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:	**August 16, 2013**	
	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	(Interm Director of Training and Preparedness)
	Darin Hoggatt	(Paramedics)
	Michael Lockard	(General Public)
	Ed Gordon	(Volunteer Fire EMS)
	Sue Dunham	(Emergency Nurses)
MEMBERS ABSENT:	Michael Olinger	(Trauma Physicians)
	Melanie Jane Craigin	(Hospital EMS)
	Stephen Champion	(Medical Doctor)

OTHERS PRESENT: Elizabeth Fiato, Field Staff (Robin Stump, Don Watson, Steve Gressmire, Jenna Rossio, 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. Chairman Turpen led all present in the Pledge of Allegiance.

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

ADOPTION OF MINUTES

A motion was made by Commissioner Mackey to adopt the minutes of the June 7, 2013 meeting as written. The motion was seconded by Commissioner Zartman. Motion passed. Director Mike Garvey and Chairman Lee Turpen thanked EMS Chief Steve Davidson for hosting the EMS Commission meeting.

COMMENDATIONS

See Attachment #1 for the letter recommending the following individuals for commendations:

Elmer (Buddy) Kasinger, Paramedic

Lisa Urbanski, EMT

Scott Erickson, Paramedic

Mike Watkins, EMT

Jason Albin, EMT

A motion was made by Commissioner Zartman to approve the commendations. The motion was seconded by Commissioner Hamilton. The motion passed. Certificates were presented by Mr. Steve Gressmire and Mr. Jason Smith. Chairman Turpen also added comments. He stated this is the summation of what we do. He quoted an old adage "we have a tremendous large system to take care of an individual" because most often we respond to a call for help from an individual. Chairman Turpen congratulated all the responders on their positive outcome and hard work.

Data Registry

A motion was made by Commissioner Valentine to approve the draft minutes from the July 17, 2013 EMS Commission Sub-Committee for Data Collections meeting as written. The motion was seconded by Commissioner Lockard. The motion passed.

Fire Marshal James Greeson gave the following report for data registry. Marshal Greeson reported that IDHS continues to move forward. He further reports that the 4.5 release of Firehouse is now available to users. Providers can now download it and to use. We are hopeful that by September 1st we will have providers up and ready to report. Field Services staff will be going out to help providers get this accomplished. Marshal Greeson stated that the day of the meeting staff was attempting to download and test downloading records to NEMSIS. He also

reported that to date 550 data files have been downloaded to the restricted drive so that the Health Department could access them. Firehouse has completed a test download to NEMSIS. The EMS State Director, the IDHS Executive Director, and the state administrator are the ones listed for Indiana as having access to download test data. Marshal Greeson stated that he is confident all the right players are now involved to keep everything moving forward. Commissioner Lockard made some comments and discussion followed.

STAFF REPORT

Training Report

Mrs. Elizabeth Fiato reported the following information:

State Level Exercise

The Indiana Department of Homeland Security will be hosting the 2013 State Level Exercise September 23-27 at Muscatatuck Urban Training Center in Jennings County, Indiana. This exercise is developed to test the current response capabilities of the State's District Response Task Forces as well as other state and non-governmental organizations that possess response capabilities. In order to test capabilities and identify training gaps, IDHS is offering an opportunity for hospital responders to come and participate in a simulated hospital environment during the exercise. Participants will have the opportunity to exercise their incident command, triage, and patient tracking skills as well as learn from subject matter experts new skills to aid in disaster operations. Physicians, nurses, techs, or any other hospital staff is welcome to participate. Please see the training bulletin for more details.

Course Application and Check Off Sheet

The EMS Training Section has been working to improve the course approval process. With that said, we want to clarify the directive sent from our office to training institutions and primary instructors. All course requests must be submitted to the cert/course/app e-mail along with a syllabus for that course and the requirements identified on the course check off sheets. Staff must be able to see where on your syllabus the course requirements are being satisfied. For example, if your syllabus does not have a preparatory section, then you must show where on your syllabus the preparatory requirements are being met. The required hour's section and the competency narrative section of the course check sheet does not apply to Paramedic courses submitted from a fully accredited training institution. It is only for those Paramedic courses that have a Commission approved waiver to teach but have not completed their accreditation process. **All** course requests, though, ***must*** have a syllabus for that course accompanying their course application.

Certifications Explanation

The EMS Branch has been further evaluating the certifications report that is presented at each EMS Commission meeting. Several errors were identified in the numbers we have been

submitting. Our net gain/loss has been incorrect because the totals did not take into account the number of reciprocities or persons recertifying based on past certifications. Further, when calculating this total, the formula was utilizing the number of expired certifications from the previous quarter. Because we receive so many late in-services prior to the 120 day cut-off, we felt that the net gain/loss value did not accurately represent the true number of individuals either becoming certified or letting their certifications lapse. We are continuing to reassess the certifications reporting tool to determine if there are any other errors in the data being presented.

Individual Certification Report- See attachment #2.

Provider Certification Report- See attachment #3. Submitted for informational purposes.

EMS PERSONNEL WAIVER REQUEST

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 Sec. 1. (a) Applicants for original certification as an emergency medical technician shall meet the following requirements: (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. Mr. Carter's one year deadline was on May 12, 2013. He took the EMT test twice and is requesting an extension to take his final attempt. He is requesting a waiver of 836 IAC 4-4-1 (b) Staff recommends a 6 month extension to take his final EMT exam attempt. He must complete the remediation requirement before allowed to take final exam attempt.

Melvin D. Carter – EMT

A motion was made by Commissioner Zartman to approve this waiver request. The motion was seconded by Commissioner Gordon. The motion passed.

The following requested a waiver of SECTION 49. (b) An applicant for certification as an advanced emergency medical technician who currently is certified as an emergency medical technician-basic advanced shall meet the following requirements: (1)Successfully complete a bridge training course approved by the commission. (2) Pass the advanced emergency medical technician written and practical skills examinations as approved by the commission. Dougal and Markey are all RNs as well as EMT Basic Advances. They are requesting a waiver of section 49 (b) (1) based upon their coursework to attain their RN license, experience as ER nurses. Markey is currently holds ACLS, ENCP (Emergency Nursing Pediatric Course), TNCC (Trauma Nursing Core Course), and PEPP certifications. Dougal has been an ER nurse for 5 years and an RN in total for 36 years. Staff recommends approval of both waiver requests.

James H. Dougal – EMT BA

Susan L Markey-EMT BA

A motion was made by Commissioner Valentine to grant the waiver. The motion was seconded by Commissioner Hoggatt. The motion passed. After some discussion Commissioner Zartman asked for staff to follow up and obtain outcomes of individuals test results to make sure we are not setting these individuals up for failure.

The following requested a waiver of SECTION 57. **(a) This SECTION supersedes 836 IAC 4-9-5.** (b) To renew a licensure, a licensed paramedic shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements in subsection (c). (c) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following: (1) Section IA, forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty-eight (48) hours of supervising hospital-approved continuing education that includes the following: (A) Sixteen (16) hours in airway, breathing, and cardiology. (B) Eight (8) hours in medical emergencies. (C) Six (6) hours in trauma. (D) Sixteen (16) hours in obstetrics and pediatrics. (E) Two (2) hours in operations. (2) Section IB, attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic licensure expiration date. (3) Section IC, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic licensure expiration date. (4) Section II, twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section. (5) Section III, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital either at an in-service or in an actual clinical setting. The observed skills include, but are not limited to, the following: (A) Patient medical assessment and management. (B) Trauma assessment and management. (C) Ventilatory management. (D) Cardiac arrest management. (E) Bandaging and splinting. (F) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy. (G) Spinal immobilization. (H) Obstetrics and gynecological scenarios. (I) Communication and documentation. Mr. Riggs has successfully passed the National Registry renewal exam. National Registry has instituted a mechanism in their two year renewal process where an individual can take a recertification exam and if he/she successfully passes, he/she will be renewed without having to complete the continuing education requirements. Mr. Riggs is requesting a waiver of Section 57 of the Emergency rule. He wishes to use his completed exam from National Registry as the CEU equivalent for his Indiana recertification. Staff abstains

James L. Riggs –Paramedic

A motion was made by Commissioner Zartman to approve the waiver request with the stipulation that the additional Indiana requirements for audit and review and affiliation be met. The motion was seconded by Commissioner Mackey. 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 Sec. 1. (a) Applicants for original certification as an emergency medical technician shall meet the following requirements: (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. Year ended 4/12/2013. Due to working circumstances, Mr. Simon and Mr. Sloan were not able to take all of their testing opportunities. They both took the EMT test once and are requesting an extension to take rest of allowable attempts. They are requesting a waiver of 836 IAC 4-4-1 (b). Staff recommends approval of 6 month extension for both Mr. Simon and Mr. Sloan.

Donald James Simon – EMT

Kyle J. Sloan- EMT

A motion was made by Commissioner Mackey to approve the waiver request for 6 month time period. The motion was seconded by Commission Gordon. The motion passed.

The following requested a waiver of 836 IAC 4-5-2 Certification and recertification; general Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20 Affected: IC 16-31-3-14 Sec. 2. (g) An individual wanting to reacquire a primary instructor certification shall do the following: (1) Meet all prerequisites of an Indiana emergency medical services primary instructor training course. (2) Successfully complete the primary instructor written examination. (3) Successfully complete the primary instructor recertification evaluation. (4) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor. Mr. Taylor has expired PI, Paramedic, EVOC Instructor, and EVOC certifications. He has submitted a copy of his Paramedic in-service, and we are awaiting the originals and verification of hours to reinstitute his Paramedic license. Mr. Taylor is requesting a waiver of 836 IAC 4-5-2 to retest for his PI instructor based upon previous certification. He is also requesting permission to regain his EVOC Instructor based upon previous certification and permission to retest his EVOC based upon previous certification. Staff recommends tabling the PI and EVOC Instructor requests until his Paramedic License is re-instituted. If, at that time, Mr. Taylor has a renewed Paramedic License and has affiliated with a training institution, staff would support Mr. Taylor to retest the PI exams. If Mr. Taylor successfully retests for the PI, staff would further support reinstituting Mr. Taylor's EVOC Instructor with the $50 late fee.

James E. Taylor– Paramedic, Primary Instructor, EVOC Instructor

A motion was made by Commissioner Zartman to approve staff recommendation. (Staff recommends tabling the PI and EVOC Instructor requests until his Paramedic License is re-instituted. If, at that time, Mr. Taylor has a renewed Paramedic License and has affiliated with a training institution, staff would support Mr. Taylor to retest the PI exams. If Mr. Taylor successfully retests for the PI, staff would further support reinstituting Mr. Taylor's EVOC Instructor with the $50 late fee). The motion was seconded by Commissioner Lockard. The motion was passed.

EMS PROVIDER WAIVER REQUEST

The following requested a waiver of 836 IAC 2-2-1 General requirements for paramedic 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 16-31-3; IC 16-41-10 (g) Each paramedic provider organization shall do the

following: (1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Alcoa EMS is requesting the renewal of a waiver to not staff their ALS service on the rare occasions that they have a Paramedic call in sick or on vacation and no part time Paramedic is available. They state that they continue to hire Paramedics as positions become available. Staff recommends approval.

Alcoa EMS

A motion was made by Commissioner Zartman to grant this waiver. The motion was seconded by Commissioner Gordon. The motion passed.

The following requested a waiver of 836 IAC 2-14-3 Advanced life support nontransport vehicle specifications Authority: IC 16-31-2-7 Affected: IC 16-31-3 (b) All advanced life support nontransport vehicles shall meet or exceed the following minimum specifications for electrical systems: (3) Each advanced life support nontransport vehicle shall have an audible backup warning device that is activated when the advanced life support nontransport vehicle is shifted into reverse. (c) All advanced life support nontransport vehicles shall meet the following requirements for external identification: (1) Warning lights of red or red and white, at the discretion of the owner, and shall conform with Indiana law. All lights on vehicle shall be in working condition. And 836 IAC 2-2-1 General requirements for paramedic 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 16-31-3; IC 16-41-10 (g) Each paramedic provider organization shall do the following: (1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Jasper County Sheriff's Department is requesting a waiver for the audible back-up alarm and red and white warning lights specified in 836 IAC 2-14-3 as well as not running 24/7 operations since they are a SWAT only ALS response unit. Staff recommends approval based upon EMS Commission approval of Lake County STAR Team's January 18, 2013 waiver.

Jasper County Sheriff's Department

A motion was made by Commissioner Zartman to approve this waiver. The motion was seconded by Commissioner Valentine. The motion passed.

The following requested a waiver of 836 IAC 2-2-1 General requirements for paramedic 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 16-31-3; IC 16-41-10 (g) Each paramedic provider organization shall do the following: (1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services. Wayne Township Volunteer Fire Department is seeking certification at the Paramedic Provider level. They state in their request that they will have 24/7 ALS service, but in the evenings and on weekends and holidays, Paramedics will respond from their residences. Staff recommends approval (similar waiver for Salem/Daleville EMS)

Wayne Township Volunteer Fire Department-Noblesville

A motion was made by Commissioner Mackey to approve this waiver. The motion was seconded by Commissioner Zartman. The motion passed.

EMS TRAINING INSTITUTION WAIVER REQUEST

The following requested a waiver of 836 IAC 4-2-1 General requirements for training institutions; staff 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 16-21; IC 16-31-3-2; IC 20-12-62-3; IC 20-12-71-8; IC 20-18-2-7 (g) Certified advanced life support training institutions conducting paramedic training programs on or after July 1, 2008, shall show written proof of national accreditation of the program. Dearborn County Hospital/Training Institution is requesting a waiver of 836 IAC 4-2-1 (g) so that they can teach the I-99 to Paramedic bridge course. We have a letter from National Registry stating that accreditation is not needed for bridge students to test as long as they took a state approved course. Staff recommends approval.

Dearborn County Hospital

A motion was made by Commissioner Zartman to approve the waiver request with the following stipulation that the training institution official have a mentor from an CoAEMSP accredited training institution. The motion was seconded by Commissioner Lockard. The motion passed. Mrs. Elizabeth Fiato asked the Commission how they would like for the staff to monitor the relationship and progress. Commissioner Zartman stated that the current practice staff has in place as checks for a course will be fine.

PERMISSIONS

On behalf of the following staff members: Andrew Alldredge, Andy Blanton, Natalie Bratcher, Craig Brittingham, Barbara Buttry, William Bye, Byron Christie, Arica Cole, Gina Hill, Angela Johnson, James Jones, Mark Jones The above mentioned staff members are requesting the use of the following skills:

1. CPAP
2. Obtaining CO levels
3. End tidal CO2 monitoring
4. Administration of the following medications:
    a. Diphenhydramine
    b. Ipratropium

Staff submitted supporting documentation from the President and CEO of Gibson General Hospital, their medical director, and supporting protocols from Iowa and New Hampshire. All these skills were already taught and tested in their AEMT course. Staff abstains.

Chairman Turpen stated that a waiver was not needed for the obtaining CO levels due to this already being approved by the Commission as part of the curriculum for all levels clear down to the EMR level. A motion was made by Commissioner Zartman to deny this request. The motion was seconded by Commissioner Mackey. The motion passed.

ADMINSTRATIVE PROCEEDINGS

Orders Issued

a. **Personnel Orders**
    a. **1 Year Probations**

Order No. 0070-2013 Tracey J. Reel

No action required, none taken

Order No. 0075-2013 Terrell L. Vise

No action required, none taken

Order No. 0069-2013 Michael R. Wiedemann

No action required, none taken

Order No. 0076-2013 Shawn D. Yancey

b. 2 Year Probations

Order No. 0065-2013 Scott D. Bishop

No action required, none taken

Order No. 0078-2013 Jonathan K. Dawson

No action required, none taken

Order No. 0060-2013 Brenda K. Hatfield

No action required, none taken

Order No. 0067-2013 Alexander R. Leisz

No action required, none taken

Order No. 0066-2013 Andrew Oberhausen

No action required, none taken

Order No. 0068-2013 Jeremy W. Simms

No action required, none taken

Order No. 0063-2013 Craig A. Weddle

No action required, none taken

c. Suspension

Order No. 0059-2013 Justin A. Feiock

No action required, none taken

Order No. 0064-2013 Timothy Greenlee

No action required, none taken

Order No. 0056-2013 Jeremy West

No action required, none taken

d. Revocation

Order No. 0010-2013 (R) Daryn E. Hendershot

No action required, none taken

Non-final Order

a. **No objection filed**
    1. Dusty L Cox
    2. Daryn E Hendershot
    3. Horatio J Nalls

A motion was made by Commissioner Hoggatt to affirm all of the above listed non-final orders. The motion was seconded by Commissioner Valentine. The motion passed.

Appeals

1. Alex Leisz
2. Matthew Sims

A motion was made by Commissioner Valentine to grant the appeals of the above listed individuals. The motion was seconded by Commissioner Zartman. The motion passed.

FIELD SERVICES REPORT

Ms. Robin Stump reported that field staff is working on the DPMU exercise in District 5 next month. They are working on a location and will announce it as soon as it is finalized.

TRAUMA SYSTEM UPDATE

Mr. Art Logsdon reported out. Mr. Logsdon asked and recommended that the EMS Commission approve the application for IU Ball Memorial Hospital to become an "In Process" trauma center level III.

A motion was made by Director Mike Garvey to approve IU Ball Memorial Hospital as "In Process" trauma center. The motion was seconded by Commission Lockard. The motion passed.

Mr. Logsdon turned the podium over to Mr. Brian Carnes. Mr. Carnes reported that a list of facility codes has been completed and will present them to the Data Collections sub-committee. Mr. Carnes further reported that 22 providers are reporting data to the Health Department directly. Some discussion followed Mr. Carnes report. Commissioner Valentine asked who set the rule for the run sheets to be given to the hospital within 24 hours. Director Garvey stated it is in the code for the EMS Commission.

EMS FOR CHILDREN

Ms. Gretchen Huffman reported that EMSC survey has been sent out and is waiting on responses. EMSC needs 276 providers to respond to get the data sampling that is need for their

report. Commissioner Zartman asked that any EMSC documents be submitted about 2 weeks prior to the meeting to give the Commissioners time to review.

TECHNICAL ADVISORY COMMITTEE- See attachment #4, #5, and #6

Mr. Leon Bell reported back to the Commission concerning the Adams County on line course that started in December 2012 that Mr. Bell was asked to mentor and monitor. During the course it was discovered that the cardiology section needs to be live not on-line. Mr. Bell reported that only two (2) students dropped the class. This is an improved drop rate than is normally experienced during a traditional course. The class is on track to take the NREMT exam the second week of February.

Mr. Leon Bell then reported out on TAC committee business. The TAC was asked to look into the meaning of physical presence in a classroom. Mr. Bell stated that he believes the following motion will need to be made into a non-rule policy:

The TAC makes a recommendation to the EMS Commission that the following guidelines are used when defining the Primary Instructor requirements:

1. **A learning session is defined as an experience in person in which the PI and the student meet to discuss, teach, learn, and evaluate the NES curriculum.**
2. **PI needs to be responsible for the delivery of all of the objectives as set forth by the NES and the Indiana EMS Commission requirements.**
3. **In the virtual, distance or on-line experience, the definition of present means the Primary Instructor must be available to all of the students through the virtual, distance or on-line technology or other methods for coaching, evaluation, and feedback.**
4. **In a virtual, distance or on-line experience present means that the Primary Instructor directly verifies the educational content as being appropriate when prescribed by the standards (NES).**
5. **Whether in a traditional or virtual classroom the PI is responsible for the content delivered regardless of who or how the subject matter is delivered to students.**

Commissioner Zartman asked Mr. Bell if the recommendation was for all levels. Mr. Bell stated that it was for all levels. Commissioner Lockard asked Mr. Bell if #3 of the recommendation referred to at the time of the session or all the time. Mr. Bell stated that it referred to all the time. Commissioner Zartman asked, "What is in place to verify students are actually getting their required hours completed?" Mr. Bell suggested that the Commission require that to be made part of the application process for the Training Institution. The Primary Instructor must detail how they are verifying attendance.

The Commission assigned the TAC to put together an attendance standard.

A motion was made by Commissioner Valentine to accept the TAC recommendation and to give the information to legal counsel to put into language for a non-rule policy. The motion was seconded by Commissioner Zartman. The motion passed.

Mr. Bell then presented the PI process packet to the Commission (see attachment #5).

A motion was made by Commissioner Zartman to approve the PI process packet and that staff make it available on the website for use. The motion was seconded by Commissioner Hoggatt. The motion passed.

Mr. Bell announced the TAC's decisions to move their meetings from the 2nd Tuesday of the month to the 1st Tuesday of the month. Mr. Bell also reported on the on-going projects and that they would be bring some recommendations as a result of these projects to the October Commission meeting.

The Commission assigned the TAC to look at the new physco motor paramedic process which includes critical thinking.

Mrs. Fiato and Mr. Bell also discussed old assignments that were given to the TAC. Staff is going to get a list together of past assignments for the Commission and TAC to go through and determine which if any of the assignments need to be dropped or how to move them forward to get them completed.

Chairman Turpen called for a 10 minutes break – 11:34am

Chairman Turpen reconvened the meeting at 11:51am

OLD BUSINESS

Mrs. Fiato presented information on the POST curriculum. This was presented at the June 7th Commission meeting and tabled to give the Commission members time to look over the information. See attachment #7. Some discussion followed.

A motion was made by Commissioner Zartman to accept the POST curriculum. The motion was seconded by Commissioner Hoggatt. The motion passed.

Mrs. Fiato presented information regarding the AEMT additional skills testing for the skills that were approved at the last Commission meeting. See attachment #8.

A motion was made by Commissioner Zartman to send this packet of information to the physicians on the Commission and TAC for review. The motion was seconded by Commissioner Hamilton. The motion passed. After some discussion it was determined that the current information can be sent out to Training Institutions and Primary Instructors until the physicians have reviewed and approved the new information.

NEW BUSINESS

Mrs. Fiato gave the following report regarding the new Community Paramedicine working group:

On July 31, IDHS convened approximately 50 stakeholders for the first Community Paramedicine working group meeting. Representatives were present from the EMS Commission, TAC, Private EMS, Fire Based EMS, governmental services, hospitals, physicians,

ACEP, IFCA, and EMS educators. There was plenty of lively discussion on this new facet of EMS, but everyone present agreed that the development of Community Paramedicine in Indiana as initiative that requires our attention. The initial group will reconvene in the next several weeks to discuss goals and other potential stakeholders. The current intention is to invite all identified stakeholders to begin outlining a strategic plan. While this is a new and exciting change in EMS, we also recognize the complexity and potential issues that surround the development of Community Paramedicine. As the discussion moves forward, we will continue to work to keep the Commission updated on its progress.

No action required. None taken.

Mr. Chris Jones addressed the Commission. Mr. Jones announced recent changes within IEMSA including the election of a new president Mr. Faril Ward. He also thanked Mr. Randy Seals for his service as the president of IEMSA. Mr. Jones stated that IEMSA had three requests to present to the Commission. Listed below are the three requests:

1. Public education of EMS (what it is, what EMS does)- the request is to put together a working group and IEMSA spearhead this group
2. Put together a working group to look at the EMS rules, include TAC and Commission members in the group.
3. Be placed on the agenda for every meeting going forward to give them a chance to report out on the progress of the above working groups and other projects IEMSA maybe working on.

After some discussion and Chairman Turpen requesting that IEMSA including the TAC and the EMS section of the Fire Chiefs Association the following motion was made:

A motion was made by Commissioner Valentine to forward to the operations section of the TAC a comprehensive review of the rules. The motion was seconded by Commissioner Lockard. The motion passed. Chairman Turpen requested that Candice Hilton make sure that the IEMSA be added to the agenda for future meetings.

Mr. John Chaflin addressed the Commission in regards to military personnel gaining certification. Mr. Chaflin gave a packet of information to the Commission members for review. He provided course materials from different military branches for comparison to the NES. Mr. Chaflin gave the information to Mrs. Elizabeth Fiato for review. The Commission asked that staff find a tracking mechanism for military personnel through Acadis.

Mr. George Schulp addressed the Commission regarding EMS patches specifically the paramedic patches. Mr. Schulp requested permission to change the wording on the paramedic patches from certification to license.

A motion was made by Commissioner Zartman to approve the change of the wording from certification to licenses on the paramedic patches only and also for staff to develop a

generic letter to give to vendors reflecting the Commission's approval of this change. The motion was seconded by Commissioner Hamilton. The motion was approved.

Commissioner Michael Lockard addressed the Commission regarding requests concerning the Data Collections Sub-Committee. Commissioner Lockard asked for a volunteer to replace Commissioner Olinger on the Sub Committee due to Commissioner Olinger's busy schedule. Chairman Turpen asked for a volunteer, Commissioner Hoggatt volunteered to be the third member of the Data Collections Sub- Committee. Commissioner Lockard opened discussion regarding the data dictionary. After some discussion Chairman Turpen directed the sub-committee to work with the TAC in looking through the data dictionary and other data rules and regulations. Commissioner Lockard also opened discussion regarding the facility codes list that IDSH generated. Chairman Turpen stated that the agency IDHS will do any necessary work on the facility codes. Chairman Turpen also directed staff to look into sending data to the appropriate people within other agencies as what was done in the past and what needs to be done now. Staff will get contact information from Commissioner Lockard.

Mr. Emery Garwick addressed the Commission regarding a rule request. Mr. Garwick asked the Commission to put a rule in place requiring Training Institutions to report to IDHS their enrollment, drop rate, pass rate, ect in an excel format so staff can post it on the web site so students can see that information.

A motion was made by Commissioner Valentine to assign this to the TAC and for the TAC to work with Mrs. Fiato. The motion was seconded by Commissioner Zartman. The motion passed.

CHAIRMAN'S REPORT

Chairman Turpen stated that he encourages everyone that is in a clinical roll to read the article from National Association of EMS Physicians position paper about spinal immobilization. This has the potential to change EMS in a trauma setting and to reduce dramatically the response times. This has the potential to cause rule changes within EMS in the future.

ASSIGNMENTS

1. **Past Assignments**
    a. Mr. Jason Smith reported out on the Communications Subcommittee meeting. Mr. Smith reported that the subcommittee agreed that there is an issue. Operability within our own realms works fine but interoperability between other agencies is lacking. Different committee member are going to contact stakeholders to survey communications abilities.
    b. Commissioner Zartman reported our regarding the narcotics subcommittee. They are moving forward but slowly.
    c. Recertification survey is being worked on my Mr. John Buckman and Candice Hilton
    d. Reminder regarding the Administrative Order Hearing for Mr. Christopher Blaisuis on October 18, 2013 at 9:00am.

2. New Assignments
    a. Staff was assigned to obtain test results from the National Registry for AEMTs that have test to date.
    b. TAC was assigned to draft an attendance standard for the distance learning courses
    c. Commission asked that legal counsel draft non-rule policy language for the TAC recommendation for distance learning.
    d. Staff was assigned to place the PI process packet that was approved by the Commission on the web site for use.
    e. TAC was assigned to look at the new psychomotor paramedic process which includes critical thinking
    f. Physicians on the EMS Commission and TAC were asked to review the AEMT additional skills testing packet that was presented at this meeting.
    g. The operations section of the TAC was assigned to perform a comprehensive review of the EMS rules
    h. Staff was assigned to look for a way to track military personnel within ACADIS
    i. Staff was directed to draft a generic letter to give to vendors reflecting the Commission's approval of the changes to the paramedic patch
    j. TAC and the data sub- committee were assigned to work together to review the data dictionary and other data rules and regulations.
    k. Staff was assigned to look into sending data to the appropriate people within other agencies as what was done in the past and what needs to be done now. Contact information will be obtained from Commissioner Lockard.
    l. TAC was assigned to look at data reporting for Training Institutions

GENERAL INFORMATION

The next EMS Commission meeting will be held on October 18th.

A motion was made by Commissioner Lockard to adjourn the meeting. The motion was seconded by Commissioner Valentine. The motion passed. The meeting was adjourned at 1:02p.m.

Approved 

G. Lee Turpen II, Chairman

Attachment #1

(317) 460-5942

Remember - Everyone Goes Home

Sent from my iPhone

On Jul 26, 2013, at 9:48, "Gressmire, Steve" <SGressmire@dhs.IN.gov> wrote:

> On July 12, 2013 at 1622 hrs. LaPorte County EMS, along with Michigan City Fire, were dispatched to the area of Mt. Baldy. Mt. Baldy is a park/ beach area along Lake Michigan. Their dispatch was for a 6 year old young man who was "stuck in the sand". Upon arrival, responding units were advised that the young man was walking with his father and was "sucked under". Responders from LaPorte EMS, MCFD, MCPD, and other local partners worked feverishly to rescue this young man. At 1900hrs, the first responding medic unit was released from the scene and replaced by another medic unit for the recovery. At 2005hrs, the patient was located. According to the PCR, c-spine precautions were taken and the young man was removed from the sand and taken to an awaiting ambulance. Upon assessment, the paramedic cleared sand from the patient's mouth and the patient made a groaning sound. As the paramedic continued his assessment he gave the patient a sternum rub. The patient appeared to attempt to breathe. Another finger sweep was done and the patient began to breath and showed more signs of life, for example his cuts and abrasions began to bleed, and ultimately attempting to cry prior to arrival at the hospital. The EMS staff contacted the local hospital for direction and transported the patient to the ER for stabilizing treatment and ultimate transfer to a Chicago area hospital for more specialized care.
>
> On Tuesday, July 23, 2013, media reported that the young man was released from Comer Children's Hospital and is expected to make a full recovery. I truly feel that if it were not for the amazing actions of these responders, all of whom are relatively young in their EMS careers, the outcome of this incident couldn't have been this amazing.
>
> Unfortunately in our jobs we deal with negative situations quite often. Additionally, when someone is commended for their work or career it is unfortunately usually posthumous or as a retirement gift. I would like to ask the commission to commend these young responders as they set the example for what we all strive to be and reminded all of us of the reason we chose this profession.

Regards,

Steve Gressmire, EMT
Indiana Department of Homeland Security
EMS Field Coordinator
Cell: (317) 452-0691
E-mail: sgressmire@dhs.in.gov

<image002.jpg>

Attachment #2

EMS Commission Certification Report
Compiled August 1, 2013

Total Certifications		Issued Since Last Mtg		Issued Same Time - 2012		Certified Individuals
EMS - EVOC	2927	EMS - EVOC	78	EMS - EVOC	14	
EMS - EVOC INSTR	77	EMS - EVOC INSTR	0	EMS - EVOC INSTR	0	
ADVANCED EMT	10	ADVANCED EMT	5	ADVANCED EMT	0	
EMT - BA	1362	EMT - BA	7	EMT - BA	40	1362
EMT	19259	EMT	441	EMT-BASIC	366	13734
EMT-INTERMEDIATE	171	EMT-INTERMEDIATE	1	EMT-INTERMEDIATE	4	171
PARAMEDIC	3909	PARAMEDIC	52	PARAMEDIC	70	3909
EMT-PI	492	EMT-PI	4	EMT-PI	7	
EXTRICATION	1977	EXTRICATION	0	EXTRICATION	0	
EMR	5499	EMR	128	FIRST RESPONDER	150	5499
Temporary EMT	48	Temporary EMT	48	Temporary EMT	0	
Temporary Paramedic	34	Temporary Paramedic	19	Temporary Paramedic	0	
Temporary EMR	0	Temporary EMR	0	Temporary EMR	0	
Temporary Advance	1	Temporary Advance	1	Temporary Advance	0	
Totals	**35766**		**784**		**651**	**24675**

1st Qtr 2013	Count	2nd Qtr 2013	Count	3rd Qtr 2013	Count	4th Qtr 2013	Count
EMS - EVOC	33	EMS - EVOC	117	EMS - EVOC		EMS - EVOC	
EVOC INSTRUCTOR	0	EVOC INSTRUCTOR	0	EVOC INSTRUCTOR		EVOC INSTRUCTOR	
ADVANCED EMT	0	ADVANCED EMT	2	ADVANCED EMT		ADVANCED EMT	
EMT - BA	18	EMT - BA	14	EMT -BA		EMT - BA	
EMT-BASIC	970	EMT-BASIC	525	EMT-BASIC		EMT	
EMT-INTERMEDIATE	2	EMT-INTERMEDIATE	2	EMT-INTERMEDIATE		EMT-INTERMEDIATE	
PARAMEDIC	493	PARAMEDIC	24	PARAMEDIC		PARAMEDIC	
EMT-PI	8	EMT-PI	3	EMT-PI		EMT-PI	
EXTRICATION	0	EXTRICATION	0	EXTRICATION		EXTRICATION	
EMR	198	EMR	209	EMR		EMR	
Temporary EMT	0	Temporary EMT	46	Temporary EMT		Temporary EMT	
Temporary Paramedic	0	Temporary Paramedic	24	Temporary Paramedic		Temporary Paramedic	
Temporary EMR	0	Temporary EMR	0	Temporary EMR		Temporary EMR	
Temporary Advance	0	Temporary Advance	0	Temporary Advance		Temporary Advance	
Totals	**1722**		**966**		**0**		**0**

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	9/30/2013	Expired 03/31/2013	
EMS - EVOC	201	EMS - EVOC	114
EVOC INSTRUCTOR	6	EVOC INSTRUCTOR	1
EMT - BA	184	EMT - BA	35
EMT-BASIC	2099	EMT-BASIC	576
EMT-INTERMEDIATE	18	EMT-INTERMEDIATE	2
PARAMEDIC	285	PARAMEDIC	64
EMT-PI	32	EMT-PI	9
EMR	548	EMR	253
Totals	3373		1054

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

866

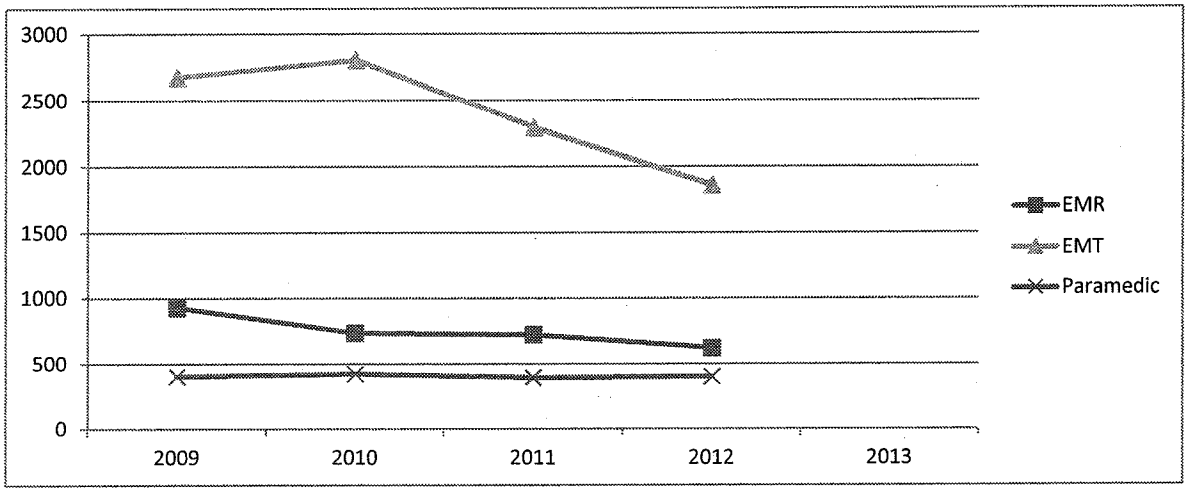
Number of New People Certified Last Quarter

780

Net gain/Loss of: -86

Trending Graph

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



Attachment #3

Emergency Medical Services
Provider Certification Report

Date : August 1, 2013 **August 16, 2013**

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 **August 16, 2013** 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	408
Ambulance Service Provider	100
EMT Basic-Advanced Organization	35
EMT Basic-Advanced Organization non-transport	21
EMT Intermediate Organization	1
EMT Intermediate Organization non-transport	0
Paramedic Organization	185
Paramedic Organization non-transport	8
Rotorcraft Air Ambulance	12
Fixed Wing Air Ambulance	3
Total Count:	778

Attachment #4

MICHAEL R. PENCE, Governor
STATE OF INDIANA

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

EMERGENCY MEDICAL SERVICES COMMISSION

TECHNICAL ADVISORY COMMITTEE MEETING MINUTES

DATE:	July 9, 2013; 10:00 a.m.
LOCATION:	Noblesville Fire Department, Station 77 15251 Olio Road Noblesville, IN 46060
PRESENT:	Leon Bell, Chairman, ALS Training Institute Tina Butt, First Responder Training Director Sherry Fetters, Vice Chairman, EMS Chief Executive Officer Jessica Lawley, ALS Training Program Director Sara Brown, EMS Medical Director Jaren Kilian, Charles Ford, EMS Chief Executive Officer Faril Ward, EMS Chief of Operating Officer
NOT PRESENT:	Elizabeth Weinstein, EMS for Children Michael Gamble, Emergency Department Director Michael McNutt, BLS Training Program Director Edward Bartkus, EMS Medical Director

OTHERS PRESENT: Myron Mackey, EMS Commissioner

John Zartman, EMS Commissioner

Elizabeth Fiato, IDHS Staff

Other IDHS Staff and members of the EMS Community

1) Meeting called to order at 10:20 a.m. by Chairman Bell.

2) Roll call, quorum present

3) Adoption of minutes:
Chairman Bell called for a motion to accept the minutes from the June 4th meeting.
A motion was made by Vice Chairwoman Fetter to accept the minutes from the June 4th meeting as written. The motion was seconded by Mr. Jaren Killian. The motion passed.

4) Public Comment:
Commissioner Myron Mackey commented that he liked it that more TAC members have been attending Commission meetings and he appreciated the TAC members. Chairman Bell had Garrett Hedeen from Indianapolis EMS introduce himself. Garrett is currently Paramedic/Instructor with IEMS, is the Region 3 (ISDH district 4 & 5) Director for IEMSA, and is on the National Association of EMTs (NAEMT) Health and Safety Committee.

Chairman Bell has Mr. Al Verbish introduce himself to the TAC members. Mr. Al Verbish is the new section chief for certification and compliance. He is retired from the Indiana State Police. He coordinates and conducts investigations.

Mr Don Watson asked that everyone encourage teams to sign up for the ambulance competition at this time we do not have any team registered.

5) Old Business:

Chairman Bell announced that there was not a presentation from the TAC at the last EMS Commission meeting. He explained that at the meeting prior to EMS Commission meeting a very brief discussion was made concerning Primary Instructors. Legal Counsel for IDHS stated that we could not do what was being proposed by the TAC to present to the Commission. This is due to the PI not being included in the emergency rule. The proposals would require a rule rewrite so for the time being nothing can be implemented and changed. The TAC can continue discussions but for now everything has to stay the way it is. After discussion it was clarified that if it is an IDHS policy but not a rule that we can change it but if it will require a rule rewrite has to go through a rule rewrite.

Chairman Bell directed everyone to the packets that were distributed at the beginning of the meeting that contained the work for today's meeting. This packet included the emergency rule for tactical medicine and some other information that he had been gathering since the last meeting. The tactical medicine emergency rule will give the ops group a little more work to do. Chairman Bell also stated that the TAC needed to start work on the provider organization level since the legislation did not choose to change the names of the organization levels to match them with the new individual levels. At the last Commission meeting it was announced that provider organizations could not apply for waivers only individuals can ask for waivers. Chairman Bell asked what would happen to the current provider waivers. Discussion followed these announcements. IDHS staff is asking for clarification from the attorney general's office concerning waivers. More discussion followed regarding waivers.

Chairman Bell called for break out session at 11:45pm.
Chairman Bell called the meeting back to order at 1:06pm

Chairman Bell stated that the PI group is ready to send the package back to the Commission. A process was written up during the break out session. It was emailed to all of the TAC members.

A motion was made by Dr. Sara Brown to accept the information that was written up and sent out. The motion was seconded by Mr. Faril Ward. The motion passed.
A motion was made by Mr. Faril Ward to accept the check list that was included in the packet that was sent out. The motion was seconded by Mr. Charles Ford. The motion passed.

Dr. Sara Brown asked about the possibility of sending information to Commission members prior to proposals and recommendations so if the Commission members wanted information it would give the TAC a chance to clarify prior to the Commission meetings.
Chairman Bell asked the TAC members to study the material that was given out as the beginning of the meeting for further discussion at the next meeting.

A motion was made by Vice Chairwoman Fetter to move the TAC meeting dates back to the first Tuesday of every month that is listed rather than the second Tuesday. Chairman Bell asked Candice Hilton to send out the updated TAC meeting dates. The motion was seconded by Ms. Tina Butt. The motion passed.

Chairman Bell asked the TAC members to review the emergency rule for discussion at the next meeting so things can be pointed out to the Commission of things that need to be fixed.

6) Good of the order

Mrs. Liz Fiato announced the next PI education working group will be on July 18th at the Lawrence Ivy Tech center. Meeting starts at 9am but the Fire Instructor to PI discussion will start about 1pm.
Hearing nothing else for the good of the order Chairman Bell called for a motion to adjourn.

A motion was made by Mr. Jaren Killian to adjourn the meeting. The motion was seconded by Ms. Tina Butt. The motion passed. The meeting was adjourned at 1:20pm.

Approved _____

Leon Bell, Chairman

Attachment #5

TECHNICAL ADVISORY COMMITTEE – TASK SUMMARY

INDIANA STATE E.M.S. COMMISSION

TASK INFORMATION

Date Assigned:	**February 5, 2013**	**Assigned to:**	**TAC**
Job Task:	**Meaning of physically present**		
Commission Staff:			
Review Period:	**April 2013**		

ASSIGNMENT REVIEW - GUIDELINES - GOALS

The Technical Advisory Committee was asked to look into the subject of the meaning in the rules of what constitutes a physical presence of a PI in the classroom.

Over the last 39 years of regulations, this requirement has been the foundation of EMS Education in Indiana. The founding EMS Commission believed that a certified provider of the Commission's educational blueprint (The DOT Curriculum) had to be present when guest lectures were presenting to lay people learning to be EMTs. This has been debated since that day in 1974 as we grew in sophistication and became an organized educational system.
Arrays of technologies present today educators new opportunities that change the meaning of physical presence. Traditionally, one thought of physical presence being associated with brink and motor classroom. That is not the case in today's classroom. From the university level to grade schools, classrooms are now virtual environments. The brink and mortar concept now may not be the only way of thinking about teaching an EMT class or for that matter any of the EMS education courses in Indiana.
The TAC assigned the task of review to the Vice Chair Sherry Fetters. She and a group of members researched the idea and made a recommendation to the TAC at its April 2013 meeting.
The committee looked at two items, the meaning of present. The physical classroom in the present language is interrupted as in person or face to face the Primary Instructor is to oversee the learning experience directly by physically be present at every class session. Currently meaning of distance is open to interpretation by the PI, student, and Commission staff.

TAC RECOMMENDATION

1. A learning session is defined as a experience in person in which the PI and the students meet to discuss, teach, learn, and evaluate the NES curriculum.
2. PI needs to be responsible for the delivery of all of the objectives as set forth by the NES and the Indiana EMS Commission requirements.
3. In the virtual, distance or on-line the definition of **present** means the Primary instructor must be available to all the students through the virtual, distance or on-line technology or other methods for coaching, evaluation, and feedback.
4. In a virtual, distance or on-line experience **present** means that the Primary Instructor directly verifies the educational content as being appropriate when prescribed by the standards (NES).
5. Whether in a traditional or virtual classroom the PI is responsible for the content delivered regardless of who or how the subject matter is delivered to students.

LIMITATIONS – CHALLENGES – FISCAL IMPACT

None

FORMAL MOTION

The TAC makes a motion to the EMS Commission that the following guidelines are used when defining the Primary Instructor requirements:

1. A learning session is defined as a experience in person in which the PI and the students meet to discuss, teach, learn, and evaluate the NES curriculum
2. PI needs to be responsible for the delivery of all of the objectives as set forth by the NES and the Indiana EMS Commission requirements. .
3. In the virtual, distance or on-line the definition of **present** means the Primary instructor must be available to all the students through the virtual, distance or on-line technology or other methods for coaching, evaluation, and feedback.
4. In a virtual, distance or on-line experience **present** means that the Primary Instructor directly verifies the educational content as being appropriate when prescribed by the standards (NES).
5. Whether in a traditional or virtual classroom the PI is responsible for the content delivered regardless of who or how the subject matter is delivered to students.

ADDITIONAL COMMENTS

VERIFICATION OF REVIEW AND SUBMISSION

By signing this document, the (TAC) Technical Advisory Committee formally submits to the Indiana State EMS Commission the above proposed recommendations for review, consideration, and implementation. We acknowledge receipt of review, and submit this document for consideration to the Indiana EMS Commission on the date listed below.

Chairman, TAC Committee *Date*

Vice-Chairman, TAC Committee *Date*

EMS COMMISSION – RECOMMENDATION - ACTION

Commission Actions: **Date:**

- ☐ Approved, as listed.
- ☐ Approved, with changes listed below.
- ☐ Re-assigned for future recommendation.
- ☐ Rejected
- ☐ Other

COMMENTS:

The Technical Advisory Committee met in Noblesville Indiana on April 2, 2013. With a quorum present, we conducted business. We are making one recommendation and may make a second interrelated recommendation. The second recommendation will come late to the members of Commission due to the timing of our June meeting and the Commission meeting occurring in the same week on Friday. That remediation if completed by the sub-committee and approved by the TAC at our June 4, 2013 involves the elements of PI internship and interpretation for your discussion the meaning of various deadlines associated with becoming a PI.

We have also begun looking into the future of EMS in Indiana. We brainstormed many subjects that members of the TAC visualize as being part of the yet to come of EMS in Indiana. They include but are not limited to: the following broad subjects:

- Testing for competency for post-graduation
- Build exams
- Refresher courses
- NREMT-specifically
- Grants where can we find money
- Primary Instructor
    - Application
    - Affiliation
    - Pre-requisites
    - Validation of add-ons beyond NES
- Military pass thru of EMS Certifications
- Transition bridge
- Hybrids
- Community based Paramedicine
- Post graduate gateways to certification
- Tactical medicine
- Exceptions for AEMT providers

Attachment #6

TECHNICAL ADVISORY COMMITTEE – TASK SUMMARY

INDIANA STATE E.M.S. COMMISSION

TASK INFORMATION

Date Assigned:	06/04/2013	Assigned to:	TAC Chairman – Mr. Bell
Job Task:	Review of IAC 836-4-5-2 EMS PI Certification Intern Process		
Commission Staff:	Elizabeth Fiato		
Review Period:			

ASSIGNMENT REVIEW - GUIDELINES - GOALS

In follow up discussion regarding TAC assignment on clarification of IAC 836-4-5-2, the EMS Primary Instructor Certification, it was determined that the Primary Instructor internship process and internship objectives required review and proposed updates.

TAC RECOMMENDATION

The TAC Education Sub-committee drafted a proposed updated process that, while still consistent with existing code, clarifies the Primary Instructor process for all parties involved including the following: IDHS staff, the Primary Instructor Candidate, the Training Institution affiliating the Primary Instructor Candidate, and currently certified Primary Instructors that may mentor the Primary Instructor Candidate.

Additionally, the TAC Education Sub-committee reformatted and expounded upon the current "PI Intern Checklist" to create the "Objective Checklist for the Primary Instructor Intern/Candidate." The reformatted checklist offers additional clarity regarding the cognitive, affective, and psychomotor objectives for the internship process where the Primary Instructor Candidate shall demonstrate competence in these objective.

Lastly, an instructional forward, citing current IAC 836 code, further clarifies internship requirements for not only the Primary Instructor Candidate, but also for the Training Institution affiliating said candidate.

The TAC makes the following recommendations:

1. For the EMS Commission to approve the revised Primary Instructor Intern Process and direct IDHS to make said process available on the IDHS website for viewing and use.
2. For the EMS Commission to approve the Objective Checklist for the Primary Instructor Intern/Candidate" and direct IDHS to make said process available on the IDHS website for viewing and use.

LIMITATIONS – CHALLENGES – FISCAL IMPACT

The TAC does not believe there is a fiscal impact. The staff is currently using a similar process and intern checklist, however the current process is not clearly documented, and the current checklist in use is less specific. The TAC does not believe there will be any expected limitations or challenges.

FORMAL MOTION

TAC makes a motion that:

1. The EMS Commission to approve the revised Primary Instructor Intern Process and direct IDHS to make said process available on the IDHS website for viewing and use.
2. The EMS Commission to approve the Objective Checklist for the Primary Instructor Intern/Candidate" and direct IDHS to make said process available on the IDHS website for viewing and use.

ADDITIONAL COMMENTS

Reference attached forms "TAC proposed PI process" and "TAC proposed Objectives Checklist for PI Intern."

VERIFICATION OF REVIEW AND SUBMISSION

By signing this document, the (TAC) Technical Advisory Committee formally submits to the Indiana State EMS Commission the above proposed recommendations for review, consideration, and implementation. We acknowledge receipt of review, and submit this document for consideration to the Indiana EMS Commission on the date listed below.

Chairman, TAC Committee *Date*

Vice-Chairman, TAC Committee *Date*

EMS COMMISSION – RECOMMENDATION - ACTION

Commission Actions: **Date:**

- ☐ Approved, as listed.
- ☐ Approved, with changes listed below.
- ☐ Re-assigned for future recommendation.
- ☐ Rejected
- ☐ Other

COMMENTS:

Internship Objectives for the Primary Instructor Intern/Candidate

Background: Those interested in certification as a Primary Instructor, must successfully complete an internship with their affiliated Training Institution, in addition to the other requirements outlined in IAC 836 Article 4. The Internship Objectives for the Primary Instructor Intern/Candidate are intended to provide the PI intern/candidate, the Primary Instructor mentor(s), the Training Institute Official, and the Medical Director(s) with a comprehensive overview of skills that will provide a foundation for our future Primary Instructors.

Intent: The individual objectives listed in the Internship Objectives for the Primary Instructor Intern/Candidate are to be initialed and dated when the candidate has demonstrated that they have satisfied the said objective, in accordance with the Training Institution's policies and procedures. Successful completion of all Internship Objectives constitutes successful completion of the PI internship checklist and process.

Training Institution requirements: As listed in IAC 836 Article 4, a Training Institution must have policies regarding course completion requirements as follows:

836 IAC 4-2-1 General requirements for training institutions; staff
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 16-21; IC 16-31-3-2; IC 20-12-62-3; IC 20-12-71-8; IC 20-18-2-7
Sec. 1. (c)

(5) Medical director approval form listing affiliated instructor or instructors.
(6) In-course standards and criteria by which the instructor is to determine successful completion of the didactic and clinical portions of the course to include the following:
(A) Attendance requirements and absentee policies.
(B) Testing procedures.
(C) Number and scope of in-course tests.
(D) Didactic pass/fail grade average and criteria.
(E) Provision for makeup test and classes.
(F) Minimal age for enrollment.
(G) Policies for provider organization reasonable accommodations under the Americans with Disabilities Act.
(H) Description of the screening and evaluation process for acceptance into any certified training program.

Additionally, the Training Institution that is affiliating the PI intern/candidate will have and follow their policies regarding:

1. Time frame for successful completion of internship objectives
2. Percentage or number of occurrences that indicate competence, need for remediation, or failure regarding the requirements as outlined in the Internship Objectives for the Primary Instructor Intern/Candidate
3. Criteria for termination of the Training Institution Affiliation agreement between the TI and the PI intern/candidate

PI Internship Process

1. Said Primary Instructor candidate will secure Training Institution affiliation on appropriate forms
2. Once Training Institution affiliation has been agreed upon and formalized, the Training Institution will provide the Instructor Candidate with the required paperwork for the IDHS EMT written exam for Pre-Primary Instructor candidate
3. The Training Institution will add the PI candidate to their TI roster and remit the updated roster to the Indiana EMS Office within 30 days, as required by IAC 836 Article 4
4. Primary Instructor candidate successfully completes Primary Instructor course within one year of passing the IDHS EMT written exam for Pre-Primary Instructor candidate
5. The PI course completion date will serve as the PI application date
6. Upon successful completion of Primary Instructor course, PI candidate will successfully pass the Indiana EMT skills practical examination within one year of the PI application date
7. Upon successful completion of Primary Instructor course, PI candidate will successfully pass the Indiana Primary Instructor written examination within one year of the PI application date
8. Upon successful completion of Primary Instructor course, PI candidate will successfully complete the Indiana Primary Instructor Internship Requirements within one year of the PI application date
9. Upon successful completion of all of the above, the PI candidate will remit all required documentation to the State of Indiana EMS office within one year of the PI application date.
10. Upon EMS staff review and compliance with the above outlined process, the PI candidate will be issued Primary Instructor Certification.

Objective Checklist for the Primary Instructor Intern/Candidate

Instructions for PI candidate and PI mentor: The boxes [initials | date] are to be completed by the PI mentor when the PI candidate successfully demonstrates or completes the indicated required objective, as specified by the Training Institution's policies and procedures.

Preparatory Objectives for the Primary Instructor Intern/Candidate		
Cognitive	**Affective**	**Psychomotor**
[___|___] Has knowledge level consistent with State of Indiana course curriculum	[___|___] Displays behavior consistent with State of Indiana course curriculum	[___|___] Has skill level consistent with State of Indiana course curriculum
[___|___] Understands learning requirements for successful course completion	[___|___] Understands behavioral requirements for successful course completion	[___|___] Understands skill requirements for successful course completion
[___|___] Understands course learning goals and objectives	[___|___] Understands course behavioral goals and objectives	[___|___] Understands course skill goals and objectives
[___|___] Understands completion process for State of Indiana pre-course paperwork	[___|___] Comply with completion process for State of Indiana pre-course paperwork	[___|___] Successfully completes State of Indiana pre-course paperwork
[___|___] Identifies required components of the lesson plan(s)	[___|___] Participates in creation/revision of lesson plan(s)	[___|___] Integrates lesson plan(s) appropriately into course
Delivery Objectives for the Primary Instructor Intern/Candidate		
Cognitive	**Affective**	**Psychomotor**
[___|___] Has knowledge level consistent with State of Indiana course curriculum	[___|___] Displays behavior consistent with State of Indiana course curriculum	[___|___] Possesses skill level consistent with State of Indiana course curriculum
[___|___] Understands learning requirements for successful course completion	[___|___] Understands behavioral requirements for successful course completion	[___|___] Understands skill requirements for successful course completion
[___|___] Understands course learning goals	[___|___] Understands course behavioral goals	[___|___] Understands course skill goals
[___|___] Understands completion process for State of Indiana in-course paperwork	[___|___] Comply with completion process for State of Indiana in-course paperwork	[___|___] Successfully completes State of Indiana in-course paperwork
[___|___] Describes proper instructor appearance and attire	[___|___] Complies with prescribed dress code	[___|___] Independently displays proper appearance and attire
[___|___] Discuss the significance of the instructor displaying professionalism, integrity, empathy, self-motivation, and respect	[___|___] Exhibits professionalism, integrity, empathy, self-motivation, and respect	[___|___] Routinely demonstrates professionalism, integrity, empathy, self-motivation, and respect
[___|___] Discuss the need for effective time management	[___|___] Exhibits appropriate time management	[___|___] Routinely manages time appropriately
[___|___] Describe the significance of teamwork and diplomacy	[___|___] Exhibits teamwork and diplomacy	[___|___] Routinely works well with others and displays diplomacy
[___|___] Discuss the importance of timely peer/mentor correspondence and timely communication with students	[___|___] Exhibits timeliness regarding peer/mentor correspondence and student communication	[___|___] Routinely corresponds with peer/mentor and students in a timely manner
[___|___] Identifies class times and locations	[___|___] Exhibits punctuality	[___|___] Routinely arrives at facilities with adequate time to prepare for class
[___|___] Identifies necessary equipment for proper class instruction	[___|___] Explains the benefits of technology incorporation into the classroom	[___|___] Properly operates required technology relating to effective instruction
[___|___] Identifies required components of the lesson plan(s) for successful instruction	[___|___] Formulates appropriate instructional delivery methods for lesson plan(s)	[___|___] Delivers instruction from lesson plan(s) appropriately during class
[___|___] Lists five characteristics of acceptable didactic instructional delivery	[___|___] Selects acceptable strategies and tactics for acceptable didactic instructional delivery	[___|___] Demonstrates acceptable didactic instructional delivery through use of various strategies and tactics
[___|___] Lists five characteristics of acceptable psychomotor (skills) instructional delivery	[___|___] Selects acceptable strategies and tactics for acceptable psychomotor (skills) instructional delivery	[___|___] Demonstrates acceptable psychomotor (skills) instructional delivery through use of various strategies and tactics
[___|___] Discuss the significance of the instructor displaying professionalism, integrity, empathy, self-motivation, and respect	[___|___] Exhibits professionalism, integrity, empathy, self-motivation, and respect	[___|___] Routinely demonstrates professionalism, integrity, empathy, self-motivation, and respect
[___|___] Describes acceptable practice for the development of summative and/or formative exams	[___|___] Recognizes the significance and influence of proper summative/formative exam development	[___|___] Develops appropriate summative/formative exam(s) that candidate administers to students
Evaluation Objectives for the Primary Instructor Intern/Candidate		
Cognitive	**Affective**	**Psychomotor**
[___|___] Understands completion process for State of Indiana end of course paperwork	[___|___] Comply with completion process for State of Indiana end of course paperwork	[___|___] Successfully completes State of Indiana end of course paperwork
[___|___] Describes Training Institution's grading and make-up policy	[___|___] Complies with Institution grading and make-up policy	[___|___] Follows grading policy and assists students in following make-up policy
[___|___] Describes Training Institution's summative/formative exam validation process	[___|___] Complies with Training Institution's summative/formative exam validation process	[___|___] Performs summative/formative exam validation in accordance with Training Institution's validation process
[___|___] Discuss the importance of providing timely, honest, and appropriate student feedback	[___|___] Exhibits acceptable demeanor and mannerisms during student feedback	[___|___] Consistently provides timely, honest, and appropriate student feedback
[___|___] Describes acceptable counseling/remediation techniques	[___|___] Displays professionalism during student counseling/remediation session	[___|___]Counsels/remediates student in an acceptable manner

Attachment #7

POST

The following documents outline the proposed POST objectives, curriculum, and supporting documentation that the POST working group (made up of members from IDHS, IPPC, and the IFCA) has created and compiled.

The first document is the recommend EMS Commission Policy for Advance Directive Education. This document outlines the proposed objectives as well as candidate and instructor qualifications for the POST education.

The next document is the Indiana POST and Advance Directives EMS educational manual. It is our recommendation that this manual serve as the study guide that instructors may use, self-study students may use, or any other interested party may utilize to learn about Indiana Advance Directives. The two highlighted sections (pages 4 and 18-21) are areas where our working group could not come to a consensus regarding their inclusion, so we are requesting that the EMS Commission determine whether or not to include them in the study guide.

Finally, we have placed an unpublished screen shot of the proposed site where the POST education will be placed. The bullet pointed sections will all be hyperlinked to the documents and sites listed.

It is the recommendation of this working group that all EMS personnel be required to complete training on the POST and Advance Directives curriculum. This can be completed through either a qualified instructor or self-study. In order to complete the required training, students must complete a one (1) hour course (again, either instructor led or online self study) and successfully pass the IDHS administered exam. The POST Curriculum should be incorporated as an Indiana Required Component into the EMR and EMT curriculums. All successful completions will be notated on the student's ACADIS record, and training only has to be completed once. We further recommend that all students must successfully pass the Indiana EMS POST Exam either prior to certification as an Indiana EMR, EMT, AEMT, or Paramedic or within their next recertification cycle beginning on January 1, 2014.

Advance Directives

EMS Commission Policy for Advance Directive Education

Emergency Medical Providers must expand their scope of practice to include a more thorough understanding of the Indiana Advance Directives, including the new Physician Orders for Scope of Treatment as well as the Living Will and Out-of-Hospital Do Not Resuscitate, for which their patient's may choose to utilize. The education shall be approved by the Indiana Department of Homeland Security and meet the EMS Commission approved program requirements and objectives.

Candidate Prerequisites

The following are required prerequisites for individuals seeking to expand their scope of practice to include all of the Indiana Advance Directives:

1. Must be currently certified as an Indiana EMR (or higher)
   -OR-
2. Be currently enrolled in an Indiana Department of Homeland Security approved EMS training program.

Instructor Qualifications

Shall be an experienced educator, approved by the administering Training Institution or Supervising Hospital. Instructors should be capable and able to encourage interactive learning, facilitate discussions on the topic, apply different styles of instruction as needed, and provide remedial education when required.

Minimal Equipment Needs and Instructor Resources

1. Educational component
2. Samples of the Indiana Advance Directives

Minimal Time for Didactic and Laboratory

One hour

Clinical Requirements

There is not a clinical requirement for this module.

Course Completion Requirements

All students must successfully pass the Indiana EMS POST Exam either prior to certification as an Indiana EMR, EMT, AEMT, or Paramedic or within their next certification cycle beginning on January 1, 2014.

Course Objectives

Terminal Objective:

At the completion of this unit of instruction, the participant shall be able to:

1. Formulate a treatment plan to include receiving Advance Directive forms in the prehospital setting, which may or may not result in transporting a patient - in conjunction with Medical Direction or Standing Orders.

Enabling Objective:

At the completion of this unit of instruction, the participant shall be able to:

1. Identify the following for Advance Directives, as they relate to the scope of practice:
    a. What is an Advance Directive
    b. Who qualifies as an Authorized Representative
    c. Identify a living will and determine its prehospital use(s)
    d. Identify an Out-of-Hospital Do Not Resuscitate (DNR) and determine its prehospital use(s)
    e. Identify Physician Orders for Scope of Treatment (POST) and determine its prehospital use(s)
    f. Understand the situations when you might not honor an Advance Directive
    g. Understand the role of Medical Direction in Advance Directives
    h. Competently utilize all of the Advance Directives in scenario situations
    i. Understand what is required for each Advance Directive to be valid

Individuals who show competency and successful completion of this Indiana Advance Directive Module, including didactic education, scenarios, and written exam, may participate in the utilization of the Indiana Advance Directives with full competence.

POST Information

In 2013, the Indiana Legislature adopted the POST, the Physician's Orders for Scope of Treatment. The following links will provide you with the curriculum and information on what POST is and what you need to know as an EMS responder regarding POST. All certified EMS responders in Indiana must successfully complete the Indiana EMS POST Exam beginning on January 14, 2014.

- Indiana EMS POST Educational Packet
- Indiana EMS POST Educational Packet - Audio
- Indiana EMS POST Exam

EMS Educators and Personnel may find the following information helpful in exploring POST and other Indiana Advance Directives.

- POST Curriculum approved by EMS Commission
- Indiana Code Link - POST
- Indiana Code Link - Out of Hospital DNR
- Indiana Code Link - Living Will and Life Prolonging Procedure Will
- POST form
- Department of Health Advance Directives packet
- Using the POST Form: Guidance for Health Care Professionals

Want to learn more?

- Links from IPPC packet

Physician Orders for Scope of Treatment (POST): What it means for Indiana

A summary of what POST is and how it will impact the certified individual, provider organizations, state of Indiana, and our citizens.

This is a work product of the Indiana Fire Chiefs Association EMS Section in conjunction with the Indiana Patient Preferences Coalition and approved by the Indiana Department of Homeland Security

In March of 2013, House Bill 1182 was passed by the Indiana legislature. It was filed March 12, 2013, and became effective July 1, 2013. The current act can be reviewed in its entirety at:

http://www.in.gov/legislative/bills/2013/HE/HE1182.1.html

Unlike most traditional living wills, the POST program alters the kind of treatments people receive near the end of life so that it is consistent with their preferences. Unlike traditional code status orders, which narrowly focus on decisions about resuscitation, POST permits individualization of treatment goals to better reflect the myriad decisions people face in the last year of life. (http://www.iupui.edu/~irespect/POST.html)

Contents:

Frequently Asked Questions (FAQs):

1. *What are Advance Directives?*
   a. *POST*
   b. *Out of Hospital DNR*
   c. *Living Will*
   d. *Life Prolonging Procedures Will*
2. *What is POST?*
   a. *Sections of the POST form explained*
3. *How is a POST form different from a DNR?*
4. *How is a POST form different from a living will?*
5. *How might this affect care for a patient?*
6. *Who can honor a POST form?*
7. *When might I start seeing POST forms?*
8. *What makes a POST form valid?*
9. *What if the patient has multiple Advance Directives?*
10. *Am I protected, legally, if for some reason I do not follow the POST form?*

1. What are Advance Directives?

Advance Directives are legal documents that spell out what care you would like to receive if you experience a life-altering event. There are numerous types of legally recognized advance directives in Indiana. Advance directives discussed in this packet are:

a. POST
b. Out of Hospital DNR
c. Living Will
d. Life Prolonging Procedures Will

2. What is POST?

The Indiana POST Program is designed for persons with advance chronic progressive disease, frailty, or terminal conditions. These are persons for whom the physician would not be surprised if they died within the next 12 months because of their advance disease. Persons with these life-limiting conditions experience diminished benefits from treatments and increased burden as their condition progresses. The centerpiece of the program is the POST form, which documents an individual's treatment preferences in the form of medical orders that are easily understood by healthcare providers. The POST form is designed to transfer with an individual throughout the healthcare system to ensure treatment preferences are honored across all care settings. (http://www.iupui.edu/~irespect/POST.html)

a. Sections of the POST form:

EMS will utilize Sections A, B and reference E and F

Section A on the POST form focuses on the Code Status - specifically whether a full resuscitation attempt should be initiated or should not be initiated.

Section B deals with the level of medical interventions a patient desires. This can range from comfort measures only (pain

medications and comfort but allow a natural death) to minimal interventions (IV, Intubation decision, fluids and cardiac interventions) to a choice for full treatment.

Sections C and D focus on antibiotics and artificial nutrition respectively. These are for facility use but should be noted as being on the same POST form, as there are not separate forms for separate agencies.

Section E documents that a discussion occurred with the patient or the patient's representative with the appropriate signatures.

Section F is for the physician signature and identifiers.

3. How is a POST form different from a DNR?

A DNR or Do Not Resuscitate form and a POST form have differences and similarities. The DNR must be made in conjunction with a physician and the individual or the individual's representative (legal guardian, court appointed representative, formal Healthcare Representative, or Power of Attorney) in order to state that an individual is terminally ill and would not be expected to recover well from cardiac arrest and, therefore, resuscitation efforts should be withheld. Different DNR forms are used within facilities (extended care facilities and hospitals) versus the out of hospital DNR. This has created confusion and often an inability to honor DNR forms by out of hospital providers - specifically EMS. The Out of Hospital DNR (OHDNR) must contain the individual's name, date of the DNR, the words Do Not Resuscitate and Physician signature.

A POST form has one section dedicated to the Code Status or DNR preferences (Section A). The remainder of the form is dedicated to outlining specific treatment guidelines. (example: I do want artificial

nutrition; I do not want transported to the hospital; etc.) The POST form must also be executed in conjunction with a physician and the individual or the individual's Authorized Representative, Guardian or Power of Attorney. The POST form is not intended for persons with a long life expectancy and should be revisited if a person's medical situation changes.

The end of this document has more specifics on the Out of Hospital DNR specifically and more is available via the given links.

4. *How is a POST form different from a living will?*

A living will is available for anyone over the age of eighteen (18) years of age and of sound mind. The living will is used when a situation arises such that a person cannot speak for himself or herself. The living will expresses the care a person would like to receive or does not want to receive. ***Living wills are not traditionally honored by Indiana Emergency Medical Services*** but are used in hospital situations. If a living will is to be honored by EMS Providers in any form, Medical Direction involvement is required. The living will does not require a physician signature but should be notarized.

A POST form is *only* for those already experiencing advanced disease that is life limiting or terminal. The POST does specifically outline treatments that a person would like to receive or not receive. The difference is that this form is only for those with advance disease that can expect to face decisions regarding life prolonging procedures in the near future. It requires a physician signature and is a physician's order.

POST does not allow the traditional Living Wills that are currently not honored by EMS, to be honored by EMS. It does require all healthcare providers to honor the POST form.

5. How might POST affect care for an individual?

An individual with a POST form should expect that the declarations on the form be complied with across all healthcare settings. The POST form is legally acceptable by EMS Providers (with Medical Control consultation or Standing Orders), Extended Care Facilities, Hospitals and Hospice Care. This uniformity of care will work to insure that all will follow the individual's decisions for care. The care will be guided and directed by decisions agreed upon by the individual, physician and preferably also the family.

A person with a living will can expect that the declarations on that form be followed by Hospitals, but not by Emergency Medical Services. The inability to honor a living will by most EMS Providers can cause conflicts in care, when the involved person is already living with an advanced chronic progressive disease, frailty or a terminal condition. The living will is to be used by an individual to state what they believe they would like to have, or not have, done **IF** they are suddenly unable to choose due to an acute situation.

A person with a DNR should expect that the declarations regarding code status (resuscitation or not) are upheld but will not have the rest of their treatment plan explained unless they also possess other directives.

6. Who should honor a POST form?

All healthcare providers are required to honor the POST form legally.

If, when responding to this call, the patient has the capacity to make decisions for their own care at that time, you should discuss the POST orders with the patient and reaffirm their decisions as outlined on the

POST. The patient can revoke the POST at any time and may do so during the call.

EMS personnel should have standing orders delineating how their Medical Director would like them to treat a person with a POST form or have the ability to contact Medical Control for orders in isolated situations. The POST form can be addressed just as the DNR form is currently addressed.

7. When might I start seeing POST forms?

The Indiana POST form became available on the Indiana State Department of Health website by July 1, 2013. This was the "go live" date per Legislation.

Now that the form is legally available, EMS personnel should look for POST forms: in the patient's medical record at extended care facilities; or in with the patient's medications or on their refrigerator at home. A push is being made for the POST to be printed on bright pink paper; however that is not required by statute. The POST should accompany the patient at the time of transfer. It is the property of the patient. Copies of the form are also legal documents and should be honored in the same fashion as the original.

8. What makes a POST form valid?

A POST form does not have to be completely filled out in order to be valid. Sections left empty imply full consent to receive that care.

The only requirements are that the individual's identifiers (name and date of birth), code status orders in Section A (whether attempt resuscitation/Full Code or Do Not Attempt Resuscitation/DNR), signature

(individual or the specifically stated Authorized Representatives) and the Physician signature be in place.

Copies of the POST are as valid as the original. The original remains the property of the individual and not a specific institution or physician.

9. What if the patient has multiple Advance Directives?

In a situation where an individual has multiple advance directives, the most recent or updated version should be the version that is followed. If there is a question regarding validity of the specific directive, then the physician should be contacted in order to obtain verification.

10. Am I protected, legally, if for some reason I do not follow POST?

There is a conscience clause in the POST statute that protects healthcare providers when they act in good faith to honor the POST orders. In addition, a healthcare provider may choose not to honor the POST orders if the provider believes: the form is invalid; the form has been revoked; the declarant or his/her representative have requested alternative treatment; the POST orders would be medically inappropriate for the patient; or the POST orders conflict with the care provider's religious or moral beliefs. Family members may choose to direct more aggressive care than the POST form reflects. Just remember that the POST form reflects the patient's wishes and you are protected when you honor the POST form in good faith.

SITUATIONAL EXAMPLES

You are called to the scene of an automobile collision and find a 68 year old male who is unresponsive and has sustained life-threatening injuries. His son, the driver of the vehicle, advises you that his father has a POST and presents the form to you. He states that he would like the POST followed. You note that in Section A the patient has chosen to be a DNR and in Section B the patient has chosen comfort measures only. What do you do? The trauma is obviously not the reason for the POST form, can you honor it?

POST orders do not mean that you withhold care from your patient. In trauma situations, it is best to treat and transport according to your Standing Orders. The POST orders will be used at the hospital to determine how aggressively to manage the patient's injuries. However, you should also contact Medical Direction as soon as possible so that they can adjust orders if needed, especially if the patient experiences cardiac arrest. It is crucial that every EMS system and Medical Director foresee these types of situations and address them in their protocol, and that EMS professionals be familiar with that protocol and Indiana law.

You are called to a local restaurant for a 58 year old female who is choking. When you arrive, her friend states that the patient has a POST form in her purse. She is now in respiratory arrest. The friend is able to produce the POST form and hand it to you. She is indeed in possession of her POST with Section A stating that she is a DNR and Section B stating that she would like to receive comfort measures. What do you do?

In the situation with a choking you should refer to local Standing Orders or Medical Direction, but treat the choking. The POST does not encourage you to withhold normal treatment for situations that could be completely reversible. Perhaps with the obstruction cleared the patient can continue to make verbal choices for herself. If the patient should go into cardiac arrest then you would again refer to local Standing Orders or Medical Direction regarding the treatment of this patient. It might be that the POST would then be honored. It might also be deemed a situation when the patient is transported due to the public location of the arrest. Medical Direction is the key to the intricate and individual situations that can not be predicted.

You are called to the home of Mr. Johnson, a 72 year old male who has fallen out of bed. He is non-responsive and has agonal breathing. His wife tells you he has terminal cancer and shows you his POST form that indicates he wants Comfort Measures Only. She asks you to lift the patient back in bed. She does not want him transported to the hospital. What do you do?

With POST, the ideal would be to act within your Standing Orders, or contact Medical Control, to obtain orders for pain medications in order to make Mr. Johnson more comfortable and lift him back into bed.

As was stated, when there is a reason to believe the POST is not valid, revoked or if it conflicts with the care provider's moral or religious beliefs to uphold POST, then treatment may be done. However, POST is in place precisely for situations like this where the patient and family have decided what care they are choosing for themselves or their loved ones.

You have responded to Mrs. Smith's residence, an 84 year old female patient with advance MS and diabetes. Her daughter advises you that she has a POST form for her mother with her listed as the Power of Attorney. Mrs. Smith's POST indicates that she is a DNR as well as having marked Limited Additional Interventions in Section B, allowing for IV, fluids, cardiac monitoring when necessary and transport to the hospital if she cannot be stabilized. She has asked that no other invasive procedures take place. Mrs. Smith has been lethargic but with numerous bouts of vomiting today. The daughter is concerned that her mother may require some fluids and treatment due to the hypovolemia as well as her history of diabetes. What do you do?

Checking that she would like Limited Additional Interventions allows for IV as well as IV fluids and medications necessary to stabilize her immediate condition. You should consult your local Standing Orders, or Medical Direction, for treatment and whether the patient requires transport to the hospital for further stabilization. Even if you possess the Standing Orders that would allow for a fluid bolus and medication administration - Medical Direction is always a good back up when faced with confusing and difficult comorbidities with this patient.

Useful Contacts

IPPC - Indiana Patient Preferences Coalition

http://www.iupui.edu/~irespect/POST.html

IDHS

1-800-666-7784

ISDH

1-317-233-1325

Useful Links

- Advance Care Planning *NIH* (National Institute on Aging)
- End-of-Life Decisions(National Hospice and Palliative Care Organization) - PDF
- Living Wills and Advance Directives for Medical Decisions(Mayo Foundation for Medical Education and Research)
- Put It in Writing: Questions and Answers on Advance Directives(American Hospital Association) - PDF
- Healthcare Agents: Being One(National Hospice and Palliative Care Organization)
- Making Medical Decisions for a Loved One at the End of Life(American College of Physicians) - PDF
- Medical Issues to Be Considered in Advance Care Planning(American Hospice Foundation)
- Advance Care Planning: Preferences for Care at the End of Life(Agency for Healthcare Research and Quality)
- Surrogate Decision Makers' Interpretation of Prognostic Information(American College of Physicians) - PDF
- Download Your State's Advance Directives(National Hospice and Palliative Care Organization) - PDF
- Advance care directives
- Also available in Spanish
- Deciding about treatments that prolong life
- Also available in Spanish
- Health care agents
- Also available in Spanish

POST FORM BREAK DOWN

A – CARDIOPULMONARY RESUSCITATION

A *Check One*	**CARDIOPULMONARY RESUSCITATION (CPR):** *Patient has no pulse AND is not breathing.* ☐ Attempt Resuscitation/CPR ☐ Do Not Attempt Resuscitation (DNR) When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

These orders apply only to the circumstance in which the person has no pulse and is not breathing. This section does not apply to any other medical circumstances. If a patient is in respiratory distress but is still breathing or has low blood pressure with an irregular pulse, a first responder should refer to section B for corresponding orders.

If the person wants cardiopulmonary resuscitation (CPR), and CPR is ordered, then the "Attempt Resuscitation (CPR)" box should be checked. Full CPR measures should be carried out and 9-1-1 should be called in an emergency situation. Providing full CPR typically requires intubation, mechanical ventilation, shocks to the heart when indicated and transfer to the ICU. Once CPR is initiated, patients must be transferred to a hospital setting for further evaluation and treatment.

If a person has indicated that he/she does not want CPR in the event of no pulse and no breathing, then the "Do Not Attempt Resuscitation/DNR" box should be checked. The person should understand that comfort measures will always be provided and that CPR will not be attempted.

B – MEDICAL INTERVENTIONS

B *Check One*	**MEDICAL INTERVENTIONS:** *If patient has pulse AND is breathing OR has pulse and is NOT breathing.* ☐ *Comfort Measures (Allow Natural Death)*: Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location. ☐ *Limited Additional Interventions*: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible. ☐ *Full Intervention*: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

Section B orders apply to emergency medical circumstances for a person who has a pulse but may or may not be breathing. This section provides orders for situations that are not covered in section A. These orders were developed in accordance with EMS protocol. Interventions to promote comfort should always be provided regardless of ordered level of treatment. Other orders may also be specified.

Comfort Measures – This box is checked for patients who desire only those interventions that allow a natural death with the goal of providing comfort. Use medication by any route, positioning, wound care, nd other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to a hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. The overall treatment goal is to maximize comfort through symptom management.

Limited Additional Interventions – In addition to the comfort measures noted above, include IV fluids (hydration) and cardiac monitoring as indicated to stabilize the medical condition. This may involve the use of basic airway management techniques and non-invasive positive-airway pressure. Intubation, advance airway interventions, and mechanical ventilation are not used. Transferring the patient to a hospital may be indicated to manage and stabilize medical needs or to enhance comfort, but use of intensive care is avoided.

Full Interventions – Include all care noted above with no limitation of medically indicated treatment. All support measures needed to maintain and extend life are utilized. Use intubation, advance airway interventions, mechanical ventilation, and electrical cardioversion as indicated. Transfer to hospital and use intensive care as medically indicated.

If full treatment by EMS is indicated and desired, the "Full Interventions" box is checked. In medical emergencies, health care personnel or family should call 9-1-1. If the person and physician determine that some limitation is preferred, then one of the other boxes is checked. Health care professionals should first administer the level of emergency medical services ordered and then contact the physician.

C&D - Antibiotics and Artificially Administered Nutrition

C *Check One*	**ANTIBIOTICS:** ☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means. ☐ Use antibiotics consistent with treatment goals.
D *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION:** Always offer food and fluid by mouth if feasible. ☐ No artificial nutrition. ☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____) ☐ Long-term artificial nutrition.

These sections are of no concern to EMS, but they do spell out the patient's wishes regarding antibiotics as well as artificial nutrition.

E -- Documentation of Discussion

E	**DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:** ☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian / Parent of Minor ☐ Health Care Power of Attorney		
	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE My signature below indicates that my physician discussed with me the above orders and the selected orders correctly represent my wishes. If signature is other than patient's, add contact information for representative on reverse side.		
	Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

Upon completion of the discussion during which the POST is being executed, the health care professional checks the box indicating with whom the orders were discussed. More than one box may be checked in this section depending on who participated in the discussion.

The patient or his/her legally authorized representative must sign the form in this section, as well. For situations when the patient loses or has lost decision-making capacity, the name, address, and phone number of the patient's legally authorized representative is to be listed in the "Contact Information" section on the back of the form.

F – PHYSICIAN'S SIGNATURE

F	SIGNATURE OF PHYSICIAN My signature below indicates to the best of my knowledge that these orders are consistent with the patient's **current** medical condition and preferences.		
	Print Signing Physician Name ***(required by statute)***	Physician Office Telephone Number ***(required by statute)*** ( ) ___ – ___	License Number ***(required by statute)***
	Physician Signature ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*	Office Use Only

The physician must sign the form in this section. **BOTH the patient's/representative's signature in section E and the physician's signature in this section F are mandatory. A form lacking these signatures is NOT valid.** The physician then prints his/her name, phone number, and the date and time the orders were written.

Out of Hospital DNR

The Out of Hospital DNR (OHDNR) is an advance directive that allows a person outside an acute care hospital or health facility to indicate that he or she does not wish to be resuscitated if and when cardiac or pulmonary failure occur. Any person who is 18 or older, is of sound mind, and has been certified by his or her physician as having a terminal condition or a condition in which survival of cardiac/pulmonary failure is unlikely, may execute an Out of Hospital DNR. However, the OHDNR has no effect if the patient is pregnant.

The OHDNR can be recognized by EMS. In fact, the statute clearly states that a health care provider "shall" withhold or discontinue CPR when the criteria outlined in the statute are met. The health care provider's specific duties under the statute are listed below.

IC 16-36-5-19

Health care provider duties

Sec. 19. (a) A health care provider shall withhold or discontinue CPR to a patient in an out of hospital location if the health care provider has actual knowledge of:

(1) an original or a copy of a signed out of hospital DNR declaration and order executed by the patient; or

(2) an out of hospital DNR identification device worn by the patient or in the patient's possession.

(b) A health care provider shall disregard an out of hospital DNR declaration and order and perform CPR if:

(1) the declarant is conscious and states a desire for resuscitative measures;

(2) the health care provider believes in good faith that the out of hospital DNR declaration and order has been revoked;

(3) the health care provider is ordered by the attending physician to disregard the out of hospital DNR declaration and order; or

(4) the health care provider believes in good faith that the out of hospital DNR declaration and order must be disregarded to avoid verbal or physical confrontation at the scene.

(c) A health care provider transporting a declarant shall document on the transport form:

(1) the presence of an out of hospital DNR declaration and order;

(2) the attending physician's name; and

(3) the date the out of hospital DNR declaration and order was signed.

(d) An out of hospital DNR identification device must accompany a declarant whenever the declarant is transported. As added by P.L.148-1999, SEC.12.

The OHDNR statute (IC 16-36-5) specifies the exact form that must be used. The form must be signed by two witnesses as well as the individual and his or her physician. A copy of the form is sufficient evidence of the existence of the directive (the original need not be presented to EMS). The individual may also revoke the OHDNR at any time in writing, verbally, or by destroying the document. A health care representative my revoke the OHDNR only if the declarant is incompetent to do so. The statute provides liability protection as long as a health care provider acts in good faith and in accordance with "reasonable medical standards."

LIVING WILL AND LIFE PROLONGING PROCEDURES WILL

The Living Will (LW) and Life Prolonging Procedures Will (LPP) are two different types of advance directives found in the same chapter of Indiana Code (16-36-4). These documents are used to express wishes for care in the event the person develops an "incurable injury, disease, or illness determined to be a terminal condition" and is unable to express directions for his or her care. The declarant must be at least 18 years of age and of sound mind in order to execute the LW or LPP. These documents are often created with an attorney when a will is created, but not always. Indiana law dictates the content of these documents (see samples in this packet). They must be signed by the declarant and two witnesses. Like the Out of Hospital DNR, the Living Will has no effect if the patient is pregnant.

The Living Will statute does not require a physician to act, but is considered an expression of the patient's desires. The statute does require a physician to use life prolonging procedures as requested within a Life Prolonging Procedures Will.

IC 16-36-4-8
Life prolonging procedures will declarations; living will declarations

(f) A living will declaration under section 10 of this chapter:
(1) does not require the physician to use, withhold, or withdraw life prolonging procedures but is presumptive evidence of the patient's desires concerning the use, withholding, or withdrawal of life prolonging procedures under this chapter; and
(2) shall be given great weight by the physician in determining the intent of the patient who is mentally incompetent.
(g) A life prolonging procedures will declaration under section 11 of this chapter does require the physician to use life prolonging procedures as requested.

Many EMS systems do not allow their EMS personnel to acknowledge the Living Will or Life Prolonging Procedures Will. However, this is changing. It is the EMS professional's responsibility to know how their local protocol addresses all forms of advanced directives.

The LW and LPP can only be revoked by the declarant, who may revoke the will orally, in writing, or by destruction of the document. The statute also provides immunity to health care providers who withhold care pursuant to the wishes of the patient as expressed in these documents, but, again, EMS personnel need to remain current on how their Medical Director wants them to deal with the LW and LPP. Always consult medical control if uncertain on how to proceed.

IC 16-36-4-7
Consent to medical treatment; immunity from liability for failure to treat patient after refusal of treatment
Sec. 7. (a) A competent person may consent to or refuse consent for medical treatment, including life prolonging procedures.
(b) No health care provider is required to provide medical treatment to a patient who has refused medical treatment under this section.
(c) No civil or criminal liability is imposed on a health care provider for the failure to provide medical treatment to a patient who has refused the treatment in accordance with this section.
As added by P.L.2-1993, SEC.19.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct

that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialling or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

_____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

As added by P.L.2-1993, SEC.19. Amended by P.L.99-1994, SEC.2.

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of

all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.
In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.
I understand the full import of this declaration.

Signed _____

_____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

As added by P.L.2-1993, SEC.19.

Attachment #8

ACLS Re-Write

Clarify not interp. only trans.

AEMT Indiana Additional Testing

The EMS Commission added additional skills to the Indiana Advanced EMT curriculum at their June meeting. In order to provide comprehensive and clear objectives as well as instructional guidelines, the Training Section of IDHS enlisted the expertise of seasoned and active Indiana Primary Instructors to assist in developing and reviewing this curriculum.

The following pages include the description and intent of the curriculum, candidate pre-requisites, instructor qualifications, terminal and enabling objectives, estimated lab and clinical time, and the instructional guidelines taken from the National Education Standards Paramedic Instructional Guidelines.

There are two highlighted sections. First, those in gray were not outlined in the NES, but were inserted in order to add clarity for the course instructors. Also, those highlighted in yellow will be removed as they are outside the cardiology scope assigned to AEMTs. They were left for reference purposes as you analyze the content.

This is the minimum content that AEMTs should be taught in order to understand the EKG, 12-lead, and defibrillation topics that are now a part of their curriculum. While some content may be a review, it is important to include these topics in the general guidance as the level of understanding will vary greatly from student to student.

We plan on utilizing the Cardiac Skills Practical Exam to test student's ability to recognize and treat the various EKG rhythms. This will be done by the course instructor at the completion of the AEMT course. Each exam must be successfully passed before the student can take the State AEMT Additional Content Written Exam, be conferred as passing the course on the Report of Training, or be eligible to take the National Registry Exams. The practical exam should be placed in the student's file for the life of that file.

Finally, test questions have been developed and assessed for content validity. While we will continue to assess and develop questions, we currently have a base set of questions that will accurately test the students on the aforementioned content.

Do you have any questions?

Send to the MDs on the TAC for input

Send to TAC MDs - Hamilton 2nd Approved

Zarthan 1st

AEMT Indiana Additional Curriculum Program

EMS Commission Policy on EKG Monitoring, 12-Lead Acquisition and Transmission, and Defibrillation for the Indiana AEMT

Advanced Emergency Medical Technicians seeking to expand their scope of practice to include the administration of 12-lead ECG acquisition and transmission, manual defibrillation, ECG monitoring and recognition of sinus rhythms, ventricular fibrillation, ventricular tachycardia, PEA, and asystole, must have successfully completed a training program which was approved by Indiana Department of Homeland Security and met the EMS Commission approved program requirements and objectives.

Candidate Prerequisites

The following are required prerequisites for individuals seeking to expand their scope of practice to include the administration of 12-lead ECG acquisition and transmission, manual defibrillation, ECG monitoring and recognition of sinus rhythms, ventricular fibrillation, ventricular tachycardia, PEA, and asystole:

1. Must be currently certified as a National Registry Advanced Emergency Medical Technician or Indiana Advanced Emergency Medical Technician (AEMT) **AND**
2. Must be affiliated with an Advanced Life Support Provider Organization with Medical Director approved protocol for the AEMT to utilize any or all of the following: 12-lead ECG acquisition and transmission, manual defibrillation, ECG monitoring and recognition of sinus rhythms, ventricular fibrillation, ventricular tachycardia, PEA, and asystole in their scope of practice.

   -OR-

3. An emergency medical technician (or higher) currently enrolled in an Indiana Department of Homeland Security approved AEMT training program.

Instructor Qualifications

Any instructor teaching the additional curriculum shall be an experienced educator, minimally certified or licensed to perform the skills of an Indiana AEMT and approved by the administering Training Institution and Medical Director. Instructors should be capable and able to encourage interactive learning, facilitate discussions on the topic, apply different styles of instruction as needed, and provide remedial education when required.

EKG Monitoring, Interpretation and Manual Defibrillation Minimum Course Requirements

Didactic:	**TBD** ****Successfully pass the EMS Commission approved AEMT ECG written exam**
Laboratory:	**Eight (8) hours** **** Successfully complete Indiana AEMT Cardiac Psychomotor Exam at the conclusion of training** *(Verified by course instructor. Retain proof of completion in student file).*
Clinical:	**None required. Optional, at discretion of Training Institution and Medical Director**

Terminal Objective: At the completion of this unit of instruction, the participant shall be able to:

Integrate assessment findings with principles of anatomy, physiology, and pathophysiology to formulate a field impression and implement a treatment/disposition plan for a patient experiencing normal sinus rhythm, ventricular tachycardia, ventricular fibrillation, pulseless electrical activity, and asystole, to include the use of manual defibrillation as indicated.

Enabling Objectives:

1. Describe the anatomy of the cardiovascular system.
2. Describe the Pathophysiology of the cardiovascular system.
3. Describe factors and risks for cardiovascular compromise.
4. Perform an entire cardiovascular assessment (primary survey, Hx and physical exam, secondary survey)
5. Describe how ECG wave forms are produced. Correlate the electrophysiological and hemodynamic events occurring throughout the entire cardiac cycle with the various ECG wave forms, segments and intervals.
6. Identify how heart rates may be determined from ECG recordings.
7. Describe and demonstrate a systematic approach to the analysis and interpretation of cardiac rhythms.
8. Identify the five (5) cardiac rhythms for AEMT interpretation:
    a. normal sinus rhythm (including sinus bradycardia and sinus tachycardia, as addressed at AEMT level)
    b. ventricular tachycardia (with and without pulse)
    c. ventricular fibrillation
    d. asystole
    e. pulseless electrical activity
9. List limitations of the ECG
10. List clinical indications for cardiac monitor application and manual defibrillation.
11. Identify specific mechanical, pharmacological and electrical interventions for patients with dysrhythmias
12. List the clinical indications for an implanted defibrillation device.
13. Identify the critical actions necessary in caring for the patient in cardiac arrest.
14. Discuss assessment and management of a patient experiencing return of spontaneous circulation (ROSC)
15. Display a sense of urgency necessary to protect the window of opportunity for reperfusion during assessment and management of the cardiac patient that may be indicative of acute coronary syndrome.
16. Value the urgency in rapid determination and intervention of patients in cardiac arrest.

17. Demonstrate appropriate application of ECG electrodes and leads for monitoring
18. Given a static and dynamic ECG rhythm, correctly interpret normal sinus rhythm, ventricular tachycardia, ventricular fibrillation, asystole, and PEA
19. Develop, execute, and evaluate a treatment plan based on the field impression for the patient with chest pain that may be indicative of acute coronary syndrome.
20. Synthesize patient history, assessment findings to form a field impression for the patient with chest pain and cardiac dysrhythmias that may be indicative of a cardiac emergency.

12-lead ECG Acquisition and Transmission Minimum Course Requirements

Didactic and Lab: **TBD**

**** Successful 12-lead ECG acquisition on 5 simulated or live patients** ***(Verified by course instructor. Retain proof of completion in student file).***

****Successfully pass the EMS Commission approved AEMT ECG written exam**

Clinical: **None required. Optional, at discretion of Training Institution and Medical Director**

Terminal Objective: At the completion of this unit of instruction, the participant shall be able to:

Formulate a treatment plan to include the acquisition and transmission of 12-lead ECG, as appropriate, for patient experiencing a suspected cardiac event.

Enabling Objectives:

At the completion of this unit of instruction, the participant shall be able to complete the following for 12-lead ECG acquisition and transmission, as it relates to the scope of practice of the paramedic (reference page 130 of the National Education Standards Paramedic Instructional Guidelines):

1. State the purpose of 12-lead ECG acquisition and transmission
2. Discuss the role of out-of-hospital 12-lead acquisition and transmission
3. List indications for 12-lead ECG acquisition and transmission
4. Discuss the role of the 12-lead for the following conditions:
    a. Acute coronary syndromes
    b. Acute MI
    c. Angina
    d. Aortic Aneurysm/Dissection
    e. Coronary Artery Disease
    f. Infectious Diseases of the Heart
5. Describe the procedure for successful lead placement for 12-lead ECG acquisition
6. Demonstrate the procedure for successful lead placement for 12-lead ECG acquisition
7. Describe the procedure for 12-lead ECG acquisition and transmission

NES and Indiana Specific Paramedic Instructional Guidelines

Patient Assessment-Monitoring Devices (NES pg 130)

The following Instructional Guidelines in this section include all the topics and material at the AEMT level **PLUS** the following material:

I. Continuous ECG monitoring

- A. Purpose
- B. Indication
  1. Patient's presenting with cardiac-related signs and symptoms or potential signs and symptoms of illnesses with cardiac impact
  2. Used as advanced monitoring in pre-hospital care
- C. Procedure
- D. Limitation
- E. Interpretation (see Medical Emergency: Cardiology)

II. 12-Lead ECG

- A. Purpose
  1. Shorten door to treatment time
- B. Indication
- C. Procedure
- D. How to transmit (**Added for clarity**)

Medicine-Cardiology (NES pg 168-201)

The following Instructional Guidelines in this section include all the topics and material at the AEMT level **PLUS** the following material:

I. Anatomy of the Cardiovascular System

- A. Location
  1. Layers
     - a. Myocardium
     - b. Endocardium
     - c. Pericardium
       - i. visceral (epicardium)
       - ii. parietal
       - iii. pericardial fluid
  2. Chambers
     - a. Atria
     - b. Ventricles
  3. Valves
     - a. Atrioventricular (AV) valves
       - i. tricuspid (right)
       - ii. mitral (left)
     - b. Semilunar valves
       - i. pulmonic (right)

ii. aortic (left)

4. Papillary muscles
5. Chordae tendineae
6. Myocardial blood supply
    a. Arteries
        i. Left coronary artery
            a) Anterior descending artery (LAD)
                i) distribution to the conduction system
                ii) distribution to the left and right ventricles
            b) Circumflex artery
                i) distribution to the conduction system
                ii) distribution to the left ventricle
                iii) distribution to the left atrium
        ii. Right coronary artery
            a) Posterior descending artery
                i) distribution to the conduction system
                ii) distribution to left and right ventricles
            b) Marginal artery
                i) distribution to the conduction system
                ii) distribution to the right ventricle
                iii) distribution to the right atrium
    b. Veins
        i. Coronary sinus
        ii. Great cardiac vein
7. Conduction system
    a. Sinoatrial node
    b. Atrioventricular node
    c. Atrioventricular bundle (Bundle of His)
    d. Bundle branches
        i. left anterior fascicle
        ii. left posterior fascicle
        iii. right
    e. Purkinje network
    f. Internodal and interatrial pathways
        i. Atrioventricular node
        ii. Left Atrium (Bachmann's bundle)
        iii. Middle internodal tract (Wenckebach's tract)
        iv. Posterior internodal tract (Thorel's tract)
    g. Anatomical tracts that bypass the atrioventricular node
        i. considered possible conduction routes that account for anomalous atrioventricular conduction (Wolff-Parkinson-White syndrome, Lown-Ganong-Levine syndrome)
            a) James fibers
            b) Mahaim fibers
            c) accessory bundle of Kent
8. Vascular system
    a. Aorta
        i. ascending

ii. thoracic
iii. abdominal

b. Arteries
c. Arterioles
d. Capillaries
e. Venules
f. Veins
g. Vena cava
i. superior
ii. inferior

h. Venous return (preload)
i. skeletal muscle pump
ii. thoracoabdominal pump
iii. respiratory cycle
iv. gravity
v. effects of IPPB, PEEP, CPAP and BiPAP on venous return

i. Systemic vascular resistance and capacitance (afterload)
j. Pulmonary veins

II. Physiology

A. Cardiac cycle

1. Consists of systole and diastole of atria and ventricles
2. Cycle occurs in about 0.8 seconds and 70-80 cycles/minute average
3. Events that occur in 1 cardiac cycle:

a. Atrial systole
i. AV valves open and SL valves closed
ii. ventricles relaxed
iii. preceded by P wave on ECG

b. Isovolumetric contraction
i. between start of ventricular systole and opening of SL valves
ii. ventricular volume remains constant
iii. onset coincides with R wave on ECG
iv. first heart sound heart (S_1)
a) caused by ventricles contracting and closure of cuspid valves
b) "lubb" sound

c. Ejection -- Initial, shorter, rapid ejection followed by longer phase of reduced ejection
i. Residual volume of blood remains in ventricles following ejection phase
ii. Residual volume increases in states of heart failure

d. Isovolumetric relaxation
i. period between closure of SL valves and opening of AV valves
ii. ventricles are relaxing
iii. second heart sound heard during this phase (S_2)
a) caused by closure of SL valves
b) "dubb" sound

e. Rapid ventricular filling
f. Reduced ventricular filling (diastasis)

B. Cardiac output

1. Heart rate X stroke volume
    a. Starling's law
    b. Contractility

III. Electrophysiology

A. Characteristics of myocardial cells
    1. Automaticity
    2. Excitability
    3. Conductivity
    4. Contractility
B. Electrical potential
    1. Action potential – important electrolytes
        a. Sodium
        b. Potassium
        c. Calcium
        d. Chloride
        e. Magnesium
    2. Excitability
        a. Thresholds
        b. Depolarization
        c. Repolarization
            i. relative refractory period
            ii. absolute refractory period
    3. Neurotransmitters
        a. Acetycholine
            i. effects on myocardium
            ii. effects on systemic blood vessels
        b. Cholinesterase
            i. effects on myocardium
            ii. effects on system blood vessels
C. Autonomic nervous system relationship to cardiovascular system
    1. Medulla
    2. Carotid sinus and baroreceptor
        a. Location
        b. Significance
    3. Parasympathetic system
        a. Inhibitory
        b. Vagal release of acetylcholine
    4. Sympathetic system
        a. Stimulatory
        b. Release of norepinephrine
        c. Alpha receptors
        d. Beta receptors
        i. inotropic effect
        ii. dromotropic effect
        iii. chronotropic effect

IV. Epidemiology

A. Incidence
    1. Prevalence of cardiac death outside of a hospital
    2. Prevalence of prodromal signs and symptoms
    3. Increased recognition of the need for early reperfusion
B. Morbidity/mortality
    1. Reduced with early recognition
    2. Reduced with early access to the EMS system
C. Risk factors
    1. Age
    2. Family history
    3. Hypertension
    4. Lipids
        a. Hypercholesterolemia
        b. LDL/HDL ratios
    5. Gender
    6. Smoking
    7. Carbohydrate intolerance
D. Possible contributing risks
    1. Diet
    2. Gender
    3. Obesity
    4. Oral contraceptives
    5. Sedentary living
    6. Personality type
    7. Psychosocial tensions
E. Prevention strategies
    1. Early recognition
    2. Education
    3. Alteration of life style

V. Primary survey for cardiovascular assessment

A. Level of responsiveness
B. Airway
    1. Patent
    2. Debris, blood
C. Breathing
    1. Absent
    2. Present
    3. Rate and depth
        a. Effort
        b. Breath sounds
            i. characteristics
            ii. significance
D. Circulation
    1. Pulse
        a. Absent
        b. Present
            i. Pulse deficit

iii. Pulsus alternans

2. Skin
    a. Color
    b. Temperature
    c. Moisture
    d. Turgor
    e. Mobility
    f. Edema
3. Blood pressure

VI. History and physical/ SAMPLE format

A. Chief complaint
B. Pain
    1. OPQRST
        a. Onset/ origin
            i. pertinent past history
            ii. time of onset
        b. Provocation
            i. exertional
            ii. non-exertional
        c. Quality
        d. Region/ radiation
        e. Severity
        f. Timing
            i. duration
            ii. worsening or improving
            iii. continuous or intermittent
            iv. at rest or with activity
C. Dyspnea
    1. Continuous or intermittent
    2. Exertional
    3. Non-exertional
    4. Orthopneic
D. Cough
    1. Dry
    2. Productive
E. Related signs and symptoms
    1. Level of consciousness
    2. Diaphoresis
    3. Restlessness, anxiety
    4. Feeling of impending doom
    5. Nausea/ vomiting
    6. Fatigue
    7. Palpitations
    8. Edema
        a. Extremities
        b. Sacral
    9. Headache

10. Syncope
11. Behavioral change
12. Anguished facial expression
13. Activity limitations
14. Trauma

F. Past medical history
1. Coronary artery disease
2. Atherosclerotic heart disease
a. Abnormal lipid metabolism or excessive intake or saturated fats and cholesterol
b. Subendothelial accumulation of fatty streaks
c. Altered endothelial function
d. Disruption of endothelium
e. Formation of mature fibrous plaque
f. Resultant diseases:
i. angina
ii. previous MI
iii. hypertension
iv. congestive heart failure
3. Valvular disease
4. Aneurysm
5. Pulmonary disease
6. Diabetes
7. Renal disease
8. Vascular disease
9. Inflammatory cardiac disease
10. Previous cardiac surgery
11. Congenital anomalies
12. Current/ past medications
a. Prescribed
i. compliance
ii. non-compliance
b. Borrowed
c. Over-the-counter
d. Home remedies
e. Recreational
13. Allergies
14. Family history
a. Stroke, heart disease, diabetes, hypertension
b. Age at death
15. Known cholesterol levels

VII. Secondary survey for cardiovascular assessment

A. Inspection
1. Tracheal position
2. Neck veins
a. Appearance
b. Pressure
c. Clinical significance

3. Thorax
    a. Configuration
    b. A-P diameter
    c. Movement with respirations
4. Epigastrium
    a. Pulsation
    b. Distention
    c. Clinical significance

B. Auscultation
1. Neck
    a. Normal
    b. Abnormal
2. Breath sounds
    a. Depth
    b. Equality
    c. Adventitious sounds
        i. crackles/rales
        ii. wheezes/rhonchi
            a) gurgling
            b) frothing (mouth and nose)
                i) blood tinged
                ii) foamy
3. Heart sounds
    a. Auscultatory sites
    b. Identify S_1, S_2
    c. Identify abnormal sounds (S_3, S_4)

C. Palpation
1. Areas of crepitus or tenderness
2. Thorax
3. Epigastrium
    a. Pulsation
    b. Distention

VIII. Electrocardiographic (ECG) monitoring

A. Electrophysiology and wave forms
1. Origination
2. Production
3. Relationship of cardiac events to wave forms
4. Intervals
    a. Normal
    b. Clinical significance
5. Segments

B. Leads and electrodes
1. Electrode
2. Leads
    a. Anatomic positions
    b. Correct placement
3. Surfaces of heart and lead systems

a. Inferior
b. Left lateral
c. Anterior/ posterior

4. Artifact

C. Standardization

1. Amplitude
2. Height
3. Rate
    a. Duration
    b. Wave form
    c. Segment
    d. Complex
    e. Interval

D. Wave form analysis

1. Isoelectric
2. Positive
3. Negative
4. Calculation of ECG heart rate
    a. Regular rhythm
        i. ECG strip method
        ii. "300"/triplicate method
    b. Irregular rhythm
        i. ECG strip method
        ii. "300"/triplicate method

E. Lead systems and heart surfaces

1. ECG rhythm analysis
    a. Value
    b. Limitations
2. Heart surfaces
    a. Inferior
    b. Left lateral
    c. Precordial
3. Acute signs of ischemia, injury and necrosis
    a. Rationale
        i. possible early identification of patients with acute myocardial infarction for intervention (thrombolysis PTCA)
        ii. the role of out-of-hospital 12-lead ECG is not universally available but is appropriate in most EMS settings with proper medical oversight
    b. Advantages/ disadvantages
    c. ST segment elevation
        i. height, depth and contour
        ii. ST (acute changes)
            a) anterior wall -- significant ST elevation in V1- V4 may indicate anterior involvement
            b) inferior wall -- significant ST elevation in II, III and aVF may indicate inferior involvement
        iii. ST segment depression in eight or more leads
        iv. ST segment elevation in aVR and V1

d. Q waves
i. depth, duration and significance
a) greater than 5 mm, greater than .04 seconds
b) may indicate necrosis
c) may indicate extensive transient ischemia

F. Cardiac arrhythmias
1. Approach to analysis
a. P wave
i. configuration
ii. duration
iii. atrial rate and rhythm
b. P-R (P-Q) interval
c. QRS complex
i. configuration
ii. duration
iii. ventricular rate and rhythm
d. S-T segment
i. contour
ii. elevation
iii. depression
e. Q-T interval
i. duration
ii. implication of prolongation
f. Relationship of P waves to QRS complexes
i. consistent
ii. progressive prolongation
iii. no relationship
g. T waves
h. U waves
2. Interpretation of the ECG
a. Origin of complex
b. Rate
c. Rhythm
d. Clinical significance
3. Arrhythmia originating in the sinus node
a. Sinus bradycardia
b. Sinus tachycardia
c. Sinus arrhythmia
d. Sinus arrest
4. Arrhythmias originating in the atria
a. Premature atrial complex
b. Atrial (ectopic) tachycardia
c. Re-entrant tachycardia
d. Multifocal atrial tachycardia
e. Atrial flutter
f. Atrial fibrillation
g. Atrial flutter or atrial fibrillation with junctional rhythm
h. Atrial flutter or atrial fibrillation with pre-excitation syndromes

5. Arrhythmias originating within the AV junction
    a. First degree AV block
    b. Second degree AV block
        i. Type I (Wenckebach)
        ii. Type II/ infranodal (Classical)
    c. Complete AV block (third degree block)
6. Arrhythmias sustained or originating in the AV junction
    a. AV nodal re-entrant tachycardia
    b. AV reciprocating tachycardia
        i. narrow
        ii. wide
    c. Junctional escape rhythm
    d. Premature junctional complex
    e. Accelerated junctional rhythm
    f. Junctional tachycardia
7. Arrhythmias originating in the ventricles
    a. Idioventricular rhythm
    b. Accelerated idioventricular rhythm
    c. Premature ventricular complex (ventricular ectopic)
        i. R on T phenomenon
        ii. paired/ couplets
        iii. multiformed
        iv. frequent uniform
        d. "Rule of bigeminy" pertaining to precipitating ventricular arrhythmias
    e. Ventricular tachycardia
        i. monomorphic
        ii. polymorphic (including torsades de pointes)
    f. Ventricular fibrillation
    g. Ventricular standstill
    h. Asystole
10. Pulseless electrical activity
    a. Electrical mechanical dissociation
    b. Mechanical impairments to pulsations/ cardiac output
    c. Other possible causes

> **(Sections 8-9 and 11-13 removed, complex cardiology content)**

IX. Management of the patient with an arrhythmia

A. Assessment
1. Symptomatic
2. Hypotensive
3. Hypoperfusion
4. Mechanical
5. Vagal maneuvers - if the heart rate is too fast
6. Stimulation - If heart rate is too slow
7. Cough

B. Pharmacological interventions
1. Gases

>(Sections 2-15 removed, complex pharmacology content)

C. Electrical interventions
1. Purpose
2. Methods
a. Synchronized cardioversion-identify as a method only
b. Defibrillation
c. Cardiac pacing-identify as a method only
i. Implanted pacemaker functions
a) Characteristics
b) Pacemaker artifact
c) ECG tracing of capture
d) Failure to sense

>(Sections e-g removed, complex electrical intervention content)

D. Transport
1. Indications for rapid transport
2. Indications for no transport required
3. Indications for referral

E. Support and communications strategies
1. Explanation for patient, family, significant others
2. Communications and transfer of data to the physician

X. Acute coronary syndrome

A. Epidemiology
B. Precipitating causes
1. Atherosclerosis
2. Vasospastic (Prinzmetal's)

C. Morbidity/ mortality
1. Not a self-limiting disease
2. Chest pain may dissipate, but myocardial ischemia and injury can continue
3. A single anginal episode may be a precursor to myocardial infarction
4. May not be cardiac in origin
5. Must be diagnosed by a physician
6. Related terminology
a. Defined as a brief discomfort, has predictable characteristics and is relieved promptly - no change in this pattern
b. Stable
i. occurs at a relative fixed frequency
ii. usually relieved by rest and/ or medication
c. Unstable
i. occurs without fixed frequency
ii. may or may not be relieved by rest and/ or medication
d. Initial - first episode
e. Progressive - accelerating in frequency and duration
f. Preinfarction angina

i. pain at rest
ii. sitting or lying down

7. Differential diagnoses
    a. Cholecystitis
    b. Acute viral pericarditis or any other inflammatory cardiac disease
    c. Aneurysm
    d. Hiatal hernia
    e. Esophageal disease
    f. Gastric reflux
    g. Pulmonary embolism
    h. Peptic ulcer disease
    i. Pancreatitis
    j. Chest wall syndrome
    k. Costochondritis
    l. Acromioclavicular disease
    m. Pleural irritation
    n. Respiratory infections
    o. Aortic dissection
    p. Pneumothorax
    q. Dyspepsia
    r. Herpes zoster
    s. Chest wall tumors
    t. Chest wall trauma

D. Primary survey findings
    1. Airway/ breathing
        a. Labored breathing may or may not be present
    2. Circulation
        a. Peripheral pulses
            i. quality
            ii. rhythm
        b. Peripheral perfusion
            i. changes in skin (color, temperature and moisture)

E. History of the present illness/SAMPLE history
    1. Chief complaint
        a. Typical - sudden onset of discomfort, usually of brief duration, lasting three to five minutes, maybe 5 to 15 minutes; never 30 minutes to 2 hours
        b. Typical - usually relieved by rest and/or medication
        c. Epigastric pain or discomfort
        d. Atypical
    2. Denial
    3. Contributing history
        a. Initial recognized event
        b. Recurrent event
        c. Increasing frequency and/or duration of event

F. Secondary survey findings
    1. Airway
    2. Breathing
        a. May or may not be labored

b. Breath sounds
i. may be clear to auscultation
ii. may be congested in the bases

3. Circulation
a. Alterations in heart rate and rhythm may occur
b. Peripheral pulses are usually not affected
c. Blood pressure may be elevated during the episode and normalize afterwards
d. ECG Devices
i. monitor
ii. transmission
iii. documentation
iv. computerized pattern identification
v. pitfalls
vi. common errors
e. Findings
i. ST segment changes are often not specific
ii. arrhythmias and ectopy may not be present

G. Management
1. Position of comfort
2. Refer to ILCOR Consensus for treatment
3. ECG
a. Whenever possible, and scene time is not delayed, record and transmit 3-lead and/ or 12-lead ECG during pain, since ECG may be normal during the pain-free period
b. Measure, record and communicate ST segment changes
4. Indications for Rapid Transport
a. Sense of urgency for reperfusion
b. No relief with medications
c. Hypotension/hypoperfusion with CNS involvement
d. Significant changes in ECG
5. No transport
a. Patient refusal
b. Referral

H. Support and communications strategies
1. Explanation for patient, family, significant others
2. Communications and transfer of data to the physician

XI. Acute myocardial infarction/Angina

A. Epidemiology
B. Precipitating causes (as with angina)
1. Atherosclerosis
2. Persistent angina
3. Occlusion
4. Non-traumatic
a. Recreational drugs
5. Trauma
C. Morbidity/ mortality
1. Sudden death

2. Extensive myocardial damage
3. May result in ventricular fibrillation

D. Primary survey findings
1. Airway/ breathing
2. Circulation
a. Peripheral pulses
i. quality
ii. rhythm
b. Peripheral perfusion
i. changes in skin
a) color
b) temperature
c) moisture

E. History of the present illness/SAMPLE history
1. Chief complaint
a. Typical onset of discomfort, usually of long duration, over 30 minutes
b. Typically unrelieved by rest and/ or nitroglycerin preparation
c. Epigastric pain or discomfort
d. Atypical
2. Contributing history
a. First time
b. Recurrent
c. Increasing frequency and/ or duration
3. Denial

F. Secondary survey findings
1. Airway
2. Breath sounds
a. May be clear to auscultation
b. Congestion in bases may be present
3. Circulation
a. Skin
i. pallor during the episode
ii. temperature may vary
iii. diaphoresis is usually present
b. Alterations in heart rate and rhythm may occur
c. Peripheral pulses are usually not affected
d. Blood pressure may be elevated or lowered
e. ECG findings
i. ST segment elevation
a) height, depth and contour
b) ST changes
c) ST segment depression in reciprocal leads
ii. Q waves
a) depth, duration and significance
b) greater than 5 mm, greater than .04 seconds
c) may indicate necrosis
d) may indicate extensive transient ischemia
iii. ECG Rhythm analysis

a) criteria for patient selection for rapid transport and reperfusion

b) value

c) signs of acute ischemia, injury, and necrosis

d) criteria for patient selection for rapid transport and reperfusion

i) time of onset of pain

ii) location of ischemia and infarction

iii) ST segment elevation

e) cardiac arrhythmias

i) sinus tachycardia with or without ectopy

ii) narrow or wide QRS complex tachycardia

iii) sinus bradycardia

iv) heart blocks

v) ventricular fibrillation

vi) pulseless electrical activity (PEA)

vii) asystole (confirmed in a second lead)

G. Management

1. Position of comfort
2. Refer to ILCOR Consensus for treatment
   a. Discuss when to administer:
      i. Oxygen
      ii. Nitroglycerin
      iii. ASA
      iv. IV/fluids
      v. Nitrous Oxide **(Added for clarity)**
3. Transport
   a. Criteria for rapid transport
      i. no relief with medications
      ii. hypotension/ hypoperfusion
      iii. significant changes in ECG
         a) ectopy
         b) arrhythmias
   b. ECG criteria for rapid transport and reperfusion
      i. time of onset of pain
      ii. ECG rhythm abnormalities
4. Indications for "no transport"
   a. Refusal
   b. No other indications for no-transport
5. Support and communications strategies
   a. Explanation for patient, family, significant others
   b. Communications and transfer of data to the physician

> **(Sections XII-XV removed, advanced cardiac illnesses content)**

XVI. Cardiac arrest

A. Pathophysiology

B. Precipitating causes
    1. Trauma
    2. Medical conditions (for example)
        a. End stage renal disease
        b. Hyperkalemia with renal disease
C. Primary survey critical findings
    1. Unresponsive
    2. Apneic
    3. Peripheral pulses absent
    4. Heart rate/ rhythm
        a. Ventricular fibrillation
        b. ventricular tachycardia
        c. asystole
        d. PEA
D. History of the present illness/SAMPLE history (consider precipitating causes listed above)
    1. Witnessed event
    2. Witnessed by EMS personnel
    3. Bystander cardiopulmonary resuscitation (CPR)
    4. Time from discovery to activation of CPR
    5. Time from discovery to activation of EMS
    6. Past medical history
E. Management
    1. Related terminology
        a. Resuscitation - to provide efforts to return spontaneous pulse and breathing to the patient in full cardiac arrest
        b. Survival - patient is resuscitated and survives to hospital discharge
        c. Return of spontaneous circulation (ROSC) - patient is resuscitated to the point of having pulse without CPR; may or may not have return of spontaneous respirations; patient may or may not go on to survive
    2. Indications for WITHHOLDING resuscitation efforts
    3. Advanced airway management and ventilation
    4. Circulation
    5. IV therapy as appropriate
    6. Refer to ILCOR Consensus for treatment
        a. Pulseless Ventricular Tachycardia and Ventricular Fibrillation
            i. Defibrillation as soon as possible / energy dosage
        a.) in accordance with type and model of defibrillator
b.) determined by child's age and weight
        b. Pulseless Electrical Activity (PEA) and Asystole
            i. Confirm pulselessness
            ii. Cardiopulmonary resuscitation (CPR)
            iii. Monitor ECG / Basic ECG rhythm
            iv. Intravenous fluids / Fluid challenge **(Added for clarity)**
    7. Rapid transport
F. Return of Spontaneous Circulation
    1. Assess and monitor
    2. Initiate therapeutic hypothermia (per protocol and medical direction)

a. What is therapeutic hypothermia?
b. How to achieve therapeutic hypothermia **(Added for clarity)**

G. Support and communications strategies
1. Explanation for patient, family, significant others
2. Communications and transfer of data to the physician

H. Termination of resuscitation efforts
1. Inclusion criteria (for example)
a. 18 or older
b. Arrest is presumed cardiac in origin and not associated with a condition potentially responsive to hospital treatment (for example - hypothermia, drug overdose, toxicological exposure, etc.)
c. Endotracheal intubation has been successfully accomplished and maintained
d. Standard advanced cardiac life support (ACLS) measures have been applied throughout the resuscitative effort
e. On-scene ALS resuscitation efforts have been sustained for 25 minutes or the patient remains in asystole through four rounds of appropriate ALS drugs
f. Patient has a cardiac rhythm of asystole or agonal rhythm at the time the decision to terminate is made and this rhythm persists until the arrest is actually terminated
g. Victims of blunt trauma in arrest whose presenting rhythm is asystole, or who develop asystole while on scene
2. Exclusion criteria - for example
a. Under the age of 18 years
b. Etiology for which specific in-hospital treatment may be beneficial
c. Persistent or recurrent ventricular tachycardia or fibrillation
d. Transient return of pulse
e. Signs of neurological viability
f. Arrest was witnessed by EMS personnel
g. Family or responsible party opposed to termination
3. Criteria **NOT** to be considered as inclusionary or exclusionary
a. Patient age - for example, geriatric
b. Time of collapse prior to EMS arrival
c. Presence of a non-official do-not-resuscitate (DNR) order
d. "Quality of life" valuations
4. Procedures (according to local protocol)
a. Direct communication with medical oversight
i. medical condition of the patient
ii. known etiologic factors
iii. therapy rendered
iv. family present and apprised of the situation
v. communicate any resistance or uncertainty on the part of the family
vi. maintain continuous documentation to include the ECG
vii. mandatory review after the event
a) grief support (according to local protocol)
i) EMS assigned personnel
ii) community agency referral
b) law enforcement (according to local protocol)
i) on-scene determination if the event/ patient requires assignment of the patient to the medical examiner

ii) on-scene law enforcement communicates with attending physician for the death certificate
iii) if there is any suspicion about the nature of the death, or if the physician refuses or hesitates to sign the death certificate
iv) no attending physician is identified (the patient will be assigned to the medical examiner)

> (Sections XVII removed, advanced cardiac illnesses content)

XVIII. Aortic Aneurysm/Dissection

A. Thoracic
B. Abdominal

> (Sections XIX-XXI removed, advanced cardiac illnesses content)

XXII. Coronary Artery Disease

- A. Atherosclerosis
- B. Intravascular Lesion
  - 1. Coronary Vasospasm
    - a. Reduced blood flow
    - b. Decreased oxygen delivery to myocardium
    - c. May be drug induced (cocaine)
  - 2. Plaque rupture
    - a. Vasoconstriction
    - b. Platelet Adherence
    - c. Thrombus formation
      - i. partial occlusion
      - ii. complete occlusion

XXIII. Infectious Diseases of the Heart

- A. Result from intravascular contamination by pathogen
  - 1. Endocarditis
  - 2. Pericarditis
  - 3. Myocarditis
- B. Damages heart valves
- C. Damages heart muscle
- D. Embolizes

> (Sections XXIV- XXVII removed, advanced cardiac illnesses content)

XXVIII. Integration

- A. Apply pathophysiological principles to the assessment of a patient with cardiovascular disease
- B. Formulation of field impression; decisions based on:
  - 1. Primary examination
  - 2. History of the present illness/SAMPLE history
  - 3. Secondary examination
- C. Develop and execute a patient management plan based on field impression

1. Initial management
    a. Airway support
    b. Ventilation support
    c. Circulation support
    d. Non-pharmacological interventions
    e. Pharmacological interventions
    f. Electrical interventions
2. Re-assessment
3. Transport criteria
    a. Appropriate mode
    b. Appropriate facility
4. Non-transport criteria
5. Advocacy
6. Communications
7. Prevention
8. Documentation
9. Quality assurance

INSTRUCTIONS TO THE PRACTICAL SKILLS EXAMINER

Indiana A-EMT Practical Examination

CARDIAC ASSESSMENT AND MANAGEMENT

This station is designed to test the candidate's ability to effectively manage pre-hospital cardiac patients by integrating CPR skills, defibrillation, airway adjuncts, and patient/scene management skills. This includes the integration of people and equipment commonly associated with an ambulance responding to a cardiac scene in an advanced life support scenario. The candidate will be required to immediately apply a cardiac monitor/defibrillator and deliver appropriate treatment.

The current American Red Cross and American Heart Association CPR courses instruct students in the techniques of CPR, however they do not instruct the student in the use and integration of adjunctive equipment, including cardiac monitoring and interventions, or how to prepare the patient for transportation as he/she will be required to do in an actual field situation. Since this station tests the candidate's ability to integrate CPR skills into cardiac scene management, it is required that before entering this station the candidate present documentation of successful completion (card or certificate) of current CPR course. The course must meet, or exceed the criteria set forth in the American Heart Association's Basic Life Support Course "Basic Life Support for Heath Care Providers" or the American Red Cross equivalent.

The candidate must demonstrate effective history gathering skills by obtaining information about the events leading up to and during the event.

If the patient is found to be in cardiac arrest, the candidate must ask, at minimum, how long has the patient been in arrest?

Although gathering a history on the cardiac event is an assessment item, it should not be construed that it overrides the need for treatment of the patient. The current standards for CPR should be adhered to at all times during the situation. The candidate must assess for the presence of a spontaneous pulse and be informed by you that there is not spontaneous pulse. When you are directed to do so by the scenario, the candidate must direct the actions of the assistant EMT or the first responder while he/she prepares the monitor/defibrillator for use. The candidate must, within one minute of arrival at the patient's side, apply the MANUAL defibrillator to the mannequin and determine the first rhythm.

The **candidate must direct the EMT assistant and the first responder**. Also during this segment, the **candidate must prepare or direct the airway and ventilation adjuncts to be used in the integration segment.** The candidate should attempt to gather additional information from bystanders about the events leading to the cardiac event. When asked questions about the event, you should indicate that bystanders did not see anything and are unaware of any associated medical problems. The candidate may decide/verbalize initiation of an IV line. The IV line placement must NOT delay transport of the patient.

The candidate must continually re-evaluate the patient, interpret and manage the present rhythms.

The candidate is required to verbalize moving the patient onto a long spine board or onto a CPR board/spoke board, if appropriate, and an ambulance cot.

The supplies/equipment needed for this station include a manual monitor/defibrillator, IV supplies, a bag-valve-mask, a pocket mask or demand valve, supplemental oxygen set up, oxygen connection tubing, and portable suction equipment. The candidate must be informed of the mock set-ups and what they indicate before starting the procedures. **Note: The candidate may choose to bring his/her own equipment to use in this station. The state examination representative must inspect this equipment before the candidate uses it to test.**

This skill station requires the presence of an EMT assistant (the examiner may act as the EMT assistant), a first responder, and a defibrillation mannequin. Candidates are to be tested individually with the EMT assistant and the first responder acting as assistants who provide no input in the application of skills or equipment. The EMT assistant and first responder would be told not to speak but to follow the commands of the candidate. Errors of omission or commission by the first responder or assistant cannot result in failure of the candidate unless they were improperly instructed by the candidate.

Due to the extra individuals involved in this skill station, it is essential that you observe the actions of the candidate at all times. Do not be distracted by the actions of the first responder or the EMT assistant because they should do only as instructed by the candidate. As you observe the candidate ventilating the patient, remember that the ability to ventilate the patient with adequate volumes of air is not being evaluated. Adequate ventilation of the mannequin is evaluated in the "Bag-Valve-Mask Apneic Patient with Pulse." You are evaluating scene/situation control, integration skills, and decision-making ability.

INSTRUCTIONS TO THE CANDIDATE

CARDIAC ASSESSMETN & MANAGEMENT

This station is designed to test your ability to manage a pre-hospital cardiac patient by integrating CPR skills, defibrillation, airway adjuncts, and patient/scene management skills. There will be a first responder and an EMT assistant in this situation. They will arrive with you and only do as you instruct them. As you arrive on the scene, you will encounter a cardiac patient. You must immediately establish control of the scene and begin treatment of the patient. At the appropriate time, the patient's airway must be controlled and you may need to ventilate or direct the ventilation of the patient using adjunctive equipment. You may use any of the supplies available in this room. You have eight (8) minutes to complete this skills station.

Do you have any questions?

IF APPROPRIATE: inform the candidate if the skill station has a mock-up or supplemental oxygen and/or portable suction equipment.

INDIANA EMT-BASIC Advanced Practical Skills Examination

CARDIAC SKILLS STATION

Start Time:_____ Stop Time:_____ Date:_____

Candidate's_____ Scenario Num-_____

Evaluator's Name:_____

	Points Possible	Points Awarded
Demonstrates/Ventilates initial or continued consideration of BSI Precautions		
Checks level of responsiveness		
Checks ABC's (skill examiner states "no pulse, no respirations"		
Initiates CPR if appropriate (verbally)		
Performs "Quick Look" with paddles or applies pads		
Correctly interprets initial rhythm		
Notes change in rhythm		
Checks patient condition to include pulse and if appropriate BP		
Correctly interprets second rhythm		
Appropriately manages second rhythm		
Notes change in rhythm		
Checks patient condition to include pulse and if appropriate BP		
Correctly interpretes third rhythm		
Appropriately manages third rhythm		
Notes change in rhythm		
Checks patient condition to include pulse and if appropriate BP		
Correctly interprets fourth rhythm		
Appropriately manages fourth rhythm		
Order high flow oxygen at proper times		
TOTAL:	24	

Critical Criteria

_____ Failure to verify rhythm before delivering each shock
_____ Failure to ensure the safety of self and others (verbalizes AND observed ALL CLEAR)
_____ Inability to deliver DC shock (does not use machine properly)
_____ Failure to deliver appropriate defibrillation(s) as indicated by rhythm, in timely manner
_____ Failure to order initiation or resumption of CPR when appropriate
_____ Failure to order correct management of airway
_____ Failure to order high flow oxygen at proper time
_____ Failure to correctly diagnose or adequately treat v-fib, v-tach, or asystole/PEA

You must factually document your rationale for checking any of the critical items on the reverse side of this evaluation form.