvement Committee has been meeting formally for the past year but informally for the past several decades. Decreasing infant and maternal fatalities due to inadequate care has been a mission for the dozens of members of the IPQIC, and the Office of EMS has been honored to begin working with them to make their goal a reality. Let me introduce James Cameron and who will brief you in more detail on the IPQIC program. In your packets you will find two drafts. The first is a draft of the standards for Perinatal transportation that were developed by the IPQIC. After discussing the importance of these standards for these types of patient transports, it was proposed that rather than leaving these as standards that people should follow, it is necessary to develop these into rules that transport services ***must*** follow. The second draft document is a rendition of the standards placed into the IAC 836 format. The intent of providing you the draft in this format is to demonstrate how clearly these standards fit in the progression of the IAC 836 rules. An article 5 of this nature would not only allow for the oversight of the Perinatal program, but it could be another place where future transportation initiatives, such as the Community Paramedicine/Mobile Integrated Healthcare standards, could be placed. Maintaining and enhancing the quality and standards of EMS is the foundation of the work that we all perform, and the creation of these rules would be a step towards enhancing the survivability of some of our state's most fragile patients. On March 21, the IPQIC will present their final work products to the Governing Council at the Indiana State Department of Health for their approval. It is our hope that the EMS Commission will support this initiative. We welcome any questions you may have. (See attachment #6 -copy of the Indiana Perinatal Transport Standards, Attachment #7- copy of the draft rules, Attachment #8- hard copy of power point presentation) Mr. James Cameron gave a summary of his background then presented information on what IPQIC does and their purpose. Commissioner Craigin and Chairman Turpen recommended different organizations that may also help with the IPQIC initiatives.

Chairman Turpen directed staff to compose a letter from the Commission in initial support of the IPQUIC's initiatives.

Mrs. Elizabeth Fiato reported the following information:
Indiana EMS Education Working Group: Skills Recommendation: At the February 12 EMS Education Working Group Meeting, members discussed at length the psychomotor evaluation exam. Last year, it was recommended to remove the oxygen administration station from the random skills lists for both EMR and EMT, and this was approved by the TAC and EMS Commission. The group members have reported complaints regarding the removal of the skill and have received requests to add it back into the random skills station for EMR and EMT. The EMS Education Working group supports this request and asks the Commission to support it as well. Alternatively, the group has recommended removal of the mouth-to-mask administration skill station from the random skills for both EMR and EMT. Members agreed that this skill is practiced at length and tested in all CPR courses. To continue to have it as a

random skill is both redundant and non-productive. The group recommends removal of this station from both EMR and EMT random skills and replacing it with the previously removed oxygen administration station.

A motion was made by Commissioner Hamilton to approve the above recommended skills station changes. The motion was seconded by Commissioner Zartman. The motion passed.

EMT and AEMT Exams: Two new exam versions, one for the EMT and the Indiana Advanced EMT Supplemental exam, have been given to Ivy Tech for implementation. They estimate that these two test versions will be administered beginning on February 28 at the latest. IDHS will notify all Advanced EMTs who are awaiting the release of the Indiana supplemental exam once it is available. There are approximately 84 AEMTs who currently need the Indiana AEMT test to begin practicing the Indiana additional skills. Due to accusations of the State EMT Exam being compromised, IDHS convened a Primary Instructor test construction group to create an interim EMT exam until our new process of test creation is completed. This exam is content validated, and we anticipate being able to utilize most of the 350 new questions created by this group for the future EMT exam. Mrs. Fiato introduced Mrs. Elizabeth Westfall to speak regarding the test development process. Mrs. Westfall stated that the group went through test banks that were purchased by IDHS and some questions had to be handwritten to match the National Education Standards. The new test is now available.

Psychometrician: The EMS Education Working Group will begin working with Indiana University Psychometrician Dr. Charles Hobson and his staff members on developing a system to create, validate, and maintain unbiased and reliable EMS exams. The contract should be executed within the next 2-3 weeks, and we should have our first session during the March EWG meeting. PI/TI Updates: The EWG members are in the process of scheduling PI/TI updates to educate the EMS community on the policies and procedures for Indiana EMS Training. There will be a total of 30 sessions, 10 in the northern region, 10 in the central region, and 10 in the southern region. If you or your organization would like to host a session, please e-mail me at e-fiato@dhs.in.gov and I will route you to the appropriate contact. These will begin in April as to avoid conflict with the upcoming EMS forums. AEMT: (see attachment #9)

- 57 more students have attempted the AEMT exam since the December report.
- An additional 39 students have successfully passed the cognitive exam since the December Report.
- Of the 1308 Basic-Advanced EMTs certified at the implementation of the new Advanced level, 84 have successfully transitioned to the new certification level (6.46%)
- Of the 1308 Basic-Advanced EMTs certified at the implementation of the new Advanced level, 141 have completed training and challenged the exam (10.85%)
- State AEMT passing rates have increased:

	Indiana AEMT Cognitive Exam Passing Rates	
	December	February
First Attempt	50%	52%
3rd Attempt	52%	59%
6th Attempt	54%	60%

Paramedic-Accreditation: At the direction of the EMS Commission at the last meeting, a thorough study of the CAAHEP Accreditation process along with Paramedic Training Institution passing rates and year end reports was conducted:

- Year End Reports

The yearend report is an 11 page document that poses questions regarding an institution's Paramedic program. These questions range from narrative type questions to numerical assessments of passing rates. CoAEMSP stated that in 2013, they began utilizing the Certification Exam results as the threshold to determine compliance. Any reported pass rates below 70% would be issued notices to improve and must submit progress reports. Review: The yearend reports for 2011 and 2012 were reviewed. Many deficiencies were found including reports with little to no information, data that does not accurately represent the passing rates pulled from National Registry, and narratives that do not provide information to give a clear picture of the program. While inspecting the pass/fail rates, it was noted that the two training institutions that were issued notices for improvement had overall NREMT-P passing rates (after 6 attempts) of 71%, exceeding the 70% threshold. Upon inspection of the NREMT-P pass fail report from the same period, three (3) other institutions met the same threshold but had not been issued letters for improvement; this is likely due to their year-end reports not showing rates below 70%. CoAEMSP does not indicate what scores an institution must report in regards to certification pass rates after the first, third, or sixth attempts*, so it is clear that this lack of specification contributes to inaccurate reporting and inconsistent assigning of progress reports. The following is from the CoAEMSP Interpretation Guide for CAAHEP Standards. *Terminal Competence: The program must document that all students have reached terminal competence as an entry level paramedic in all three learning domains. Determination of terminal competence is a joint responsibility of the program and the medical director. The Medical Director must certify and document terminal competence. [see III.B.2.a.4)]. Program Evaluation: Program evaluation should be a continuing and systematic process with internal and external curriculum validation in consultation with employers, faculty, preceptors, students and graduates.

- 5-year Report

We pulled the 5-year National Registry Paramedic Report in order to get a clearer view and more consistent statistical analysis of the accredited Training Institution pass rates.

- 7 training institutions had passing rates after 3 attempts of at or below 70%
- 4 training institutions had passing rates after 6 attempts of at or below 70%
- 8 training institutions had 25% or more of their students who completed the course not attain Paramedic certification.

If you compare this to the most recent 3 year report (2011-2013), these are the same training institutions. Discussion: The question we are posing is what are the standards that the EMS Commission will hold training institutions to? Is this accreditation serving the purpose it was intended to serve? I would like to open the topic up for discussion. Some discussion followed concerning passing rates and training institutions not being held to standards.

A motion was made by Commissioner Zartman to have staff investigate the four questionable training institutions with testing percentages below standard and to have the whole process sent to the Accreditation sub-committee. The motion was seconded by Commissioner Mackey. The motion passed.

Hazardous Material

Mr. David Probo presented information concerning the new Learning Management System training for Hazardous Materials. (see attachment # 10). The Hazardous Material on line course is available through your portal account.

SUB-COMMITTEE REPORTS

Narcotics working group:

Commissioner John Zartman summarized the meeting from January 14, 2014 (see attachment #11).

INDIANA DEPARTMENT OF HEALTH

Trauma Registry Report

Mr. Art Logsdon reported that there was a very good turn-out for the EMS Medical Director conference. The conference was held at Fort Benjamin Harrison. More then140 individual attended the conference. The Indiana Department of Health plans on holding another EMS Medical Director conference next year and in following years.

Mr. Logsdon reported that the 4th application for in the process application has been approved for IU Health Arnett.

A motion was made by Commissioner Zartman to approve the application. The motion was seconded by Commissioner Valentine. The motion passed.

Ms. Katie Gatz reported out (see attachment #12)

EMS PERSONNEL WAIVER REQUEST

The following requested a waiver of Rule 4. Certification of Emergency Medical Technicians 836 IAC 4-4-3 Certification based upon reciprocity Authority: IC 16-31-2-7 Affected: IC 16-31-3-8; IC 16-31-3-10 Sec. 3. (a) To obtain certification based upon reciprocity, an individual shall be a minimum of eighteen (18) years of age and meet one (1) of the following requirements: (1) Be a person who: (A) possesses a valid certificate or license as an emergency medical technician from another state; and (B) successfully completes the written and practical skills certification examinations as prescribed by the commission. (b) Any nonresident of Indiana who possesses a certificate or license as an emergency medical technician that is valid in another state, or a valid registration issued by the National Registry, upon affiliation with an Indiana certified provider organization may apply to the agency for temporary certification as an emergency medical technician. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification, which shall be valid for the duration of the applicant's current certificate or license or for a period not to exceed six (6) months from the date that the reciprocity request is approved by the agency, whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule. Mr. Brown is asking for an extension due to lack of completing his EMT Class by January, as stated in his previous waiver request. His extension expired on January 18th 2014; Mr. Brown has held a temporary EMT Certification since 3-12-2013. He is requesting a waiver of 836 IAC 4-4-3 (b). Staff recommends: Denial

Charles M. Brown EMT

A motion was made by Commissioner Mackey to accept staff recommendation and deny the waiver request. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of SECTION 47. (a) A registered nurse may challenge the advanced emergency medical technician course if he or she meets the following requirements: (1) Be a registered

nurse in Indiana. (2) Be an Indiana certified emergency medical technician. (3) Be able to document one (1) year of experience in an emergency department or as a flight nurse with an air ambulance service. (4) Hold an advanced cardiac life support certification. (5) Hold either an American Heart Association or American Red Cross health care provider card or equivalent. (6) Be able to meet prerequisites required by the commission, the advanced emergency medical technician curriculum, and the local training institution course. (b) For successful completion of the advanced emergency medical technician training course, a registered nurse must meet all of the requirements set forth by the training institution for all students or meet the prerequisites as described in subsection (a) and the following: (1) May earn credit by written examination for individual modules of the advanced emergency medical technician course. (2) Test out of a module to be completed prior to the beginning of that module by completing: (A) the written examination with a passing score; and (B) the practical skills examination with a passing score. Failure of any module exam will require the students to participate in the entire module. (3) Successfully complete the advanced emergency medical technician program comprehensive final examination. (4) Demonstrate skill proficiency by completing the advanced emergency medical technician level skills with course proficiency. (5) May earn credit of clinical hours by review of the student's past experience in the clinical areas. (6) Complete all field internship and required hospital clinical hours. (7) Pass the advanced emergency medical technician written and practical skills examinations as approved by the commission. (8) Meet general certification requirements in SECTION 49 of this document. Mr. Craigin is requesting a petition to challenge the AEMT written and practical exams. Mr. Craigin is requesting to substitute his RN education for the bridge course Mr. Craigin is currently licensed as an RN, and he has valid ACLS, PALS, CPR, EMT-B, EMT-A, and Firefighter certifications. Mr. Craigin is also an active member of a paramedic provider. Mr. Craigin fulfills the above requirements experience in an emergency department as an ER Nurse. Mr. Craigin is requesting to waive Section 47. Staff recommends: Approval

Cody F. Craigin EMT

A motion was made by Commissioner Mackey to accept staff recommendation and approve the waiver request. The motion was seconded by Commissioner Zartman. Commissioner Craigin abstains from the vote. The motion passed.

The following requested a waiver of Rule 4. Certification of Emergency Medical Technicians 836 IAC 4-4-1 General certification provisions Authority: IC 16-31-2-7 Affected: IC 16-31-3 (1) Be a minimum of eighteen (18) years of age. (2) Successfully complete the Indiana basic emergency medical technician training course as approved by the commission and administered by a certified training institution. (3) Pass the emergency medical technician written and practical skills examinations as set forth and approved by the commission. (b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report. (c) The minimum requirement for basic emergency medical technicians training shall be as follows: (1) The current version of the Indiana basic emergency medical technician training course as amended and approved by the commission. (2) Each Indiana basic emergency medical technician course shall be supervised by a program director who is affiliated with the course sponsoring training institution as described in this article. (d) No course shall be approved as equivalent to subsection (c) unless the course meets the training standards in effect on the date an equivalency determination is requested. (e) Emergency medical technicians shall comply with the following: (1) An emergency medical technician shall not perform procedures for which the emergency medical technician has not been specifically trained: (A) in the Indiana basic emergency medical technician curriculum; and (B) that have not been approved by the commission as

being within the scope and responsibility of the emergency medical technician. (2) An emergency medical technician shall not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public. (3) An emergency medical technician shall comply with the state and federal laws governing the confidentiality of patient medical information. (4) An emergency medical technician shall not delegate to a less qualified individual any skill that requires an emergency medical technician. (5) An emergency medical technician shall comply with the protocols established by the commission, the provider organization, and the provider organization's medical director. Mr. Eacret is requesting that his written exam dated on 1/3/2014 be accepted even though it falls outside the 1 year time frame. This was due to Cancer treatment complications. He is requesting a waiver of 836 IAC 4-4-1.3(b). Staff recommends: Approval: accept his test taken on 1-3-2014

Michael J. Eacret EMT

A motion was made by Commissioner Lockard to accept staff recommendation to approve Mr. Eacret's waiver request. The motion was seconded by Commissioner Hamilton. The motion passed.

The following requested a waiver of 836 IAC 4-3-2 Certification standards Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-2-8; IC 16-31-3 Sec. 2. (a) Applicants for original certification as a first responder shall meet the following requirements: (c) To renew a certification, a first responder shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report twenty (20) hours of continuing education according to the following: (1) Participate in a minimum of sixteen (16) hours of any combination of lectures, critiques, skills proficiency examination, or audit and review that reviews subject matter presented in the Indiana first responder curriculum. (2) Participate in a minimum of four (4) hours in defibrillation and airway management as presented in the Indiana first responder curriculum. (d) An individual who fails to comply with the continuing education requirements described in this article: (1) forfeits all rights and privileges of a certified first responder; and (2) shall cease from providing the services authorized by a first responder certification as of the date of expiration of the current certificate. Mr. Grimes is asking to be recertified beyond the 120 day rule due to a major back issue that had him on medical leave from March thru August of 2013. He was able to complete the required in-service hours prior to his expiration of July 31st, 2013. He is requesting a waiver of 836 IAC 4-4-2. Staff recommends: Approval and pay the $ 50.00 late fee.

Kenneth L Grimes EMT

A motion was made by Commissioner Zartman to accept staff recommendation to approve Mr. Grimes waiver request. The motion was seconded by Commissioner Hoggatt. The motion passed.

The following requested a waiver of 836 IAC 4-9-4 Application for certification; renewal Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 Sec. 4. (a) Application for certification as a paramedic shall be made on forms provided by the agency. An applicant shall: (1) complete the required forms; and (2) submit the forms to the agency. (b) All applicants for original certification shall provide evidence of compliance with the requirements for certification. (c) Certification as a paramedic shall be valid for two (2) years. (d) Individuals who have failed to comply with the continuing education requirements shall not exercise any of the rights and privileges nor administer advanced life support services to emergency patients. (e) If a properly completed renewal application is submitted within one hundred twenty (120) calendar days after the expiration of the certification, together with the required documentation to show that the applicant has completed all required continuing education within the two (2)

years prior to the expiration of the certification, and a fifty dollar ($50) reapplication fee, the certification will be reinstated on the date that the commission staff determines that the required application, documentation, and reapplication fee have been properly submitted. The expiration date will be two (2) years from the expiration of the previous, expired certification. (f) An individual wanting to reacquire a certification shall complete a paramedic recertification training course and successful completion of state written and practical skills examinations as set forth and approved by the commission. If the individual fails the certification examinations, the person shall retake an entire paramedic training course. Due to work related responsibilities (He does not work full or part-time in EMS anymore: he only volunteers) and family commitments, he has fallen behind on continuing education hours. Mr. Holmen is requesting an extension on his recertification date. He is requesting a waiver of 836 IAC 4-9-4(c). Staff recommends: Denial: based on past EMS Commission actions. Brent Bowman: 6-7-13 meeting Donald Crabtree: 6-7-13 meeting

John Holmen EMT

A motion was made by Commissioner Lockard to accept staff recommendation to deny Mr. Holmen's waiver request. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of Rule 4. Certification of Emergency Medical Technicians 836 IAC 4-4-3 Certification based upon reciprocity Authority: IC 16-31-2-7 Affected: IC 16-31-3-8; IC 16-31-3-10 Sec. 3. (a) To obtain certification based upon reciprocity, an individual shall be a minimum of eighteen (18) years of age and meet one (1) of the following requirements: (1) Be a person who: (A) possesses a valid certificate or license as an emergency medical technician from another state; and (B) successfully completes the written and practical skills certification examinations as prescribed by the commission. (b) Any nonresident of Indiana who possesses a certificate or license as an emergency medical technician that is valid in another state, or a valid registration issued by the National Registry, upon affiliation with an Indiana certified provider organization may apply to the agency for temporary certification as an emergency medical technician. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification, which shall be valid for the duration of the applicant's current certificate or license or for a period not to exceed six (6) months from the date that the reciprocity request is approved by the agency, whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule. Mr. Pike is asking for an extension he was unable to complete his practical exam due to his mother going into surgery on the day of his exam. He does not work for an EMS provider but his job requires an EMT-B certification. He is requesting a waiver of 836 IAC 4-4-3 (b). Staff recommends: Denial he had a 6 month extension that expired on 12/12/13.

Dylan Pike EMT

A motion was made by Commissioner Zartman to accept staff recommendation to deny Mr. Pike's waiver request. The motion was seconded by Commissioner Lockard. The motion passed.

EMS PROVIDER WAIVER REQUEST

The following requested a waiver of 836 IAC 2-7.2-3 Emergency medical technician-intermediate provider organization operating procedures Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd)

metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v) Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Spencer County Emergency Ambulance Services is requesting renewal of their Staffing Waiver 836 IAC 2-7.2-3 to allow their EMT-Intermediates to administer Glucagon. The original waiver was approved March 19, 2010. They are requesting this waiver until the Intermediates are replaced or the two year renewal period. Staff recommends: approval of this renewal.

Spencer County EMS

A motion was made by Commissioner Lockard to approve the renewal of this waiver for Spencer Co. EMS. The motion was seconded by Commissioner Zartman. The motion passed.

The following requested a waiver of Rule 7.2. Requirements and Standards for Emergency Medical Technician-Intermediate Provider Organizations 836 IAC 2-7.2-1 General requirements for emergency medical technician-intermediate provider organizations Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 4-21.5; IC 16-31-3; IC 16-41-10 (g) An emergency medical technician-intermediate ambulance service provider organization must be able to provide an emergency medical technician-intermediate level response. For the purpose of this subsection, "emergency medical technician intermediate response" consists of the following: (1) An emergency medical technician-intermediate. (2) An emergency medical technician or higher. (3) An ambulance in compliance with the requirements of section 3(d)(2) of this rule. (4) During transport of the patient, the following are the minimum staffing requirements: (A) If emergency medical technician-intermediate level advanced life support treatment techniques have been initiated or are needed: (i) the ambulance must be staffed by at least an emergency medical technician-intermediate and an emergency medical technician; and (ii) an emergency medical technician-intermediate shall be in the patient compartment. (B) If advanced life support treatment techniques have not been initiated and are not needed: (i) the ambulance must be staffed by at least an emergency medical technician; and (ii) an emergency medical technician shall be in the patient compartment. Spencer County Emergency Ambulance Services is requesting renewal of their Staffing Waiver 836 IAC 2-7.2-1(g) that was approved March 1, 2007. This waiver has helped our service during many weather emergencies. It is not used for day to day staffing; it is used for emergencies within the county or weather. Staff recommends: approval of this renewal.

Spencer County EMS

A motion was made by Commissioner Mackey to accept staff recommendation and approve the renewal of this waiver request. The motion was seconded by Commissioner Lockard. The motion passed.

The following requested a waiver of 836 IAC 2-7.2-3 Emergency medical technician-intermediate provider organization operating procedures Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3 (D) Medications limited to, if approved by the medical director, the following: (i) Acetylsalicylic acid (aspirin). (ii) Adenosine. (iii) Atropine sulfate. (iv) Bronchodilator (beta 2 agonists): (AA) suggested commonly administered medications: (aa) albuterol; (bb) ipratropium; (cc) isoetharine; (dd) metaproterenol; (ee) salmeterol; (ff) terbutaline; and (gg) triamcinolone; and (BB) commonly administered adjunctive medications to bronchodilator therapy: (aa) dexamethasone; and (bb) methylprednisolone. (v)

Dextrose. (vi) Diazepam. (vii) Epinephrine (1:1,000). (viii) Epinephrine (1:10,000). (ix) Vasopressin. (x) Furosemide. (xi) Lidocaine hydrochloride, two percent (2%). (xii) Amiodarone hydrochloride. (xiii) Morphine sulfate. (xiv) Naloxone. (xv) Nitroglycerin. Spencer County Emergency Ambulance Services is requesting renewal of their Staffing Waiver 836 IAC 2-7.2-3 that was approved March 16, 2012. This waiver allows our EMT-Intermediates to administer Zofran and Benadryl. Staff recommends: approval of this renewal.

Spencer Co. EMS

A motion was made by Commissioner Zartman to approve the renewal of this waiver until the Individual Intermediate level expires. The motion was seconded by Commissioner Valentine. The motion passed.

ADMINSTRATIVE PROCEEDINGS

1. **Administrative Orders Issued**
   - a. **Personnel Orders**
     - i. **1 Year Probations**

Order No. 0153-2013 Jesus M. Garcia

No action required, none taken

Order No. 0149-2013 Nathan W. Shoaf

No action required, none taken

- ii. **2 Year Probations**

Order No. 0154-2013 Ibn F. Akbar

No action required, none taken

Order No. 0151-2013 Kari M Cash

No action required, none taken

Order No. 0004-2014 Caymen N. Crouch

No action required, none taken

Order No. 0007-2014 Paul A. Edelen

No action required, none taken

Order No. 0005-2014 Jonathan Frederick

No action required, none taken

Order No. 0003-2014 Ashley R. Harders

No action required, none taken

Order No. 0150-2013 Nicholas E. Kopf

No action required, none taken

Order No. 0011-2014 Andrew S. Priem

No action required, none taken

Order No. 0006-2014 Michael R. Quiroz

No action required, none taken

Order No. 0152-2013 Adam C. White

No action required, none taken

iii. **Revocation**

Order No. 0008-2014 James E. Taylor Jr.

No action required, none taken

iv. **Emergency Order**

Order No. 0002-2014 Jeremy R. Bontrager

No action required, none taken

Order No. 0001-2014 Allen M. Soppet

No action required, none taken

v. **Revocation of Denial Order**

Order No. 0135-2013 Jack D. Eads II

No action required, none taken

Order No. 0130-2013 Dylan Romandine

No action required, none taken

vi. **Suspension**

Order No. 0010-2014Amanda Clark

No action required, none taken

2. **Non-Final Orders**
   a. Alex Leisz

Mr. Leisz's non-final order has been brought back to the Commission for consideration after being tabled at the last meeting (December 20, 2013).

A motion was made by Commissioner Valentine to affirm the non-final order. The motion was seconded by Commissioner Mackey. The motion passed.

b. James R. Schurman

A motion was made by Commissioner Valentine to affirm the non-final order with the amendment of the Fire and Building Safety Commission by changed to the EMS Commission. The motion was seconded by Commissioner Mackey. The motion passed.

Chairman Turpen called for a break at 11:33am.

Chairman Turpen called the meeting back to order at 12:08pm.

EMS FOR CHILDREN

Ms. Gretchen Huffman was unable to be at the meeting however Ms. Candice Hilton announced that EMS for Children is now taking nominations for EMSC Pediatric Healthcare Hero (see attachment # 13). Contact Ms. Huffman at ghuffman@iupui.edu to submit your nomination.

TECHNICAL ADVISORY COMMITTEE

Mr. Leon Bell, Chairman of the Technical Advisory Committee, stated that due to the weather the TAC has not been able to meet since the last Commission meeting. The next TAC meeting is scheduled for March 4, 2014 at Noblesville Fire Station #77 starting at 10am.

Indiana Emergency Medical Services Association

Mr. Faril Ward president of the Indiana Emergency Medical Services Association reported that the legislative breakfast was held and the association members had a chance to speak to several legislators regarding EMS issues. Mr. Ward also stated that the plans for the May conference have been finalized and the keynote speaker on the first day is from the National Association of EMT's. Director Mike Garvey will also be speaking at the conference.

Mr. Ward stated that there has been small progress made with EMS memorial they have secured one senator that is willing to lend legislative support for the space for the memorial. The Ball State school of Architecture is working on a design for the memorial.

OLD BUSINESS

Mrs. Liz Fiato spoke briefly regarding the POST. Mrs. Fiato stated that the curriculum for the POST was presented to the Commission and was voted on and passed. Mrs. Fiato also stated that it was also passed for all responders must take the state test by their next certification cycle. Director Garvey stated that the POST was presented again just to make sure that everyone knows about the POST and are aware that they have to complete the POST test.

Non-rule policy for reciprocity was introduced by Director Garvey. Director Garvey stated that the non-rule policy is to clarify the reciprocity rule. Chairman Lee Turpen read the policy in to record:

836 IAC - EMERGENCY MEDICAL SERVICES COMMISSION

Title: Interpretation of LSA Doc. #12-393(E) SECTION 31(b)(2), SECTION 52(b)(2), SECTION 58(c)(2) and 836 IAC 4-4-3(b).

Date: February 28, 2014

Purpose: To clarify that the six months temporary certification or license, based on reciprocity, cannot be issued more than once

Interpretation: The Emergency Medical Services Commission interprets these rules as follows:
Only one (1) six-month temporary certification or license is authorized under LSA Doc. #12-393(E) SECTION 31(b)(2), SECTION 52(b)(2), SECTION 58(c)(2) and 836 IAC 4-4-3(b). When that six-month temporary certification or license has expired, it is not renewable, nor can any other six month temporary certification or license be issued based on the same certificate or license issued by another state.

A motion was made by Commissioner Zartman to approve the non-rule policy as read. The motion was seconded by Commissioner Valentine. The motion passed.

Director Mike Garvey spoke briefly regarding the Affordable Care Act. He stated that Volunteer Firefighters and Emergency Responders were not affected by the Act (see attachment #14).

Dr. Dan O'Donnell spoke regarding the Intranasal Narcan Pilot Program (see attachment #15). Dr. O'Donnell stated that this program was with the Southwest district of Indianapolis Metropolitan Police Department. This report was to just make the EMS Commission aware of the program. The law enforcement officers are being trained to recognize opioid overdose and how to administer the nasal narcan. This is not to substitute for EMS response. Dr. O'Donnell stated that at the next or in two meeting from today (2/14/2014) there will be a report on the progress of the program. Commissioner Craigin asked who was funding the program. Dr. O'Donnell stated that at this time Indianapolis EMS was supplying the narcan.

Legislation Report

Submitted for information purposes (see attachment # 16). Please note that House Bill No. 1336 is expected to have a public hearing held on Tuesday February 19th. Director Garvey stated that it is a good idea for all EMS personnel to stay aware of the legislation that is being presented during legislation sessions.

EMS STATE DIRECTOR'S REPORT

Director Garvey gave a report on the following:

Referred to the provider forum that Mrs. Robin Stump reported about earlier in the meeting.

See attachment #17 regarding a training opportunity.

CHAIRMAN'S REPORT AND DIRECTION

Chairman Lee Turpen reported that there are several studies that should be watched. EMS is rapidly changing. Chairman Turpen stated that the National Association of EMS Physicians meeting in Tucson AZ. There are peer reviews and poster presentations. There were a lot of presentations that had a direct impact on practices out in the field. Chairman Turpen also stated that Indiana has its some certified EMS Medical Director. He encourages everyone to stay abreast of the changes through EMS journals and publications such as Journal of National Association of EMS Physicians pre hospital care.

ASSIGNMENTS

1. Past Assignments
    a. John Buckman survey
2. New Assignments

NEXT MEETING

April 25th in Evansville, IN

ADJOURNMENT

A motion was made by Commissioner Lockard to adjourn the meeting. The motion was seconded by Commissioner Hamilton. The motion passed. The meeting was adjourned at 12:47p.m.

Approved _____

G. Lee Turpen II, Chairman

Attachment #1

MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

February 14, 2014

Indiana Emergency Medical Services Commission
c/o Indiana State Fire Marshal's Office – EMS Branch
ATTN: G. Lee Turpen, Chairman
302 West Washington Street – Room E239
Indianapolis, IN 46204
Dear Mr. Turpen,

Whereas, on the morning of Friday, January 31st, after an eventful twelve hour overnight shift at LaGrange County EMS, Paramedic Garry Hammer suffered a fatal medical incident at his home; and

Whereas, Paramedic Hammer had devoted his life to serving others, specifically as a Critical Care Paramedic with LaGrange, Noble, and DeKalb County EMS for 39 years. Hammer was also a Primary Instructor, and was serving on the EMS Education Working Group; and

Whereas, Paramedic Hammer also served as a Deputy Coroner in LaGrange and Noble counties, as a SWAT medic for Noble and LaGrange counties, a search and rescue/cadaver K-9 handler, and a member of the Critical Incident Stress Debriefing Team;

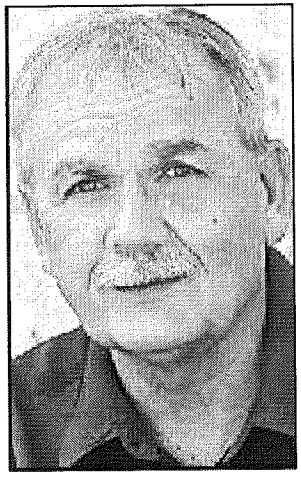
Therefore, on behalf of the State of Indiana EMS staff, and the entire Indiana EMS community, I respectfully request that the Indiana Emergency Services Commission posthumously honor Paramedic Gerald "Garry" Hammer with "Honorary Lifetime" Paramedic license and Primary Instructor certification.

Respectfully submitted,

Jason R. Smith, EMS District Manager
Office of the State Fire Marshal –
Emergency Medical Services Branch
302 West Washington Street – Rm E239
Indianapolis, IN 46204

GERALD B. "GARRY" HAMMER

Obituary



Hammer

GERALD B. "GARRY" HAMMER, 62, of Wolcottville, died in the line of duty, Friday, Jan. 31, 2014 upon returning home. He was born on June 22, 1951 in Fort Wayne, Ind., the son of Kenneth J. and Virginia E. (Rinehold) Hammer. Garry moved to the LaGrange County area in 1975 from Fort Wayne. He was a Critical Care Paramedic with LaGrange, Noble and DeKalb Co. EMS for 39 years. He also worked as a Deputy Coroner with LaGrange and Noble Co. He was a SWAT Medic for Noble and LaGrange Co., a Primary Instructor for EMS and on the District #3 Task Force for Home Land Security serving with the Search and Rescue Dogs. He served on the EMS Education Board for the State of Indiana and on the Critical Incident Debriefing Team. On Sept. 16, 1972 he married Pamela K. Roach in Fort Wayne, Ind. She survives in Wolcottville, Ind.; also surviving are three daughters, Janae (Gregory) Dull of Waterloo, Joni (Brian) Humbarger of Auburn; Jenny Hammer (fiancée Ian Molen) of Rome City; two sons, Jeremy (Joy) Hammer of Waterloo, Joshua (Janet) Hammer of Auburn; and his search and rescue dog, Aeros; twelve grandchildren; two sisters, Janice Ellis of Parker City, Ind. and Cheryl and Steven Petty of Monroe, Mich. Funeral service is 10 a.m. Tuesday, Feb. 4, 2014 at St. Anthony Catholic Church in Angola, Ind., with calling one hour prior. Father Fred Pasche officiating. Visitation also from 2 to 8 p.m. Monday, Feb. 3, 2014 at LaGrange Church of God, 777 N. Detroit St., LaGrange, Ind. Burial will take place in Woodruff Cemetery in rural Wolcottville, Ind. Memorials may be contributed to the Supporting Heroes, P.O. Box 991547, Louisville, (KY 40269-1547). Online condolences may be submitted the family at www.fruripmayfuneralhome.com Frurip-May Funeral Home, LaGrange, Ind., is handling arrangements.

Published in Fort Wayne Newspapers on Feb. 2, 2014

Attachment #2

February 3, 2014

To Whom it May Concern

I would like to request a Life time Certification for two very special Volunteers.

Ralph and Roxie Dalton have served the communities of Greenboro, Knightstown and other areas of Henry County. The hours they have put in, all Volunteer, is too numerous to count.

They have served on the local fire department and ambulance service as fire fighters and EMT's. Ralph joined the Greensboro Fire since 1964 devoting 50 years. In 1991 at 50 years of age Roxie joined the fire department and became an EMT. They each have served as EMT's with Southwest District Ambulance since the beginning in 1997.

This couple always goes above and beyond the "call of duty" when it comes to helping their neighbor.

Please support me in this great opportunity to show our appreciation for their service.

Sincerely

Terri R. Hamilton

Terri R. Hamilton, AS, NREMT-P, PI
EMS Commissioner
Indiana EMS Commission
(Office) 317-355-2433
(Mobile) 317-538-1722

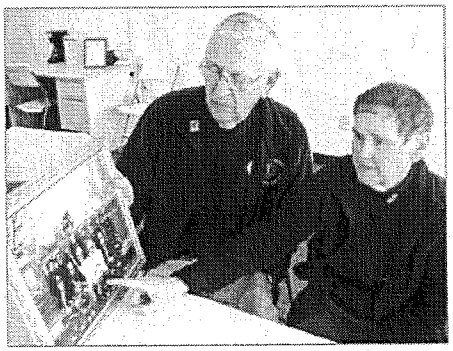
Courier Times
NEW CASTLE, HENRY COUNTY, INDIANA

1/30/2014 3:42:00 PM

RETIRING. KIND OF.

Daltons have combined for more than 70 years of service; party will honor them

By DONNA CRONK
dcronk@thecouriertimes.com



Ralph and Roxie Dalton look over a photo of members of the Greensboro Fire Department from several years ago. (Donna Cronk / C-T photo)

GREENSBORO - Ralph and Roxie Dalton have a combined 73 years of service to the Greensboro and Greensboro Township Volunteer Fire Department. With such a length of community service, the word "retirement" doesn't roll easily off their tongues.

Even though Ralph is 77 and Roxie will be soon, and they officially retired from department service earlier this month, they won't be strangers around the station.

"We still have our keys and still have our pagers - in case of emergency," Roxie points out. In fact, Ralph made a medical run a couple of weeks ago.

A retirement party is planned in their honor from 2-4 p.m. Sunday in the Greensboro Community Building, next to the fire station. Department firefighter and Ralph's niece, Renee Brown, is helping with the gathering and encourages the public to attend.

"Ralph and Roxie devote many selfless hours to our department and our community that many people have no idea to the time and money they give," says Brown. "If I could only be half of what they are, to say the least. They are my angels and have taught me so much."

She says that "they have given so much to the community over the years."

That service started with a move to the Greensboro community in 1958 for babysitting reasons. Ralph's folks had settled there and his mother babysat for the couple.

Their community involvement took off when Ralph and Roxie ran Dalton's Grocery in town. It was the early 1960s and the store was the heart of the community. The couple sold groceries, fresh meat, kerosene at 15 cents a gallon and gasoline at 35 cents. It was the community gathering spot.

"We knew everybody in town," Ralph recalls. Roxie adds that having the store "set the tone for the rest of our lives."

Their lives would include children John and Diane, four grandchildren and three great-grandchildren. Ralph joined the fire department in 1964 and has put in 50 years, serving as chief for a stretch and becoming an EMT in 1977. He left the grocery business to work at Delco-Remy in Anderson, retiring in 1991.

When the couple's daughter was in high school, Roxie went to nursing school at Indiana University East and then worked as a registered nurse at the New Castle State Developmental Center, where she retired.

Another life reinvention came in 1991 when, in her 50s, she joined the fire department, then went on to get her EMT certification. In addition to the Greensboro department, the couple also volunteered with Southwest Ambulance in Knightstown, retiring from that a year ago.

The couple agrees that the department, and the town - population 175 - are like family.

Says Brent Muse, owner of the Longhorn General Store, "They pretty much take after everything in this town. They take care of the park. Anytime anybody's sick they check on them; Freedom Center at the church. They have 110 percent involvement on anything that's going on."

Will Stay Involved

Even though they officially retired from the department, their involvements won't likely change. Ralph says they are in good health but realize some age limitations and it's time for someone else to take over.

They were happy to see some particular goals met before they left the department. Among them, a new fire station, a new truck three years ago and new air packs. Grants of various kinds have made those possible. "The Henry County Community Foundation has been wonderful to us," says Roxie. "I can't sing their praises enough."

One of Ralph's highlights was when the fire station got a FEMA-AFG grant for a brand-new 2011 pumper tanker worth $200,000. The firetruck, along with a bright orange pumper the station was given in 1990 for $1 from Morgantown, shine like diamonds in the station bays.

Ralph and several other firefighters made the trip to a tiny town in South Dakota to pick up the new truck from the factory and drive it back to Greensboro. "It was so neat to do that, get to tour the factory," Ralph says.

They say they will be around and if they can help out, they will. Both are very involved in many capacities with the Greensboro United Methodist Church.

'Just Keep on Doing What I'm Doing'

As for personal goals, they will maintain their church work, go camping, he'll continue twice-a-year fishing trips to Canada and enjoy his hobby of restoring and selling vintage gas pumps. Roxie plans to "just keep on doing what I'm doing" and continue service as a CPR instructor.

The two speak highly of their adopted community. Says Roxie, "It's small, People are friendly, supportive." Ralph says "a lot of folks are like us from the south."

Southern Roots

Roxie is originally from Byrdstown, Tenn. Her family moved to New Castle for jobs in 1949. Ralph's family came from Kentucky for jobs as well. The two met when a woman Roxie babysat for told her to check out the guy who worked as a meat cutter at the then-Beaver's Grocery Store. On June 4, they will celebrate their 59th wedding anniversary.

Greensboro Fire Chief Steve Ferrell says it was Ralph who talked him into joining the department in 1974.

"Ralph has been my fire chief. I've been his," Ferrell says.

He said not only have the Daltons been good for the whole community, they have been good neighbors and good friends for many years. "I can't say enough about them."

Donna Cronk is Neighbors editor for The Courier-Times.

Article Comment Submission Form

Please feel free to submit your comments.

Article comments are not posted immediately to the Web site. Each submission must be approved by the Web site editor, who may edit content for appropriateness. There may be a delay of 24-48 hours for any submission while the web site editor reviews and approves it.

Note: All information on this form is required. Your telephone number is for our use only, and will not be attached to your comment.

Submit an Article Comment

First Name:
Required

Last Name:
Required

Telephone:
Required

Email:
Required

Comment:
Required

Passcode:

Henry County Emergency Services
Southwest District Ambulance Service, Inc.
6450 West U.S. 40
PO Box 11
Knightstown, IN 46148
Phone # 765-345-7753
Fax#765-345-9713
Southwest District Ambulance Service, Inc.

To The Indiana EMS Commission

Please accept this as a letter recommendation for Ralph and Roxie Dalton to have an Honorary Life Time EMT Certification.

Ralph and Roxie have been Charter Members of our ambulance service, since February 1, 1997 , they both have held offices as well as being On our Board of Directors for many years. They both have been competent, kind, and compassionate not only to the job at hand, but to their patients as well. They retired from our service in February 2013 after13 years of dictated service to the people in our response area.

As EMS Chief of Southwest District Ambulance Service, Inc. I personally can not

Think of a more deserving couple for this honor.

Sincerely,

Bill Windsor

Bill Windsor

Ems Chief

Southwest District Ambulance Service, Inc.

7984 W. U.S. 40

Knightstown, Indiana 46148

Attachment #3

2014

EMS Forums

March 6, 2014
D6
EMS Station #3
4501 Memorial Drive
Muncie, IN
5p – 8p

March 11, 2014
D1
Porter regional Hospital
Community Room
Valparaiso, IN
6:00p – 9:00p

March 18, 2014
D8
Seymour Police Department
205 N. Ewing Street
Seymour, IN
9a – 12P

March 21, 2014
D9
Ripley County Annex Building
102 West First North Street
Commission's Room
Versailles, IN
9a – 12p

March 24, 2014
D10
Vincennes University
New Classroom Building
Vincennes, IN
9a – 12p

March 25, 2014
D7
Putnam County EOC
Greencastle, IN
9a – 12p

April 1, 2014
D4
St. Elizabeth School of Nursing Auditorium
1501 Hartford Street
Lafayette, IN
6p – 9p

April 4, 2014
D3
Parkview Regional Medical Center
11109 Parkview Plaza Drive
Conference Room A&B
Fort Wayne, IN
9a- 12p

April 15, 2014
D5
Seals Ambulance Service
2400 Roosevelt Avenue
Indianapolis, IN
9a – 12p

April 21, 2014
D2
EMS Education Center
403 E Madison Avenue
South Bend, IN
5:30p – 8:30p

Attachment #4

EMS Commission Certification Report
Compiled February 7, 2014

Total Certifications		Issued Since Last Mtg		Issued Same Time - 2012		Certified Individuals
EMS - EVOC	2928	EMS - EVOC	0	EMS - EVOC	15	
EMS - EVOC INSTR	74	EMS - EVOC INSTR	0	EMS - EVOC INSTR	0	
ADVANCED EMT	52	ADVANCED EMT	22	ADVANCED EMT	0	
EMT - BA	1265	EMT - BA	0	EMT - BA	9	1265
EMT	19093	EMT	99	EMT-BASIC	777	13435
EMT-INTERMEDIATE	157	EMT-INTERMEDIATE	0	EMT-INTERMEDIATE	3	157
PARAMEDIC	4010	PARAMEDIC	52	PARAMEDIC	59	4010
EMT-PI	502	EMT-PI	5	EMT-PI	5	
EXTRICATION	1977	EXTRICATION	0	EXTRICATION	0	
EMR	5493	EMR	38	FIRST RESPONDER	132	5493
Temporary EMT	171	Temporary EMT	33	Temporary EMT	0	
Temporary Paramedic	49	Temporary Paramedic	12	Temporary Paramedic	0	
Temporary EMR	2	Temporary EMR	1	Temporary EMR	0	
Temporary Advance	4	Temporary Advance	1	Temporary Advance	0	
Totals	**35777**		**263**		**1000**	**24360**

1st Qtr 2013	Count	2nd Qtr 2013	Count	3rd Qtr 2013	Count	4th Qtr 2013	Count
EMS - EVOC	33	EMS - EVOC	117	EMS - EVOC	63	EMS - EVOC	209
EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	1
ADVANCED EMT	0	ADVANCED EMT	2	ADVANCED EMT	11	ADVANCED EMT	15
EMT - BA	18	EMT - BA	14	EMT -BA	1	EMT - BA	0
EMT-BASIC	970	EMT-BASIC	525	EMT-BASIC	464	EMT	391
EMT-INTERMEDIATE	2	EMT-INTERMEDIATE	2	EMT-INTERMEDIATE	1	EMT-INTERMEDIATE	0
PARAMEDIC	493	PARAMEDIC	24	PARAMEDIC	76	PARAMEDIC	74
EMT-PI	8	EMT-PI	3	EMT-PI	15	EMT-PI	6
EXTRICATION	0	EXTRICATION	0	EXTRICATION	0	EXTRICATION	0
EMR	198	EMR	209	EMR	93	EMR	226
Temporary EMT	0	Temporary EMT	46	Temporary EMT	73	Temporary EMT	
Temporary Paramedic	0	Temporary Paramedic	24	Temporary Paramedic	19	Temporary Paramedic	
Temporary EMR	0	Temporary EMR	0	Temporary EMR	0	Temporary EMR	
Temporary Advance	0	Temporary Advance	0	Temporary Advance	3	Temporary Advance	
Totals	**1722**		**966**		**819**		**922**

1st Qtr 2012	Count	2nd Qtr 2012	Count	3rd Qtr 2012	Count	4th Qtr 2012	Count

EMS - EVOC	44	EMS - EVOC	13	EMS - EVOC	89	EMS - EVOC	92
EVOC INSTRUCTOR	5	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	1	EVOC INSTRUCTOR	7
ADVANCED EMT		ADVANCED EMT		ADVANCED EMT	0	ADVANCED EMT	5
EMT - BA	43	EMT - BA	58	EMT -BA	52	EMT - BA	13
EMT-BASIC	574	EMT-BASIC	523	EMT-BASIC	492	EMT	268
EMT-INTERMEDIATE	0	EMT-INTERMEDIATE	7	EMT-INTERMEDIATE		EMT-INTERMEDIATE	
PARAMEDIC	119	PARAMEDIC	92	PARAMEDIC	111	PARAMEDIC	79
EMT-PI	11	EMT-PI	12	EMT-PI	4	EMT-PI	13
EXTRICATION	0	EXTRICATION	0	EXTRICATION	0	EXTRICATION	0
FIRST RESPONDER	158	FIRST RESPONDER	199	FIRST RESPONDER	144	EMR	124
Totals	**954**		**904**		**893**		**601**

1st Qtr 2011	Count	2nd Qtr 2011	Count	3rd Qtr 2011	Count	4th Qtr 2011	Count
EMS - EVOC	120	EMS - EVOC	40	EMS - EVOC	127	EMS - EVOC	73
EVOC INSTRUCTOR	8	EVOC INSTRUCTOR	3	EVOC INSTRUCTOR	11	EVOC INSTRUCTOR	6
EMT - BA	50	EMT - BA	51	EMT - BA	56	EMT - ADVANCED	46
EMT-BASIC	652	EMT-BASIC	781	EMT-BASIC	516	EMT-BASIC	341
EMT-INTERMEDIATE	4	EMT-INTERMEDIATE	3	EMT-INTERMEDIATE	4	EMT-INTERMEDIATE	3
PARAMEDIC	79	PARAMEDIC	135	PARAMEDIC	94	PARAMEDIC	87
EMT-PI	4	EMT-PI	2	EMT-PI	7	EMT-PI	6
EXTRICATION	0	EXTRICATION	0	EXTRICATION	30	EXTRICATION	7
FIRST RESPONDER	168	FIRST RESPONDER	250	FIRST RESPONDER	145	FIRST RESPONDER	165
Totals	**1085**		**1265**		**990**		**734**

1st Qtr 2010		2nd Qtr 2010		3rd Qtr 2010	Count	4th Qtr 2010	Count
EMS - EVOC	124	EMS - EVOC	166	EMS - EVOC	240	EMS - EVOC	107
EVOC INSTRUCTOR	1	EVOC INSTRUCTOR	1	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	5
EMT - BA	41	EMT - BA	35	EMT - BA	51	EMT - BA	47
EMT-BASIC	801	EMT-BASIC	767	EMT-BASIC	841	EMT-BASIC	400
EMT-INTERMEDIATE	4	EMT-INTERMEDIATE	5	EMT-INTERMEDIATE	4	EMT-INTERMEDIATE	7
PARAMEDIC	121	PARAMEDIC	123	PARAMEDIC	95	PARAMEDIC	83
EMT-PI	9	EMT-PI	15	EMT-PI	3	EMT-PI	5
EXTRICATION	20	EXTRICATION	10	EXTRICATION	12	EXTRICATION	0
FIRST RESPONDER	230	FIRST RESPONDER	274	FIRST RESPONDER	131	FIRST RESPONDER	105
Totals	**1351**		**1396**		**1377**		**759**

1st Qtr 2009		2nd Qtr 2009		3rd Qtr 2009	Count	4th Qtr 2009	Count
EMS - EVOC	47	EMS - EVOC	163	EMS - EVOC	82	EMS - EVOC	331
EVOC INSTRUCTOR	4	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	0
EMT - BA	74	EMT - BA	23	EMT - BA	70	EMT - BA	55
EMT-BASIC	738	EMT-BASIC	514	EMT-BASIC	856	EMT-BASIC	570
EMT-INTERMEDIATE	7	EMT-INTERMEDIATE	5	EMT-INTERMEDIATE	6	EMT-INTERMEDIATE	13
PARAMEDIC	135	PARAMEDIC	91	PARAMEDIC	93	PARAMEDIC	83
EMT-PI	14	EMT-PI	10	EMT-PI	15	EMT-PI	14
EXTRICATION	0	EXTRICATION	47	EXTRICATION	0	EXTRICATION	1
FIRST RESPONDER	178	FIRST RESPONDER	268	FIRST RESPONDER	239	FIRST RESPONDER	247
Totals	**1197**		**1121**		**1361**		**1314**

Certs Due for Re-N	3/31/2014	Expired 09/30/2013	
EMS - EVOC	109	EMS - EVOC	149
EVOC INSTRUCTOR	8	EVOC INSTRUCTOR	3
EMT - BA	137	EMT - BA	54
EMT-BASIC	1803	EMT-BASIC	465
EMT-INTERMEDIATE	25	EMT-INTERMEDIATE	7
PARAMEDIC	377	PARAMEDIC	31
EMT-PI	39	EMT-PI	6
EMR	495	EMR	182
Totals	**2993**		**897**

Number of People Failed to Recertify Past the 120 day time frame

708

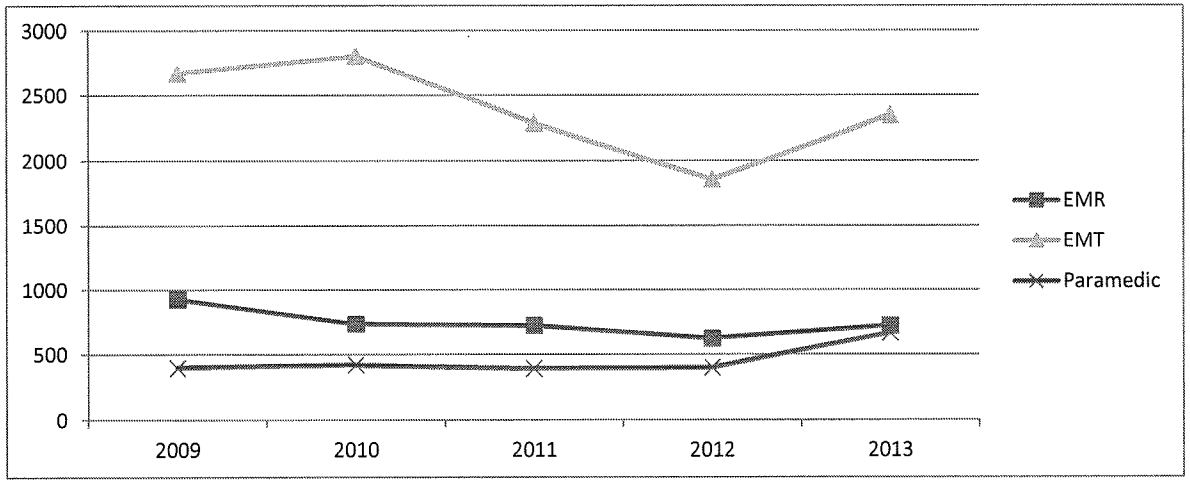
Number of New People Certified Last Quarter

780

Net gain/Loss of: 72

Trending Graph

Year	2009	2010	2011	2012	2013
EMR	932	740	728	625	726
EMT	2678	2809	2290	1857	2350
Paramedic	402	422	395	401	667



Attachment #5

Emergency Medical Services
Provider Certification Report

Date : February 7, 2014 **February 14, 2014**

In compliance with the Rules and Regulations for the operation and administration of Emergency Medical Services, this report is respectfully submit to the Commission at the **February 14, 2014** Commission meeting, the following report of agencies who have meet the requirements for certification as Emergency Medical Service Providers and their vehicles.

Provider Level	Counts
Rescue Squad Organization	5
Basic Life Support Non-Transport	418
Ambulance Service Provider	102
EMT Basic-Advanced Organization	33
EMT Basic-Advanced Organization non-transport	21
EMT Intermediate Organization	3
EMT Intermediate Organization non-transport	0
Paramedic Organization	188
Paramedic Organization non-transport	10
Rotorcraft Air Ambulance	13
Fixed Wing Air Ambulance	3
Total Count:	796

Attachment #6

Indiana Perinatal Transport Standards

All contracted or center-based transport systems must comply with standards established in 836 IAC 1-3-5. The following standards reflect the additional standards necessary for Maternal-Fetal and Neonatal Transport.

Standard	Title
I.	Maternal-Fetal Quality Assurance
II	Maternal-Fetal Competencies
III	Maternal Fetal Transport Equipment
IV	Maternal-Fetal Medication
V	Neonatal Quality Assurance
VI	Neonatal Competencies
VII	Neonatal Transport Equipment
VIII	Neonatal Medication
IX	Personnel Licensure and Certification
X	Training Modules
XI	Safety Measures
XII	Policies and Protocols

MATERNAL FETAL TRANSPORT STANDARDS

a) All contracted and or center based maternal fetal transport teams shall be accredited by the Commission on Accreditation of Medical Transport Services (CAMTS) or its equivalent.
b) Vision statement
    a. To establish a statewide interfacility standards for the care of women in need of specialized care who have a viable pregnancy (≥23 weeks) to the appropriate level of OB and or neonatal facility as defined by the Indiana Perinatal levels of Care document taking into consideration time/distance/acuity
    b. Change the paradigm from neonatal transport to maternal fetal when feasible
        i. Improved neonatal outcomes
        ii. Enhanced maternal infant bonding
        iii. Provide a higher level of maternal fetal care during interfacility transports

Standard I: Maternal-Fetal Quality Assurance
1.1 The Maternal Fetal Transport Program shall track the following benchmarks: a. Delivery ≤30 minutes from arrival at receiving hospital; b. Diversion of transport due to maternal and or fetal status change in route; c. Loss of communication with medical control for anything longer than 5 minutes; d. Change in transport asset (ground to air or vice versa); e. Delivery in route; f. Transport crew member injury during transport; g. Any reason for transport delay: iv. Accident—MVA, flight; v. Delay in dispatch as defined as ≥ 15 minutes; vi. Mechanical failure of ambulance or aircraft that leads to a transport delay; vii. Equipment failure; viii. Weather or road related (constructions, accidents) issues; ix. Crew member; h. Maternal fetal injury during transport; and i. Maternal and or fetal status deemed unstable for transport at sending facility.
1.2 Teams need to establish the definition of "sentinel events" that require immediate team debriefing, as soon as practical,

Standard I: Maternal-Fetal Quality Assurance
that includes the transport medical director, the entire team involved and medical control for the run.
1.3 Routine transport debriefing on all missions.
1.4 Transport Team conducts a Quarterly Review for accreditation of the following elements: a) Transport indication(s); b) Medical and/or nursing intervention performed or maintained; c) Time of intervention consistently documented: a. patient response to interventions; and b. appropriateness of intervention performed or omission of needed intervention d) Patient outcome at arrival of destination; e) Patient's change in condition during transport; f) Timeliness and coordination of the transport from reception of request to lift off or ambulance enroute time; g) Safety practices documented; h) Operational criteria to include at a minimum quantity indicators: a. number of completed transports; b. number of aborted or canceled flights/transports due to weather; c. number of aborted or canceled flights/transports due to maintenance; d. number of aborted or canceled flights/transports due to patient condition and alternative modes of transportation; and e. number of aborted or canceled flights/transports due to unavailable team. i) Communications center or organization must monitor and track: a. IFR/VFR; b. Weather at time of request of the referring and accepting facility and during transport if changes occur; c. Transport acceptance to lift off times or the road times; and d. All aborted and cancelled transport requests - times, reasons and disposition of patients as applicable.

Standard II: Maternal-Fetal Competencies
2.1 Nursing: 2.1.1 Maternal fetal transport nurses shall adhere to the Standards for Professional Nursing Practice In The Care of Women and Newborns (reference attached) in the following areas: a) Assessment;

Standard II: Maternal-Fetal Competencies
b) Diagnosis; c) Outcomes identification; d) Planning; e) Implementation; f) Coordination of care and health care teaching; g) Evaluation; h) Quality of practice; i) Ethics; j) Leadership; k) Research; l) Resources and technology; m) Collaboration; n) Communication; and o) Professional practice evaluation. 2.1.2 MF transport nurses shall have documented achievement of the competencies outlined in the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN)"Basic, High Risk and Critical Intrapartum Nursing Clinical Competencies and Education Guide—Current Edition" (Reference attached)
2.2 Paramedic: a) Must meet and/or exceeds the requirements established in 836 IAC 4-4-1; ***or*** a) Applicants for original certification as an emergency medical technician shall meet the following requirements: b) Be a minimum of eighteen (18) years of age. c) Successfully complete the Indiana basic emergency medical technician training course as approved by the commission and administered by a certified training institution. d) Pass the emergency medical technician written and practical skills examinations as set forth and approved by the e) commission. f) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report. g) The minimum requirement for basic emergency medical technicians training shall be as follows: (1) The current version of the Indiana basic emergency medical technician training course as amended and approved by the commission.

Standard II: Maternal-Fetal Competencies
(2) Each Indiana basic emergency medical technician course shall be supervised by a program director who is affiliated with the course sponsoring training institution as described in this article. No course shall be approved as equivalent to subsection (c) unless the course meets the training standards in effect on the date an equivalency determination is requested.
2.3 Medical Director: a) A physician who is responsible and accountable for supervising and evaluating the quality of medical care provided during a MF transport. b) Must be licensed and authorized to practice in the location in which the medical transport service is based and have educational experience in the area of high risk obstetrics or utilize specialty physicians as consultants when appropriate. c) Current concepts of appropriate use of transport assets - annually must include but is not limited to: a. "Just Culture" : Highly reliable standards of patient safety as described in 13.1 b. Patient care capabilities and limitations c. Continuing education in transport d. Crew resources management e. Stress recognition and management f. Infection control d) Risk management and safety training
2.4 Clinical Care Supervisor: a) Responsible for supervision of patient care provided by the members of the team directly employed by the transport program and works collaboratively with the medical director b) QM, QA PI of the program c) Hire, train, and continuing ed for the service d) Evaluation of the crew members e) Competencies as outlined above
2.5 Program Manager: a) Overall responsibility for a program b) Competencies: c. Human factors d. Just culture: Highly reliable standards of patient safety as described in 13.1 e. Sleep deprivation

Standard II: Maternal-Fetal Competencies
f. Stress recognition and management g. Safety and risk management h. Quality management i. Knowledge of national, regional and local standards of clinical practice, aviation and ground regulations as appropriate.

Standard III: Maternal Fetal Transport Equipment
3.1 The ambulance used for maternal-fetal transport must have emergency care equipment as identified in 836 IAC 1-3-5. In addition, each hospital with an in-house maternal-fetal transport team must have the following equipment: a) Filter needles; b) Blue port caps; c) Syringes; d) Pump tubing; e) Piggyback tubing; f) Stopcocks; g) Stopcock extension set ; h) Y ports with blue locks; i) IV start kits; j) 18 g angiocaths; k) Blue luerlocks; l) SW flushes; m) Integrative Therapies (optional): a. iPod; b. Ear buds; c. Essential oils; n) Minifan (optional); o) Infa therm mattress; p) Adult Stethoscope; q) Sterile gloves (variety of sizes); r) NRP pouch: a. Baby stethoscope;

Standard III: Maternal Fetal Transport Equipment
b. Ambu bag; c. Regular newborn mask; d. Preemie mask; e. Infant pulse ox; f. Neo wrap (plastic wrap); g. Blanket; h. Syringe; i. Cord clamps; j. Hat; k. Diaper; s) Vaginal exam pouch: a. Sterile exam gloves; b. Peri-pads; c. KY gel; t) Fetal monitor: a. monitor paper; b. power cables; c. Toco; d. EFM; e. Gel; f. Belts; g. Doppler; u) IV pump; and v) Cable/Lock.

Standard IV: Maternal-Fetal Medication
4.1 The ambulance used for maternal-fetal transport must have medication as identified in 836 IAC 1-3-5. In addition, the following medications must be maintained on the maternal-fetal transport vehicle: a) Calcium Gluconate; b) Tums calcium carbonate;

Standard IV: Maternal-Fetal Medication
c) Furosemide; d) Hydralazine; e) Indomethacin; f) Labetolol; g) Misoprostol; h) Morphine; i) Nifedipine; j) Ondansetron; k) Oxytocin; l) Terbutaline; m) Magnesium; n) Oxytocin; and o) Lactated Ringers.

NEONATAL TRANSPORT STANDARDS

Standard V: Neonatal Quality Assurance
5.1 The Neonatal Transport Program shall track the following benchmarks: a) Unplanned dislodgement of therapeutic devices; b) Radiograph verification of tracheal tube placement; c) Average mobilization time of transport team; d) First attempt tracheal tube placement success: a. visualizations; b. attempts at placement; e) Rate of transport-related patient injuries; f) Rate of medication administration errors; g) Rate of CPR performed during transport; h) Rate of serious reportable events; i) Unintended neonatal hypothermia upon arrival to destination; j) Rate of transport related crew injury; and k) Standardized patient care hand-off performed (site specific protocol used).
5.2 Each in-house transport team should have written internal quality review procedures/protocols.

Standard V: Neonatal Quality Assurance
5.3 Each hospital with an in-house transport team shall implement a routine schedule of Quality Improvement meetings and a record of minutes maintained.
5.4 The Transport Team conducts a Quarterly Review for accreditation of the following elements:: a) Reason for transport; b) Mechanism of illness; c) Medical intervention performed or maintained; d) Time of intervention consistently documented for: a. patient response to interventions; and b. appropriateness of intervention performed or omission of needed intervention; e) Patient outcome at arrival of destination; f) Patient's change in condition during transport; g) Timeliness and coordination of the transport from reception of request to lift off or ambulance enroute time; h) Safety practices documented; i) Operational criteria to include, at a minimum, the following qualtity indicators: a. number of completed transports; b. number of aborted or canceled flights/transports due to weather; c. number of aborted or canceled flights/transports due to maintenance; d. number of aborted or canceled flights/transports due to patient condition and alternative modes of transport; j) Communications Center of organization must monitor and track: a. IFR/VFR b. weather at time of request and during transport if changes occur; and c. all aborted and canceled transport request s - times, reasons and disposition of patients as applicable.

Standard VI: Neonatal Competencies
6.1 All neonatal transport team members must demonstrate the following competencies at a minimum on a quarterly basis: a) Venous access and heel sticks; b) Glucometer and/or I-STAT; c) IO insertion; d) NG/OG insertion; e) Bag/valve/mask ventilation/capnography and/or end tidal CO2;

Standard VI: Neonatal Competencies
f) Radial sticks (to include RT); g) Oxygen delivery methods; h) LMA; i) Oral/nasal airways; j) Use and ability to troubleshoot equipment such as transport isolette, med infusion pumps, ventilators, C/A monitor; k) Suctioning of patients; l) Medication administration (to include vasoactive medication, fluid resuscitation); m) Surfactant administration (to include vasoactive medication, fluid resuscitation); n) Umbilical line insertion and management; o) Transport ventilator management (RT); p) High frequency ventilator management (if hospital uses HF transport) q) Needle decompression and chest tube management; and r) Urinary catheter placement.
6.2 The following competencies are recommended but not required: a) Central line insertion and management (PICC or cut down); b) Trach management (required if center transports/manages tracheostomy patients; c) Nitric oxide administration (required if center uses in transport); and d) Cooling blanket, cooling cap (required if center uses in transport).
6.3 Neonatal transport teams must use patient-based simulation as a component in their competency training a minimum of every six months.
6.4 A written record of competency training for all transport team members must be maintained.

Standard VII: Neonatal Equipment
7.1 The ambulance used for neonatal transport must have emergency care equipment as identified in 836 IAC 1-3-5. In addition, each hospital with an in-house neonatal transport team must have the following equipment: a) Cardiopulmonary monitor; b) Capnography; c) Pulse oximetry; d) Portable transilluminators; e) Heimlich valves;

Standard VII: Neonatal Equipment

f) Suction, including stand alone battery-powered device with adjustable pressure;
g) Chest tubes;
h) Transport ventilator;
i) Transport incubator:
j) Airway management tools:
    a. Ambu bag;
    b. Laryngoscope;
    c. LMA; and
    d. Oxygen blender
k) Oxygen and air cylinders with volume capable of delivery for two times the anticipated duration of the transport;
l) Inhaled nitric oxide (optional but considered standard);
m) Temperature monitoring;
n) Infusion pumps capable of delivering neonatal volumes;
o) Defibrillator (optional: depending on likelihood of use); and
p) Point of care testing:
    a. glucometer or device capable of providing glucose measure; and
    b. blood gas analyzer.

Standard VIII: Neonatal Medications

8.1 The ambulance used for transport must have medication as identified in 836 IAC 1-3-5. In addition, the following nenatal medications must be maintained on the transport vehicle:

a) Weight dose tables for code drugs, drips and antibiotics should be available to facilitate administration;
b) Drug cards should be made by each team to assist in mixing and administration of medications;
c) IVF:
    a. D10W;
    b. D5W;
    c. NS and 1/2 NS;
d) Ionotropic agents:
    a. epinephrine;
    b. dopamine;
    c. dobutamine; and

Standard VIII: Neonatal Medications
d. consider norepinephrine and milrinone; e) Code medications: a. epinephrine; b. naloxone; c. lidocaine; d. sodium bicarbonate; e. adenosine; and f. atropine; f) Paralytic - short half-life; g) Furosemide; h) Antibiotics: a. ampicillin; b. gentamicin; c. cefotaxime, d. cefazolin; and e. acyclovir i) Prostaglandin; j) Surfactant; and k) Anticonvulsant.

UNIVERSAL STANDARDS

Standard IX: Personnel Licensure and Certification
9.1 All transport personnel must be licensed in the state appropriate for their job title (i.e. RN, RT, EMT, MD, APN, PA).
9.2 All maternal-fetal transport staff in the patient compartment shall have the following current certifications: a) BLS b) NRP c) The Learner S.T.A.B.L.E. Program d) ACLS or OB-ACLS e) For RN's, APN's, NCC—Inpatient Obstetrics or Maternal or Newborn, EFM (RNC) shall be obtained within two years of

hire unless NNP/PA status is current.
9.3 All neonatal transport staff in the patient compartment shall have the following current certifications or documentation of successful completion: a) BLS; b) NRP; c) STABLE; d) PALS; e) CFRN; and f) CNPT.

Standard X: Training Modules
10.1 Continuing education/competencies shall be documented in the clinical and or transport setting
10.2 Maternal transport reviews shall occur at least every six months and annually under the supervision of the specialty medical director or their designee.
10.2.1 24 hours of area specific didactic and/or continuing education shall be completed by all maternal transport team members annually.
10.3 The following neonatal educational modules should be conducted at least quarterly: a) Information pertaining to maternal physiologic/pharmacologic issues related to the neonate; b) Neonatal assessment to include modules on all systems; c) Assessment of gestational age; d) Interpretation of diagnostic data to include: a. lab values; and b. radiograph basics (pneumothorax, diaphragmatic hernia, pneumoperitoneum, ETT positioning); e) Thermoregulation; f) Arterial blood gas interpretation and ventilator management basics; g) Fluids and Electrolyte Balance; h) Ambulance/Aircraft safety and orientation and use of equipment within ambulance/aircraft; i) Ambulance/Aircraft physiology; j) Family-centered care; and k) Professionalism and Teamwork.

Standard XI: Universal Safety Measures
11.1 Each hospital with an in-house transport team must ensure the following safety measures are in place: a) Criteria for emergent vs. non-emergent status - protocol driven; a. track percentage of emergent transports as portion of QI process; b. protocol driven; and c. can be overridden by any member of the team; b) Document pre-transport check of rig by EMT on Transport records; c) Return of ground transport by "red lights and sirens" reviewed for appropriateness; d) Record of safety meetings and minutes should be maintained; e) Training for driver or pilot to recognize aircraft or ambulance tampering; and f) Security policy in place to address aircraft or ambulance if left unattended on a helipad, hospital ramp, or unsecured parking lot.

Standard XII: Universal Policies and Protocols
12.1 Each hospital with an in-house transport team must have written documentation for the following: a) Standardized departure protocol; b) Protocol for communication with referring facility: a. receiving facility should provide update to staff and physicians within 24 hours of admission; b. Follow-up should include outcome of transport, therapies initiated at admission and current status of infant; c) If possible, referring physician and delivering physician should be notified of infant status.

Attachment #7

Article 5. Emergency Medical Services Specialty Transport

Rule 1. PERINATAL TRANSPORT

836 IAC 5-1-1 General certification

Sec. 1. All contracted and/or center-based perinatal transport teams shall be certified by the commission as an ambulance provider organization. ("commission" means the Indiana Emergency Medical Services Commission (836 IAC 1-1-1 (15)).

836 IAC 5-1-2 Maternal-Fetal Quality Assurance

Sec.2. (1) In addition to complying with all reports and records rules in 836 IAC 1-1-5, the Certified Provider of the Maternal-Fetal Transport program shall track the following benchmarks:

A. Delivery ≤30 minutes from arrival at receiving hospital;
B. Diversion of transport due to maternal and or fetal status change in route;
C. Loss of communication with medical control for anything longer than 5 minutes;
D. Change in transport asset (ground to air or vice versa);
E. Delivery in route;
F. Incidence of sentinel events
G. Transport crew member injury during transport;
H. Any reason for transport delay:
    i. Accident—MVA, flight;
    ii. Delay in dispatch as defined as ≥ 15 minutes;
    iii. Mechanical failure of ambulance or aircraft that leads to a transport delay;
    iv. Equipment failure;
    v. Weather or road related (constructions, accidents) issues;
    vi. Crew member;
    vii. Maternal fetal injury during transport; and
    viii. Maternal and or fetal status deemed unstable for transport at sending facility.

(2) When a sentinel event occurs, the transport team, medical director, and medical control physician must have a debrief. The debrief must be initiated with 72 hours and the root cause analysis completed within 5 working days.

(3) Teams are required to have a pre-transport debriefing regarding the patient(s) condition prior to assuming care of the patient(s).

(4) Each in-house transport team shall have written internal quality review procedures/protocols.

(5) Each hospital with an in-house transport team shall implement a routine schedule of Quality Improvement meetings and a record of minutes maintained.

(6) Transport team must conduct quarterly reviews of the following elements and maintain documentation of the reviews in compliance with 836 IAC 1-1-5 (c)

A. Transport indication(s);
B. Medical and/or nursing intervention performed or maintained;
C. Time of intervention:
    i. patient response to interventions; and
    ii. appropriateness of intervention performed or omission of needed intervention
D. Patient outcome at arrival of destination;
E. Patient's change in condition during transport;
F. Timeliness and coordination of the transport from reception of request to lift off or ambulance enroute time;
G. Review of Pre-transport inspection documentation
H. Safety practices documented;
I. Operational criteria:
    i. number of completed transports;
    ii. number of aborted or canceled flights/transports due to weather;
    iii. number of aborted or canceled flights/transports due to maintenance;
    iv. number of aborted or canceled flights/transports due to patient condition and alternative modes of transportation; and
    v. number of aborted or canceled flights/transports due to unavailable team.
J. Communications center or organization must monitor and track:
    i. IFR/VFR;
    ii. Weather at time of request of the referring and accepting facility and during transport if changes occur;
    iii. Transport acceptance to lift off times or the road times; and
    iv. All aborted and cancelled transport requests - times, reasons and disposition of patients as applicable.

<u>836 IAC 5-1-3 Maternal-Fetal Competencies</u>

Sec. 3. (1) Nursing: In addition to compliance with IC 25-23 and IAC 848, Maternal-Fetal transport nurses shall adhere to the Standards for Professional Nursing Practice in the Care

of Women and Newborns. The documentation of compliance with the standards must be maintained in the employee personnel files.

(2) Emergency Medical Technician/Paramedic: Must meet and/or exceed the requirements established in 836 IAC Article 4.

(3) Medical Director:

A. A physician who is responsible and accountable for supervising and evaluating the quality of medical care provided during a MF transport.
B. Must be licensed and authorized to practice in the location in which the medical transport service is based and have educational experience in the area of high risk obstetrics or utilize specialty physicians as consultants when appropriate.
C. Must have current concepts of appropriate use of transport assets - annually must include but is not limited to the following
    i. "Just Culture" : Highly reliable standards of patient safety as described in 13.1
    ii. Patient care capabilities and limitations;
    iii. Continuing education in transport;
    iv. Crew resources management;
    v. Stress recognition and management; and
    vi. Infection control
D. Must have expertise in risk management and safety training.

(4) Clinical Care Supervisor:

A. Responsible for supervision of patient care provided by the members of the team directly employed by the transport program and works collaboratively with the medical director.
B. QM, QA, PI of the program
C. Must hire, train, and provide continuing education for the service
D. Responsible for evaluation of the crew members; and
E. Must maintain documentation of competencies in each employee's personnel file.

(5) Program Manager:

A. The Program Manager will be responsible for the management and oversight of the perinatal transport program.
B. Competencies:
    i. Human factors
    ii. Just culture: Highly reliable standards of patient safety as described in 13.1

iii. Sleep deprivation
iv. Stress recognition and management
v. Safety and risk management
vi. Quality management
vii. Knowledge of national, regional and local standards of clinical practice, aviation and ground regulations as appropriate

C. Documentation of competencies must be maintained in the employee personnel file.

(6) All maternal-fetal transport team members shall complete 24 hours of area specific didactic and/or continuing education on an annual basis. The 24 hours include the maintenance of competencies above.

<u>836 IAC 5-1-4 Maternal-Fetal Transport Equipment</u>

Sec.4. The ambulance used for maternal-fetal transport must have emergency care equipment as identified in 836 IAC 1 and/or 2 depending on patient acuity as determined by ISDH established algorithms. In addition, each hospital with an in-house maternal-fetal transport team must carry the following equipment or its equivalent:

A. Filter needles;
B. Blue port caps;
C. Syringes;
D. Pump tubing;
E. Piggyback tubing; Stopcocks;
F. Stopcock extension set ;
G. Y ports with blue locks;
H. IV start kits;
I. 18 g angiocaths;
J. Blue luerlocks;
K. SW flushes;
L. Integrative Therapies (optional):
    i. iPod;
    ii. Ear buds;
    iii. Essential oils;
M. Minifan (optional);
N. Activated chemical infant thermal mattress;
O. Adult Stethoscope;
P. Sterile gloves (variety of sizes);
Q. NRP pouch:
    i. Baby stethoscope;

ii. Ambu bag;
iii. Regular newborn mask;
iv. Preemie mask;
v. Infant pulse ox;
vi. Polyethylene or plastic barrier;
vii. Blanket;
viii. Syringe;
ix. Cord clamps;
x. Hat;
xi. Diaper;

R. Vaginal exam pouch:
i. Sterile exam gloves;
ii. Peri-pads;
iii. KY gel;

S. Fetal monitor:
i. Monitor paper;
ii. Power cables;
iii. Tocodynomonitor;
iv. Fetal heartrate ultrasound monitor;
v. Transducer Gel;
vi. Fetal Monitor Belts;
vii. Doppler;
viii. IV pump

<u>836 IAC 5-1-5 Maternal-Fetal Medication</u>

Sec.5. The ambulance used for maternal-fetal transport must have medication as identified in 836 IAC 1 and/or 2 depending on patient acuity as determined by ISDH established algorithms. In addition, the following medications, or an alternative as determined by the maternal-fetal medical director, must be carried by the maternal-fetal transport team:

A. Calcium Gluconate;
B. Tums calcium carbonate;
C. Furosemide;
D. Hydralazine;
E. Indomethacin;
F. Labetolol;
G. Misoprostol;
H. Morphine;
I. Nifedipine;

J. Ondansetron;
K. Oxytocin;
L. Terbutaline;
M. Magnesium;
N. Oxytocin; and
O. Lactated Ringers.

836 IAC 5-1-6 Neonatal Quality Assurance

Sec.6. (1) In addition to complying with all reports and records rules in 836 IAC 1-1-5, the Certified Provider of the Neonatal Transport Program shall track the following benchmarks:

A. Unplanned dislodgement of therapeutic devices;
B. Radiograph verification of tracheal tube placement;
C. Average mobilization time of transport team;
D. First attempt tracheal tube placement success:
    i. visualizations;
    ii. attempts at placement;
E. Incidence of transport-related patient injuries;
F. Incidence of medication administration errors;
G. Rate of CPR performed during transport;
H. Incidence of sentinel events;
I. Unintended neonatal hypothermia upon arrival to destination;
J. Rate of transport related crew injury; and
K. Standardized patient care hand-off performed (site specific protocol used).

(2) When a sentinel event occurs, the neonatal transport team, medical director, and medical control physician must have a debrief that is initiated within 72 hours and the root cause analysis completed within 5 working days.

(3) Teams are required to have a pre-transport debriefing regarding the patient(s) condition prior to assuming care of the patient(s).

(4) Each in-house transport team shall have written internal quality review procedures/protocols.

(5) Each hospital with an in-house transport team shall implement a routine schedule of Quality Improvement meetings and a record of minutes maintained.

(6) The Transport Team conducts a Quarterly Review of the following elements and maintain documentation of the reviews in compliance with 836 IAC 1-1-5 (c)

A. Reason for transport;
B. Mechanism of illness;
C. Medical intervention performed or maintained;
D. Time of intervention consistently documented for:
    i. patient response to interventions; and
    ii. appropriateness of intervention performed or omission of needed intervention;
E. Patient outcome at arrival of destination;
F. Patient's change in condition during transport;
G. Timeliness and coordination of the transport from reception of request to lift off or ambulance enroute time;
H. Pre-transport check of rig by EMT on Transport records;
I. Operational criteria to include, at a minimum, the following quality indicators:
    i. number of completed transports;
    ii. number of aborted or canceled flights/transports due to weather;
    iii. number of aborted or canceled flights/transports due to maintenance;
    iv. number of aborted or canceled flights/transports due to patient condition and alternative modes of transport;
J. Communications Center of organization must monitor and track:
    i. IFR/VFR
    ii. weather at time of request and during transport if changes occur; and all aborted and canceled transport request s - times, reasons and disposition of patients as applicable.

<u>836 IAC 5-1-7 Neonatal Competencies</u>

Sec.7. (1) . (1) Nursing: In addition to compliance with IC 25-23 and IAC 848, Neonatal transport nurses shall adhere to the Standards for Professional Nursing Practice in the Care of Women and Newborns. The documentation of compliance with the standards must be maintained in the employee personnel files.

(2) Emergency Medical Technician/Paramedic: Must meet and/or exceed the requirements established in 836 IAC Article 4.

(3) Medical Director:

A. Must be a physician who is responsible and accountable for supervising and evaluating the quality of medical care provided during a neonatal transport.

B. Must be licensed and authorized to practice in the location in which the medical transport service is based and have educational experience in the area neonatalogy or utilize specialty physicians as consultants when appropriate.
C. Must have current concepts of appropriate use of transport assets - annually must include but is not limited to the following
    a. "Just Culture" : Highly reliable standards of patient safety as described in 13.1
    b. Patient care capabilities and limitations;
    c. Continuing education in transport;
    d. Crew resources management;
    e. Stress recognition and management; and
    f. Infection control
D. Must have risk management and safety training.

(4) Clinical Care Supervisor:

A. Responsible for supervision of patient care provided by the members of the team directly employed by the transport program and works collaboratively with the medical director.
B. QM, QA PI of the program
C. Must hire, train, and provide continuing education for the service
D. Responsible for the evaluation of the crew members; and
E. Must maintain documentation of competencies in each employee's personnel file.

(5) Program Manager:

A. Has overall responsibility for a program
B. Must demonstrate the following competencies:
    i. Human factors
    ii. Just culture: Highly reliable standards of patient safety as described in 13.1
    iii. Sleep deprivation
    iv. Stress recognition and management
    v. Safety and risk management
    vi. Quality management
    vii. Knowledge of national, regional and local standards of clinical practice, aviation and ground regulations as appropriate
B. Must maintain documentation of competencies in each employee's personnel file.

(6) At least one member of the neonatal transport team members must demonstrate the following competencies at a minimum on a quarterly basis.

A. Arterial access;
B. Glucometer and/or I-STAT;
C. NG/OG insertion;
D. Bag/valve/mask ventilation/capnography and/or end tidal CO2;
E. Radial sticks (to include RT);
F. Oxygen delivery methods;
G. LMA;
H. Oral/nasal airways;
I. Use and ability to troubleshoot equipment such as transport isolette, med infusion pumps, ventilators, C/A monitor;
J. Suctioning of patients;
K. Medication administration;
L. Surfactant administration;
M. Umbilical line insertion and management;
N. Transport ventilator management (RT);
O. High frequency ventilator management (if hospital uses HF transport)
P. Needle decompression and chest tube management; and
Q. Urinary catheter placement.

(7) The following competencies are recommended but not required:

A. Central line insertion and management (PICC or cut down);
B. Trach management (required if center transports/manages tracheostomy patients;
C. Nitric oxide administration (required if center uses in transport); and
D. Cooling blanket, cooling cap (required if center uses in transport).

(8) Neonatal transport teams must use patient-based simulation as a component in their competency training a minimum of every six months.

(9) A written record of competency training for all transport team members must be maintained.

(10) In addition to the competencies, the following neonatal educational modules must be conducted at least quarterly:

A. Information pertaining to maternal physiologic/pharmacologic issues related to the neonate;
B. Neonatal assessment to include modules on all systems;
C. Assessment of gestational age;
D. Interpretation of diagnostic data to include:

i. lab values; and
ii. radiograph basics (pneumothorax, diaphragmatic hernia, pneumoperitoneum, ETT positioning);

E. Thermoregulation;
F. Arterial blood gas interpretation and ventilator management basics;
G. Fluids and Electrolyte Balance;
H. Ambulance/Aircraft safety and orientation and use of equipment within ambulance/aircraft;
I. Ambulance/Aircraft physiology;
J. Family-centered care; and
K. Professionalism and Teamwork.

836 IAC 5-1-8 Neonatal Equipment

Sec.8. The ambulance used for neonatal transport must be at a minimum ALS and have emergency care equipment as identified in 836 IAC Article 2. In addition, the in-house neonatal transport team must carry the following equipment:

A. Cardiopulmonary monitor;
B. Pulse oximetry;
C. Portable transilluminators;
D. Heimlich valves;
E. Suction, including stand alone battery-powered device with adjustable pressure;
F. Chest tubes;
G. Transport ventilator;
H. Transport incubator:
I. Airway management tools:
i. Ambu bag;
ii. Laryngoscope;
iii. LMA; and
iv. Oxygen blender
J. Oxygen and air cylinders with volume capable of delivery for two times the anticipated duration of the transport;
K. Inhaled nitric oxide (optional but considered standard);
L. Temperature monitoring;
M. Infusion pumps capable of delivering neonatal volumes;
N. Defibrillator (neonatal pads); and
O. Point of care testing:
i. glucometer or device capable of providing glucose measure; and blood gas analyzer.

836 IAC 5-1-9 Neonatal Medications

Sec.9. The ambulance used for transport must have medication as identified in 836 IAC Article 2. In addition, the following neonatal medications or an alternative as determined by the neonatal medical director must be available and carried by the neonatal transport team:

A. Weight dose tables for code drugs, drips and antibiotics should be available to facilitate administration;
B. A mechanism must be in place to assist in mixing and administration of medications;
C. IVF:
    i. D10W;
    ii. D5W;
    iii. NS and 1/2 NS;
D. Ionotropic agents:
    i. Epinephrine;
    ii. Dopamine;
    iii. Dobutamine; and
    iv. consider Norepinephrine and Milrinone;
E. Code medications:
    i. Epinephrine;
    ii. Naloxone;
    iii. Lidocaine;
    iv. Sodium bicarbonate;
    v. Adenosine; and
    vi. Atropine;
F. Paralytic - short half-life;
G. Furosemide;
H. Antibiotics:
    i. Ampicillin;
    ii. Gentamicin;
    iii. Cefotaxime,
    iv. Cefazolin; and
    v. Acyclovir
I. Prostaglandin (when appropriate);
J. Surfactant (when appropriate); and
K. Anticonvulsant.

836 IAC 5-1-9 Perinatal Personnel Licensure and Certification

Sec.9. (1) All transport personnel must be certified/licensed in the state appropriate for their job title (i.e. RN, RT, EMT, MD, APN, PA).

(2) The maternal-fetal transport team must have a minimum staff of:

A. maternal-fetal transport nurse; and

B. one of the following:

i. Paramedic;

ii. Nurse

iii. Nurse Practitioner; or

iv. Physician.

(3) All maternal-fetal transport staff in the patient compartment shall have the following current certifications:

A. BLS

B. NRP

C. The Learner S.T.A.B.L.E. Program

D. ACLS or OB-ACLS

E. For RN's, APN's, NCC—Inpatient Obstetrics or Maternal or Newborn, EFM (RNC) shall be obtained within two years of hire unless NNP/PA status is current.

(4) The neonatal transport team must have a minimum staff of:

A. Respiratory Therapist; and

B. one of the following:

i. Neonatal Nurse; or

ii. Neonatal Nurse Practitioner.

(5) All neonatal transport staff in the patient compartment shall have the following current certifications or documentation of successful completion:

A. BLS;

B. NRP; and

C. The Learner STABLE Program.

836 IAC 5-1-10 Perinatal Safety Measures

Sec.11. All Certified Providers of Perinatal transport teams must ensure the following safety measures are in place:

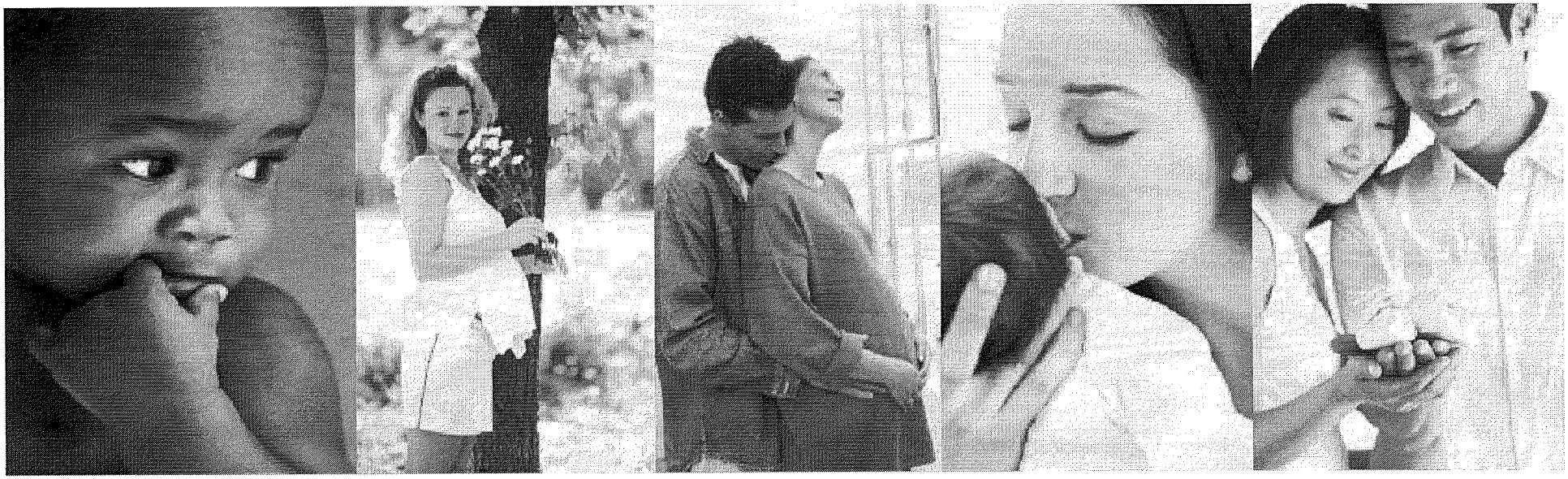
A. Criteria for emergent vs. non-emergent status - protocol driven;
    i. track percentage of emergent transports as portion of QI process;
    ii. protocol driven; and
    iii. can be overridden by any member of the team;
B. Document pre-transport check of rig by EMT on Transport records;
C. Return of ground transport by "red lights and sirens" reviewed for appropriateness;
D. Record of safety meetings and minutes should be maintained;
E. Training for driver or pilot to recognize aircraft or ambulance tampering; and
F. Security policy in place to address aircraft or ambulance if left unattended on a helipad, hospital ramp, or unsecured parking lot.

<u>836 IAC 5-1-11 Perinatal Policies and Protocols</u>

Sec.12. All Certified Providers of Perinatal transport teams must have written documentation for the following:

A. Standardized departure protocol;
B. Protocol for communication with referring facility:
    i. receiving facility should provide update to staff and physicians within 24 hours of admission;
    ii. Follow-up should include outcome of transport, therapies initiated at admission and current status of infant;
C. If possible, referring physician and delivering physician should be notified of infant status.

Attachment #8

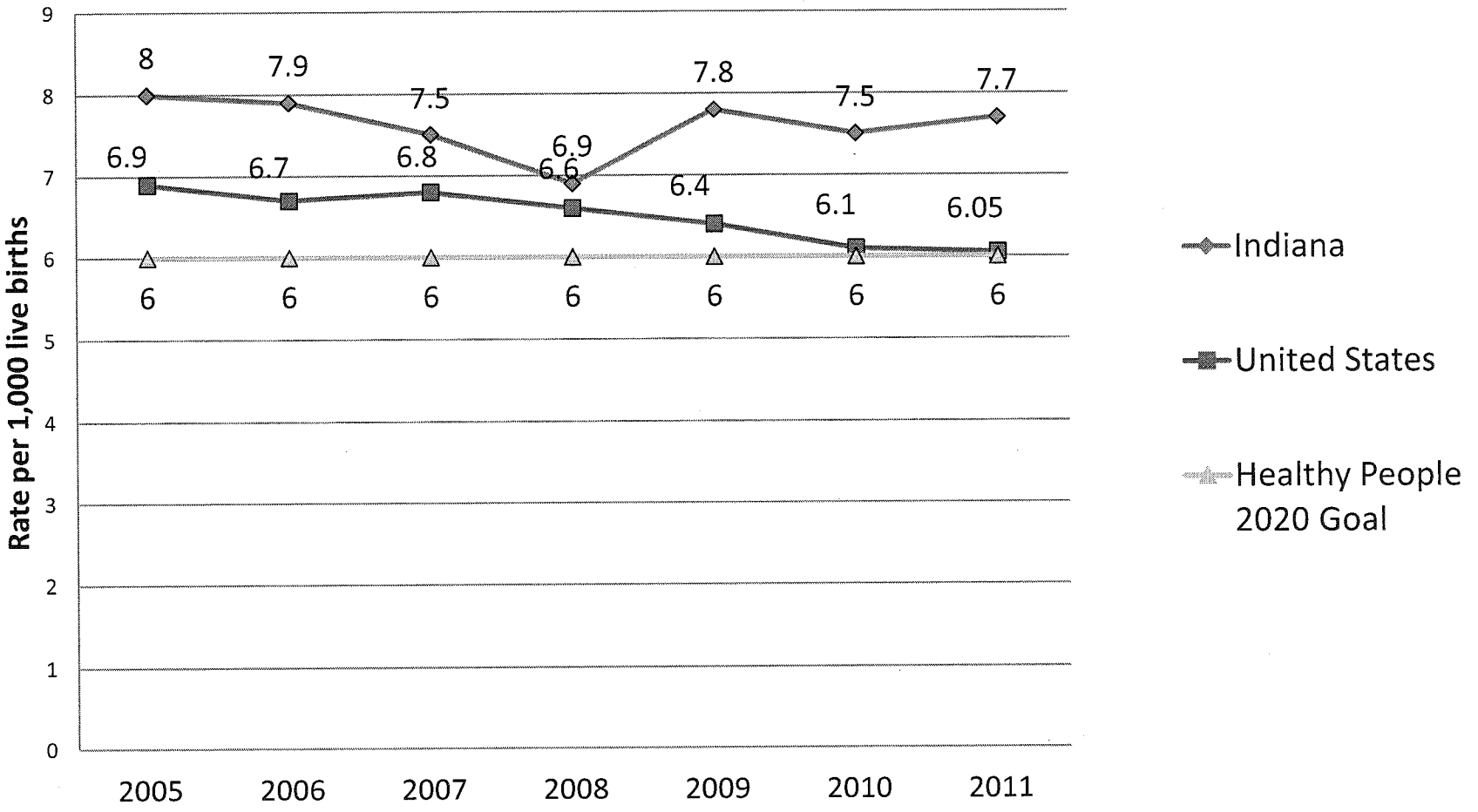


Indiana Perinatal Quality Improvement Collaborative (IPQIC) Overview

IPQIC Finance Committee

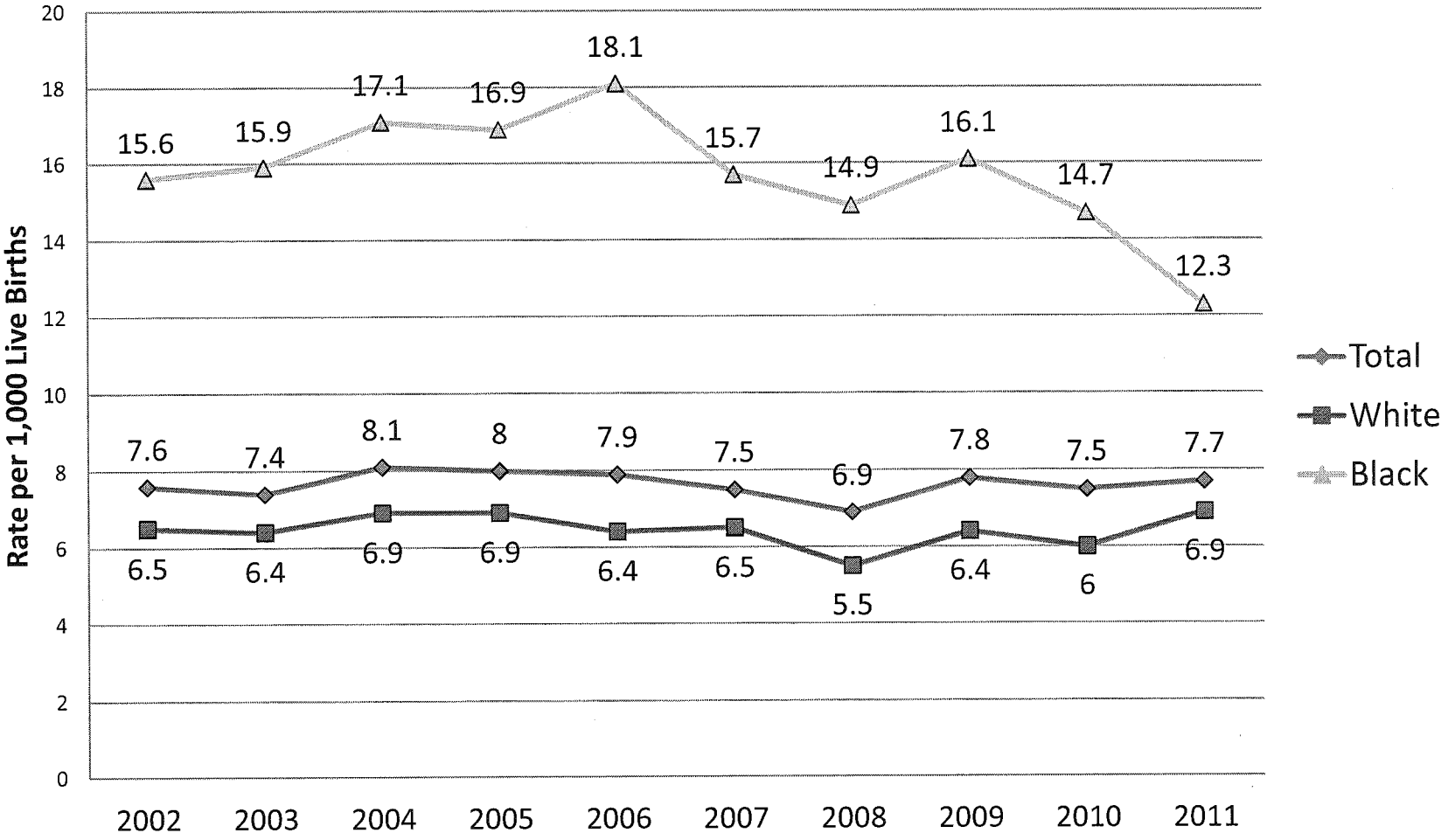
February 26, 2014

Infant Mortality Rates



Source: Indiana State Department of Health, Maternal & Child Health Epidemiology Division (August 12, 2013)
United States Original Source: Centers for Disease Control and Prevention National Center for Health Statistics
Indiana Original Source: Indiana State Department of Health, PHP, ERC, Data Analysis Team

Infant Mortality Rates by Race, Indiana, 2002-2011



Source: Indiana State Department of Health, ERC, Data Analysis Team, 2013

Indiana top 5 causes of IM in 2011 (643 deaths)

- Perinatal Risks = *45.7%* (294 deaths)
  - Examples include..Pre-term, LBW, VLBW, placental complications, premature rupture of membranes, bacterial sepsis, respiratory conditions, etc.
- Congenital malformations = *26.3%* (169)
- SIDS/SUIDS/Accidents = *15.6%* (95)
  - SIDS =51
  - Accidental suffocations=28
  - Other accidents= 16
- Assault/Neglect = *1.4%*
- All Other = *11%* (71)

Vision of IPQIC

- All perinatal care providers and all hospitals have an important role to play in assuring all babies born in Indiana have the best start in life.
- All babies in Indiana will be born when the time is right for both the mother and the baby.
- Through a collaborative effort, all women of childbearing age will receive risk appropriate health care before, during and after pregnancy.

IPQIC Infrastructure

Indiana Perinatal Quality Improvement Collaborative

Vision

- *All perinatal care providers and all hospitals have an important role to play in assuring all babies born in Indiana have the best start in life.*
- *All babies born in Indiana will be born when the time is right for both the mother and the baby*
- *Through a collaborative effort, all women of childbearing age will receive risk appropriate health care before, during and after pregnancy*

Governing Council
Co-chairs: William VanNess, MD, ISDH
Douglas Leonard, Indiana Hospital Association

Quality Assurance Committee
Co-Chairs:
Kathy Wallace
Nancy Swigonski, MD

Education Committee
Co-Chairs:
Minjoo Morlan
Lauren Dungy- Poythress, MD

Perinatal Systems Development Committee
Co-Chairs:
Lee Learman, MD
Nicata Bradburn, MD

Data Committee
Co-Chairs:
Joe Gibson
Waldo Mikels-Carrasco

Finance Committee
2014
Co-Chairs
Kimberly Roop, MD
Keith Reissaus

System Implementation Subcommittee
Co-Chairs
Chris Ryan
Dana Watters

Transport Subcommittee
Co-Chairs:
Beth McIntire
James Cameron, MD

Centers Subcommittee
Co-Chairs
Maria DelRio Hoover, MD
Renata Sawyer, MD

Data Committee

- Co-chairs: Waldo Mikels-Carrasco and Joe Gibson
  - Facilitate the accurate collection of data and analysis of data needs for the IPQIC
  - Work with the Quality Improvement Committee to coordinate collection of population data and QI Project Data
  - Identify data gaps and how/where to obtain data
  - Advise and assist the IPQIC on analysis strategies and techniques as needed; and
  - Review progress and outcome measures on a regular basis and make policy recommendations regarding data to the IPQIC Governing Council

Education Committee

- Co-chairs: Minjoo Morlan and Dr. Lauren Dungy-Poythress

  - Serve as a forum, clearinghouse and educational resource regarding perinatal issues for health care professionals and consumers;
  - Increase awareness of infant mortality, preterm birth, preconception and interconception health care;
  - Provide consistent evidence-based educational messages;
  - Increase recognition of the influence of non-medical issues on perinatal outcomes;
  - Make recommendations to IPQIC and ISDH regarding effective educational strategies for Indiana
  - Work with QI Committee to identify promising practices to share with broader Indiana perinatal community

Quality Improvement Committee

- Co-chairs: Dr. Nancy Swigonski and Kathy Wallace
  - Analyze IPQIC data and review current, relevant literature.
  - Define indicators and benchmarks, recommend quality improvement objectives and projects
  - Provide models for performance improvement.
  - Develop an organization that supports the perinatal providers in their work of improving perinatal outcomes and effectiveness
  - Support the provision of data that inform and organize work through reports that measure the achievement of desired tasks; local data quality monitoring; local perinatal quality monitoring

Systems Development Committee

- Co-Chairs: Dr. Lee Learman and Dr. Niceta Bradburn
  - Develop a strategic plan to implement and monitor the Indiana Perinatal Standards of Care
  - Develop standardized procedures for stabilization, consultation and transport of high risk pregnant women and neonates
  - Develop standards and responsibilities for hospitals designated as perinatal centers of excellence

Attachment #9

Attachment #10

Hazardous Materials presentation for the EMS Commission Meeting

Currently the Fire Training Office has created an online Hazardous Materials Awareness training program that providers can use to provide initial training for their personnel. This training program focuses on recognition/identification, notification and self/public protection. The challenge facing organizations engaged in EMS operations is what level of training/certification is required pertaining to hazardous materials. In relation to this question OSHA regulation 29CFR1910.120 (q) (6) states that *Training shall be based on the duties and function to be performed by each responder of an emergency response organization. The skill and knowledge levels required for all new responders, those hired after the effective date of this standard, shall be conveyed to them through training before they are permitted to take part in actual emergency operations on an incident.* In a nutshell the level of training is based upon their duties. To assist in this decision the follow two excerpts from 29CFR1910.120 (q) (6)(i) state *First responder awareness level. First responders at the awareness level are individuals who are likely to witness or discover a hazardous substance release and who have been trained to initiate an emergency response sequence by notifying the proper authorities of the release. They would take no further action beyond notifying the authorities of the release.* Also 29CFR1910.120 (q) (6)(ii) states *First responder operations level; First responders at the operations level are individuals who respond to releases or potential releases of hazardous substances as part of the initial response to the site for the purpose of protecting nearby persons, property, or the environment from the effects of the release. They are trained to respond in a defensive fashion without actually trying to stop the release. Their function is to contain the release from a safe distance, keep it from spreading, and prevent exposures.*

The first question that EMS agencies must answer is what level of service they deliver and what duties their employees are expected to perform? If they are tied to a first response agency such as a fire department then it would be safe to assume that they will need to be trained to the operations level. If they do not then they need to determine if awareness will suffice. One consideration for the entire EMS community is that the current fire based operations certification may not be sufficient training for EMS responders. At the very least they are performing skills that are not part of the typical EMS agency such as firefighting foam operations, damming, diking etc... We have searched for hazardous materials operations training programs for EMS but have been unsuccessful. The next question is what the EMS community considers minimum standard for hazardous materials operations. Looking through NFPA 473 we have found two issues that need to be discussed before determining whether this document constitutes operations level training. First issue is that the requirements in the standard are very extensive and it is written in an ALS and BLS format instead of Awareness, Operations and Technician.

We are all searching for resolutions that provides for the safety of EMS responders and the general public. Training should be provided that is relevant to the responders and

educates agency leaders so they can determine their level of response and provide for any gaps in response. One thing that should be occurring is partnerships between smaller agencies and larger agencies to fill operational gaps in relation to EMS. Agencies should also reach out to local hospitals to determine their capabilities in hazardous materials emergencies.

Attachment #11

MICHAEL R. PENCE, Governor
STATE OF INDIANA

INDIANA DEPARTMENT OF HOMELAND SECURITY
302 West Washington Street
Indianapolis, IN 46204

EMERGENCY MEDICAL SERVICES

EMSC NARCOTICS Subcommittee Work Group

Minutes

DATE: **January 14, 2013**

TIME: **1:30 P.M.**

LOCATION: Indiana Government Center South Building
302 West Washington Street Conference Room 17
Indianapolis, IN 46221

INDIVIDUALS PRESENT:

Commissioner, John Zartman - Chairman, State EMS Director-Mike Garvey, Commissioner, Robin Stump, Don Watson, Candice Hilton, Al Verbish, Dr. Michael Gamble- TAC member, Chris Jones-Seals Ambulance Service and IEMSA, Dr. Michael Kaufmann- St. Vincent.

MEMBERS INVITED, NOT PRESENT: Dr. Sara Brown-TAC member.

Meeting called to order at 1:35 pm by Commissioner John Zartman. Commissioner Zartman presented a brief history of a needs assessment, and a summary of the last meeting was presented. Mr. Zartman stated that this committee was form by the recommendation of the EMS Commission to review current process, rules, regulations, and the lack of consistency among EMS providers in the use, storage and purchasing of narcotics.

Discussion regarding several issues followed Commissioner Zartman's opening comments. A new point of discussion and item that needs to be looked at is student access to narcotics. How are students monitored while handling narcotics?

Dr. Kaufmann spoke regarding the process he uses (222 form) to regulate distribution for providers under his Medical Direction. Dr. Gamble spoke regarding the process he uses as well. Regulations need to be tightened up to help protect the medical directors. There were some options put on the table as to the direction the group might take:

1. Best practice paper written up and distribute to medical directors and provider organizations
2. Rule rewrites
3. Non-rule policy

Mr. Chris Jones suggested the possibility of getting away from pre-filled syringes/carp jets and go to vials that are sealed in pill bottles that are sealed one the seal is broken it is documented and the left over is "wasted". It was stated that the "wasting" of the drugs is not air tight there are opportunities for the narcotics to be stolen.

It is believed that not all medical directors know the rules and what is expected of them regarding being a medical director for an EMS provider service. Medical Directors need to be educated as to their role and responsibilities.

Commissioner Zartman stated he believes we need to maintain the communication and working relationship between IDHS and the DEA.

After discussion with in the group it was decided to break down the overall issue into sections:

1. ordering, supplying and tracking of narcotics
2. security, storage, and dispensing

After discussion it was decided that Commissioner Zartman, Dr. Gamble and Dr. Kaufman will gather the narcotics policies from their providers to bring back to the next meeting. Mr. Chris Jones will ask the members of IEMSA to send in their narcotics policies. Commissioner Zartman stated he would ask Commissioner Valentine to request the information from the members of the Indiana Fire Chiefs Association.

The district coordinators will start focusing on ALS drug use as they do inspections and get a copy of the services current policies.

The meeting was adjourned at 2:43p.m.

Respectfully Submitted,

John R. Zartman,

EMS Commission Member
Subcommittee Chairman

Attachment #12

ISDH EMS Registry

Report for February 2013

This report from the Indiana State Department of Health (ISDH) EMS registry includes 96,410 runs from 84 pre-hospital providers during the time frame from January 1, 2013 through January 25, 2014. This report also focuses on several sub-populations in this timeframe:

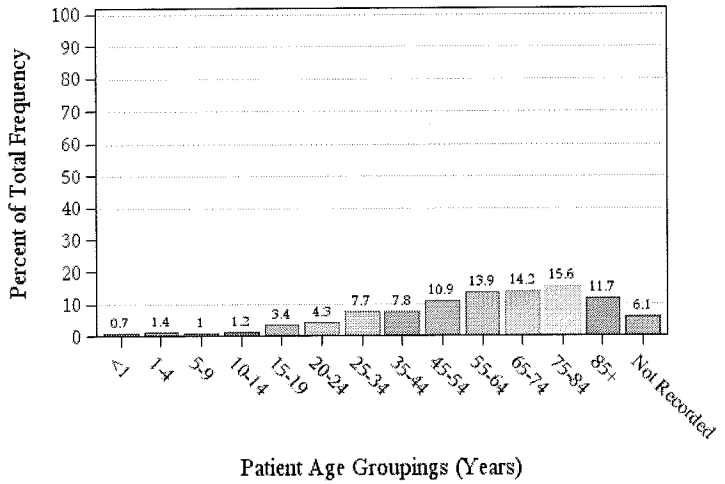
1. 7,175 chest pain incidents where chest pain was the complaint reported by dispatch or the provider's primary or secondary impression was chest pain/ discomfort
2. 6,492 incidents where the 12 lead ECG procedure was performed.

Lastly, 20,657 incidents were reported to the ISDH Indiana Trauma Registry from the same time period (January 1, 2013 to January 25, 2014) and were included to provide data on the injury severity score (ISS) by public health preparedness district.

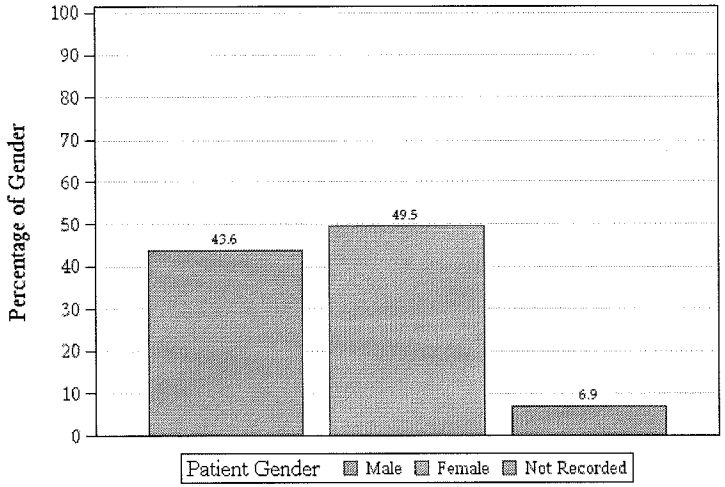
At a previous EMS Commission meeting, it was requested that prior aid data be provided, specifically to know if aspirin (ASA) was given before the EMS arrived on the scene in cases of chest pain. Additionally, it was requested that medical history of aspirin allergy be provided for incidents of chest pain. Approximately 1% of chest pain cases were reported to have allergies to aspirin (81 cases). Please note that the medication allergies data element is a National Emergency Medical Services Information System (NEMSIS) gold element which is not required by either the Indiana Department of Homeland Security (IDHS) or ISDH EMS registries.

Prehospital Statewide *84 Total Providers Reporting*
01/01/2013 - 1/25/2014 *96,410 Incidents*

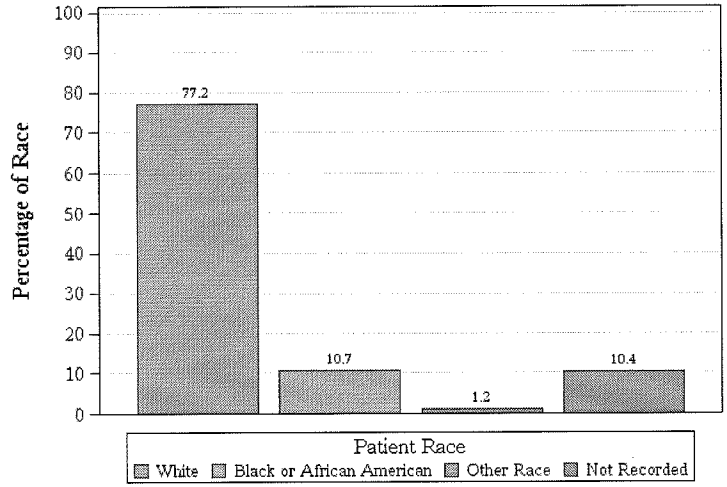
Patient Age (Years)



Patient Gender

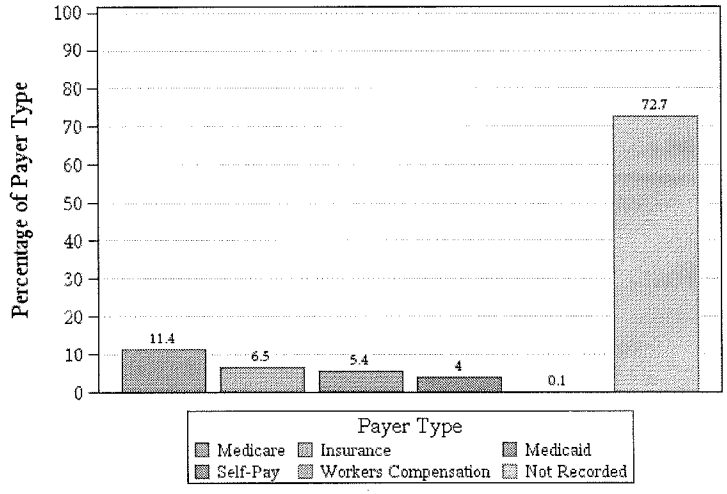


Patient Race

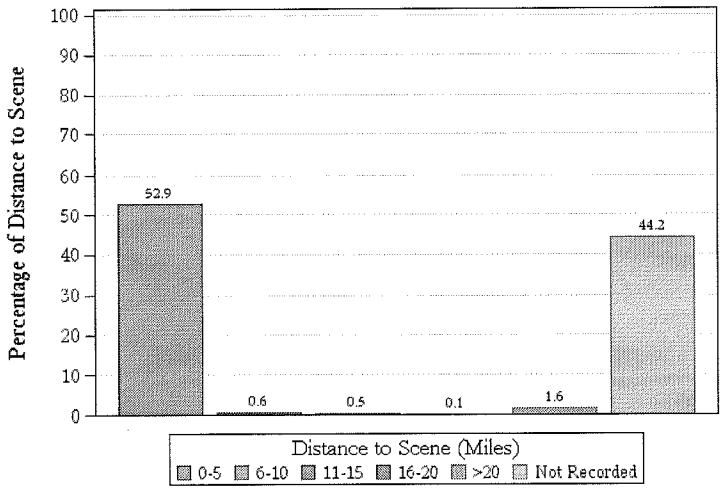


<1% Race: Asian, Native Hawaiian, American Indian/Alaskan Native

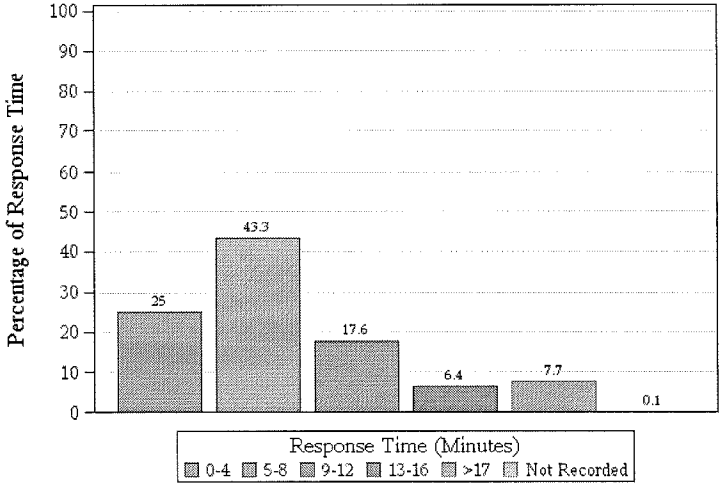
Payer Type



Distance to Scene (Miles)

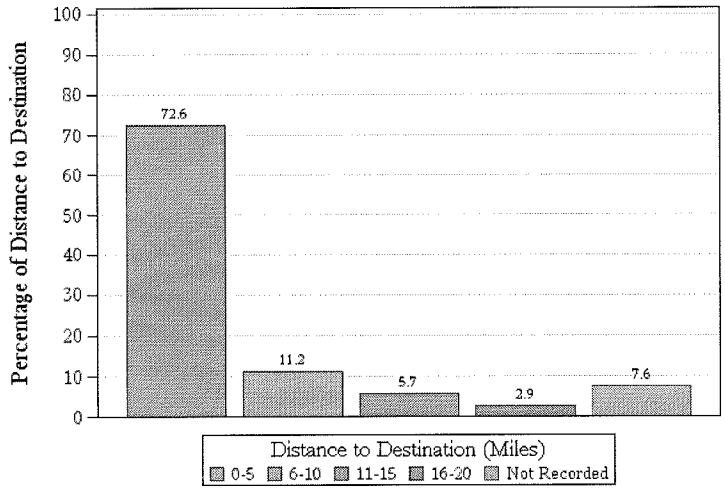


Response Time (Minutes)

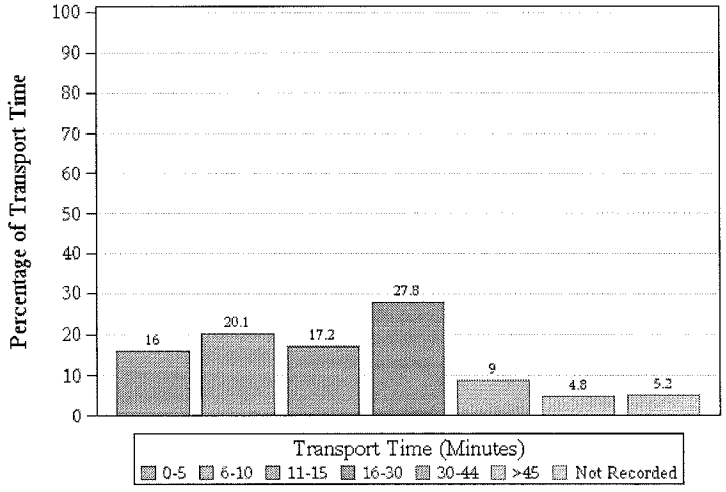


Response Time: Difference in Time from Dispatch to Arrival on Scene

Distance to Destination (Miles)

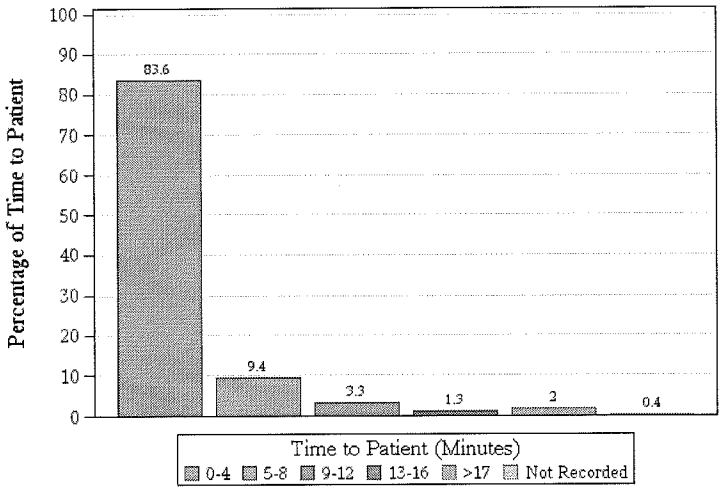


Transport Time (Minutes)



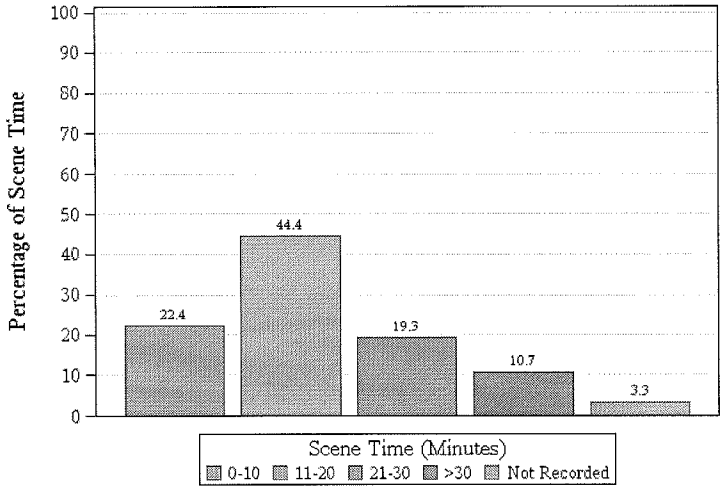
Transport Time: Difference in Time from Departure from Scene to Arrival At Destination

Time to Patient (Minutes)



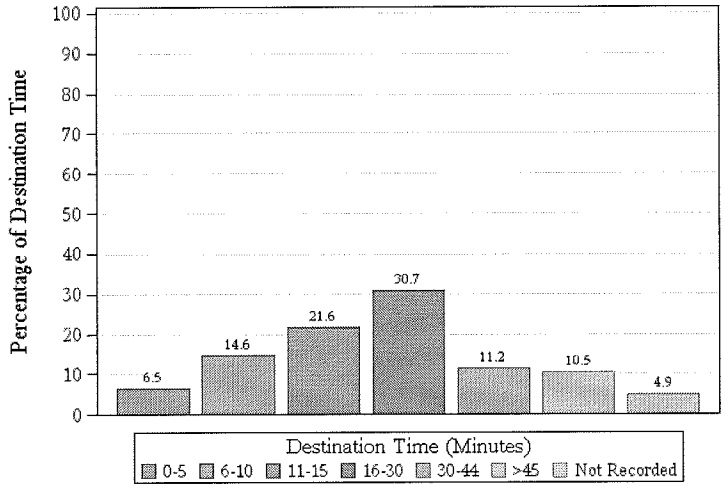
Time To Patient: Difference in Time from Arrival at Scene to Patient Arrival

Scene Time (Minutes)



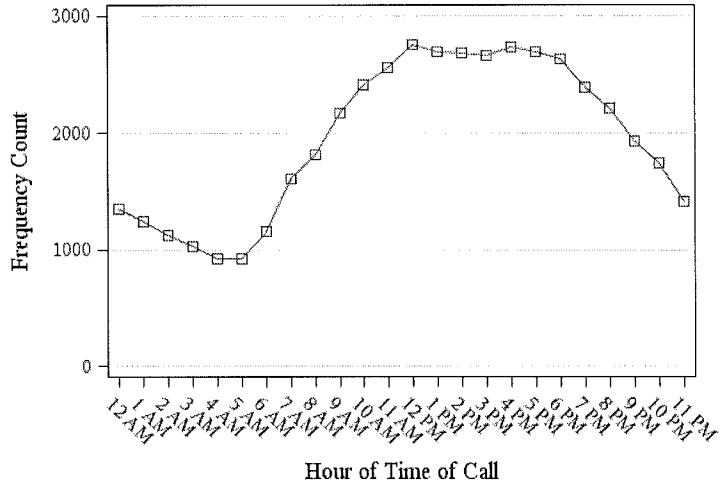
Scene Time: Difference in Time from Arrival at Scene to Leaving Scene

Destination Time (Minutes)



Scene Time: Difference in Time from Arrival at Destination to Unit Back in Service

Time of Call



Time of Call Not Recorded for 49,586 Incidents

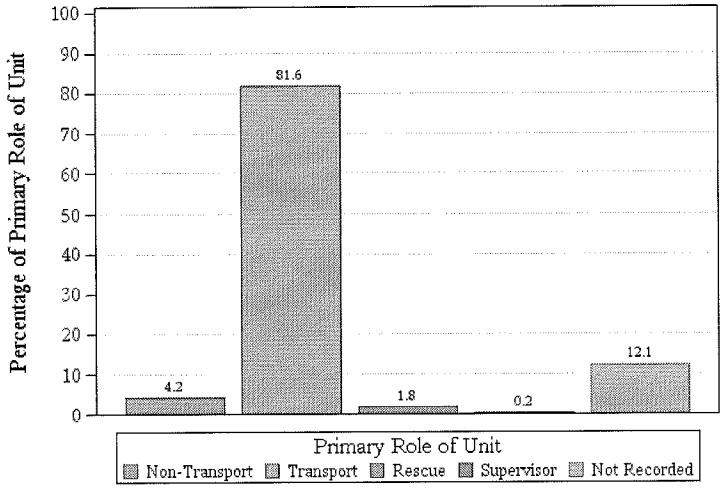
Average Run Mileage

Obs	Destination	Miles
1	Mileage to Scene	1.4
2	Mileage to Destination	3.3
3	Total Mileage	5.6

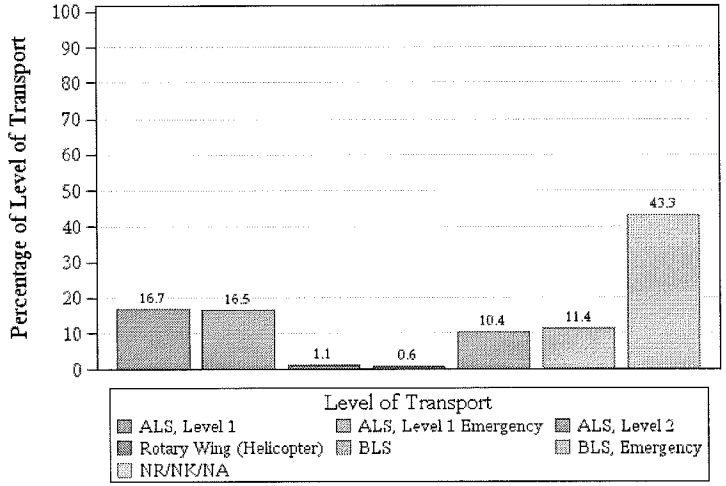
Average Run Time

Obs	Destination	Minutes
1	Time to Scene	8.89
2	Time to Patient	2.89
3	Time at Scene	18.31
4	Time to Destination	17.60
5	Back in Service	23.03
6	Total Run Time	60.24

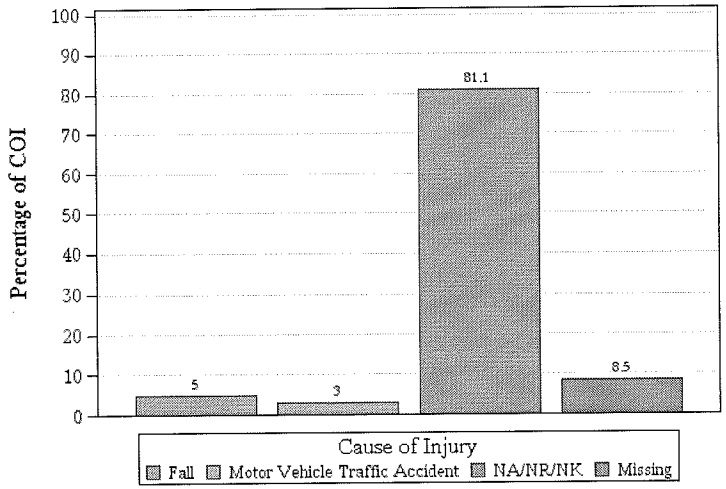
Primary Role of Unit



Level of Transport

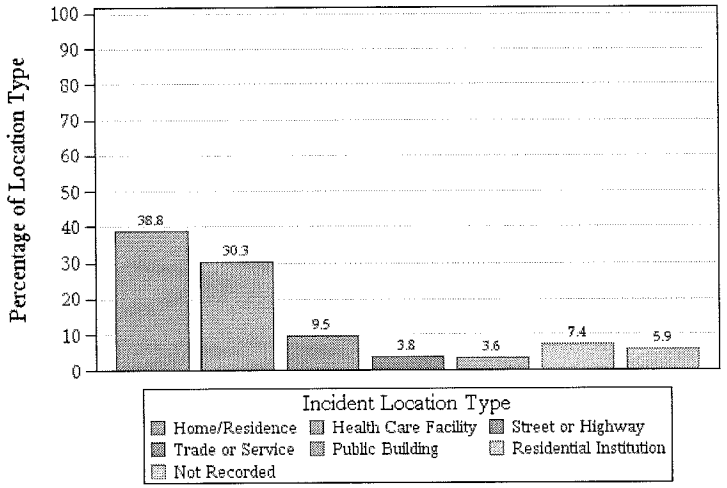


Cause of Injury (COI)



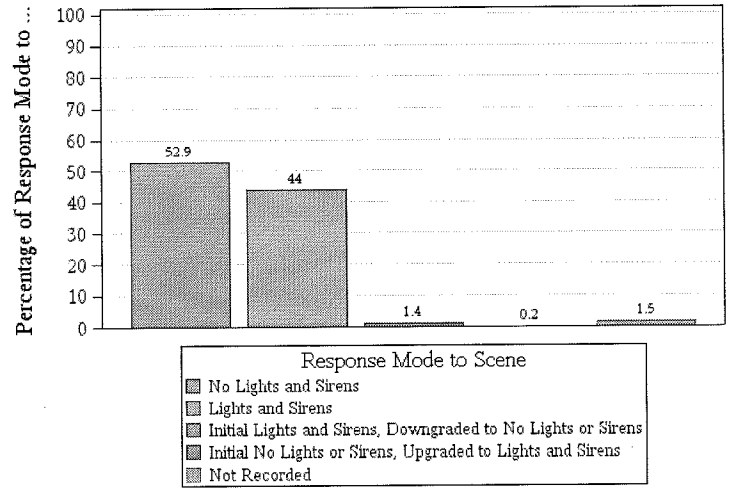
<1.5% COI: Motorcycle Accident, Stabbing/Cutting Assault, Bites, Machinery Accidents, Fire/Flames, Pedestrian Traffic Accident, Bicycle Accident, Firearm Injuries

Incident Location Type

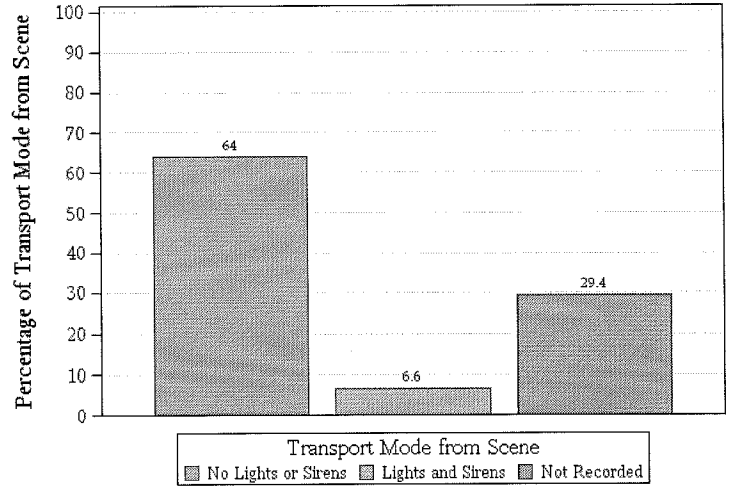


<1% Location Type: Mine or Quarry, Lake/River/Ocean, Place of Recreation of Sport, Not Recorded

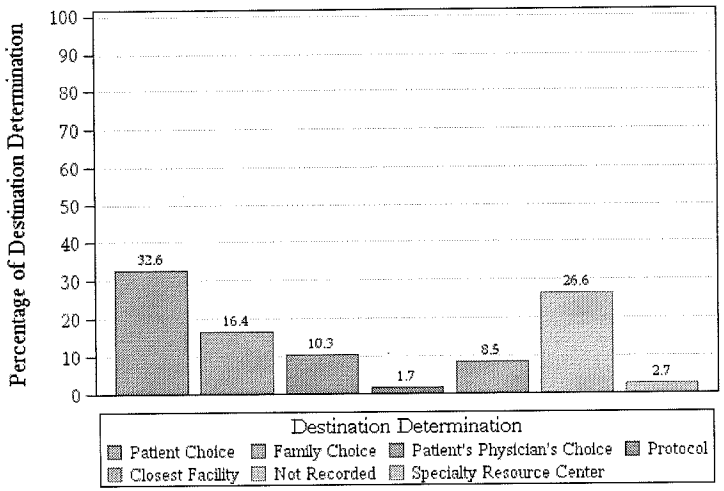
Response Mode to Scene



Transport Mode from Scene

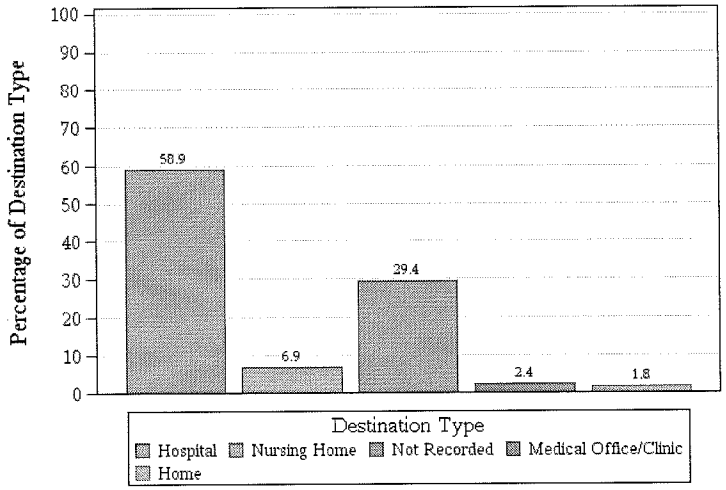


Destination Determination



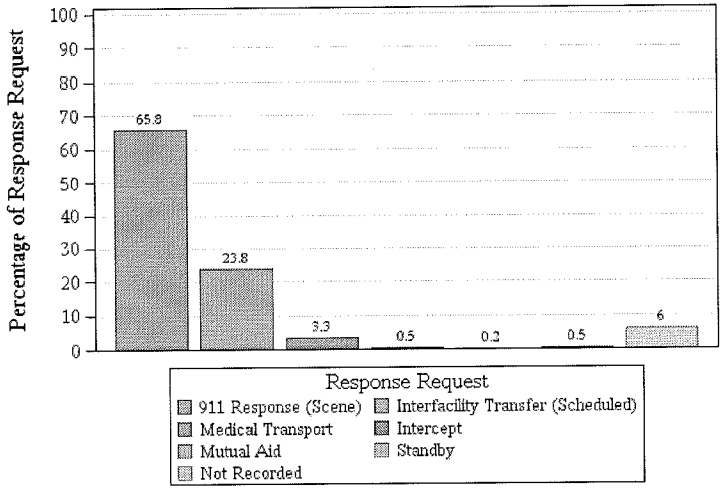
<1% Destination Determination: On-line Medical Direction, Insurance Status, Diversion

Destination Type

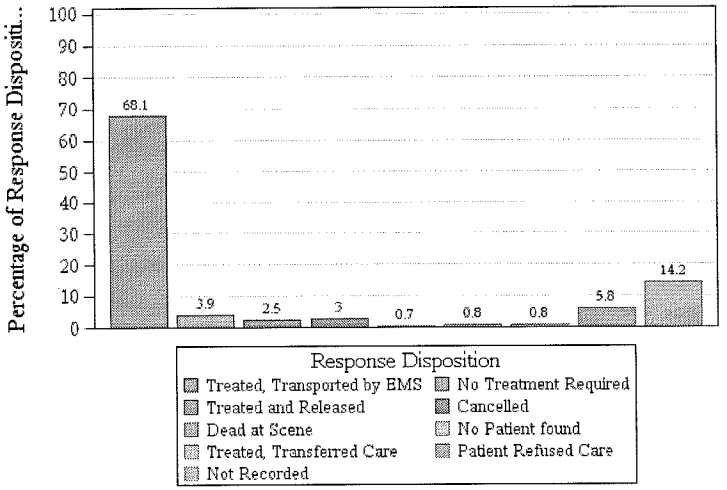


<1% Destination Type:EMS Responder (Ground),Other Morgue, Other EMS Responder (Air), Police/Jail

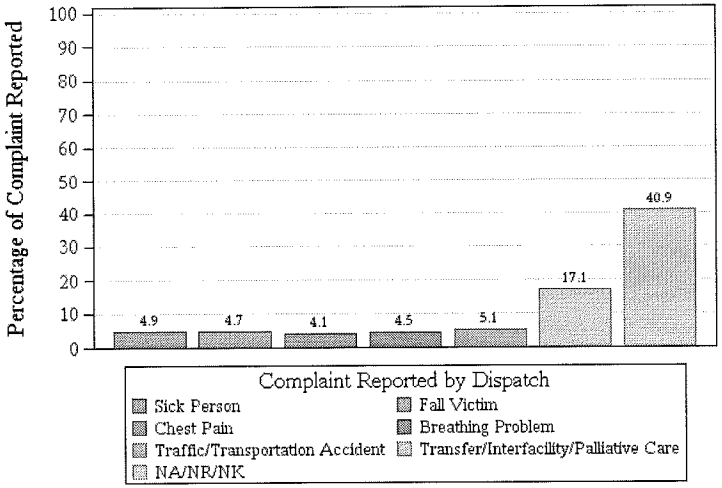
Response Request



Response Disposition

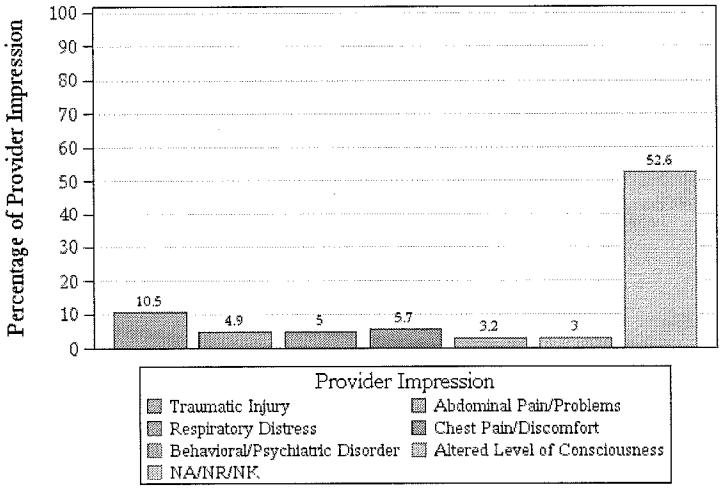


Complaint Reported by Dispatch



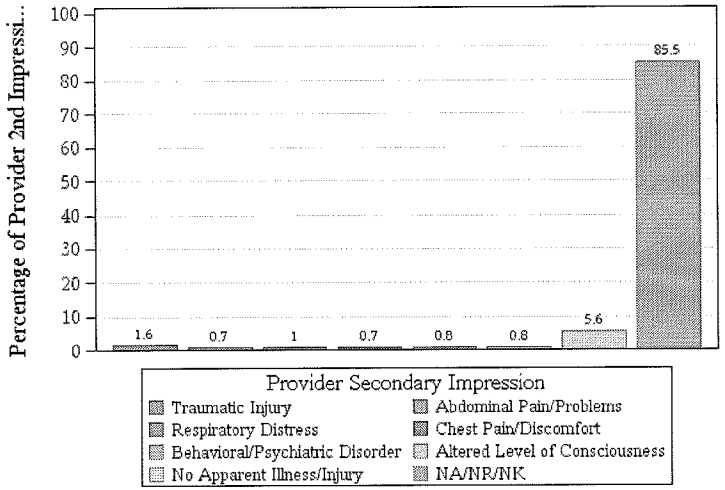
<2.5% P.I.: Assault, Unconscious/Fainting, Stroke/CVA, Seizure Traumatic Injury, Abdominal Pain, Cardiac Arrest, Diabetic, Unknown Problem/Man Down, Psychiatric Problems, Other

Provider Primary Impression



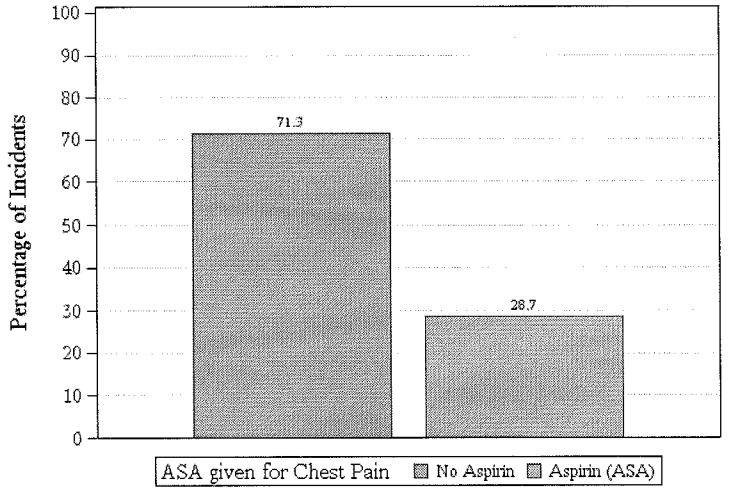
<2.5% P.I.:Stroke/CVA, Diabetic Symptoms, Syncope/Fainting, Cardiac Arrest, Pregnancy/OB Delivery, Obvious Death, Poisoning/Drug Ingestion, Cardiac Rhythm Disturbance, Allergic Reaction, Hypovolemia/Shock

Provider Secondary Impression



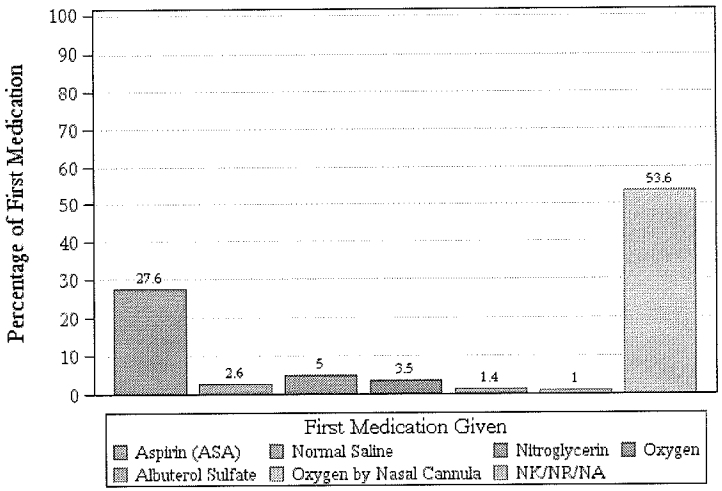
<.5% P.I.:Pain, Seizure, Other. Stroke/CVA,Syncope/Fainting Poisoning/Drug Ingestion, Cardiac Rhythm Disturbance, Diabetic Symptoms

Chest Pain Incidents where ASA Given



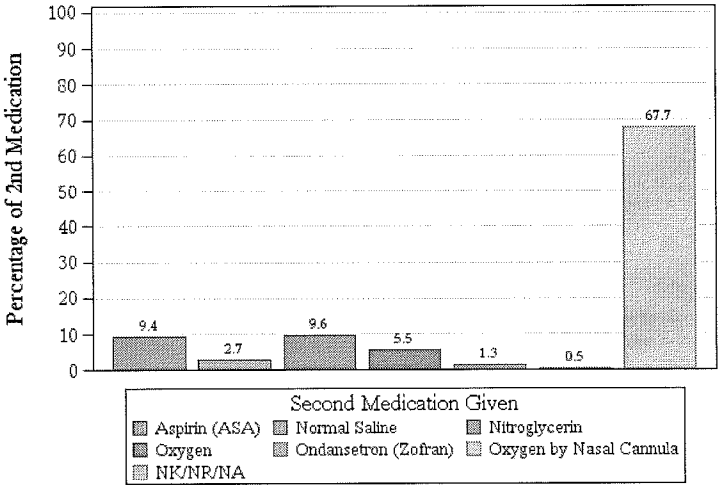
Chest Pain Incidents where ASA was Given (2013 YTD)
Chest Pain as complaint reported by dispatch or the provider's primary or secondary impression; N= 7,175

First Medication Given for Chest Pain



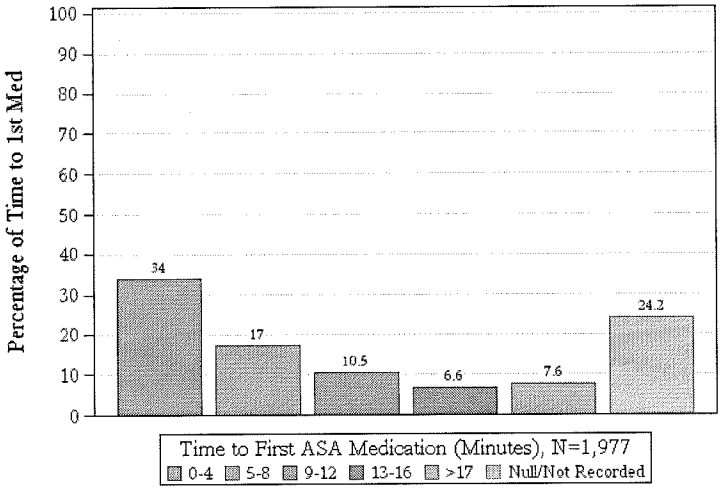
<.5% 1st Med: Fentanyl, Adenosine, Oxygen by Nasal Cannula Dopamine, Amyl Nitrate,Ondansetron (Zofran), Ketorolac (Toradol), Metoclopramide (Reglan), Other

Second Medication Given for Chest Pain



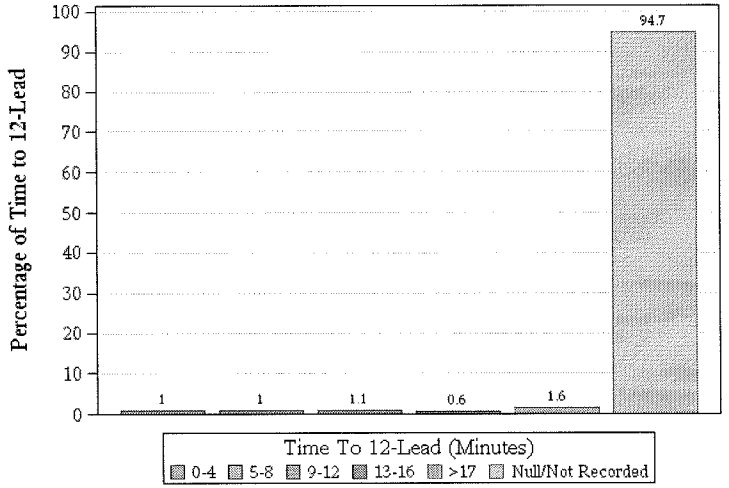
<1% 2nd Med: Fentanyl, Morphine Sulfate, Dopamine, Atropine Sulfate, Adenosine, Other

Time to First ASA Medication (Minutes)



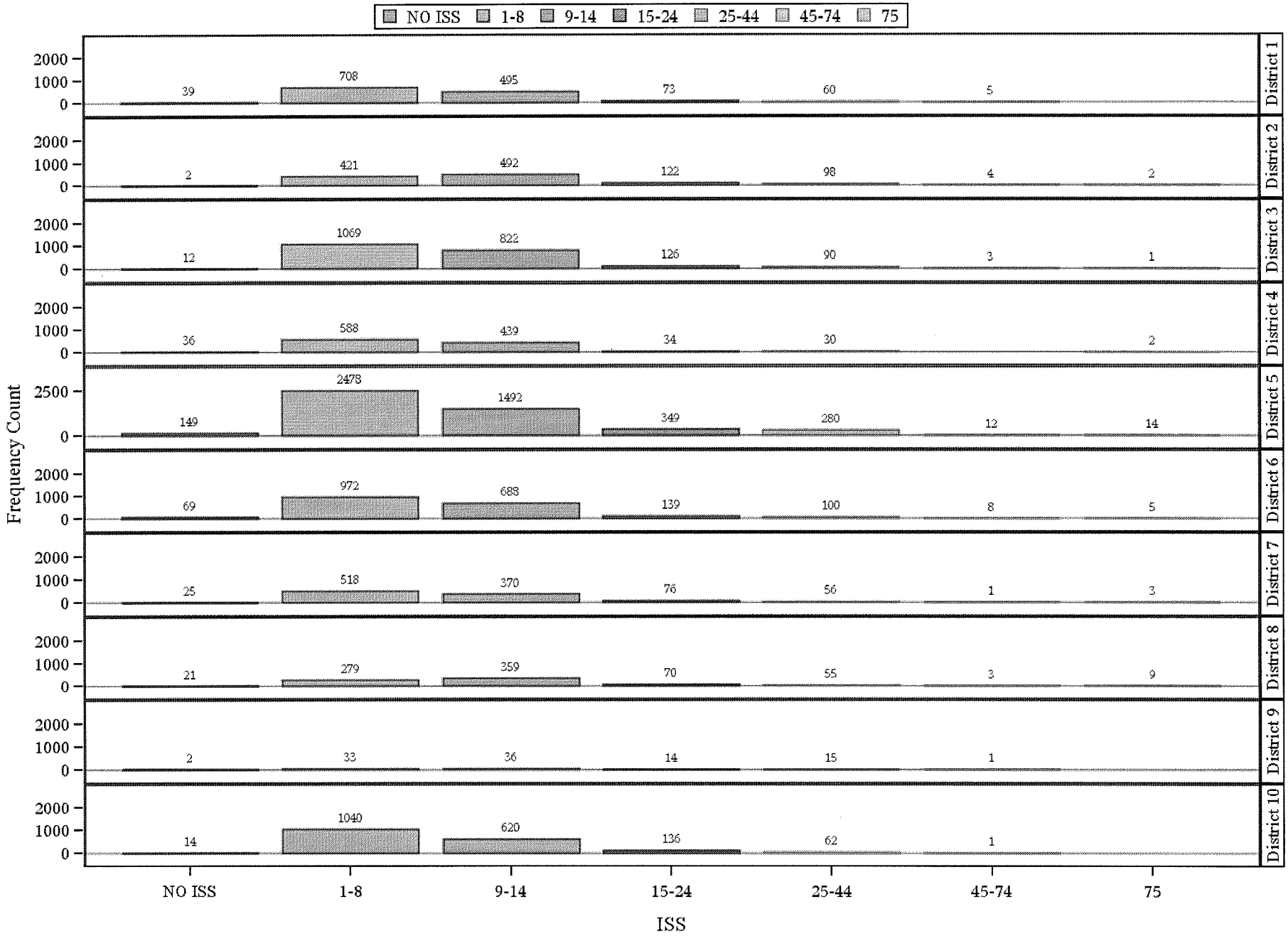
Time to 1st Med: Time from Arrived at Patient to First Medication (Aspirin[ASA]) Administered for Chest Pain

Time to 12-Lead (Minutes)



Time to 12-Lead: Time from Arrived at Patient to Time 12 lead ECG Procedure Performed; N=6,492

Indiana Trauma Registry- January 1, 2013 to January 25, 2014 - 20,657 Incidents
Injury Severity Score By Public Health Preparedness Districts



Attachment #13

EMSC

Do you know someone that goes above and beyond for children? Do you know a provider that went above the call of duty for a child?

Well nominate them as this year's Indiana EMSC Pediatric Healthcare Hero.

Nominate your healthcare provider, public safety workers or community leaders that are having an impact on the kids of Indiana. Contact Gretchen at ghuffman@iupui.edu to submit your nomination.

Attachment #14

Hilton, Candice

From: Garvey, Mike
Sent: Tuesday, January 14, 2014 9:16 AM
To: Hilton, Candice
Subject: FW: Special Statement from the US Treasury on Volunteer Responders Under the ACA

Importance: High

Need to add this to the EMS Commission Agenda as General Information.

Mike

Michael S. Garvey, **EMS Director**
State Fire Marshal's Office
Indiana Department of Homeland Security
Telephone: 317/232-3983
Facsimile: 317/233-0497
mgarvey@dhs.in.gov
"If You See Something, Say Something"

From: Kathy Robinson [mailto:krobinson@asmii.net]
Sent: Monday, January 13, 2014 9:18 AM
To: wu@lists.nasemso.org
Subject: [wu] Special Statement from the US Treasury on Volunteer Responders Under the ACA
Importance: High

NASEMSO Washington Update List -
The following statement is currently available at http://www.treasury.gov/connect/blog/Pages/Treasury-Ensures-Fair-Treatment-for-Volunteer-Firefighters-and-Emergency-Responders-under-the-Affordable-Care-Act-Under-ACA.aspx

Treasury Ensures Fair Treatment for Volunteer Firefighters and Emergency Responders Under the Affordable Care Act

By: Mark J. Mazur, Assistant Secretary for Tax Policy
1/10/2014

The Affordable Care Act requires that an employer with 50 or more full-time employees offer affordable and adequate health care coverage to its employees. For this purpose, full time means 30 hours or more per week on average, with the hours of employees working less than that aggregated into full-time equivalents. Employers that do not fulfill this obligation may be required to make a payment in lieu of meeting their responsibilities, which are described in what are called the employer shared responsibility provisions. An important question arises about how the hours of volunteer firefighters and other volunteer emergency responders should be taken into account in determining whether they are full-time employees and for counting toward the 50-employee threshold. Treasury is acting to ensure that emergency volunteer service is accorded appropriate treatment under the Affordable Care Act.

Treasury and the IRS issued proposed regulations on the employer shared responsibility provisions (Section 4980H of the Tax Code) in December 2012 and invited public comments. Numerous comments were received from individuals and local fire and Emergency Medical Service departments that rely on volunteers. The comments generally suggested that the employer responsibility rules should not count volunteer hours of nominally compensated volunteer firefighters and emergency medical personnel in determining full-time employees (or full-time equivalents). In addition, Treasury heard from numerous members of Congress who expressed these same concerns on behalf of the volunteer emergency responders in their states and districts.

Treasury and the IRS carefully reviewed these comments and spoke with representatives of volunteer firefighters and volunteer emergency personnel to gain a better understanding of their specific situations. Treasury and the IRS also reviewed various rules that apply to such volunteer personnel under other laws. These include the statutory provisions that apply to bona fide volunteers under Section 457(e)(11) of the Tax Code (relating to deferred compensation plans of state and local governments and tax-exempt organizations) and rules governing the treatment of volunteers for purposes of the Federal wage and hour laws. As a result of that review and analysis, the forthcoming final regulations relating to employer shared responsibility generally will not require volunteer hours of bona fide volunteer firefighters and volunteer emergency medical personnel at governmental or tax-exempt organizations to be counted when determining full-time employees (or full-time equivalents).

These final regulations, which we expect to issue shortly, are intended to provide timely guidance for the volunteer emergency responder community. We think this guidance strikes the appropriate balance in the treatment provided to traditional full-time emergency responder employees, bona fide volunteers, and to our Nation's first responder units, many of which rely heavily on volunteers.

Mark J. Mazur is the Assistant Secretary for Tax Policy at the United States Department of the Treasury.

Kathy Robinson, RN, EMT-P
National Association of State EMS Officials
201 Park Washington Court
Falls Church, VA 22046
Email: robinson@nasemso.org
Mobile: 703-403-7404

Mark Your Calendar:
March 3-5, 2014: NASEMSO Mid-Year Meeting, Rosen Center, Orlando, FL
October 6-10, 2014: NASEMSO Annual Meeting, Westin Cleveland and Cleveland Public Auditorium, Cleveland, OH
Fall 2015: NASEMSO Annual Meeting, Louisville, KY

Attachment #15

Intranasal Naloxone Pilot Program

Overview:

Deaths from Accidental opiod overdoses (i.e. heroin, prescription medications) continue to grow at an alarming rate. This major public health emergency affects all levels of public safety from EMS, Fire and Police. In the fall of 2012, Commander Brian Roach from IMPD Southwest district along with Linda Lynne from Midtown Mental Health convened a group composed of leaders from police, EMS, mental health, and other community leaders to explore options to address the growing problem. One of the proposed solutions was the administration of intranasal naloxone by police officers.

Naloxone (Narcan) is a synthetic opioid antagonist that reverses the effects of opioids. Specifically, Narcan is used to reverse the life threatening respiratory depression and decreased level of consciousness, which is the leading cause of death in opioid overdoses. Narcan is an extremely safe medication with a relatively rapid onset and minimal side effects. When given appropriately, Narcan has the potential to save the life of somebody suffering from an opioid overdose. The Mucosal Atomizer device (MAD) is a safe, needle free, method of administering Narcan. Narcan administration via the MAD device can be easily taught to non-medical public safety personnel (i.e. police).

The following program will explore the impact police administration of Narcan has on opiate overdose cases in the IMPD Southwest District. This unique partnership between IMPD, IEMS, and Midtown Mental Health is an important first step in combating this growing epidemic.

Examples from Other Cities:

Intranasal administration of Narcan by Law Enforcement is a proven entity. There have been many successful programs around the country. Specifically, Quincy Massachusetts and Nassau County (Long Island NY) have attributed hundreds of lives saved with the introduction of IN Narcan by LEO.

Program Proposal:

- 1 hour training program provided to officers in IMPD Southwest District
    - Training provided by IEMS Medical Director and IEMS Operations Commander
    - Focus:
        - Recognition of opioid overdose
        - Appropriate administration of Narcan
        - Steps to take after administration
            - What to expect when opiates are reversed

        - Avoidance of law enforcement practices
        - Appropriate paperwork
    - Timeline: Approximately 2 months
- Issue 2mg Naloxone Intranasal packets
    - 1 per duty car
    - To be transferred at roll call
- Quality Improvement/Assurance
    - 100% case review by IEMS medical director
    - Program evaluation at 3 months, 6 months, 12 months
        - Continued annual evaluation

Logistics/Cost:

- Approximately $20/dose ($10-15 narcan + $5 administrating supplies)
- 25 doses distributed = $500
- Training to be done by IEMS MD at no cost
- QI/QA by IEMS at no cost
- Mechanism for rotating stock with IEMS
- Mechanism for pushing stock to IEMS in event of shortage

IMPD Intranasal Narcan Training Program Lesson Plan

Goal: To educate IMPD officers on the signs and symptoms of opioid overdose and proper indications for safely administering intranasal Naloxone (Narcan)

Length of Program: 1 hour

Target Audience: All IMPD Southwest District Patrol officers

Overview:

I. Statement of the problem:
   - a. Opioid overdose is a growing epidemic around the united states
   - b. Southwest district stats
   - c. Increase in use leading to an increase in fatalities
     - i. Not just "chronic users" dying

II. Unique solution
   - a. Naloxone administration by LEO is being done successfully around the US
     - i. Massachusetts
     - ii. Nassau County
   - b. Early administration of this medication can have immediate life saving effects
     - i. Before EMS arrives
     - ii. No harm in administration

III. **What are Opiates?**
   - a. Synthetic or natural substances with similar effects
     - i. Heroin
     - ii. Pills (Hydrocodone, Oxycodone, Morphine, etc...)
   - b. Commonly used to treat pain and sedate patients
   - c. All work on certain receptors in the body (opiate)
     - i. Brain, Respiratory system, GI tract
       1. At normal levels cause decreased transmission of pain
       2. At high levels cause slowing of vital functions
          - a. *Respiration
          - b. *Level of Consciousness
   - d. Prescription vs. Illicit
     - i. Illicit: Can't predict effect
     - ii. Prescription: Usually have a dose response
       1. Effects users differently
     - iii. Route of delivery effects response (Injecting vs. oral)

IV. **Opiate Overdose**
   - a. Drug having a life threatening effect on the body
   - b. 2 major threats to live
     - i. Respiratory system: No oxygen= greatest risk
     - ii. Central Nervous System: Decreased level of consciousness

iii. ALL of these can be reversed if done in a timely manner

c. Signs of Opiate Overdose
   i. Person not breathing (Blue lips and blue skin)
   ii. Limp body
   iii. Slow pulse
   iv. Person unconscious
   v. Choking sounds/gurgling

d. Determining High vs. Overdose

V. Naloxone (Narcan)

a. Pharmacology
   i. Opioid Antagonist = "Antidote"
      1. Reverses effects of Opioids
   ii. Fast Acting
      1. Immediate→ 8 minutes
   iii. Safe to give and no potential for abuse
   iv. Competes with opiate for timing
      1. Lasts 30 minutes
      2. Some opiates last much longer and may need redoes

b. Administration
   i. Can be given IV, IM, IN
   ii. Intranasal is a safe and effective delivery method
      1. Uses Mucosal Atomizer Device (MAD)
         a. Turns medication into fine mist
         b. Gets absorbed through nasal mucosa

c. What to expect
   i. Usually gently reversal of symptoms
      1. Respiratory rate increases
      2. Level of consciousness will improve
      3. Can have more severe reactions
         a. Vomiting/Diarrhea
         b. Become combative
            i. Important to avoid aggressive restraint in these cases
               1. Goal is to safely transfer them to EMS providers

VI. Procedure

a. Naloxone distention systems
   i. 2mg vials (1mg/1ml)
   ii. MAD device

b. In event of recognized overdose
   i. History and appearance consistent with opiate overdose
   ii. Flow chart
      1. Assess for breathing
      2. If no breathing with stimulation
         a. Give Narcan
         b. Make sure they are in the recovery position

i. Want to prevent them from choking on vomit

c. Monitor respirations

d. Ensure EMS is enroute

c. Paperwork

i. Will file brief report

ii. Will be included in EMS report

iii. Feedback 48 hours

Attachment #16

Reprinted
January 28, 2014

SENATE BILL No. 227

DIGEST OF SB 227 (Updated January 27, 2014 2:59 pm - DI 104)

Citations Affected: IC 7.1-5; IC 16-18; IC 16-31; IC 34-31; IC 35-38.

Synopsis: Alcohol and medical emergencies. Provides that a person is immune from arrest or prosecution for certain alcohol offenses if the arrest or prosecution is due to the person: (1) reporting a medical emergency; (2) being the victim of a sex offense; or (3) witnessing and reporting what the person believes to be a crime. (Current law provides immunity from arrest or prosecution only if the person reports a medical emergency that is due to alcohol consumption.) Establishes a mitigating circumstance for the sentencing of a person convicted of a controlled substance offense if the person's arrest or prosecution was facilitated in part because the person requested emergency medical assistance for an individual in need of medical assistance due to the use of alcohol or a controlled substance. Permits a court to defer entering a judgment of conviction for an individual arrested for an alcohol offense if the individual was arrested after a report that the person needed medical assistance due to the use of alcohol if certain conditions are met. Permits an emergency medical responder, a firefighter, or a law enforcement officer to administer an overdose prevention drug to a person suffering from an overdose. Allows certain health care providers to prescribe, and a pharmacist to dispense, an overdose prevention drug for an emergency medical responder, a law enforcement agency, or a fire department.

Effective: Upon passage.

Merritt, Head, Randolph

January 9, 2014, read first time and referred to Committee on Judiciary.
January 23, 2014, amended, reported favorably — Do Pass.
January 27, 2014, read second time, amended, ordered engrossed.

Reprinted
January 28, 2014

Second Regular Session 118th General Assembly (2014)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2013 Regular Session and 2013 First Regular Technical Session of the General Assembly.

SENATE BILL No. 227

A BILL FOR AN ACT to amend the Indiana Code concerning criminal law and procedure.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 7.1-5-1-6.5, AS ADDED BY P.L.93-2012, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6.5. (a) A law enforcement officer may not take a person into custody based solely on the commission of an offense involving alcohol described in subsection (b) if the law enforcement officer, after making a reasonable determination and considering the facts and surrounding circumstances, reasonably believes that all of the following apply:

(1) The law enforcement officer has contact with the person because the person:

(A) either:

~~(A)~~ **(i)** requested emergency medical assistance; or

~~(B)~~ **(ii)** acted in concert with another person who requested emergency medical assistance;

for an individual who reasonably appeared to be in need of medical assistance; ~~due to alcohol consumption.~~

(B) is the victim of a reported sex offense (as defined in IC 11-8-8-5.2); or

(C) witnessed and reported what the person reasonably believed to be a crime.

(2) The person described in subdivision (1)(A), ~~or~~ (1)(B), **or (1)(C):**

(A) provided:

(i) the person's full name; and

(ii) any other relevant information requested by the law enforcement officer; **and**

(B) in the case of a person described in subdivision (1)(A):

~~(B)~~ **(i)** remained at the scene with the individual who reasonably appeared to be in need of medical assistance ~~due to alcohol consumption~~ until emergency medical assistance arrived; and

~~(C)~~ **(ii)** cooperated with emergency medical assistance personnel and law enforcement officers at the scene.

(b) A person who meets the criteria of subsection (a)(1) and (a)(2) is immune from criminal prosecution for an offense under:

(1) section 3 of this chapter if the offense involved a state of intoxication caused by the person's use of alcohol;

(2) section 6 of this chapter if the offense involved the person being, or becoming, intoxicated as a result of the person's use of alcohol; and

(3) IC 7.1-5-7-7.

(c) A person may not initiate or maintain an action against a law enforcement officer based on the officer's compliance or failure to comply with this section.

SECTION 2. IC 7.1-5-1-6.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 6.6. (a) This section applies only to a person:**

(1) arrested for a violation of:

(A) section 3 of this chapter if the offense involved a state of intoxication caused by the person's use of alcohol;

(B) section 6 of this chapter if the offense involved the person being, or becoming, intoxicated as a result of the person's use of alcohol; or

(C) IC 7.1-5-7-7; and

(2) whose arrest was facilitated because another person reported that the person appeared to be in need of medical assistance due to the use of alcohol.

(b) If a person described in subsection (a):

(1) does not have a prior conviction for an offense described in subsection (a);

(2) pleads guilty to an offense described in subsection (a); and

(3) agrees to be placed in the custody of the court;

the court, without entering a judgment of conviction, shall defer further proceedings and place the person in the custody of the court under conditions determined by the court.

(c) If the person placed in the custody of the court violates the conditions of custody, the court may enter a judgment of conviction. However, if the person fulfills the conditions of the custody, the court shall dismiss the charges against the person.

(d) There may be only one (1) dismissal under this section with respect to a person.

SECTION 3. IC 16-18-2-263.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 263.9. "Overdose prevention drug", for purposes of IC 16-31, means naloxone or any other drug that:**

(1) is an opioid, opiate, or morphine antagonist; and

(2) prevents or reverses the effects of:

(A) opioids;

(B) opiates; or

(C) morphine;

including respiratory depression, sedation, and hypotension.

SECTION 4. IC 16-31-2-9, AS AMENDED BY P.L.77-2012, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. The commission shall establish the following:

(1) Standards for persons who provide emergency medical services and who are not licensed or regulated under IC 16-31-3.

(2) Training standards for the administration of antidotes, vaccines, and antibiotics to prepare for or respond to a terrorist or military attack.

(3) Training and certification standards for the administration of epinephrine through an auto-injector by an emergency medical technician.

(4) Training standards to permit the use of antidote kits containing atropine and pralidoxime chloride for the treatment of exposure to nerve agents by an emergency medical technician or an emergency medical responder.

(5) Standards for distribution, administration, use, and

training in the use of an overdose prevention drug.

SECTION 5. IC 16-31-3-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 23.5. (a) An emergency medical responder, a firefighter, or a law enforcement officer who is providing emergency medical services in the course of the individual's employment may administer an overdose prevention drug to an individual who is suffering from an overdose.**

(b) A health care provider who is licensed in Indiana and whose scope of practice includes the prescribing of medication may write a prescription, drug order, or protocol for an overdose prevention drug for an emergency medical responder, a law enforcement agency, or a fire department.

(c) A pharmacist licensed under IC 25-26 may dispense a valid prescription, drug order, or protocol for an overdose prevention drug issued in the name of any emergency medical responder, a law enforcement agency, or a fire department.

SECTION 6. IC 16-31-6-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. (a) Except for an act of gross negligence or willful misconduct, an emergency medical responder, a firefighter, or a law enforcement officer who administers an overdose prevention drug according to standards established by:**

(1) the department or agency that oversees the individual's employment in providing emergency medical services; or

(2) the commission under IC 16-31-2-9;

to an individual suffering from an overdose is immune from civil liability for acts or omissions when administering the drug.

(b) If the emergency medical responder, a firefighter, or a law enforcement officer is immune from civil liability for the individual's act or omission, a person who has only an agency relationship with the emergency medical responder, a firefighter, or a law enforcement officer is also immune from civil liability for the act or omission.

SECTION 7. IC 34-31-2-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. IC 16-31-6-2.5 (Concerning certain persons who administer an overdose prevention drug).**

SECTION 8. IC 35-38-1-7.1, AS AMENDED BY P.L.126-2012, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 7.1. (a) In determining what sentence to impose for a crime, the court may consider the following aggravating

circumstances:

(1) The harm, injury, loss, or damage suffered by the victim of an offense was:

(A) significant; and

(B) greater than the elements necessary to prove the commission of the offense.

(2) The person has a history of criminal or delinquent behavior.

(3) The victim of the offense was less than twelve (12) years of age or at least sixty-five (65) years of age at the time the person committed the offense.

(4) The person:

(A) committed a crime of violence (IC 35-50-1-2); and

(B) knowingly committed the offense in the presence or within hearing of an individual who:

(i) was less than eighteen (18) years of age at the time the person committed the offense; and

(ii) is not the victim of the offense.

(5) The person violated a protective order issued against the person under IC 34-26-5 (or IC 31-1-11.5, IC 34-26-2, or IC 34-4-5.1 before their repeal), a workplace violence restraining order issued against the person under IC 34-26-6, or a no contact order issued against the person.

(6) The person has recently violated the conditions of any probation, parole, pardon, community corrections placement, or pretrial release granted to the person.

(7) The victim of the offense was:

(A) a person with a disability (as defined in IC 27-7-6-12), and the defendant knew or should have known that the victim was a person with a disability; or

(B) mentally or physically infirm.

(8) The person was in a position having care, custody, or control of the victim of the offense.

(9) The injury to or death of the victim of the offense was the result of shaken baby syndrome (as defined in IC 16-41-40-2).

(10) The person threatened to harm the victim of the offense or a witness if the victim or witness told anyone about the offense.

(11) The person:

(A) committed trafficking with an inmate under IC 35-44.1-3-5; and

(B) is an employee of the penal facility.

(b) The court may consider the following factors as mitigating circumstances or as favoring suspending the sentence and imposing

probation:

(1) The crime neither caused nor threatened serious harm to persons or property, or the person did not contemplate that it would do so.

(2) The crime was the result of circumstances unlikely to recur.

(3) The victim of the crime induced or facilitated the offense.

(4) There are substantial grounds tending to excuse or justify the crime, though failing to establish a defense.

(5) The person acted under strong provocation.

(6) The person has no history of delinquency or criminal activity, or the person has led a law-abiding life for a substantial period before commission of the crime.

(7) The person is likely to respond affirmatively to probation or short term imprisonment.

(8) The character and attitudes of the person indicate that the person is unlikely to commit another crime.

(9) The person has made or will make restitution to the victim of the crime for the injury, damage, or loss sustained.

(10) Imprisonment of the person will result in undue hardship to the person or the dependents of the person.

(11) The person was convicted of a crime involving the use of force against a person who had repeatedly inflicted physical or sexual abuse upon the convicted person and evidence shows that the convicted person suffered from the effects of battery as a result of the past course of conduct of the individual who is the victim of the crime for which the person was convicted.

(12) The person was convicted of a crime relating to a controlled substance and the person's arrest or prosecution was facilitated in part because the person:

(A) requested emergency medical assistance; or

(B) acted in concert with another person who requested emergency medical assistance;

for an individual who reasonably appeared to be in need of medical assistance due to the use of alcohol or a controlled substance.

(c) The criteria listed in subsections (a) and (b) do not limit the matters that the court may consider in determining the sentence.

(d) A court may impose any sentence that is:

(1) authorized by statute; and

(2) permissible under the Constitution of the State of Indiana;

regardless of the presence or absence of aggravating circumstances or mitigating circumstances.

SECTION 9. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Judiciary, to which was referred Senate Bill No. 227, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Replace the effective dates in SECTIONS 1 through 3 with "[EFFECTIVE UPON PASSAGE]".

Page 2, line 3, after "reported" insert "**what the person reasonably believed to be**".

Page 3, between lines 12 and 13, begin a new paragraph and insert:

"SECTION 3. IC 16-18-2-263.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 263.9. "Overdose prevention drug", for purposes of IC 16-31, means naloxone or any other drug that:**

(1) is an opioid, opiate, or morphine antagonist; and

(2) prevents or reverses the effects of:

(A) opioids;

(B) opiates; or

(C) morphine;

including respiratory depression, sedation, and hypotension.

SECTION 4. IC 16-31-2-9, AS AMENDED BY P.L.77-2012, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. The commission shall establish the following:

(1) Standards for persons who provide emergency medical services and who are not licensed or regulated under IC 16-31-3.

(2) Training standards for the administration of antidotes, vaccines, and antibiotics to prepare for or respond to a terrorist or military attack.

(3) Training and certification standards for the administration of epinephrine through an auto-injector by an emergency medical technician.

(4) Training standards to permit the use of antidote kits containing atropine and pralidoxime chloride for the treatment of exposure to nerve agents by an emergency medical technician or an emergency medical responder.

(5) Standards for distribution, administration, use, and training in the use of an overdose prevention drug.

SECTION 5. IC 16-31-3-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE UPON PASSAGE]: **Sec. 23.5. An emergency medical responder may administer an overdose prevention drug to an individual who is suffering from an overdose.**

SECTION 6. IC 16-31-6-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. (a) Except for an act of gross negligence or willful misconduct, an emergency medical responder who administers an overdose prevention drug according to standards established by the commission under IC 16-31-2-9 to an individual suffering from an overdose is immune from civil liability for acts or omissions when administering the drug.**

(b) If the emergency medical responder is immune from civil liability for the emergency medical responder's act or omission, a person who has only an agency relationship with the emergency medical responder is also immune from civil liability for the act or omission.

SECTION 7. IC 34-31-2-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. IC 16-31-6-2.5 (Concerning emergency medical responders who administer an overdose prevention drug).**".

Page 5, after line 16, begin a new paragraph and insert:

"SECTION 9. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 227 as introduced.)

STEELE, Chairperson

Committee Vote: Yeas 9, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 227 be amended to read as follows:

Page 4, line 4, after "23.5." insert "**(a)**".

Page 4, line 5, delete "responder" and insert "**responder, a firefighter, or a law enforcement officer who is providing emergency medical services in the course of the individual's employment**".

Page 4, between lines 6 and 7, begin a new paragraph and insert:

"(b) A health care provider who is licensed in Indiana and whose scope of practice includes the prescribing of medication may write a prescription, drug order, or protocol for an overdose prevention drug for an emergency medical responder, a law enforcement agency, or a fire department.

(c) A pharmacist licensed under IC 25-26 may dispense a valid prescription, drug order, or protocol for an overdose prevention drug issued in the name of any emergency medical responder, a law enforcement agency, or a fire department.".

Page 4, line 10, delete "responder" and insert "**responder, a firefighter, or a law enforcement officer**".

Page 4, line 12, after "by" insert "**:**

(1) the department or agency that oversees the individual's employment in providing emergency medical services; or

(2)".

Page 4, line 12, delete "IC 16-31-2-9 to" and insert "**IC 16-31-2-9;**".

Page 4, line 12, beginning with "to" begin a new line blocked left.

Page 4, line 15, delete "responder" and insert "**responder, a firefighter, or a law enforcement officer**".

Page 4, line 16, delete "emergency medical responder's" and insert "**individual's**".

Page 4, line 18, delete "responder" and insert "**responder, a firefighter, or a law enforcement officer**".

Page 4, line 22, delete "emergency" and insert "**certain persons**".

Page 4, line 23, delete "medical responders".

(Reference is to SB 227 as printed January 24, 2014.)

MERRITT

Reprinted
January 28, 2014

HOUSE BILL No. 1336

DIGEST OF HB 1336 (Updated January 27, 2014 4:51 pm - DI 104)

Citations Affected: IC 10-19; IC 16-31.

Synopsis: EMS state medical director. Requires the executive director of the department of homeland security to appoint a state emergency medical services (EMS) medical director (EMS director) to oversee all medical aspects of the state EMS system. Sets forth qualifications and duties for the EMS director. Allows the emergency medical services commission to approve the appointment within 30 days.

Effective: July 1, 2014.

Brown T, Frye R, Klinker, Forestal

January 15, 2014, read first time and referred to Committee on Veterans Affairs and Public Safety.
January 21, 2014, reported — Do Pass.
January 27, 2014, read second time, amended, ordered engrossed.

Reprinted
January 28, 2014

Second Regular Session 118th General Assembly (2014)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2013 Regular Session and 2013 First Regular Technical Session of the General Assembly.

HOUSE BILL No. 1336

A BILL FOR AN ACT to amend the Indiana Code concerning public safety.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 10-19-7-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: **Sec. 5. (a) For purposes of this section, "EMS" means emergency medical services.**

(b) For purposes of this section, "state EMS director" refers to the state emergency medical services medical director appointed under subsection (c).

(c) The executive director shall appoint an individual to serve as the state emergency medical services medical director. The individual must have the following qualifications:

(1) Thorough knowledge of state EMS laws and administrative rules and regulations.

(2) At least five (5) years experience in the following:

(A) Medical direction of out of hospital EMS.

(B) Emergency department treatment of acutely ill and injured patients.

(3) Significant experience and familiarity with the following:
(A) The design and operation of statewide EMS systems.
(B) Working with national and other state EMS committees.
(4) At the time of the individual's appointment, has a valid and unrestricted license to practice medicine in Indiana.
(5) Be certified by the American Board of Emergency Medicine.
(6) Other areas of knowledge and expertise that the executive director determines essential.

The state EMS director shall be an employee of the department.

(d) The executive director shall submit the name of the individual whom the executive director would like to appoint as state EMS director to the Indiana emergency medical services commission created by IC 16-31-2-1. The commission may, by a majority of the members, vote not later than thirty (30) days after the submission on whether to approve the appointment. If the commission:

(1) does not take any action; or
(2) by a majority of the commission votes to approve the appointment of the individual;

not later than thirty (30) days after, the appointment shall become effective. If a majority of the commission votes not later than thirty (30) days after the submission of the appointment to not approve the appointment, the executive director shall restart the appointment process and submit an alternative individual for appointment.

(e) The state EMS director shall oversee all pre-hospital trauma care medical aspects of the statewide EMS system, including the following:

(1) Medical components for systems of care that interface or integrate with the statewide EMS system, including the following:
(A) Statewide planning for trauma, burn, cardiac, and stroke care.
(B) Domestic preparedness.
(C) EMS for children, including neonatal transport.
(2) For all levels of emergency responders, establishment of the following:
(A) Statewide model guidelines and best practices for all patient care activities to ensure delivery of medical care consistent with professionally recognized standards.

(B) A statewide EMS continuous quality improvement program.

(C) A statewide EMS advocacy program.

(3) In cooperation with appropriate state and local agencies, training and certification of all EMS providers.

(f) The state EMS director shall assist the executive director on all issues related to statewide EMS, including the following:

(1) Consulting with EMS medical directors.

(2) In consultation with the Indiana emergency medical services commission created by IC 16-31-2-1, providing guidance and assistance on the following matters:

(A) Scope of practice for EMS providers.

(B) Restrictions placed on EMS certifications.

(C) Appropriate corrective and disciplinary actions for EMS personnel.

(D) Education and training on emerging issues in EMS.

(3) EMS system research.

(4) Coordination of all medical activities for disaster planning and response.

(5) Improving quality of care, research, and injury prevention programs.

SECTION 2. IC 16-31-2-8, AS AMENDED BY P.L.77-2012, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 8. The commission may do the following:

(1) Develop training and certification standards for emergency medical responders under this article.

(2) Require emergency medical responders to be certified under the standards developed under subdivision (1).

(3) Develop reciprocal certification training standards for individuals who have received medical training by a branch of the United States armed forces.

(4) Not later than thirty (30) days after the executive director of the department of homeland security submits an appointment for state emergency medical services medical director to the commission, vote concerning whether to approve the appointment in accordance with IC 10-19-7-5(d). If the commission votes on the appointment in accordance with IC 10-19-7-5(d), a vote by a majority of the members of the commission is necessary under this subdivision in order to approve or not approve the appointment.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Veterans Affairs and Public Safety, to which was referred House Bill 1336, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill do pass.

(Reference is to HB 1336 as introduced.)

Committee Vote: Yeas 12, Nays 0

Representative Frye R

HOUSE MOTION

Mr. Speaker: I move that House Bill 1336 be amended to read as follows:

Page 2, line 12, after "(d)" insert "**The executive director shall submit the name of the individual whom the executive director would like to appoint as state EMS director to the Indiana emergency medical services commission created by IC 16-31-2-1. The commission may, by a majority of the members, vote not later than thirty (30) days after the submission on whether to approve the appointment. If the commission:**

(1) does not take any action; or

(2) by a majority of the commission votes to approve the appointment of the individual;

not later than thirty (30) days after, the appointment shall become effective. If a majority of the commission votes not later than thirty (30) days after the submission of the appointment to not approve the appointment, the executive director shall restart the appointment process and submit an alternative individual for appointment.

(e)".

Page 2, line 32, delete "(e)" and insert "**(f)**".

Page 3, after line 5, begin a new paragraph and insert:

"SECTION 2. IC 16-31-2-8, AS AMENDED BY P.L.77-2012, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 8. The commission may do the following:

(1) Develop training and certification standards for emergency medical responders under this article.

(2) Require emergency medical responders to be certified under the standards developed under subdivision (1).

(3) Develop reciprocal certification training standards for individuals who have received medical training by a branch of the United States armed forces.

(4) Not later than thirty (30) days after the executive director of the department of homeland security submits an appointment for state emergency medical services medical director to the commission, vote concerning whether to approve the appointment in accordance with IC 10-19-7-5(d). If the commission votes on the appointment in accordance with IC 10-19-7-5(d), a vote by a majority of the members of the commission is necessary under this subdivision in order to approve or not approve the appointment.".

(Reference is to HB 1336 as printed January 21, 2014.)

BROWN T

Attachment #17

Indiana State Department of Health

the INDIANA STATE DEPARTMENT OF HEALTH presents:

INDIANA DISASTER MEDICINE COURSE

For a complete list of dates and locations please see **www.meshcoalition.org/training**

SPECIFIC TAKEAWAYS WILL INCLUDE:

- **Effectively providing care as a member of the disaster medical management team.**
- **Utilizing reference and resource materials during a disaster medical response.**
- **Providing medical care in a coordinated disaster response, and improvisation techniques in resource-depleted environments.**

DATES/TIMES/ LOCATION INFO

for a complete list of dates and locations, visit: meshcoalition.org/training

The Indiana State Department of Health, in partnership with the MESH Coalition, is excited to offer a **FREE**, advanced disaster medical management course aimed at clinical professionals interested in volunteering as part of a medical assistance team in response to disasters. Participants will be provided hands on experience in patient triage and treatment as it relates to incidents resulting in acute traumatic injuries, chemical and biological exposures, and extreme weather injuries.

Upon successful completion of the two day course and examination, participants will be provided a certificate of completion. Attendees must provide proof of licensure or certification as a physician, physician assistant, registered nurse, nurse practitioner, paramedic, or emergency medical technician in order to participate.

For a complete list of dates and locations please see **www.meshcoalition.org/training**.

If you have any questions please email **info@meshcoalition.org**.