



Emergency Ambulance Services

2022
EVALUATION REPORT

Program Evaluation Division
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • Judy Randall, Legislative Auditor

February 2022

Members of the Legislative Audit Commission:

Minnesotans rely on ambulance services to provide care and transport when they experience a medical emergency. Hundreds of ambulance services around the state provide that care and transport; they vary by organizational type and the level of care they provide. The Emergency Medical Services Regulatory Board (EMSRB) is responsible for regulating ambulance services in Minnesota and supporting the overall emergency medical services system.

In this report, we raise serious concerns about the regulation of ambulance services, the viability of some ambulance services, and EMSRB's operations. Overall, EMSRB has been ineffective in its role as a systemwide leader on emergency medical issues and has failed to perform some of its basic responsibilities. We recommend that the Legislature and EMSRB take action to address these and other issues.

Our evaluation was conducted by David Kirchner (project manager), Gretchen Becker, Ryan Moltz, and Katherine Theisen. EMSRB board members and staff cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

Judy Randall
Legislative Auditor



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Summary

Emergency Ambulance Services

The Legislature should strengthen the state's oversight of ambulance services and do more to support struggling services. The Emergency Medical Services Regulatory Board (EMSRB) should improve its operations.

Key Findings:

- In Fiscal Year 2021, more than 250 licensed ground ambulance services responded to approximately 540,000 calls to 911 for medical emergencies in Minnesota. EMSRB is the state agency that regulates ambulance services in Minnesota. (pp. 3, 10)
- Each ground ambulance service license must be tied to a “primary service area,” the geographic area in which the ambulance service operates. EMSRB has little authority to alter primary service area boundaries without the cooperation of the ambulance services assigned to them. (pp. 13, 19)
- Minnesota law does not provide meaningful oversight of ambulance services during the license renewal process. (p. 33)
- EMSRB has not used its existing authority to create performance standards for ambulance services. Further, it does not have authority to set standards for some key elements of practice. (pp. 40, 41)
- Ambulance services face persistent staffing and funding challenges across the state, but especially in outstate Minnesota. (pp. 52, 56)
- EMSRB has been largely ineffective in its regulation and support of ambulance services in Minnesota, and the board has failed to provide sufficient oversight of the agency's activities. EMSRB's board composition and unique responsibilities create risks for conflicts of interest. (pp. 62, 69, 73)

Key Recommendations:

- The Legislature should retain primary service areas for ambulance services, but it should restructure how they are created, modified, and overseen. (p. 24)
- The Legislature should adopt more stringent statutory requirements for renewal of ambulance service licenses. (p. 35)
- The Legislature should direct EMSRB to develop and enforce performance standards for ambulance services. (p. 48)
- The Legislature should explore options for improving ambulance service sustainability in Minnesota, potentially through pilot programs. (p. 59)
- The EMSRB board should improve its oversight of the executive director and ensure that the organization fulfills its responsibilities and maintains adequate staff to do so. (p. 70)
- The Legislature should consider whether to make structural changes to the EMSRB board. It should also clarify what constitutes a conflict of interest for EMSRB board members. (pp. 74, 76)

Report Summary

Ambulances are vehicles used to provide transportation for ill or injured persons or expectant mothers to, from, or between health care facilities. In Fiscal Year 2021, ground ambulances responded to approximately 540,000 calls to 911. *Ambulance services* are the organizations that send ambulances and crews to respond to emergencies. Ambulance services in Minnesota are operated by local governments, tribes, health care systems, or private organizations.

The Emergency Medical Services Regulatory Board (EMSRB) is responsible for regulating ambulance services in Minnesota. As of July 2021, there were 277 ambulance services licensed to operate in Minnesota.

State statutes recognize two levels of health care provided by ambulance services: basic life support (BLS) and advanced life support (ALS). BLS care involves basic emergency care and administration of a limited number of drugs. It is generally provided by emergency medical technicians. ALS care can include additional treatments and procedures, such as narcotic medications or advanced heart monitoring. It is generally provided by paramedics.

EMSRB has little authority to alter service boundaries without the cooperation of the ambulance services assigned to them.

Minnesota is divided into more than 250 “primary service areas,” the geographic areas in which licensed ambulance services have the right to provide care and transportation. Within area boundaries, the licensee must ensure 24-hour coverage every day of the year. An ambulance service may not deny ambulance care to anyone within the service area based upon the individual’s ability to pay.

Once an ambulance service obtains a license for a primary service area, it retains the right to provide service in that area as long as it maintains its license. There are no provisions in state law for EMSRB to alter primary service area boundaries without the consent of the license holder, even if EMSRB finds a public health benefit to doing so.

The extent of local government control over who provides ambulance service in a community depends on historical precedent.

Whether a local unit of government controls its ambulance service provider depends largely on what entity ran an ambulance service in that governmental unit’s area in the early 1980s. As a result, there are disparities in local control throughout the state. Local governments that do not already control ambulance provision in their communities have no easy way of gaining control. Conversely, once a licensee obtains control of a service area, it is straightforward for the licensee to maintain control.

We recommend that the Legislature retain primary service areas. However, it should restructure how they are created, modified, and overseen. The Legislature should create a process for periodically reviewing service area boundaries and empower EMSRB to redraw boundaries to address overlaps and gaps. The Legislature should also establish a process through which local units of government can provide input into which service provides ambulance care and transportation in their areas.

Minnesota law does not provide meaningful oversight of ambulance services during the license renewal process.

The process by which an ambulance service obtains its initial license provides an opportunity for public input and state oversight. However, once an ambulance service obtains a license, renewal is practically automatic. Statutes do not require EMSRB to inspect an ambulance service or assess its performance in any way as a condition of approving a renewal application.

Even though the law’s requirements are minimal, EMSRB has not collected all required information during the renewal process for ambulance service licenses. We recommend that the Legislature adopt more stringent statutory requirements for ambulance service license renewal, and that EMSRB ensure that ambulance services meet requirements in law.

EMSRB has limited authority to oversee ambulance service license transfers and changes in service providers.

Ambulance services can transfer their licenses to other entities through merger or acquisition; entities receiving licenses in this way do not have to go through the initial licensure process. Statutes do not require EMSRB to conduct onsite inspections or otherwise ensure that license transfers will not negatively affect public health. EMSRB typically asks the new licensee to simply attest that it meets legal requirements.

In some instances, the license holder is different from the provider that runs the ambulance service. Statutes do not require license holders to notify EMSRB or local governments if they discontinue providing care and instead contract with an external provider, or if the license holder terminates a contract with one provider and enters into a contract with another provider. Statutes also do not provide a mechanism through which EMSRB could ensure that the new provider meets legal requirements before it begins providing service.

We recommend that the Legislature require ambulance services to go through the initial licensure process—a process that provides an opportunity for stronger public input and state oversight—whenever there is a change in ownership or provider.

Minnesota has no standards for ambulance services related to actual outcomes.

Minnesota ambulance laws require ambulance services to meet a number of standards in order to obtain a license. For example, ambulance crews must have a minimum level of training, and ambulances must carry certain equipment, such as oxygen and defibrillators.

However, all of these standards relate only to an ambulance service's resources and abilities; Minnesota has no standards related to actual outcomes. For example, there are no performance standards or targets for whether ambulance services have provided appropriate care to patients with difficulty breathing. If a service has not provided sufficient care, it is up to the service itself to identify that a problem exists and address it.

EMSRB has not adopted performance standards even though it has the authority to do so as a rulemaking agency. However, for some key elements of ambulance practice (such as the speed of ambulance response), EMSRB's authority to set standards is limited.

We recommend that the Legislature direct EMSRB to develop and enforce performance standards for ambulance services. EMSRB should work with the Legislature to determine whether it needs additional statutory authority to set appropriate performance standards.

Ambulance services face persistent staffing challenges across the state, but especially in outstate Minnesota.

Many ambulance service directors responding to a survey we conducted were not confident their services will be able to meet the needs of their communities five years from now.

Although ambulance services in all parts of the state reported staffing challenges, staffing shortages appeared to be more acute in outstate Minnesota. In response to our survey, 61 percent of outstate service directors reported that during the previous month, they had difficulty staffing ambulance shifts at the level needed to adequately respond to 911 calls. Severe staffing shortages have sometimes led ambulance services to be unable to respond to calls from their primary service areas.

Ambulance services with low numbers of ambulance runs may not receive enough revenue from billing patients to cover their costs.

Unlike fire and police services, ambulance services typically are not primarily supported by taxes; instead they bill the individuals who use their service. However, services with low numbers of ambulance runs may have more difficulty covering the cost of providing continuous coverage than services with high numbers of ambulance runs. In addition, most ambulance service directors indicated that Medicare and Medicaid reimbursements are insufficient to cover costs. Services with revenue challenges instead rely on local government funding or volunteer ambulance personnel.

We recommend that the Legislature explore options for improving ambulance service sustainability in Minnesota, potentially through pilot programs.

EMSRRB has been largely ineffective in its regulation and support of ambulance services in Minnesota.

EMSRRB—composed of a 19-member governing board, an executive director, and several staff—is the primary entity in Minnesota responsible for ensuring that ambulance care is delivered by licensed ambulance services and certified personnel. In addition to its regulatory responsibilities, the Legislature also created EMSRRB to serve in a broad support role for emergency medical services in the state.

However, EMSRRB has been ineffective in its role as a systemwide leader on emergency medical issues. For example, EMSRRB has not created or implemented a statewide plan for emergency medical services and has taken limited action to address staffing and sustainability issues in Minnesota as a whole. Further, EMSRRB has not updated emergency medical services regulations to account for changes in technology and service provision.

EMSRRB has also failed to perform some of its basic responsibilities. For example, an EMSRRB staff person told us that many complaints EMSRRB received from about 2017 to 2020 were not investigated at the time, in part because EMSRRB did not have sufficient numbers of staff.

The board has not adequately overseen the agency's operations for some time. Although the board's policies indicate it must annually evaluate the performance of the executive director, it has not conducted a performance appraisal in more than five years.

EMSRRB's board composition and unique responsibilities create risks for conflicts of interest.

Although statutes require that EMSRRB's board members represent a variety of interests, nearly two-thirds of the board's voting members as of September 2021 had professional ties to ambulance services. Only 1 of the board's 17 voting members (6 percent) must be a member of the general public.

Further, unlike similar state boards, EMSRRB regulates businesses. The relationships EMSRRB board members have to ambulance services can create an appearance of conflicts of interest. Statutes and board policies define conflicts of interest narrowly, and do not take into account EMSRRB's unusual circumstances.

We make a number of recommendations to the Legislature and EMSRRB to improve EMSRRB's operations. Most notably, we recommend that the Legislature consider whether to make structural changes to the EMSRRB board. We also recommend that the Legislature clarify what constitutes a conflict of interest for EMSRRB board members.

Summary of Agency Response

In a letter dated February 18, 2022, Emergency Medical Services Regulatory Board Executive Director Dylan Ferguson and Board Chair J.B. Gupton wrote that the evaluation report "raises several serious and important issues" and described efforts the agency has undertaken in recent months to address the concerns presented in the report. Although stating that "We are pleased with the early progress" of the agency, they acknowledged that "significant work remains" and called for further "swift and appropriate actions" from emergency medical services providers, policymakers, and regulators. They stated that EMSRRB is "committed to working diligently and collaboratively with a broad range of stakeholders, including the Minnesota Legislature, to continue the process in implementing recommendations contained within this report."

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Chapter 2: Primary Service Areas

- 18 2.1 Some parts of the state—such as the area around Rochester—have many overlapping primary service areas.

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- 29 3.1 Different areas of Minnesota are covered by different levels of ambulance care.



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Introduction

Minnesotans rely on ambulance services to provide emergency health care and transportation to or between hospitals. Although these services are available throughout the state, differences exist—particularly between sparsely and more heavily populated areas—in terms of the level of care provided, the amount of control local governments can exert over ambulance services, and the ability of ambulance services to financially sustain themselves.

In June 2021, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate emergency ambulance services. Our evaluation addressed the following questions:

- **To what extent do all Minnesotans have adequate and equitable access to ambulance care and transportation?**
- **Does the Emergency Medical Services Regulatory Board (EMS RB) provide adequate oversight and governance of the state’s ambulance services?**

To answer these questions, we examined statutes and rules related to ambulance services, and conducted several interviews with EMS RB staff and board members. We also spoke with staff from the departments of Health, Human Services, and Public Safety and representatives from regional emergency medical service organizations. Additionally, we spoke with representatives of the Minnesota Ambulance Association, Minnesota Rural Health Association, and the League of Minnesota Cities.

To gain local perspectives, we interviewed ambulance service directors, medical directors, and other administrators from nine ambulance services: Arlington Area Ambulance Service, CentraCare Emergency Medical Services (Redwood Falls), Hennepin EMS (Minneapolis), Nashwauk Ambulance Service, North Memorial Ambulance Service (Brooklyn Center), Ridgeview Ambulance Service (Gaylord and Waconia), Ringdahl Ambulance (Fergus Falls), Tri-County EMS District (Karlstad), and White Bear Lake Fire Department. In several of these locations, we also interviewed one or more local stakeholders, such as administrators of county 911 dispatch centers, fire departments, police departments, and hospitals. We also surveyed the directors of all 258 ground ambulance services licensed to respond to 911 calls in Minnesota as of August 2021. We received responses from 186 directors, for a response rate of 72 percent.

We analyzed several different types of data from EMS RB. The Minnesota State Ambulance Reporting (MNSTAR) data system provides data on each event (or “run”) involving an ambulance response. The eLicense system provides data on ambulance services’ licenses and the certifications of individual emergency medical technicians and paramedics. Lastly, we obtained records of the boundaries of the areas served by each ambulance service, converted those records into geographic information systems data, and produced the maps which appear in the Appendix.

We examined a variety of EMSRB documents, including board minutes and license applications from the two most recent fiscal years. We also reviewed EMSRB’s internal policies and procedures.

Finally, we spoke with officials from ambulance regulatory agencies in four other states—Massachusetts, Michigan, Pennsylvania, and Wisconsin—to understand similarities and differences with Minnesota’s regulatory structure.¹

We restricted the scope of our evaluation to ground ambulance services and did not evaluate broader emergency medical services, such as the operation of 911 dispatch centers, the provision of initial care by first responders like police and firefighters, or the support provided by regional emergency medical services organizations. We also did not evaluate air ambulance services or community paramedicine programs.

Our report spans six chapters. Chapter 1 presents key background information. Chapter 2 discusses “primary service areas,” the geographic areas that ambulance services are licensed to serve. Chapter 3 examines EMSRB’s licensing activities related to ambulance services. Chapter 4 discusses the mechanisms by and the extent to which ambulance services are subject to accountability. Chapter 5 is about the challenges that some ambulance services face with respect to sustainability. And Chapter 6 is about EMSRB’s effectiveness as an agency.

¹ We selected states similar to Minnesota in the proportions of uninsured or publicly insured residents, the number of primary care providers compared to population needs, the number of 911 calls per 100,000 residents, and range of driving distances to hospitals. Of the six state agencies we contacted for an interview, four agreed.

Chapter 1: Background

In any location in Minnesota, a person experiencing a medical emergency can call 911 and request that an ambulance be dispatched to their location. Approximately 540,000 ambulance trips of this type took place in Minnesota in Fiscal Year 2021. Individuals call ambulances to respond to a wide range of medical emergencies, including falls, burns, abdominal pain, cardiac arrests, strokes, and depression. Ambulances also transport patients between health care facilities, such as from the emergency department at a hospital near the patient's home to a more distant hospital that offers specialized care that the patient needs.

Despite the availability of emergency ambulance services across the state, there is considerable variation in how those services are organized, operated, and financed. In this chapter, we provide an overview of the major types of ambulance services, their structure, and the laws that regulate them.

Key Findings in This Chapter

- Ambulance services combine both public safety and health care functions.
- Persons with the same medical conditions receive different care based on where they are when they need an ambulance.
- Some ambulance services rely heavily or entirely on volunteers to staff their ambulances.

Ambulance Services in Minnesota

Ambulances are vehicles used to provide transportation for ill or injured persons or expectant mothers to, from, or between health care facilities.¹ *Ambulance services*, as we use the term throughout this evaluation, are the organizations that send ambulances and crews to respond to emergencies.² As of July 2021, there were 277 ambulance services licensed in Minnesota. The state licenses ambulance services to ensure that they meet certain requirements. We discuss the licensing process in Chapter 3.

The state also registers or certifies several categories of ambulance service personnel. As described in the box on the next page, the categories represent different levels of expertise in patient care. Emergency medical responders (EMRs) are individuals who may perform basic emergency care either before the arrival of a licensed ambulance service or when assisting an ambulance crew member with a higher certification. As of July 2021, there were approximately 16,000 registered EMRs in Minnesota. Emergency medical technicians (EMTs) and paramedics are the key providers of patient care when an ambulance responds to a call. State certification in either category

¹ *Minnesota Statutes* 2021, 144E.001, subds. 2 and 3.

² The statutory definition of “ambulance service” is “transportation and treatment which is rendered or offered to be rendered preliminary to or during transportation to, from, or between health care facilities for ill or injured persons or expectant mothers” (*Minnesota Statutes* 2021, 144E.001, subd. 3). However, many statutes clearly intend that “ambulance service” refer to an organization. For example, “No publicly or privately owned ambulance service shall be operated in the state unless its ambulance service personnel are certified...” (*Minnesota Statutes* 2021, 144E.101, subd. 1(a)).

requires completion of a course that meets standards set by the U.S. Department of Transportation.³ As of July 2021, there were approximately 10,000 EMTs and 3,400 paramedics certified in Minnesota.

Individuals can be registered as EMRs or certified as EMTs or paramedics without working for an ambulance service. For example, all Minneapolis firefighters are certified as EMTs, even though the Minneapolis Fire Department does not operate an ambulance service.

Ambulance services make several different types of responses or “runs.” Most ambulance runs occur in response to 911 calls. In Fiscal Year 2021, ground ambulances responded to approximately 540,000 calls to 911; these responses accounted for about 79 percent of ground ambulance runs in Minnesota. Most of the remaining runs (about 112,000 ground ambulance runs, 16 percent of the total) that year were interfacility transports—that is, transfers of patients via ambulance from one health care facility to another.⁴ Facilities such as hospitals and nursing homes cannot provide interfacility transports themselves without an ambulance service license.



Types of Ambulance Personnel

Least
training

Emergency medical responders (EMRs) are trained to recognize immediate life threats, provide oxygen delivery and cardiopulmonary resuscitation, and control shock and bleeding.

Emergency medical technicians (EMTs) can use basic devices to assist patients to breathe, provide automatic defibrillation, and administer basic medications.

Paramedics can provide advanced care, including insertion of breathing tubes, advanced heart monitoring, and administration of intravenous medications.

Most
training

Role of Ambulance Services

Ambulance care and transport is part of a larger category known as “emergency medical services.” This system includes not only ambulances, but communications and transportation networks, hospitals, trauma centers, and fire and police departments.

Ambulance services combine both public safety and health care functions.

Like public safety organizations—such as fire and police departments—the general public expects ambulance services to be available at all times at any location in response to 911 calls. Like other public safety services, ambulance care is available to all, regardless of income or place of residence. Another similarity is that ambulance crews are expected to deal with sudden, unexpected crises that most members of the general public are unprepared to handle.

³ *Minnesota Statutes* 2021, 144E.001, subds. 5c and 5e; and 144E.28, subd. 1. The Emergency Medical Services Regulatory Board also certifies advanced EMTs, community EMTs, and community paramedics. Approximately 300 people held one of these other certifications in Minnesota as of July 2021.

⁴ The remaining 5 percent were other miscellaneous runs, such as “standby” runs, when an ambulance is on site at a sporting event in case an athlete is injured.

As with fire and police departments, consumers do not choose which ambulance service responds to a 911 call. In Minnesota, 911 calls are generally answered by staff who work for county sheriffs' offices. Dispatchers determine which emergency services, including ambulance services, to dispatch based on the information the caller provides.



Ambulance Runs

A "run" occurs when an ambulance is dispatched to a scene. The term can encompass both emergency and nonemergency responses, responses that do not result in a patient transport, and responses that are cancelled while en route due to false alarms or other reasons.

However, ambulance personnel also function as health care providers. They may provide health care both on scene and during transport to a hospital. Similar to other forms of health care, ambulance personnel must make medical decisions regarding patients' conditions and treatments. It is important for ambulance personnel to keep up-to-date on changes in recommended practices and the use of new equipment.

Ambulance services, like other health care providers, rely on billing patients for revenue. Ambulance services bill individuals or their insurance providers based on the level of care they provide. Fire and police services, in contrast, are typically funded through property taxes and state-provided local government aid; they do not receive the majority of their revenues from directly billing individuals.

Levels of Care

State statutes recognize two levels of health care provided by ambulance services: basic life support and advanced life support.⁵ The distinction between these two levels also exists in federal regulations.⁶

- **Basic life support (BLS).** All ambulances operating in Minnesota must be able to provide BLS care. BLS care can include delivering oxygen, providing intravenous fluids (without medication), placing devices into the mouth and pharynx to assist breathing, and administering a very limited set of medications. BLS care providers should recognize serious or life-threatening conditions and transport patients to a facility that can address their needs. An ambulance crew providing this level of service must include at least one EMT.⁷

⁵ The definitions we present are not absolute. The exact dividing line between basic and advanced care varies among providers.

⁶ 42 *CFR*, sec. 414.605 (2020). Federal regulations further divide advanced life support services into two levels, ALS-1 and ALS-2. This distinction is not recognized in Minnesota law.

⁷ State law allows services offering BLS care in most of outstate Minnesota to staff their ambulances with only one EMT and one EMR; the EMT must accompany the patient in the ambulance. For BLS services in Duluth, Mankato, Moorhead, Rochester, St. Cloud, and the seven-county Twin Cities metropolitan area, two EMTs are required, unless the service is based in a community with a population of less than 2,500 (*Minnesota Statutes* 2021, 144E.101, subd. 6(e)).

- **Advanced life support (ALS).** ALS care can only be provided by ambulance services that operate with an ALS-level license. In addition to offering the same care as BLS services, ALS ambulance staff can administer many more medications—including narcotics—and can perform more sophisticated procedures, such as advanced heart monitoring or insertion of a breathing tube directly into the trachea (windpipe). To provide ALS service, state law requires an ambulance to be staffed, at a minimum, with one person with paramedic training and one EMT.⁸

Statutes require each ambulance service to have a medical director—a physician with experience providing emergency care.⁹ Medical directors oversee the ambulance service’s guidelines for triage, transportation, and treatment. Medical directors may choose to use standard templates for the guidelines, or they may write their own guidelines within certain parameters. Medical directors must also annually assess the practical skills of their service’s personnel and ensure that they follow standards and procedures the director has established.

Ambulance service levels of care vary substantially. Persons with the same medical conditions receive different care based on where they are when they need an ambulance.

The type of care available to a patient depends on whether the responding ambulance service provides ALS or BLS care. An ALS service can provide a patient with intravenous medication or perform an emergency surgical procedure to enable a patient to breathe; a BLS service cannot do either. ALS services predominate in the Twin Cities metropolitan region and in outstate population centers such as Duluth, Mankato, Rochester, and St. Cloud; locations in Minnesota that have only BLS services tend to be rural.¹⁰ An ALS service would respond to a 911 call from a patient who has a heart attack at their home in a Twin Cities suburb.

However, a BLS service would likely respond if that same person were to have a heart attack during a hunting or fishing trip in parts of northern Minnesota. In Chapter 3, we present a map showing the distribution of ALS and BLS coverage around the state.



488,742

Total ground ALS 911 runs,
Fiscal Year 2021

47,245

Total ground BLS 911 runs,
Fiscal Year 2021

⁸ *Minnesota Statutes* 2021, 144E.101, subd. 7. Ambulance services that demonstrate hardship may receive a variance to operate an ALS ambulance staffed by one EMR driver and one paramedic. Only ambulance services primarily operating outside of Duluth, Mankato, Moorhead, Rochester, St. Cloud, and the seven-county Twin Cities metropolitan area are eligible for such a variance.

⁹ *Minnesota Statutes* 2021, 144E.101, subd. 1(b); and 144E.265.

¹⁰ In this report, we follow the regional designations that are used by the eight regional emergency medical services programs, which we discuss later in this chapter. Using that definition, the Twin Cities metropolitan region includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, and Washington. “Outstate” refers to all other Minnesota counties.

Although patients in locations served by BLS services do not immediately have access to ALS care, nearly all BLS services have arrangements with the nearest ALS services to provide backup assistance for patients needing advanced care. Generally, the BLS service will begin transporting the patient to a hospital and, while en route, a paramedic from an ALS service will meet the BLS ambulance and provide the patient with ALS care for the remainder of the trip to the hospital. Such “ALS intercepts” enable patients to receive more advanced care, though they may not receive that care at the scene of the incident. Similarly, for especially severe injuries or medical conditions, BLS or ALS services may seek backup from air ambulance services, all of which provide ALS care.

While each ambulance service provides BLS or ALS care, the specific medical procedures its ambulance crews provide depend on the treatment protocols set by the service’s medical director. Variations may occur because each medical director can set their own protocols. For example, a medical director for one BLS service may authorize its EMTs to administer a particular drug—such as glucagon, which is used to treat very low blood sugar—while the medical director for a neighboring BLS service does not. We discuss medical direction further in Chapter 4.

Organizational Models

Ambulance services have a variety of organizational forms.

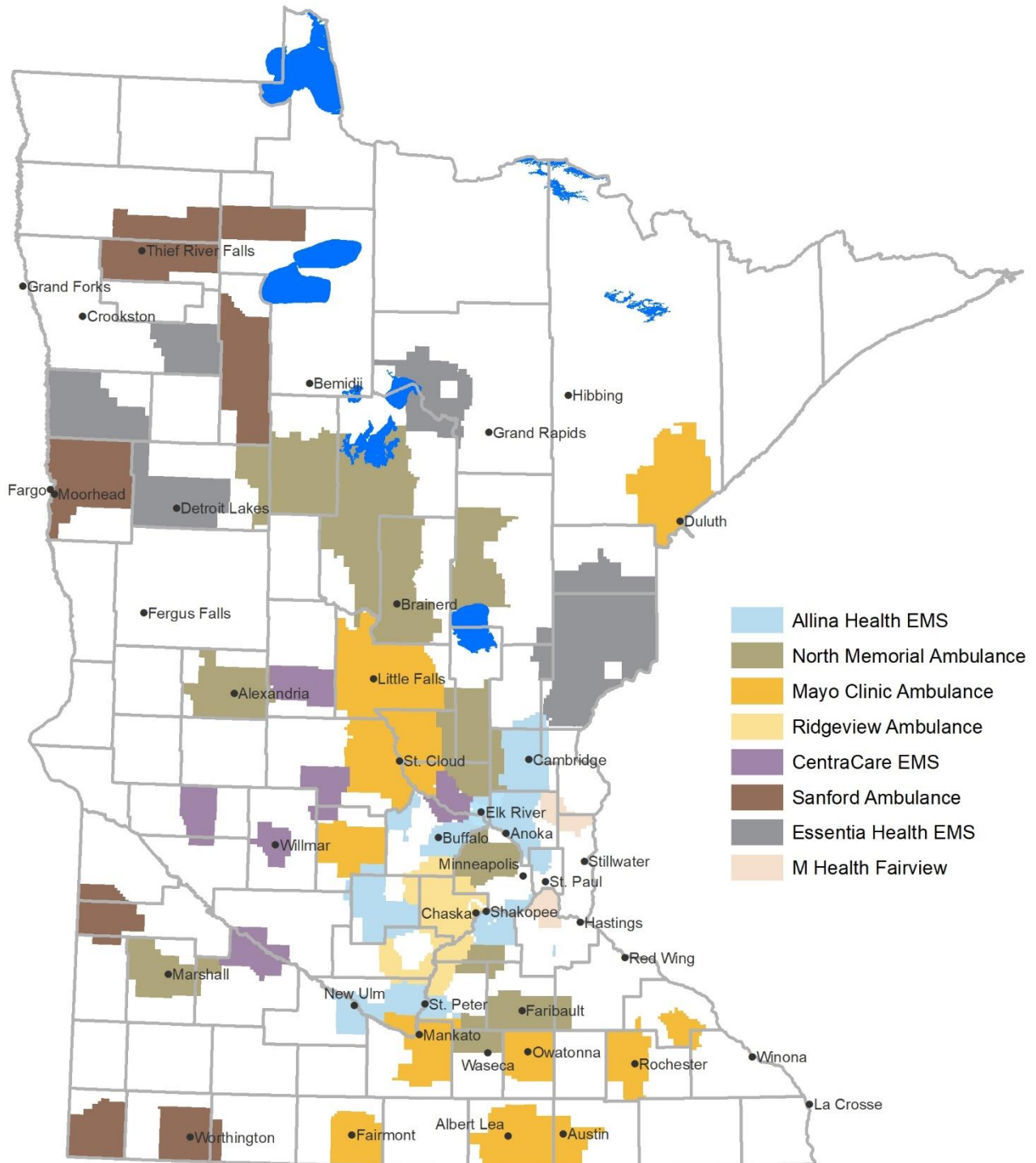
Ambulance services in Minnesota are operated by local governments, tribes, health care systems, or private organizations.

Units of government operate many ambulance services in Minnesota. These include services operated by cities, such as Dodge Center Ambulance Service; services operated by tribal governments, such as Grand Portage Ambulance; and those formed through joint powers agreements, such as the Lower St. Croix Valley Fire Department.¹¹

Another large category of ambulance services in Minnesota are services run by health care systems. Examples include Allina Health Emergency Medical Services, Mayo Clinic Ambulance, and North Memorial Ambulance. These systems often operate services in several different locations in the state, as shown in Exhibit 1.1. For example, Allina Health Emergency Medical Services provides ambulance care and transport in 12 geographic areas encompassing parts of the Twin Cities metro area as well as cities like Buffalo, Cambridge, Glencoe, Hutchinson, and New Ulm.

¹¹ Several ambulance services operated by tribes hold state licenses. Our evaluation did not explore tribal sovereignty with regard to state licensing of ambulance services.

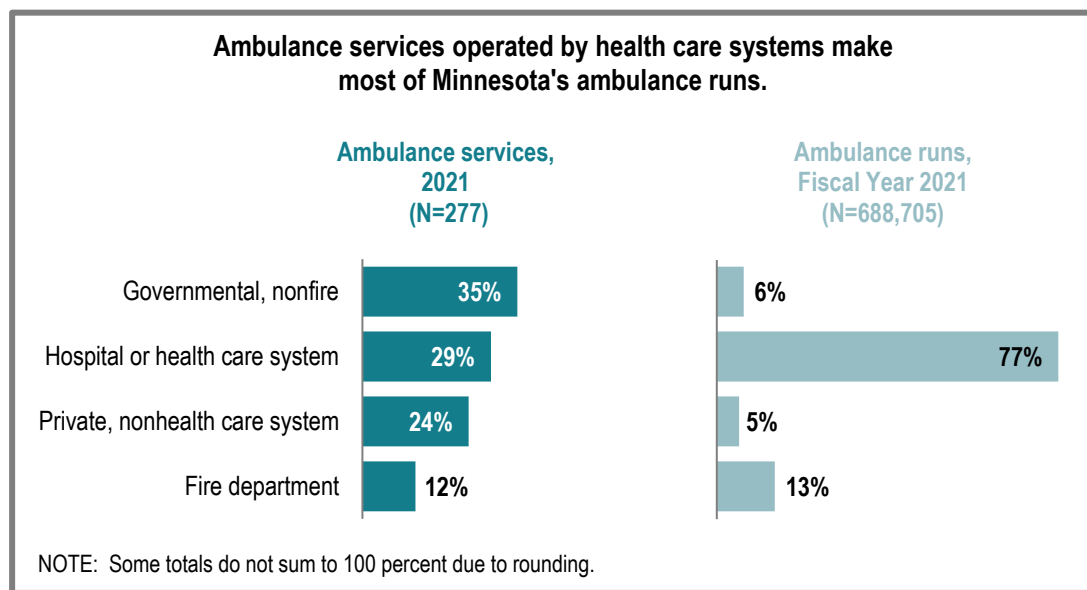
Exhibit 1.1: Several health care systems run ambulance services in multiple service areas.



NOTES: Areas that overlap with other services are not shown. For maps showing overlaps, see the Appendix.

SOURCE: Office of the Legislative Auditor, analysis of Emergency Medical Services Regulatory Board data.

Some ambulance services are private and nonprofit but are not affiliated with a health care system, such as Lake County Ambulance, Tracy Ambulance, and Winona Area Ambulance. A few private, for-profit ambulance services also exist, such as Ringdahl EMS, which operates in Fergus Falls, Pelican Rapids, and locations in North Dakota; Ortonville Ambulance; and Stevens County Ambulance.



Just under one-half of the ambulance services in Minnesota are operated by units of government. The remaining services are almost evenly split between private providers affiliated with a health care system, and those without such an affiliation. Although government-operated ambulance services are the most prevalent services in Minnesota, they do not go on the majority of ambulance runs. In Fiscal Year 2021, health care system-based services provided 77 percent of all runs, and government-based services provided 19 percent of those runs.

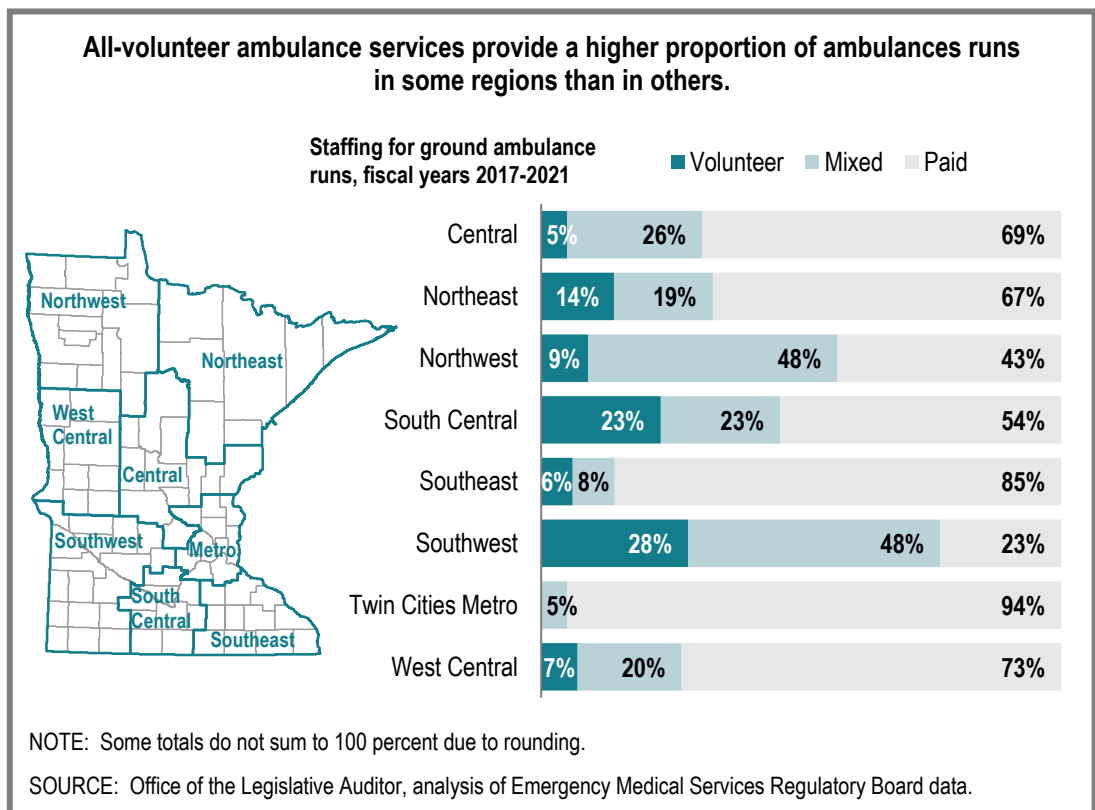
Some ambulance services rely heavily or entirely on volunteers to staff their ambulances.

As we discussed earlier in this chapter, ambulances are generally staffed by personnel who hold EMT or paramedic certifications. These personnel may be paid staff, or they may be volunteers. Volunteers, like paid staff, must hold registrations or certifications from EMSRB to serve on ambulance crews. Many ambulance services pay volunteers a stipend.¹² Some services pay a nominal stipend whenever a volunteer is on call; when the volunteer goes on an ambulance run, the service pays an additional per-hour stipend. For example, one rural service we spoke with pays volunteers \$10 per shift to be on call for a 12-hour weekday shift, and \$12 per shift for a 12-hour weekend shift. When this service's staff respond to a call, the service pays EMRs an additional \$11 per hour and pays EMTs an additional \$13 per hour. Other services, by contrast, simply pay volunteers a flat amount per shift.

¹² State statutes define a "volunteer ambulance attendant" as a person who earns no more than \$6,000 per year through their stipend or other nominal fees (*Minnesota Statutes* 2021, 144E.001, subd. 15).

Because volunteers are often “on call” and not situated at a central location, volunteer crews are dispatched through a multistep process. Typically, an on-call volunteer receives a page that the ambulance service is needed, leaves their home or workplace, and goes to where the ambulance is located. Once the full crew of two persons has arrived, they proceed to the scene of the emergency in the ambulance. To provide BLS service in most areas of outstate Minnesota, at least one crew member must have at least an EMT certification, while a second crew member must have at least an EMR registration.¹³

An ambulance service’s workforce may consist of all paid staff, all volunteers, or a mix of the two. As shown in the box below, about one-quarter of ambulance runs during the most recent five fiscal years in south central and southwestern Minnesota were provided by ambulance services with an all-volunteer workforce. By contrast, runs in the Twin Cities metro and southeast regions were provided largely by services with all-paid workforces, with little use of volunteers. We discuss volunteer staffing further in Chapter 5.



State Regulation

The Emergency Medical Services Regulatory Board (EMSRB) is the state agency that regulates ambulance care and transport in Minnesota. EMSRB is a 19-member board whose members, by statute, must include a certified emergency physician; representatives of hospitals, fire chiefs, professional and volunteer firefighters, sheriffs,

¹³ *Minnesota Statutes* 2021, 144E.101, subd. 6(e).

community health boards; an ambulance director; and others. As of January 2022, EMSRB employed nine full-time-equivalent staff members and one student worker.

Authority

EMSRB began operating in 1996, prior to which its responsibilities had been performed by the Minnesota Department of Health. EMSRB has the authority to license



EMSRB has the authority to:

- License ambulance services.
- Certify or register emergency medical services personnel.
- Inspect ambulance services.
- Make recommendations to the Legislature for improving the state's emergency medical services system.
- Investigate complaints about ambulance services and crew members.
- Prepare a biennial work plan.
- Collect data on each ambulance run in the state and financial data on each ambulance service.
- Distribute grant funds related to training, equipment, operations, communications, public engagement, and regional coordination.

— *Minnesota Statutes 2021, Chapters 144E and 62J.49*

ambulance services and investigate complaints about the services, among other things. We briefly list EMSRB's responsibilities in the box at left; we discuss its performance in greater detail in Chapter 6.

Licensing helps ensure that every ambulance service operating in Minnesota meets minimum requirements in state law. Inspections and complaint investigations also ensure that services comply with state requirements, especially requirements that protect patients receiving emergency care. Statutes do not require EMSRB to inspect ambulance services but give the agency the authority to conduct inspections “as frequently as deemed necessary.”¹⁴ During an inspection, EMSRB staff review documentation and check to see whether ambulances are properly stocked with the supplies and equipment needed to provide either ALS or BLS service. An inspection may result in a correction order to bring the ambulance service into compliance with the law. For example, a service may need to restock expired medication.

Another key EMSRB function is investigating the complaints it receives about ambulance services and personnel. Anyone who has knowledge of impermissible conduct—such as maltreatment of a patient, stealing narcotics, providing services under lapsed credentials, or other conduct prohibited by statute—may file a complaint with EMSRB.¹⁵ Ambulance service license holders with knowledge of such conduct are mandated by statute to report it to EMSRB.¹⁶ EMSRB staff investigate such complaints, as appropriate. A committee of the EMSRB board then reviews the investigation results and may make a recommendation for disciplinary action to the full board. For example, the committee may recommend that the board deny, suspend, or revoke an EMT certification. License holders must also report to EMSRB the dismissal of EMRs, EMTs, and paramedics from employment.¹⁷

¹⁴ *Minnesota Statutes 2021, 144E.18.*

¹⁵ *Minnesota Statutes 2021, 144E.305, subd. 1.* Conduct that may result in a denial, suspension, or revocation of an EMSRB certification is specified in *Minnesota Statutes 2021, 144E.28, subd. 5.*

¹⁶ *Minnesota Statutes 2021, 144E.305, subd. 2(a).*

¹⁷ *Minnesota Statutes 2021, 144E.305, subd. 2(b).*

Expenditures

EMSRB's annual expenditures for its operations ranged between approximately \$1.1 million and \$1.4 million in inflation-adjusted 2020 dollars in fiscal years 2012 to 2020. In Fiscal Year 2021, EMSRB's operations expenditures rose to approximately \$1.7 million. For the 2022-2023 biennium, EMSRB has a total budget of about \$9.4 million. This budget includes \$1.9 million per year for EMSRB's operations, about \$1.8 million per year for grant programs, and about \$1 million per year for a program that provides monetary awards to volunteer ambulance crew members upon their retirement based on their length of service.

EMSRB distributes most of its grant funds among eight regional emergency medical services organizations. The map in the box on page 10 depicts the regions. The regional organizations support the ambulance services of each region through promoting cost-effective delivery of emergency medical care throughout the state. They enable the sharing of ideas and resources across ambulance services in their regions, and they offer training and continuing education, among other services.

Chapter 2: Primary Service Areas

One distinctive feature of Minnesota’s emergency medical services system is the use of “primary service areas,” through which an ambulance service’s license to provide ambulance care is tied to the geographic area where it operates.¹ When applying for a license, an ambulance service must declare its intention to be responsible for ambulance care and transport throughout a primary service area, which is defined in statute as “the geographic service area that can reasonably be served by an ambulance service.”² Several other states have a system where ambulance services cover specific geographic areas, but Minnesota’s approach—which limits competition and does not allow local governments to choose their ambulance service—is unusual.

Key Findings in This Chapter

- Primary service areas are a means of promoting access to emergency medical services.
- EMSRB has little authority to alter primary service area boundaries without the cooperation of the ambulance services that hold the corresponding licenses.
- The extent of local government control over who provides ambulance service in a community depends on historical precedent.

Minnesota is divided into more than 250 different primary service areas, as we show in the maps in the Appendix. The size of primary service areas—and the size of the populations within them—varies greatly. Some primary service areas are fewer than 50 square miles, while others are larger than 1,000 square miles.

In this chapter, we describe Minnesota’s primary service area system in detail, exploring its intended purpose, discussing how it has been implemented over time, and explaining its implications for local control.

Purpose

The primary service area system was developed in the early 1980s by the Minnesota Department of Health (MDH), after the 1979 Legislature extensively revised the state’s ambulance laws.³ The Emergency Medical Services Regulatory Board (EMSRB) inherited the primary service area system and its associated laws and rules when the 1995 Legislature created the board.⁴

¹ Primary service areas do not apply to air ambulance services. See *Minnesota Statutes* 2021, 144E.12.

² *Minnesota Rules*, 4690.3400, subp. 2E, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021; and *Minnesota Statutes* 2021, 144E.001, subd. 10.

³ *Laws of Minnesota* 1979, Chapter 316.

⁴ *Laws of Minnesota* 1995, chapter 207, art. 9, sec. 35.

Primary service areas are a means of promoting access to emergency medical services.

A key theoretical underpinning of the primary service area model is the guarantee of access.⁵ Upon receiving a license, an ambulance service obtains the right (usually, the exclusive right) to operate in a certain geographic area, but in return, it commits to providing ambulance care and transport for the entire area.

Within area boundaries, the licensee must ensure 24-hour coverage every day of the year.⁶ An ambulance service may not deny ambulance care to anyone within the primary service area based upon the individual's

ability to pay.⁷ Further, each ambulance service must have an agreement with one or more neighboring services to provide “mutual aid” backup coverage within the primary service area whenever the service lacks resources to respond itself.⁸



Primary Service Area

A primary service area is a geographic area in which an ambulance service provides ambulance care and transport. State law requires that every ambulance service license be tied to a primary service area (except for air ambulance services).

In addition, the primary service area model creates a mechanism to support access to ambulance care and transport in many low-population areas in Minnesota. Many primary service areas encompass both a population center and smaller surrounding communities. These smaller communities may not have a large enough population to support an ambulance service themselves, but their residents receive ambulance care because these communities are grouped together with a larger municipality.



Without primary service areas there could be pockets of uncovered areas because of the lack of volume...to generate revenue from calls. If City A has a large population and City B right next door does not have a large population, services may not want to be responsible for City B because it doesn't generate enough calls to support an ambulance service—so they are left without ambulance coverage. With the current [model] we are responsible for everything in that primary service area.

— Ambulance service director

Further, once an ambulance service obtains a license to serve a primary service area, it must continue to serve the entire area even if some portions of the area are less profitable than others. An ambulance service may not retract service from any portion of its primary service area without ensuring that another ambulance service will provide coverage in its place.⁹

⁵ The following discussion is based on our interviews with EMSRB staff and board members and documents describing the primary service area system produced by MDH in the 1980s and 1990s. We also infer the Legislature's intent, in part, from its decision to incorporate into statutory language elements of a 1977 Minnesota Supreme Court decision. In that case, the Court found that the state had a legitimate interest in limiting the number of ambulance services operating in the same area to protect the public welfare from “deleterious competition” (*Twin Ports Convalescent, Inc., v. Minnesota State Board of Health*, 257 N.W.2d 343, 348 (Minn. 1977)).

⁶ *Minnesota Statutes* 2021, 144E.101, subd. 3; and 144E.101, subd. 12.

⁷ *Minnesota Statutes* 2021, 144E.101, subd. 4.

⁸ *Minnesota Statutes* 2021, 144E.101, subd. 12.

⁹ *Minnesota Statutes* 2021, 144E.07, subd. 2.



Specialized Services

As we discuss in Chapter 3, a few ground ambulance services, licensed as “specialized” services, provide only transportation between medical facilities (for example, transporting a patient from an acute care hospital to a long-term recovery facility).

Because these services do not respond to 911 calls, EMSRB (and MDH before it) has not required them to specify primary service areas when applying for or renewing their licenses. Thus, our descriptions in this chapter of how ambulance services operate within primary service areas do not necessarily apply to specialized services.

Allowing specialized services to operate without primary service areas does not technically comply with the law. However, we consider it an instance where statutes have not kept pace with actual ambulance service practices. We recommend that the Legislature update the state’s ambulance laws in Chapter 6.

Another way that primary service areas promote access to ambulance care is by limiting competition, and thus supporting the viability of existing ambulance services. Services cannot operate outside their own primary service areas without another service’s permission to enter its area.¹⁰ As a result, ambulance services are guaranteed all business for a certain population base, thus ensuring an income stream. Ideally, this guaranteed income ensures the financial sustainability of the ambulance service, and thus access to ambulance care for individuals in its service area.

For example, in the 1980s, MDH (prior to the creation of EMSRB, but operating under similar statutory language) refused to issue licenses to some applicants that wanted to operate ambulance services in outstate Minnesota solely for interfacility transports.¹¹ MDH found that the local ambulance services that answered 911 calls needed the additional income from interfacility trips to sustain their operations.¹²

Although there is no formal requirement that a geographic area is served by only one ambulance service, statutes direct EMSRB to consider the “deleterious effects on the public health from duplication” whenever it considers a new license application (as we discuss in Chapter 3).¹³ Essentially, statutes direct EMSRB to serve as a gatekeeper for ambulance services, licensing enough services to ensure that ambulance care and transport is available for all, but not licensing additional services unless it can be shown that public health actually benefits from multiple services operating in the same area.¹⁴



The primary service area ensures that the license holder is designated for all ambulance calls originating in that PSA [primary service area]. This includes both the emergency 911 and the interfacility transports. This ensures that another provider can’t just come into a service area and take interfacility transfers and revenue away from the local license holder. This is important because the interfacility transfers in rural areas help offset the cost of providing emergency 911 services.

— Ambulance service director

¹⁰ *Minnesota Statutes* 2021, 144E.101, subd. 13. An ambulance service may also provide service outside its service area if requested by a “transferring physician,” the patient has an immediate medical need, and the ambulance service licensed for the primary service area is unavailable.

¹¹ As we explained in Chapter 1, interfacility transports are when an ambulance transports a patient from one medical facility to another. Unlike 911 ambulance responses, such transfers may be prescheduled or allow ambulance services some flexibility in timing.

¹² In contrast, MDH granted licenses for several interfacility-transport-only services in the Twin Cities metropolitan area; it found ambulance services in the region did not need the additional income from interfacility transports to remain financially viable.

¹³ *Minnesota Statutes* 2021, 144E.11, subd. 6.

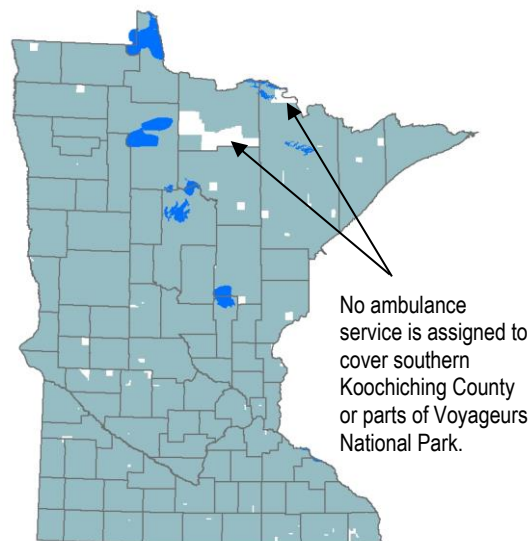
¹⁴ EMSRB cannot deny licenses for air ambulance services in order to limit competition. The Minnesota Supreme Court has ruled that the state cannot preempt the federal authority that permits air taxi services—including air ambulances—to operate. However, the state may regulate the medical care provided by such services by requiring certain levels of training or types of equipment (*Hiawatha Aviation of Rochester, Inc., v. Minnesota Department of Health*, 389 N.W.2d 507 (Minn. 1986)).

While nearly all parts of Minnesota are covered by primary service areas, state law does not require that all Minnesotans have access to ambulance services.

As the map below shows, nearly all areas of the state are within a primary service area, and thus nearly all Minnesotans have guaranteed access to ambulance services. However, there is no legal requirement that every location in Minnesota have ambulance care and transport available. It is up to local initiative (either public or private) to develop an ambulance service. Organizations or individuals apply to deliver ambulance care and transport within a specific geographic area. If an existing ambulance service closes and no one successfully applies to cover the area, there could be no service.

Currently, there is a swath of sparsely populated area in southern Koochiching County with no assigned ambulance service, and no ambulance service is assigned to provide coverage in parts of Voyageurs National Park. However, even though no ambulance service has formal responsibility for those locations, nearby ambulance services do cover those areas. Any ambulance service *can* respond to calls in unassigned territory; however, their license does not *require* them to do so.¹⁵

Nearly all areas of the state are within an ambulance service's primary service area.



NOTE: The map shows county boundaries. For primary service area boundaries, see the Appendix.



Practices in Other States

Unlike Minnesota, Pennsylvania law declares that emergency medical services are an “essential public service.” A clause at the start of the chapter in Pennsylvania statutes on emergency medical services further states that “This chapter shall be liberally construed to establish and maintain an effective and efficient emergency medical services system which is accessible on a uniform basis to residents of this Commonwealth and to visitors to this Commonwealth.”

— 35 *Pennsylvania Consolidated Statutes*, sec. 8102(8)

Minnesota is not unusual in having no statewide requirement concerning ambulance care. Gaps in coverage have occurred in other states. For example, Michigan regulators told us they are currently struggling to find solutions for ambulance coverage in portions of the Upper Peninsula. Ambulance services that used to provide service in those regions have closed, and no other services have taken their places. The regulators told us that people with medical emergencies in that region have waited a long time for ambulances to arrive from distant services.

¹⁵ The map shows a number of other small areas with no assigned ambulance service; we believe these are mostly recordkeeping errors by EMSRB (possibly inherited from MDH).

According to a 2019 report from NBC News, only 11 states require that emergency medical services be available statewide.¹⁶

Limits on Regulatory Authority

The law regarding primary service areas places substantial limits on EMSRB's authority to define, administer, or alter primary service areas once they are created.

EMSRB does not draw primary service area boundaries; primary service areas are defined by the ambulance services themselves.

Primary service areas are defined by ambulance services in their applications for an initial ambulance service license.¹⁷ EMSRB can approve or deny the license application, but it does not draw primary service areas itself.

As noted above, primary service areas were first created in the early 1980s, when MDH regulated ambulance services. According to descriptions of the process written in the 1980s and 1990s, MDH initially created primary service areas by asking the then-existing ambulance services where they provided coverage during the 1980 relicensing process.¹⁸ There was no formal process for determining whether the size or shape of a primary service area was appropriate or if it accurately reflected where ambulance services were providing coverage.

MDH's process led to widely different primary service areas based on the preferences of the ambulance services then in existence. For example, most of the northern and western suburbs of the Twin Cities are encompassed within large primary service areas covering dozens of municipalities. North Memorial Ambulance covers the northern half of Hennepin County, and Allina Health Emergency Medical Services and M Health Fairview together cover Anoka County. However, many eastern suburbs—such as Mahtomedi, Maplewood, Oakdale, White Bear Lake, and Woodbury—are within small primary service areas comprising little more than a single municipality.

Under state rules, a service area can be any size as long as a service has enough ambulances and ambulance crews to cover it.¹⁹ Several metro-area services use fleets

¹⁶ Erika Edwards, "What if you call 911 and no one comes? Inside the collapse of America's emergency medical services," NBC News, October 22, 2019, <https://www.nbcnews.com/health/health-care/there-s-shortage-volunteer-ems-workers-ambulances-rural-america-n1068556>, accessed January 7, 2022. The 11 states requiring emergency services statewide were Connecticut, Delaware, Hawaii, Indiana, Louisiana, Nebraska, Nevada, Oregon, Pennsylvania, Virginia, and West Virginia.

¹⁷ *Minnesota Rules*, 4690.0200, subp. 1R; and 4690.3400, subp. 1, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021.

¹⁸ See Wayne Arrowood, *Primary Service Areas: Staff Paper Prepared For Licensing and Regulation Subcommittee, Statewide EMS Advisory Task Force* (St. Paul, Minnesota Department of Health, 1989), 3; and Minnesota Department of Health, Occupational and Systems Compliance Division, *Primary Service Areas: A Discussion Guide* (St. Paul, 1995), 2.

¹⁹ *Minnesota Rules*, 4690.3400, subps. 2 and 3, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021. State rules define the maximum geographic limits of a primary service area in terms of travel time or distance from a central "base of operation" or satellite "substations" from which ambulances are dispatched. Because there is no limit to the number of substations, there is no limit on primary service area size.

of ambulances to cover large service areas encompassing hundreds of thousands of residents. Meanwhile, some small rural services use a single ambulance with a rotating volunteer crew to cover a few dozen sparsely populated towns and townships.

Although statutes direct EMSRB to limit duplication of services, EMSRB does not have the authority to resolve primary service area overlaps created decades ago.

There are several locations in the state with significant primary service area overlaps, as shown in maps in the Appendix, and as highlighted in Exhibit 2.1 for the area surrounding Rochester. Where two services have state-granted authority to respond to 911 calls in the same area, both have the right to respond to requests for ambulance care. Further, as the law is currently written, a neighboring ambulance service cannot technically provide mutual aid in an overlapped area unless it determines that neither service that holds a license for the overlapped area is available to respond.²⁰

Exhibit 2.1: Some parts of the state—such as the area around Rochester—have many overlapping primary service areas.



SOURCE: Office of the Legislative Auditor, analysis of Emergency Medical Services Regulatory Board data.

²⁰ *Minnesota Statutes* 2021, 144E.101, subd. 13(2).

Many of these overlaps apparently date back to the original designation of primary service areas in the 1980s. At that time, MDH relied on the proposed areas that ambulance services submitted, regardless of whether they overlapped areas submitted by other services. Although statutes direct EMSRB to consider the “deleterious effects on the public health from duplication” when reviewing initial license applications, there is no statutory or regulatory prohibition on primary service areas overlapping.²¹

Where service areas overlap, 911 dispatch centers and local ambulance services generally must work out among themselves how dispatchers will assign calls to ambulance services. However, as a practical matter, 911 dispatch centers will not ordinarily dispatch two different ambulance services for the same call.²²

State law does not empower EMSRB to resolve overlapping areas without the cooperation of the services involved.²³ Although EMSRB has tried to resolve these overlaps for years, it can only encourage ambulance services to reach agreements among themselves to voluntarily cede portions of their territory. However, EMSRB staff told us that some services are resistant to giving up sections of their primary service areas.

EMSRB has little authority to alter primary service area boundaries without the cooperation of the ambulance services that hold the corresponding licenses.

Once an ambulance service obtains a license with a corresponding primary service area, it retains the right to provide service in that area as long as it maintains its license. There are no clear provisions in state law for EMSRB to alter primary service area boundaries, even if EMSRB finds a public health benefit to doing so.²⁴

For example, EMSRB cannot displace an ambulance service if another service providing a higher level of care successfully applies for a license to cover part or all of the same area. Even if EMSRB determines that the new service would provide superior care, it would only be able to license the new service to duplicate coverage in the same area as the existing service. It could not unilaterally take the primary service area away from the existing service.

EMSRB also does not have the ability to redraw primary service areas in response to changes in ambulance service capabilities, population, demographics, roadway infrastructure, hospital services or locations, or other social and technological changes.

²¹ *Minnesota Statutes* 2021, 144E.11, subd. 6(2).

²² A dispatch center might dispatch two different services if a second service can provide a higher level of care, though that could happen anywhere (not just in an overlapped location) as long as there are appropriate mutual aid agreements among the services involved. For example, for a severe trauma injury, a dispatcher could send both an EMT-staffed unit from the closest service, and a paramedic-staffed ground or air unit from another service that would take longer to arrive but could provide additional care.

²³ *Minnesota Statutes* 2021, 144E.07, subd. 3.

²⁴ State statutes only direct EMSRB to adopt “rules defining primary service areas under which the board shall designate each licensed ambulance service as serving a primary service area or areas” (*Minnesota Statutes* 2021, 144E.06).

For example, M Health Fairview holds two primary service areas for 911 response in the Twin Cities metropolitan area, one based in Eagan and one in Forest Lake. Since primary service areas were first delineated in the 1980s, the first area has approximately doubled in population, the second has approximately quadrupled. EMSRB has no ability to adjust these primary service area boundaries as these populations continue to grow, unless the service itself requests a change.



Practices in Other States

Like Minnesota, Connecticut uses primary service areas to assign ambulance services to the territories they serve. However, unlike Minnesota, Connecticut's Department of Public Health has the authority to revoke a primary service area if it finds that doing so is in the best interest of patient care.

Connecticut law also creates a process for local governments to petition the Department to revoke a primary service area when serious performance concerns arise.

EMSRB can take a primary service area away from an ambulance service only by revoking or not renewing its license, which it can do only through a finding that the ambulance service has violated the state's ambulance laws or is no longer providing the services for which it is licensed.²⁵ However, even if it revokes a service's license, EMSRB does not have the authority to delineate new primary service area boundaries.

As described above, it would still have to rely on new applicants to define in their applications any new primary service area boundaries for the location where the previous ambulance service had operated.

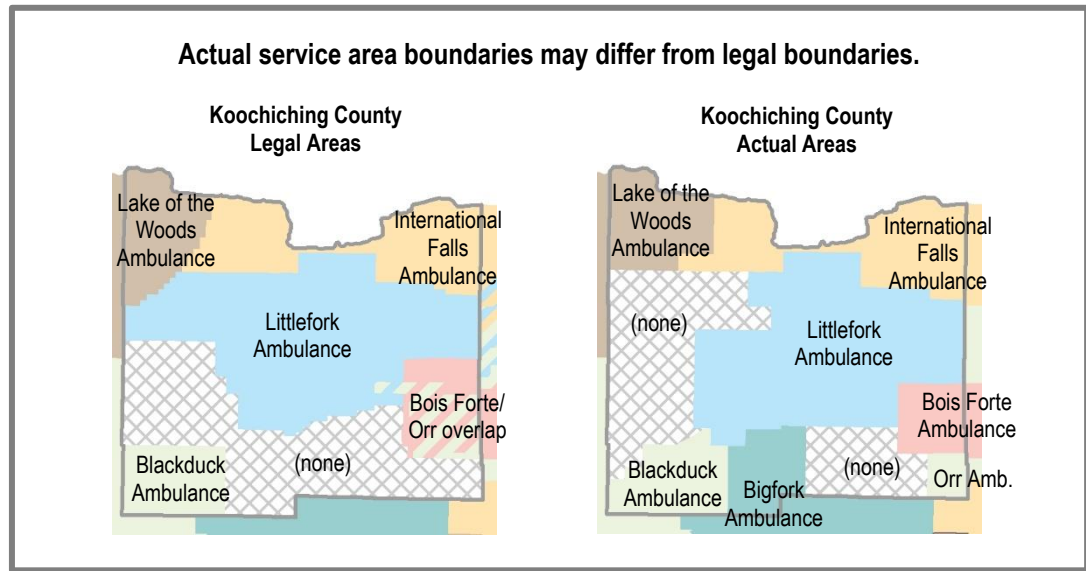
As far as we are aware, most changes to primary service areas since their original formation in the 1980s have been modifications sought by the services themselves (EMSRB must approve all boundary changes). Some areas have been merged together as ambulance services have closed or been acquired. At other times, services have traded or ceded small portions of their primary service areas that were more easily served by others.

Actual service boundaries may differ from the legal primary service area boundaries assigned by EMSRB.

Technically, state law prohibits an ambulance service from operating outside of its primary service area boundaries without the permission of the ambulance service that holds the license for that area.²⁶ However, EMSRB does not attempt to monitor the areas in which ambulance services actually respond to calls unless it receives a complaint. In some instances, the service areas that are actually in use have been worked out locally by ambulance services and 911 dispatch centers, and do not follow the EMSRB-designated boundaries. For example, as the box on the next page shows, the legal service area boundaries in Koochiching County differ substantially from the actual areas in which ambulance services provide care and transport.

²⁵ *Minnesota Statutes* 2021, 144E.19, subd. 1; and 144E.31, subd. 4.

²⁶ *Minnesota Statutes* 2021, 144E.101, subd. 13.



Implications for Local Control

As we explained above, once a primary service area is defined, it persists unless the ambulance service itself seeks to change it. As a result, historical decisions have created significant differences in local control of ambulance services across Minnesota.

The extent of local government control over who provides ambulance service in a community depends on historical precedent.

A local unit of government's amount of control over its ambulance service provider depends largely on what entity ran an ambulance service in the area in the early 1980s. Communities that ran their own ambulance service at that time obtained primary service

areas when MDH initially created them. However, where ambulance services were run by private firms, hospitals, or nonprofit organizations, those entities obtained the primary service areas.

As a result, there are disparities in local control throughout the state. For example, in the Twin Cities metropolitan area, St. Paul, Chaska, and White Bear Lake either run ambulance services or contract with others to provide ambulance services within their city limits; Minneapolis, Eagan, and Roseville do not. In outstate Minnesota, International Falls, Marshall, Red Wing, and Sauk Centre control who provides ambulance service in their cities; Duluth, Fergus Falls, Mankato, and Willmar do not.



A Tale of Two Cities

St. Paul: The St. Paul Fire Department provides ambulance care and transport for 911 calls. If residents of St. Paul are unhappy with their ambulance care, they can complain to city government—their city councilperson, the mayor, or the fire department. The city can require changes to improve the satisfaction of constituents.

Minneapolis: Hennepin EMS and North Memorial Ambulance provide ambulance care and transport for most 911 calls. If residents of Minneapolis complain to city leadership about their ambulance care, their city leadership has no authority to require changes. Hennepin EMS and North Memorial are part of large private health care corporations.

Variations in local control also create variations in ambulance service funding and revenues. Cities that run their own ambulance service may gain additional money if revenues exceed expenses, but may also lose money and be forced to subsidize the service if expenses exceed revenues. In locations where private firms, hospitals, or nonprofits run ambulance services, those entities bear the financial risks and local governments do not.

Local governments that do not already control ambulance provision in their communities have no easy way of gaining control. To do so, a city would have to apply to EMSRB for a new ambulance service license to cover an area that already has coverage. Since there is no way for an applicant to request that another service *lose* a portion of its primary service area, the applicant would have to show that the public health is served by having *two* ambulance services cover the same geographic area despite the requirement that EMSRB consider the “deleterious effects on the public health from duplication” when determining whether to grant a license.²⁷ Further, past court decisions have found that state law places the burden of proof on the applicant; absent persuasive evidence to the contrary, EMSRB can simply assume that increased competition would negatively affect public health.²⁸



Once a PSA [primary service area] is decided, it is “set in stone” and is inflexible and almost impossible to change. Theoretically, we know a PSA could be changed. But in practice, it is impossible.

— Ambulance service director

Conversely, it is straightforward for a licensee to maintain control of a service area once it is obtained. As we discuss in Chapter 3, a license holder does not need to provide ambulance service itself; it can contract out the provision of ambulance service to another entity while continuing to hold the license and control the service area. Thus, some municipalities that have long since ceased running their own ambulance services continue to control who provides ambulance service in their jurisdictions.

In one example, the city of Chaska decided in 2007 to shift its ambulance service provider from Allina Health Emergency Medical Services to Ridgeview Ambulance Service. Because Chaska had once had its own ambulance service and had retained its license and primary service area, it was able to discontinue its contract with Allina and reach a new contract with Ridgeview. By comparison, nearby Eden Prairie would be unable to make such a decision. Hennepin County Medical Center, not the city, holds the license for providing ambulance service in Eden Prairie.

Similarly, nongovernmental license holders may continue to retain their licenses while contracting out to others. For example, Fairview Health Services obtained the ambulance license for the primary service area around Forest Lake when it absorbed District Memorial Hospital in the 1990s. It retained the license for the following two decades while contracting with North Memorial Ambulance to provide service to the area. After Fairview Health Services merged with HealthEast Care System to form the entity now called M Health Fairview, the new organization ended its contract with North Memorial and began providing ambulance service itself in the Forest Lake area, using the license it had retained.

²⁷ *Minnesota Statutes* 2021, 144E.11, subd. 6(2).

²⁸ See *North Memorial Medical Center v. Minnesota Department of Health*, 423 N.W.2d 737, 739 (Minn. Ct. App. 1988); and *In re License Application of Rochester Ambulance Service*, 500 N.W.2d 495, 498-499 (Minn. Ct. App. 1993).

Although local governments may have little say in *who* delivers ambulance service, they sometimes have more ability to influence *how* service is delivered. Many ambulance services receive public funding or other governmental resources (such as garage and office space). Where this is the case, local governments may exert influence over ambulance service operations. One county official we interviewed described to us a meeting between county staff and an ambulance service run by a nonprofit organization that had not been providing satisfactory service. Because the county periodically provided funding that enabled the ambulance service to purchase new vehicles, it was in a position to insist that quality improvements occur.

Further, state law permits local units of government to establish local standards for ambulance services that may go beyond those enforced by EMSRB.²⁹ As far as we are aware, Hennepin County is the only jurisdiction in the state that has created such standards.³⁰ We discuss local standards further in Chapter 4.



The extent of local control varies by organizational model.

All of the following organizational arrangements exist in Minnesota.

More local control

- The local government runs its own ambulance service. *Examples: Dodge Center, International Falls, St. Paul.*
- The local government contracts with another entity to provide ambulance service. *Examples: Chaska, Marshall, Walker.*
- A consortium of local governments runs an ambulance service under a joint powers agreement. *Examples: Cloquet, Perham, southern Washington County.*
- A nongovernmental entity runs the ambulance service, but relies on some local government funding. *Examples: Albert Lea, Cambridge, Crookston.*
- A nongovernmental entity runs the ambulance service, but is subject to locally enacted standards and rules. *Examples: Bloomington, Minneapolis.*
- A neighboring local government runs the ambulance service. *Examples: townships that surround Hibbing, Red Wing, Sauk Centre.*

Less local control

- A nongovernmental entity runs the ambulance service without local oversight. *Examples: Duluth, Rochester, Stillwater.*

Communities with small populations may have less control over ambulance services.

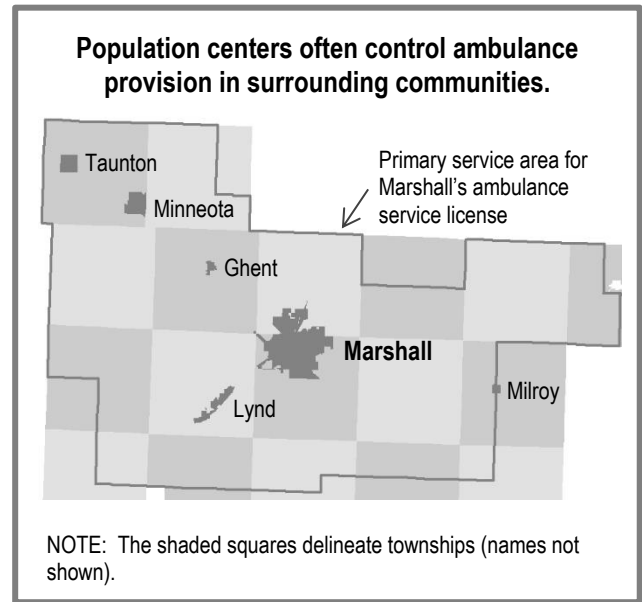
Even when a local government does control the ambulance service in a primary service area, frequently only the largest city in the service area truly has “local control.” Surrounding townships and small municipalities are generally subject to the decisions made by the largest city.

²⁹ *Minnesota Statutes* 2021, 144E.16, subd. 5. EMSRB must approve locally created standards.

³⁰ We refer here to standards that apply to nongovernmental ambulance services, not ordinances or policies regarding the ambulance services that local governments operate themselves.

For example, the city of Marshall controls the ambulance service for its primary service area. As shown in the box at right, Marshall's primary service area encompasses several smaller municipalities and all or part of more than a dozen surrounding townships. Marshall is the only local government within the primary service area that controls its ambulance service.

However, a population center's control over ambulance care in surrounding communities may come with a cost. In many smaller Minnesota cities, municipally run ambulance services are unable to cover all of their costs through billing and receive public funding for a portion of their



We are stuck in that PSA [primary service area], it is too large and we cannot give it up. We as a city entity are sending resources and services outside of our political boundaries and nobody is paying for it. We are trying to start a taxing district, but there is no lever to get the county to contribute, they know we are tied to the PSA.

— Ambulance service director

and receive public funding for a portion of their budgets. Although it is not uncommon for neighboring localities to help pay for the costs of providing ambulance service for their residents, there is no state requirement that they do so. The ambulance service licensee must provide service to all the localities in their primary service area, whether they help pay for the service or not.

Recommendations

Although the primary service area system has some advantages for communities, ambulance services, and public health, the framework created in the 1980s was not designed to change with the times—and it has not.

RECOMMENDATION

The Legislature should retain primary service areas, but it should restructure how they are created, modified, and overseen.

In our view, the most compelling argument in favor of primary service areas is universal access to ambulance service. Minnesotans expect that they will be able to call 911 and get an ambulance anywhere in the state. Primary service areas are Minnesota's means of government regulation to ensure ambulance coverage, and for the most part, they have worked. With primary service areas tying together small population communities with larger population centers, practically all areas of the state have some form of consistent ambulance service coverage.

For this reason, we see clear disadvantages to abandoning the primary service area model, as some stakeholders have advocated. However, success in guaranteeing coverage does not mean that the current version of the model is operating effectively or fairly. Substantial changes are needed, as detailed in the recommendations below.

RECOMMENDATIONS

The Legislature should create processes for modifying primary service area boundaries.

- **The Legislature should create a process for reviewing and revising primary service area boundaries on a periodic basis to address demographic and other societal changes.**
 - **The Legislature should authorize EMSRB to administratively resolve overlaps and gaps in primary service area coverage—if necessary, without the consent of the ambulance services involved.**
-

The current primary service area system is inflexible and unable to evolve to address shifts in demographics, transportation, technology, or health care. Even if the primary service area boundaries created in the 1980s were the best possible boundaries for that era, that does not necessarily mean they are the best possible boundaries for today or forty years from now. The Legislature should amend statutes so that primary service area boundaries can be more easily changed.

First, we recommend that the Legislature create a process for periodically reviewing primary service area boundaries and revising them when appropriate to maintain or improve public health. One possibility, for example, would be for EMSRB to conduct a formal statewide redrawing process after each decennial census. Another approach could be to develop a process for localities to petition EMSRB to move from one primary service area to another. A third approach might be to require county review and endorsement of service area boundaries on a periodic basis. Whatever approach it takes, we recommend that the Legislature consult with various stakeholders to develop a feasible process and timeline for implementation.

We intend this recommendation to be considered in conjunction with our recommendations in Chapter 4 that EMSRB develop performance standards for ambulance services. Without meaningful measures of performance, it will be difficult to reach conclusions about the potential for revised boundaries to improve public health.

Second, we recommend that the Legislature give EMSRB the authority to intervene to resolve primary service area overlaps and gaps when local agreements cannot be reached within a reasonable period of time. Currently, EMSRB has little independent authority to resolve the many overlaps and gaps that exist where primary service areas border one another. It must rely upon the services involved to agree. Some services have been very resistant to ceding any portions of their primary service areas, even when they have not provided ambulance coverage in those locations for decades.

RECOMMENDATION

The Legislature should establish a process through which local units of government have input into which services provide ambulance care and transportation in their areas.

Under Minnesota's current framework, some local governments control who provides ambulance service in their areas and others do not. This is unfair in two ways. First, some local governments are tied to private service providers regardless of their satisfaction with the services provided. Unlike a contractual relationship, local governments cannot seek improved services from the service provider or a competitor when a contract expires; primary service areas persist as long as the ambulance service maintains its license. Second, some small local governments are tied to decisions made by larger neighboring communities that control the ambulance services that cover their shared primary service areas.

In our view, if local governments believe their residents would be better served by a competitor, they should be able to seek a change in their ambulance service provider. However, the ability to seek change should still take place within the primary service area framework. Otherwise, local decisions made independently by multiple municipalities could have the cumulative effect of reducing access to ambulances in neighboring communities.

The Legislature could address this recommendation in several ways. One approach would be to enable local governments to advocate for their interests at the time of ambulance service relicensure. As we discuss in Chapter 3, EMSRB is required to seek the input of local governments and others when ambulance services are initially licensed, but not when existing ambulance services renew their licenses.

Another approach could be to create a specific role for counties in the evaluation of ambulance services. Because counties serve larger geographic areas, they may be better positioned than municipalities to advocate for the interests of both more populated and less populated areas.

Chapter 3: Ambulance Service Licensure

Ambulance services respond to calls for a variety of medical emergencies. One way for the state to ensure that ambulances are available, and that ambulance crews provide appropriate care, is to require prospective ambulance services to meet certain requirements before they are allowed to operate. Minnesota enforces such requirements by mandating that every ambulance service obtain a license.¹ It is particularly important for the state to oversee ambulance services because individuals cannot choose their ambulance service.

In this chapter, we explain the different types of ambulance service licenses and the ways in which entities may obtain licenses. Then, we examine the extent to which Minnesota's ambulance service licensing structure allows the state to effectively oversee emergency ambulance services.

Key Findings in This Chapter

- The process by which ambulance services obtain new licenses provides an opportunity for public input and state oversight. However, the process is infrequently used because nearly all licensures are renewals.
- Minnesota law does not provide meaningful oversight of ambulance services during the license renewal process.
- EMSRB has limited authority to oversee ambulance service license transfers.

License Types and Structure

The Emergency Medical Services Regulatory Board (EMSRB) is responsible for issuing ambulance service licenses.² Statutes provide for four types of ambulance service licenses:³

- **Basic Life Support (BLS).** BLS services use emergency medical technicians (EMTs) to care for patients.⁴ BLS ambulance crews provide basic emergency care, which may include controlling shock and bleeding, providing oxygen, performing cardiopulmonary resuscitation (CPR), providing intravenous fluids

¹ *Minnesota Statutes* 2021, 144E.10, subd. 1.

² *Ibid.*

³ *Minnesota Statutes* 2021, 144E.101, subd. 5.

⁴ Ambulance services that serve the seven-county Twin Cities metropolitan area (with the exception of services based in communities with a population of less than 2,500), or the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, must staff their BLS ambulance crews with two EMTs. Ambulance services in less populated areas of Minnesota may staff their BLS ambulance crews with one EMT, who must accompany the patient, and one emergency medical responder driver (*Minnesota Statutes* 2021, 144E.101, subd. 6(e)).

(without medication), placing devices to assist breathing into the mouth and pharynx, and administering a very limited set of medications.⁵

- **Advanced Life Support (ALS).** ALS services generally use paramedics to care for patients.⁶ ALS ambulance crews can administer many more medications—including narcotics—and can perform more sophisticated procedures, such as advanced heart monitoring or insertion of a breathing tube directly into the trachea (windpipe). An ALS service must have the capacity for its crews to be in two-way communication with a physician whenever needed.
- **Part-Time ALS.** Part-time ALS licenses function as add-on licenses; every service with a part-time ALS license also holds a BLS license. These services provide ALS service that is not available 24 hours per day, seven days per week. When a paramedic is on duty, the service provides ALS service. Otherwise, it provides BLS service.
- **Specialized.** Generally, specialized licenses for ground ambulance services are reserved for services that provide interfacility transportation or other special care and do not respond to 911 calls. As we noted in Chapter 2, most specialized licenses do not have associated primary service areas. Instead, EMSRB approves a “schedule of operations” that indicates where and when the



Example Ambulance Service: Part-Time ALS

The City of Arlington in south central Minnesota holds both a BLS and a part-time ALS license. Arlington employs paramedics who work 12 hours a day, seven days per week; during this time, the ambulance service may provide ALS care to individuals in its primary service area. When paramedics are not on duty, Arlington’s EMTs and emergency medical responders provide BLS service in response to 911 calls.



Example Ambulance Service: Specialized BLS

HealthPartners holds a specialized BLS license to transfer patients between health care facilities in a substantial portion of the Twin Cities metropolitan area. The schedule of operations limits the ambulance service to providing prearranged transportation that generally does not involve the use of lights and sirens.

specialized service may operate and whether it provides BLS or ALS care. Some specialized ALS services carry equipment designed for patients whose needs go beyond standard ALS care, and train their crews accordingly. All air ambulance services hold specialized licenses.⁷

As we explained in Chapter 2, ambulance services obtain licenses to serve specific primary service areas. In this report, we use the term “ambulance service” to refer to entities that provide service to a particular EMSRB-approved primary service area or operate under

an EMSRB-approved schedule of operations. Using this definition, Minnesota had 277 ambulance services as of July 2021.

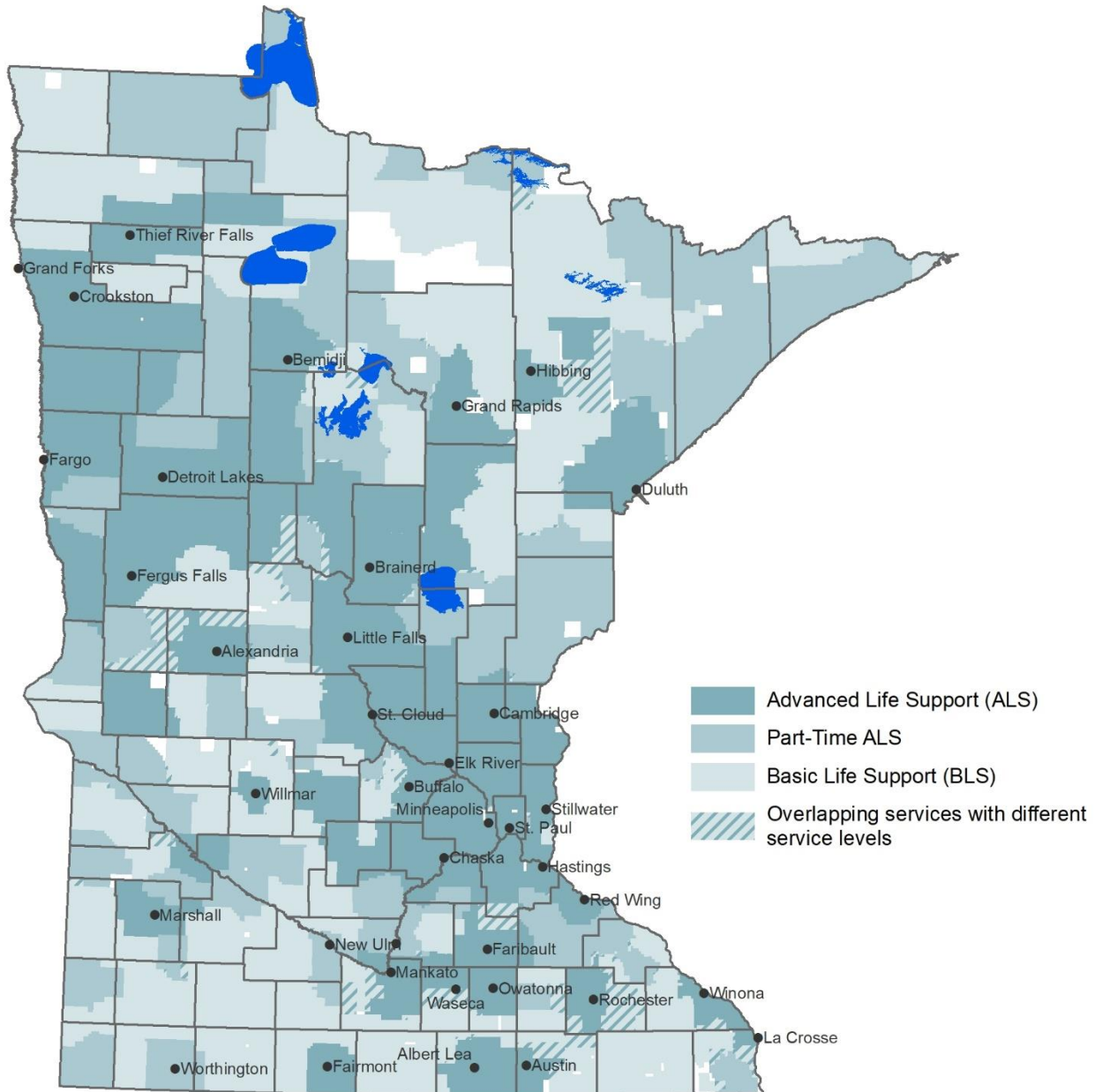
⁵ The exact scope of practice allowed by ambulance services varies, depending on what procedures each service’s medical director has authorized. Some authorizations require approval from the Emergency Medical Services Regulatory Board; others are at the discretion of the ambulance service’s medical director (*Minnesota Rules*, 4690.8300, subp. 7, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021; and *Minnesota Statutes* 2021, 144E.101, subd. 6(d)).

⁶ An ALS ambulance may be staffed by both a paramedic and an EMT. Although the EMT may also provide patient care, the paramedic has primary authority. Instead of a paramedic, state law also allows ALS care to be provided by nurses or physician’s assistants who have passed a paramedic practical skills test (*Minnesota Statutes* 2021, 144E.101, subd. 7).

⁷ As noted in the Introduction, we did not evaluate air ambulance services.

As Exhibit 3.1 shows, ground ambulance services with ALS licenses predominately cover the Twin Cities metropolitan area and outstate population centers such as Duluth, Mankato, Rochester, and St. Cloud. Services with part-time ALS licenses generally cover the areas surrounding population centers, and services with only a BLS license generally cover rural areas of the state.

Exhibit 3.1: Different areas of Minnesota are covered by different levels of ambulance care.

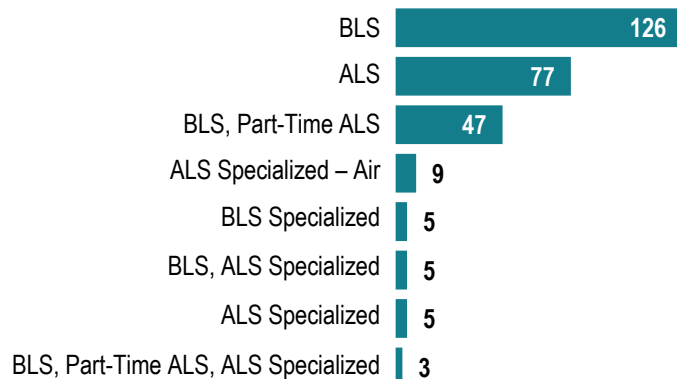


NOTES: White spaces on the map are unassigned; ambulance services may respond to requests for assistance from these locations, but are not required to do so. Primary service area boundaries are not shown on this map. See the Appendix for maps containing primary service area boundaries. The map reflects ambulance services licensed as of July 2021.

SOURCE: Office of the Legislative Auditor, analysis of Emergency Medical Services Regulatory Board data.

Under Minnesota’s licensing structure, organizations may hold multiple ambulance service licenses, and some licensees subcontract out ambulance operations to others.

Ambulance services provide care in their primary service areas under a single license or a combination of licenses.



NOTE: The chart reflects ambulance services licensed as of July 2021.

Ambulance services may operate under one or more licenses for the same primary service area. As the chart to the left shows, most ambulance services operate under one type of ambulance license. As of July 2021, 126 of the 277 licensed ambulance services provided care only under a BLS license and 77 services provided care only under an ALS license. Some ambulance services operate under two or three licenses. For example, 47 services operated under both a BLS and a part-time ALS license as of July 2021.

Further, some large hospitals or health care systems operate ambulance services in multiple primary services areas.

For example, as the table on the next page

shows, Essentia Health operates ambulance services in six different primary service areas. Because our definition of “ambulance service” counts unique primary service areas, Essentia Health appears in the chart above as six ambulance services, although it is a single health care system that operates in multiple locations. As of July 2021, there were over 200 unique providers offering ambulance care in Minnesota.⁸

Moreover, in some primary service areas, the license holder is different from the provider that runs the service. In one of Essentia Health’s primary service areas, the city of Ada holds the ambulance service license and contracts with Essentia Health to provide ambulance care. EMSRB’s licensing data does not always indicate whether the license holder runs the ambulance service itself or contracts with an external provider, so we cannot provide a complete count of ambulance services with this arrangement. In our survey of ambulance services, 11 of the 186 respondents (6 percent) reported that their organization provided ambulance care and transportation through a contract or agreement with a separate entity that held an ambulance license.⁹

⁸ Due to limitations with EMSRB’s licensing data, this number should be considered an estimate.

⁹ We surveyed directors of all 258 ground ambulance services licensed to respond to 911 calls in Minnesota as of August 2021. We received responses from 186, for a response rate of 72 percent.

Some providers—such as Essentia Health—operate multiple ambulance services.

Provider	License Holder	Ambulance Service Base	Licenses
Essentia Health	City of Ada	Ada	BLS, part-time ALS
Essentia Health	Essentia Health	Deer River	BLS, part-time ALS
Essentia Health	Essentia Health	Detroit Lakes	ALS
Essentia Health	Essentia Health	Fosston	ALS
Essentia Health	Essentia Health	Moose Lake	BLS, part-time ALS
Essentia Health	Essentia Health	Sandstone	BLS, part-time ALS
Total Providers: 1	Total License Holders: 2	Total Ambulance Services: 6	Total Licenses: 10

NOTES: "Ambulance service base" refers to the city where the service houses ambulances, related equipment, and personnel. The city of Ada downgraded its license from ALS to BLS and part-time ALS in January 2022; this change is not reflected in other charts in this report.

Licensure Process

EMSRB issues ambulance service licenses through three main processes: initial licensure, license renewal, and license transfers.¹⁰

Initial Licensure

Individuals or entities wishing to obtain a new ambulance license—or existing ambulance services that would like to obtain a new type of license—must go through the initial licensure process.¹¹

The process by which ambulance services obtain new licenses provides an opportunity for public input and state oversight. However, the process is infrequently used because nearly all licensures are renewals.

For an initial ambulance service license, applicants must provide information on the ambulance service's owners, medical director, budget, and personnel, as well as pass an onsite inspection.¹² During inspections, EMSRB staff review documents—such as the applicant's policies on maintaining ambulances and equipment and ambulance crew training records—and inspect ambulances to ensure the applicant meets minimum legal requirements for licensure.

¹⁰ EMSRB also registers or certifies several categories of ambulance service personnel, including emergency medical responders, emergency medical technicians, and paramedics. We did not review EMSRB's processes for registering and certifying individuals.

¹¹ *Minnesota Statutes* 2021, 144E.11, subd. 1. Statutes also indicate that services wishing to expand their primary service area must go through the initial licensure process. However, expansions to primary service areas have typically occurred through a less rigorous process outlined in *Minnesota Statutes* 2021, 144E.07.

¹² *Minnesota Statutes* 2021, 144E.11, subd. 7; and *Minnesota Rules*, 4690.0200, subp. 1, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021. EMSRB allows applicants to correct any deficiencies staff identify during the inspection.

After a public comment period, the process follows one of two paths: an uncontested path or a contested path. If EMSRB receives five or fewer comments opposing the application, it goes directly to the board for approval.¹³ Otherwise, the application requires a public hearing before an administrative law judge, who gathers evidence and makes a recommendation to the board.

Statutes require EMSRB to base its final licensure decision on four factors: (1) recommendations or comments from local governments and others, (2) harmful effects on public health due to any duplication of ambulance services, (3) the estimated effect of the proposed service on public health, and (4) whether the benefits to public health would outweigh the costs associated with the proposed service.¹⁴

It was difficult for us to evaluate the initial licensure process because it has occurred so rarely in recent years. EMSRB has issued only one wholly new ground ambulance license in at least a decade.¹⁵ Many of Minnesota's ambulance services were first licensed decades ago and simply keep renewing their licenses. As a result, the only services that ordinarily go through the initial licensure process are services seeking to change the level of care they provide. In the last two fiscal years (2020 and 2021), EMSRB issued five new part-time ALS licenses to existing BLS ambulance services. We reviewed EMSRB's files for two of these license changes and concluded that EMSRB generally complied with requirements in law.



Key Requirements for Ambulance Service Licensure

Ambulance services must:

- Staff ambulances with certain numbers and types of personnel, depending on the service's license type.
- Maintain at least two ambulance personnel on a written on-call schedule.
- Provide the level of care appropriate for the service's license type.
- Have a medical director.
- Offer service 24 hours a day, seven days a week.
- Provide prehospital care to patients, regardless of their ability to pay.
- Maintain certain documents, including a roster of ambulance service personnel, trauma triage and transportation guidelines, and ambulance maintenance logs.
- Have a written agreement with at least one neighboring licensed ambulance service to provide coverage when the service is not available (i.e., mutual aid).
- Carry and maintain certain therapies and equipment, such as oxygen, bandages, and a defibrillator.
- Meet ambulance vehicle specifications, such as specifications for the size of the patient compartment and the vehicle's fuel capacity.
- Equip ambulances with communications equipment.

— **Minnesota Statutes 2021, 144E.101 and 144E.103; and Minnesota Rules, 4690.1500 and 4690.1800**

¹³ As we explained in Chapter 1, EMSRB has a 19-member governing board in addition to about ten full-time staff.

¹⁴ *Minnesota Statutes 2021, 144E.11, subds. 6 and 7.* Administrative law judges are also required to consider these factors when reviewing applications.

¹⁵ In 2019, EMSRB issued an ALS specialized license to Children's Minnesota to provide interfacility transportation to pediatric patients who need advanced care.

License Renewal

Ambulance service licenses are valid for two years. Statutes require ambulance services to apply to EMSRB to renew their licenses at least one month before their licenses expire.¹⁶

Minnesota law does not provide meaningful oversight of ambulance services during the license renewal process.

Once an ambulance service obtains a license, renewal is practically automatic. There are few requirements in law that ambulance services must meet in order to renew their licenses; statutes only require ambulance services to submit a renewal application and pay required fees.¹⁷ As long as an ambulance service meets these requirements, EMSRB staff renew the license.¹⁸ Statutes do not require EMSRB to inspect the ambulance service or assess its performance in any way as a condition of approving a renewal application.¹⁹



The biannual EMSRB licensing of ambulance services is just a rubber stamp as there is no performance criteria to hold the licensee accountable to. As long as you don't have expired medications and have working equipment on the ambulance, the EMSRB does not have any real regulatory authority.

— Ambulance service director

Even though state law contains few requirements for renewing ambulance service licenses, EMSRB has not fully complied with existing legal requirements. For example, rules require EMSRB to collect the same information during the renewal process that it collects during the initial licensure process. However, it does not do so, as the table on the next page shows.²⁰ Further, EMSRB staff merely check that the information submitted is complete; EMSRB does not use the information it collects to evaluate the service seeking renewal in any way.

Additionally, EMSRB has been lenient regarding late license renewal applications. Six percent of the 193 license renewal applications EMSRB received in Fiscal Year 2020, and 11 percent of the 140 applications EMSRB received in Fiscal Year 2021 were late. EMSRB accepted and approved all of the late applications without penalty.

The low standards in law for renewing ambulance service licenses—and EMSRB's poor implementation of existing standards—limit the extent to which the state can ensure services continue to meet licensure requirements. Although EMSRB has the authority to conduct onsite inspections, statutes do not make renewal of an ambulance service license contingent on passing an inspection.²¹ However, some requirements can

¹⁶ *Minnesota Statutes* 2021, 144E.11, subd. 9.

¹⁷ Statutes require ambulance services to pay a \$150 fee plus \$96 per ambulance (*Minnesota Statutes* 2021, 144E.11, subd. 9; and 144E.29 (a)).

¹⁸ The EMSRB board does not take formal action on license renewals.

¹⁹ EMSRB may refuse to renew a license as a form of disciplinary action if it finds an ambulance service has violated statutes or rules (*Minnesota Statutes* 2021, 144E.19, subd. 1). However, EMSRB staff could not recall any instance in at least the last decade when EMSRB refused to renew a license.

²⁰ *Minnesota Rules*, 4690.0200, subp. 1, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021.

²¹ *Minnesota Statutes* 2021, 144E.18.

only be assessed in person; EMSRB staff cannot simply review documents to determine whether ambulance services comply with state law. For example, statutes require ambulance services to ensure that all patient care equipment and supplies are clean and fully operational.²² EMSRB would not be able to independently determine whether an ambulance service meets this requirement without conducting an onsite inspection.

**EMSRB does not collect all required information during the renewal process
for ambulance service licenses.**

Information required in renewal applications by <i>Minnesota Rules</i>, 4690.0200	Included in EMSRB's renewal application?
Identification, location, and telephone numbers for the proposed service and the name of the individual responsible for the application	Yes
The addresses of the base of operation and substations	Yes
The names, addresses, and telephone numbers of the medical advisor or medical director of the service and the base hospital or affiliated medical facility, if any, for the service	Partial
The location of the communications base and a description of the communications equipment on the licensee's ambulances and at its communications base	No
Whether the application is for a new license, license renewal, expansion of primary service area, change of base of operations, or change in type of service provided	Yes
The type and identification of ownership	Yes
The type and identification of the entity responsible for operation, if different from ownership	No
Backup coverage, including reserve ambulances owned by applicant, backup services, and copies of signed mutual aid agreements with neighboring providers	Partial
Other licensed providers in the primary service area	No
A description of the population to be served	No
Type of service to be licensed	Yes
Actual past and estimated future utilization of the service	No
Basic actual or estimated financial data, including actual and in-kind revenue or income, actual or projected patient charges, sources of revenue by type, and actual and imputed expenses by category and projected capital costs and operating costs	No
Qualifications of personnel, including number of and credentials of attendants and drivers and names and addresses of key personnel	Partial
A listing and description of all ambulances to be used by the service if licensed	Yes
A description of any proposed new service, change of base of operation, expansion of primary service area, or change in type of service	No
A justification of the need for any proposed new service or modification in service	No
A declaration of the proposed primary service area, including a description of the geographic features of the primary service area that have a direct bearing on the proposed service or modified service	No

²² *Minnesota Statutes* 2021, 144E.103, subd. 2a.

RECOMMENDATIONS

- **The Legislature should adopt more stringent statutory requirements for renewal of ambulance service licenses.**
 - **EMSRB should ensure that ambulance services meet requirements in law.**
-

Because individuals cannot choose which ambulance service responds to a 911 call, we think that EMSRB should have greater authority to ensure licensed ambulance services provide appropriate care. As a result, the Legislature should adopt more stringent standards for the renewal of ambulance service licenses. For example, the Legislature could amend statutes to make renewal of an ambulance service license contingent on passing an inspection. Inspections are an important regulatory function that could help EMSRB ensure that information submitted to the agency is accurate and determine whether the ambulance service complies with state licensing requirements.²³

The Legislature could also make relicensure contingent on other factors. For example, it could require that ambulance services that have not met certain performance targets be required to provide a plan for improving performance as part of the relicensure process. We discuss performance standards in Chapter 4.

We also think EMSRB should collect the information required by rule in its licensure renewal application and use it to ensure that ambulance services are still capable of providing care. We recommend in Chapter 6 that EMSRB update its rules; as a part of this process, EMSRB could consider whether the information currently required for license renewal applications is appropriate. For example, some requirements—such as providing justification of the need for any proposed new service—are appropriate for initial licensure applications but not for renewal applications.

License Transfers

Ambulance service licenses may be transferred in a variety of circumstances.²⁴ For example, an ambulance service may transfer its license to another organization as a result of a business acquisition. As another example, a municipality operating an ambulance service as a government function may decide to privatize the service and form a new nonprofit corporation. EMSRB has considered several such transfers recently (11 total in fiscal years 2020 and 2021).

²³ As we explain in Chapter 6, EMSRB has not had sufficient staff in recent years to inspect ambulance services every two years. The Legislature may wish to consider providing for an exception if the service was not inspected because EMSRB did not carry out its responsibilities.

²⁴ EMSRB also allows ambulance services to change their names through an administrative process. We did not consider situations where the same entity continued providing ambulance care and transportation under a new name to be a license transfer.

EMSRB has limited authority to oversee ambulance service license transfers.

As long as a proposed transfer does not result in a change of the ambulance service's base of operations, primary service area, or type of service offered, statutes allow a service to transfer its license to another entity without requiring the prospective licensee to apply for a new license.²⁵ Once an ambulance service notifies EMSRB that it intends to transfer its license (or that it already has), statutes require EMSRB to determine whether the new licensee meets requirements in law for providing ambulance care and transportation.²⁶ If EMSRB staff determine that the proposed transfer meets these requirements, they approve the transfer without formal board action.

Statutes do not require EMSRB to conduct onsite inspections of the new licensee or ensure that license transfers will not negatively affect public health. EMSRB typically relies on the new licensee to simply attest in writing that it meets legal requirements.

Unlike the process for initial licensure, statutes do not require EMSRB to seek the input of affected communities, or even to notify them that a transfer has occurred. For example, one ambulance service could buy another ambulance service and decide to staff the same area with fewer ambulance crews than its predecessor in an effort to reduce costs.²⁷ Affected communities might only find out that the ambulance service in their area has a new owner after experiencing changes to the quality of service.

In comparison, statutes governing several other licensed health care entities—such as assisted care living facilities, birth centers, hospitals, and nursing homes—explicitly prohibit businesses from simply transferring licenses to a new owner.²⁸ If a business is sold or transferred, the new owner must apply for a new license. For example, statutes require that assisted living facility owners apply for a new license if the existing licensee “dissolves, consolidates, or merges with another legal organization,” among other changes.²⁹ The prospective assisted living facility licensee must notify the Minnesota Department of Health at least 60 days before the anticipated transfer of ownership.³⁰

²⁵ *Minnesota Statutes* 2021, 144E.14. Statutes do not grant EMSRB authority to regulate license transfers through administrative rules. As such, rules contain no requirements related to the transfer of ambulance service licenses.

²⁶ *Minnesota Statutes* 2021, 144E.14. EMSRB staff told us that they are not involved with negotiations between the buyer and seller and may not be notified of a license transfer until after it has occurred.

²⁷ There is no minimum requirement in law for the number of ambulances a service can use to cover its service area.

²⁸ *Minnesota Statutes* 2021, 144G.19, subd. 1; 144.53; 144.615, subd. 2(b); and 144A.06, subd. 1. Nursing home licenses expire 90 days after the date of a license transfer (*Minnesota Statutes* 2021, 144A.06, subd. 1).

²⁹ *Minnesota Statutes* 2021, 144G.19, subd. 2(a).

³⁰ *Minnesota Statutes* 2021, 144G.19, subd. 2(b).

EMSRB does not have authority to approve changes that occur when a license holder contracts with a new provider.

As we noted above, some license holders do not run ambulance services themselves, but rather contract with other entities to provide ambulance care. For example, the city of Ada holds an ambulance service license and contracts with Essentia Health to provide the service. Similarly, the city of Chaska holds an ambulance license and contracts with Ridgeview Ambulance to respond to calls in its service area. Statutes neither prohibit this arrangement nor explicitly allow it.

Statutes do not require license holders to notify EMSRB if they discontinue providing care and instead contract with an external provider, or if the license holder terminates a contract with one provider and enters into a contract with another provider. Statutes also do not provide a mechanism through which EMSRB could ensure that the new provider meets legal requirements before it begins providing service. EMSRB could exercise oversight of a switch in ambulance service providers by conducting an inspection of the new provider, but it is not required to do so. Further, the inspection process only checks to see whether a provider is meeting the minimum legal requirements. EMSRB's inspection process would not assess whether the new provider is offering a similar quality of care to the previous provider.³¹

RECOMMENDATION

The Legislature should require ambulance services to go through the initial licensure process whenever there is a change in ownership or provider.

Transferring licenses or contracting with different providers could change the ambulance service for the communities in a given service area. Consumers and local governments in that area currently have no ability to review the new service, determine whether the new organization meets their needs, and advocate before the board if they oppose the change.

Because an ambulance service license typically gives its holder the responsibility of being the sole ambulance provider in an area, the state should scrutinize such changes and provide forums for public comment, which the initial licensing process provides. We think that the Legislature should require all entities wishing to start providing ambulance service in communities they have not served before—including as a result of a business acquisition or merger—to apply for initial licensure.

If the Legislature amends the statute, it should also clearly define the events that constitute a change in ownership or provider. EMSRB's board chair and vice chair told us that the board has struggled with determining whether certain business changes meet the current statute's terminology regarding "licensure or ownership transfer."³²

³¹ We discuss the difference between assessing an ambulance service's capabilities and actual performance in Chapter 4.

³² See *Minnesota Statutes* 2021, 144E.14.



OLA

Chapter 4: Accountability

As we described in the preceding chapters, individuals in Minnesota do not have the ability to choose their ambulance providers; in many cases, local governments cannot choose them either. For this reason, the state has an important responsibility to ensure the quality of ambulance services.

To determine whether ambulance services are providing quality care, there must first be a definition of “quality care”—that is, there must be standards against which services are measured. To then ensure quality care, there must be some form of corrective action taken when services do not meet these standards.

In this chapter, we discuss the extent to which Minnesota has set and enforced standards for ambulance services, and also look at the limited role of national and local entities in developing ambulance standards. Then, we specifically examine the role of ambulance service medical directors. As we explained in Chapter 1, statutes require each ambulance service to have a medical director—a physician with experience providing emergency medical care.¹ Minnesota law places considerable responsibility on medical directors to ensure that ambulance services provide quality patient care. We end the chapter with recommendations for the Legislature and the Emergency Medical Services Regulatory Board (EMSRB).

Key Findings in This Chapter

- EMSRB has not adopted any performance standards even though it has the authority to do so.
- EMSRB does not have statutory authority to set standards for some key elements of ambulance practice.
- State law requires medical directors to set standards for ambulance services, but sets limited performance expectations for medical directors themselves.

Standards

State Standards

Minnesota’s ambulance standards place requirements on a service’s *capabilities*, not on its actual *performance*.

Minnesota’s laws governing ambulance services direct them to meet a number of standards in order to be licensed. For example, ambulance crews must have a minimum level of training; ambulances must carry certain equipment, such as oxygen and defibrillators; ambulance services must have agreements with neighboring services to provide coverage when they are unavailable; and advanced life support (ALS) ambulance crews must have the ability to consult with a physician or physician’s designee at all times.²

¹ *Minnesota Statutes* 2021, 144E.101, subd. 1(b); and 144E.265.

² *Minnesota Statutes* 2021, 144E.101, subs. 6(a), 7(a), 7(d), and 12; and 144E.103, subd. 1.

However, all of these standards relate only to an ambulance service's resources and abilities; Minnesota has no standards related to actual outcomes.³ For example, there are no performance standards or targets for providing appropriate care to patients who are having difficulty breathing. If a service has not provided consistent care, it is up to the service itself to identify whether a problem exists and address it (unless EMSRB receives a complaint). EMSRB neither measures ambulance services' outcomes nor sets performance expectations for airway management.



Practices in Other States

Washington state provides five performance measures that county medical directors can use to assess performance by ambulance crews when using airway management techniques for patients having difficulty breathing. For example, one measure is the percentage of patients needing intubation (insertion of a breathing tube into the trachea) that ambulance crews successfully intubate on the first attempt.

The boxes below provide some examples of existing Minnesota standards that relate only to capabilities (on the left) and standards that do not currently exist that would be tied to performance outcomes (on the right).

Examples of Capacity Standards (Currently Required)
Ambulance crews have training in airway management.
Ambulance bases are located so that all service area locations are reachable within a maximum time.
Ambulance services agree to provide coverage 24 hours a day or arrange for others to provide coverage.

Examples of Performance Standards (Not Currently Required)
Ambulance crews have appropriately provided care for individuals having trouble breathing.
Ambulances have arrived at destinations in the service area within maximum times.
Ambulance services have replied to all dispatch center requests for service to confirm they are responding or arranging for backup.

EMSRB has not adopted any performance standards even though it has the authority to do so.

The Legislature has granted EMSRB broad rulemaking authority, which allows EMSRB to create standards that go beyond the specific requirements listed in statute. Since the second year of EMSRB's existence, the Legislature has given it the authority to regulate "staffing standards," "quality of life-support treatment," "equipment standards," "ambulance standards," and "communication standards" and to set licensing requirements.⁴

³ Although Minnesota has no standards, some ambulance services use their own internal performance standards to measure the provision of care and other outcomes. Additionally, a few large services have obtained accreditation from the independent Commission on Accreditation of Ambulance Services.

⁴ *Laws of Minnesota* 1997, chapter 199, sec. 11, codified as *Minnesota Statutes* 2021, 144E.16, subd. 4.

However, EMSRB has not adopted performance standards related to these areas of its authority. An internal workgroup report prepared for the EMSRB board in 2020 supported the development of performance standards, but expressed the opinion that EMSRB does not have statutory authority to create them.⁵ Further, the current chair of the EMSRB board told us that EMSRB has in the past believed that rulemaking is too difficult and expensive for the board to engage in. As a result, EMSRB has avoided the rulemaking process altogether for years, and has never sought to create rules including performance standards.

EMSRB does not have statutory authority to set standards for some key elements of ambulance practice.

Although EMSRB has not moved to set performance standards in areas where it does have statutory authority, there are other areas in which its authority is limited. Notably, statutes do not appear to authorize EMSRB to set performance standards for the speed of ambulance response.⁶ Thus, for example, it is not clear that EMSRB can promulgate

rules that would hold a service accountable if the time from dispatch to ambulance arrival on scene frequently exceeded the maximum time listed in state rules.⁷

EMSRB also does not appear to have authority to set standards for the number of ambulances or ambulance crews needed to serve a population of a certain size.⁸ A few ambulance service directors told us that some services do not staff sufficiently for the areas they cover and rely inappropriately on mutual aid assistance.

As another example, EMSRB does not have rulemaking authority over the use of lights and sirens by ambulance services or the ability to sanction services for unsafe driving practices.⁹



Practices in Other States

North Carolina organizes its ambulance services into “emergency medical service systems,” in which counties coordinate all emergency medical service providers operating in their jurisdictions. The state requires each system to have a “peer review” committee that assesses the providers’ performance on a quarterly basis. Among other responsibilities, state guidelines direct these committees to review data on completed ambulance trips to determine if protocols have been followed.

The guidelines further direct these committees to separately review every instance in which emergency medical crews use certain high-risk procedures, such as drug-assisted intubation or cardioversion (delivering an electric shock to the heart).

⁵ Brian Edwards, *EMS Base of Operations and Substations: A Workgroup Report For The Minnesota Emergency Medical Services Regulatory Board* (unpublished EMSRB document, 2020), 8.

⁶ Statutes do allow EMSRB to set standards for the “quality of life-support treatment” without further elaboration (*Minnesota Statutes* 2021, 144E.16, subd. 4(3)).

⁷ The maximum response times listed in state rules are used only for EMSRB to determine whether a proposed primary service area is appropriate at the time of initial licensing (*Minnesota Rules*, 4690.3400, subp. 3, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021). Several medical directors cautioned us that response times can be misused as a measurement of quality ambulance service. While some medical conditions (like strokes) are time-critical, for others (like many broken bones) patients are unlikely to obtain better outcomes if ambulances arrive more quickly. Further, services operating in rural areas often travel substantial distances to reach patients.

⁸ Statutes do allow EMSRB to set “staffing standards” and “ambulance standards” without further elaboration (*Minnesota Statutes* 2021, 144E.16, subd. 4(2) and 4(6)).

⁹ A law enforcement officer may cite an individual ambulance driver for driving recklessly or without regard for the safety of others (*Minnesota Statutes* 2021, 169.17).

EMSRB also has limited authority to set standards regarding the destinations to which patients are taken.¹⁰ Ambulance service directors we interviewed told us their services generally take patients to the hospital they ask to go to (unless the patient does not or cannot express a preference).¹¹ However, EMSRB would not have authority to sanction an ambulance service if it routinely transported patients to destinations that were better for the ambulance service, but not necessarily for the patient—for example, to hospitals affiliated with the ambulance service’s parent company.¹²



Practices in Other States

The District of Columbia Fire and Emergency Medical Services Department sets a goal that in at least 95 percent of cases it reviews where patients had suspected stroke, records will show that ambulance staff: (1) administered a stroke screening exam, (2) checked the patient’s blood glucose level, and (3) transported the patient to a hospital with a stroke center.

The District posts data on the performance of its staff in meeting this goal on a public Web page: <https://fems.dc.gov/page/stroke>.

Local Standards

State law allows local units of government to set additional ambulance service standards, including performance standards, but their ability to enforce them is unclear.

State law allows local units of government to “establish standards...which impose additional requirements” on ambulance services.¹³ EMSRB must approve such locally adopted standards before they can take effect, ensuring that they will protect public health and will not conflict with EMSRB regulations, decrease access to ambulance services, or interfere with regional systems of emergency medical care.¹⁴ As we noted in Chapter 2, Hennepin County is the only local jurisdiction we are aware of that has adopted local ambulance service standards.¹⁵

However, if an ambulance service does not meet local standards, it is unclear what recourse local governments have. State law does not address the authority of local governments to enforce the ambulance standards they set. An ambulance service

¹⁰ There are statutory requirements regarding how ambulance services choose patient destinations in instances of major trauma. See *Minnesota Statutes* 2021, 144.604.

¹¹ Service directors said that crews may not follow a patient’s preference (or suggest the patient request a different destination) if the requested hospital does not offer the health care services the patient needs.

¹² If the patient is insured by Medicare or Medical Assistance, those programs will only reimburse for the cost of transportation from the incident location to the nearest health care facility that meets the patient’s needs (42 *CFR*, sec. 410.40(f) (2020); and *Minnesota Statutes* 2021, 256B.0625, subd. 17a(a)).

¹³ *Minnesota Statutes* 2021, 144E.16, subd. 5(a).

¹⁴ *Minnesota Statutes* 2021, 144E.16, subd. 5(c).

¹⁵ Hennepin County, Ordinance 9, <https://www.hennepin.us/your-government/ordinances/ordinance-9>, accessed October 11, 2021. As of January 21, 2022, Hennepin County was actively considering revisions to its emergency medical services ordinance, but no changes had yet been made.

maintains the right to serve its primary service areas unless EMSRB revokes or does not renew their license, regardless of any action taken by a local government. Hennepin County’s emergency medical services ordinance states that the county health department “shall act to ensure appropriate compliance with [response time standards]...including, but not limited to, the submission of a recommendation to the EMS Regulatory Board for redesignation of all or a portion of a primary service area to another ambulance provider.”¹⁶ But, as we discussed in Chapter 2, EMSRB does not have the authority to redesignate primary service areas to another provider unless it revokes an ambulance service’s license altogether.



Hennepin County Standards

Information requirements: All ambulance trip reports must be on a county-approved form and can be requested at any time by the county health department. Ambulance services must provide data to the county on all ambulance requests.

Operating requirements: 911 responses are typically at the ALS level, and ALS ambulances must be staffed by two paramedics. Services may only provide BLS-level care if certain conditions are met.

Performance requirements: Ambulances should arrive within maximum response times set by the county in at least 90 percent of runs. (Maximum response times vary by community.)

Enforcement: Hennepin County may recommend changes in primary service area boundaries to EMSRB if response times are poor. The county may also take other unspecified actions.

National Standards

Although measures have been proposed, no nationwide standards currently exist for ambulance service performance.

Some efforts have been made to develop national performance standards for ambulance care and transport. However, the common measures that exist have been developed recently and are still gaining acceptance.

In 2009, the U.S. Department of Transportation published a document that identified 35 indicators or attributes of emergency medical services performance.¹⁷ The authors described the document as a “starting point and a working document” for developing performance measures; it did not establish performance standards that ambulance services must meet.¹⁸

In 2014, the National Highway Traffic Safety Administration funded a process led by the National Association of State Emergency Medical Services Officials to develop performance standards for emergency medical services that could be more widely

¹⁶ Hennepin County, Ordinance 9, section VII, subsection 2, <https://www.hennepin.us/your-government/ordinances/ordinance-9>, accessed October 11, 2021.

¹⁷ U.S. Department of Transportation, National Highway Traffic Safety Administration, *Emergency Medical Services Performance Measures: Recommended Attributes and Indicators For System and Service Performance* (Washington, DC, 2009), https://www.ems.gov/pdf/research/Studies-and-Reports/EMS_Performance_Measures_2009.pdf, accessed October 18, 2021.

¹⁸ *Ibid.*, 2.

adopted. That effort eventually spawned a new organization, the National EMS Quality Alliance (NEMSQA).



NEMSQA Performance Measures

- Percentage of patients with hypoglycemic symptoms receiving appropriate treatment
- Percentage of patients with respiratory distress receiving measurements of both respiratory rate and peripheral capillary oxygen saturation
- Percentage of patients with asthma or bronchospasm symptoms receiving beta agonist treatment
- Percentage of pediatric patients treated with medication with a weight-based dosage for whom weight was recorded
- Percentage of patients with seizures lasting longer than five minutes receiving benzodiazepine
- Percentage of patients with suspected stroke receiving a stroke assessment
- Percentage of alert patients asked to rate their pain on a pain scale
- Percentage of patients reporting pain whose pain scale score was lowered during the interaction with EMS staff
- Percentage of patients meeting trauma criteria transported to a hospital with a trauma center
- Percentage of ambulance responses to scene not using lights and sirens
- Percentage of ambulance transports of patients not using lights and sirens

Using a measurement development process that included wide consultation and public comment, NEMSQA released its first 11 approved performance measures in 2019, then updated them in 2021.¹⁹ These measures, shown at right, relate to safety, pediatrics, trauma, and to specific medical conditions—hypoglycemia, stroke, and seizure. However, these measurements are not standards; there are no targets for ambulance services to meet. Instead, NEMSQA’s goal is for ambulance services to establish a baseline and improve on their metrics over time. In the coming years, NEMSQA expects to establish additional performance measures.

Medical Oversight of Ambulance Care

In lieu of performance oversight by a state agency such as EMSRB, state law places the responsibility for ensuring the quality of medical care with each service’s medical director. By law, each ambulance service must have a medical director—a physician responsible for overseeing the medical care provided by ambulance crews.²⁰

Medical directors are responsible for “maintaining the quality of care” of an ambulance service, in part by establishing standard procedures and assessing crew members’ skills.²¹ By performing this role, medical directors both set and enforce standards for the delivery of ambulance care.

¹⁹ NEMSQA, “National EMS Quality Measure Set: Respecified Measure Set,” <https://www.nemsqa.org/completed-quality-measures/>, accessed January 13, 2022.

²⁰ *Minnesota Statutes* 2021, 144E.101, subd. 1(b); and 144E.265.

²¹ *Minnesota Statutes* 2021, 144E.265, subds. 2 and 3.

Because medical directors set the standards of care, those standards may differ from service to service based upon the philosophy of the medical director. For example, some medical directors we spoke with expressed pride that the services they worked with were using state-of-the-art equipment and techniques to provide patient care. However, another medical director we interviewed believed that it was unwise to continually add new procedures to ambulance crews' standard protocols, preferring instead to concentrate training on fundamental procedures, such as airway management and controlling bleeding.

Medical directors vary widely in the amount of time and effort they devote to ambulance service oversight.

Large and small services may have very different levels of medical director oversight. At one end of the spectrum, some large services employ medical directors who work at least half-time to provide medical direction for a single service. Some large hospital systems have developed dedicated units in which several physicians share responsibility for providing medical direction to multiple ambulance services.

At the other end of the spectrum, some small services rely on medical directors who volunteer their time in addition to working full-time as a physician. In our survey of ambulance service directors, 19 percent of respondents reported that their medical directors were uncompensated volunteers.²² Other services use medical directors on a contractual basis for limited amounts of time. One medical director we interviewed stated that he provided medical direction to about 30 to 40 ambulance services on a contracted basis in addition to serving as the medical director for a number of first responder services like fire and police departments.²³ He stated that he spends about 20 to 30 percent of his time on his medical direction responsibilities.



Medical Directors

Each ambulance service must have a medical director. Statutes outline three critical roles for this position:

1. **Determine how ambulance crews provide care.** Medical directors create standard protocols that ambulance crews use when treating and transporting patients with various conditions. They also approve the medications and equipment ambulances carry, and approve the medical training of crew members.
2. **Ensure physician participation in patient care.** ALS services must have the ability to be in two-way communication with a physician or physician's designee at all times, so crews can obtain medical guidance while responding to a call. (Although not required, BLS services generally have this capability as well.) Medical directors must approve a process for services to obtain such guidance.
3. **Review ambulance crew performance.** Medical directors must be involved in "continuous quality improvement programs," which include resolving patient complaints, and periodically reassessing crew members' proficiency.

— *Minnesota Statutes 2021, 144E.101, subds. 1(b) and 7(d); and 144E.265*

²² We surveyed directors of all 258 ground ambulance services licensed to respond to 911 calls in Minnesota as of August 2021. We received responses from 186, for a response rate of 72 percent.

²³ Some first responder departments use medical directors to guide their efforts to provide on-scene medical assistance prior to the arrival of an ambulance. For example, the Minneapolis Fire Department requires all of its firefighters to be certified EMTs. Such nonambulance emergency care was beyond the scope of our evaluation.

Given these differences in involvement, it is not surprising that the extent of performance assessment differs from one service to another. Ambulance service directors we surveyed reported a wide range of the number of their ambulance runs that had been reviewed by a medical director. Thirty-four service directors reported that their medical director had conducted 100 or more run reviews for calendar year 2020; 12 reported zero run reviews.²⁴

State law requires medical directors to set standards for ambulance services, but sets limited performance expectations for medical directors themselves.



Run Reviews

According to medical directors we interviewed, a run review generally involves the medical director examining the crew's documentation of the patient's condition and the medical care subsequently provided. In some cases, it may also include interviews with ambulance staff or reviewing information from the hospital about the patient's condition upon arrival.

The requirements for medical directors in law are fairly broad. Medical directors are required to approve standards for training and equipment; establish protocols for triage, treatment, drug administration, and transportation; participate in “continuous quality improvement programs” that include addressing patient complaints; and take overall responsibility for “maintaining the quality of care.”²⁵ There are no requirements in statute or rule regarding how often a service's medical protocols should be updated or whether a medical director should routinely conduct run reviews to assess crew performance.²⁶ Instead, these decisions are left to each medical director's professional judgment.

Statutes do allow EMSRB to adopt rules to restrict the medical treatments or procedures performed by ambulance services.²⁷ EMSRB has made very limited use

of this authority, modifying rules once in 1998 to make changes to the medications that could be carried and administered by BLS ambulances.²⁸

In a 2016 survey of rural ambulance services conducted by the Minnesota Department of Health, approximately one-half of the responding services reported that their medical directors did not approve continuing education for ambulance staff, which is a statutorily required responsibility for ambulance service medical directors.²⁹ Substantially more than

²⁴ Almost one-half of service directors responding to our question about the number of run reviews conducted in the past year answered “do not know.” Some responded with a percentage, for example, that their medical director reviewed 5 or 10 percent of all runs.

²⁵ *Minnesota Statutes* 2021, 144E.265, subd. 2.

²⁶ Statutes require medical directors to participate in quality improvement programs including “case review and resolution of patient complaints” (emphasis added). According to EMSRB's interpretation, this law only requires medical directors to conduct run reviews in connection with patient complaints. *Minnesota Statutes* 2021, 144E.265, subd. 2(5).

²⁷ *Minnesota Statutes* 2021, 144E.16, subd. 4(4).

²⁸ 22 *State Register*, pp. 1396-1399 and 1877 (1998); codified in *Minnesota Rules* 4690.0800, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021.

²⁹ Minnesota Department of Health, Office of Rural Health and Primary Care, *2016 Rural EMS Sustainability Survey Results* (St. Paul, n.d.), 27; and *Minnesota Statutes* 2021, 144E.265, subd. 2.

half reported that their medical directors were not involved in complaint investigation, another statutorily required responsibility.³⁰



Practices in Other States

Minnesota is unusual in the nearly unlimited power it gives medical directors to set patient treatment protocols.

As of 2020, it was one of only seven states that do not have either a list of permitted medical procedures or a list of permitted medications for ambulance services. The other states that leave both of these decisions solely to ambulance services and their medical staff were Florida, Indiana, Missouri, Montana, Nevada, and Texas.

In addition to having lists of permitted procedures, some states require that each service's medical protocols be approved by a statewide or regional entity. A few states go even further and create statewide medical protocols so that the treatment a patient receives should be the same anywhere in the state, regardless of which service responds.

When we inquired how EMSRB had responded to these results, the chair and vice-chair of the Board told us that EMSRB had increased its education and outreach to medical directors. However, EMSRB does not have direct authority over medical directors. If EMSRB does discover through an inspection or complaint investigation that a medical director is not meeting their responsibilities, its only recourse would be to fine or otherwise penalize the ambulance service, not the medical director directly.

Medical directors have limited ability to enforce the standards they set for ambulance services.

On the other hand, when medical directors are actively involved and provide strong oversight, their ability to require ambulance services to meet performance standards can be limited. If a medical director believes an ambulance service's performance is unacceptable, there is little the medical director can do other than use persuasion or resign. We interviewed one medical director who worked at a hospital emergency medical services program that provides medical direction for multiple ambulance services. He described his program's dissatisfaction with the performance of two different ambulance services; in one instance his program withdrew its medical direction from the ambulance service, in the other it threatened to do so before changes were made. However, he acknowledged that while withdrawing medical direction is "a strong statement," there is nothing to prevent a service from simply finding another medical director who might not be as rigorous.³¹

Recommendations

Ambulance services play an important role in public health, yet neither consumers nor many local governments have the ability to choose their ambulance services. Consequently, we believe the state has an important role to play in monitoring performance and requiring improvements when needed to ensure that ambulance services are providing appropriate care.

³⁰ Minnesota Department of Health, Office of Rural Health and Primary Care, *2016 Rural EMS Sustainability Survey Results* (St. Paul, n.d.), 27; and *Minnesota Statutes* 2021, 144E.265, subd. 2.

³¹ The ambulance service that lost its medical direction was in a neighboring state and not licensed in Minnesota, so we did not make further inquiries about what course that service pursued.

RECOMMENDATION

The Legislature should direct EMSRB to develop and enforce performance standards for ambulance services.

The Legislature should mandate that EMSRB develop performance standards and a framework through which it can monitor and enforce the standards. When developing performance standards, we encourage EMSRB to consider what performance standards might be appropriate in two separate areas of practice:

1. **Availability and response.** For example: Is an ambulance and crew available when needed? How quickly does the ambulance arrive on the scene?
2. **Patient care.** For example: Do ambulance crews correctly recognize life-threatening conditions? Do they follow the service's procedures for providing treatment? Do crews identify when a patient needs treatment beyond their capabilities and seek assistance from another service that can provide a higher level of care?

Once EMSRB has established performance standards, it should have the ability to address circumstances where ambulance services are not meeting the standards. We do not necessarily envision a solely punitive structure; the state's interest should be to ensure the best possible patient outcomes. For example, if a service is not meeting certain standards for patient care, EMSRB could conclude that requiring increased training or an advisory consultation by an outside medical director would be more likely to improve performance than fines or licensing sanctions.

It is important that the Legislature provide EMSRB sufficient time to develop performance standards that take into account the diversity of Minnesota's ambulance services. Developing performance standards will be challenging and should involve extensive consultation with ambulance services and other stakeholders. Because different environments exist across the state, EMSRB should be cautious of one-size-fits-all approaches. For example, response times can vary dramatically based on the distance that must be covered and road and weather conditions. Appropriate care for the same medical condition may differ when the nearest hospital is 40 minutes away instead of 4 minutes away. Treatment expectations appropriate for urban settings where every ambulance is staffed by a paramedic may not be attainable for rural services that rely on EMTs.

We believe EMSRB should also have some additional authority over the performance of medical directors.³² We have no evidence that there are widespread problems with the medical direction of ambulance services in Minnesota, but we are concerned that EMSRB can only act indirectly—by penalizing the service—if it discovers a medical director is not meeting their statutory responsibilities. If, for example, an individual is the medical director for several services and is not carrying out their responsibilities, EMSRB should be able to sanction the medical director directly (instead of penalizing

³² We do not intend to suggest that EMSRB regulate *how* physicians conduct their work, which is a matter of professional clinical judgment.

all the individual services). The Legislature should also consider whether to strengthen the statutory requirements for medical directors—for example, by requiring that medical directors update protocols every two or three years or conduct run reviews on a regular basis.³³

Further, we think it would be appropriate to require physicians to notify EMSRB whenever they stop providing medical direction to an ambulance service. If the decision to stop providing medical direction was based on performance concerns, EMSRB should immediately conduct an inspection of the service.³⁴

RECOMMENDATION

EMSRB should work with the Legislature to ensure it has sufficient authority to implement performance standards.

EMSRB has not made use of its statutory authority to measure performance and hold ambulance services responsible for meeting standards. However, some elements of ambulance service performance also lie outside of the statutory authority granted to the agency. EMSRB does not appear to have the ability to set standards regarding response times, the numbers of ambulances and crews needed to cover a population, the use of lights and sirens, the selection of patient destinations, or medical director performance.

We are disturbed by the lack of any performance measures, but we do not have the expertise to specify what standards are the most appropriate. Therefore, we do not make recommendations directly to the Legislature regarding an expansion of EMSRB's authority. Instead, we suggest that EMSRB determine what performance standards are most appropriate, and then request that the Legislature grant the board the authority to measure and enforce those standards.

³³ Any requirement to conduct run reviews must take into account the differences between large services that make thousands of runs annually and small services that only make dozens. For example, a requirement for medical directors to review 5 percent of runs annually might be prohibitively time-consuming for very large services and meaningless for very small services (because 5 percent might be only one or two runs).

³⁴ EMSRB provides a form that ambulance services can use to notify the agency when they switch medical directors. However, the form does not require services to state the reason for the change.



OLA

Chapter 5: Ambulance Service Sustainability

Ambulance services exist so that individuals can obtain emergency medical care and transportation to a health care facility whenever and wherever needed. However, operating an ambulance service that is available 24 hours a day, seven days a week, requires significant staffing and financial resources.

A sustainable ambulance service is able to consistently meet those staffing and funding needs, ensuring that ambulances and crews are available to respond to incoming emergency calls and provide the assistance that the public expects.

Key Findings in This Chapter

- Ambulance services face persistent staffing challenges across the state, but especially in outstate Minnesota.
- Severe staffing shortages have sometimes led ambulance services to be unable to respond to calls from their primary service areas.
- Ambulance service directors overwhelmingly said that Medicare and Medicaid reimbursements are insufficient to cover costs.

Many ambulance service directors are not confident their services will be able to meet the needs of their communities five years from now.

In a survey we conducted of ambulance service directors statewide, 54 service directors (29 percent) disagreed or strongly disagreed with the statement: “I am confident that five years from now my ambulance service will be able to meet the needs of the area it serves.”¹ Given the importance of ambulance services, we found it concerning that such a high proportion of directors expressed pessimism about their ambulance services’ long-term sustainability. Directors of services with only volunteer personnel were even more likely to disagree with the statement (42 percent). While not all volunteer ambulance services in Minnesota are struggling to survive, a significant number clearly are.



Over half of our staff is over the age of 55, including one in the 70s and four in their 60s. It is only a matter of time (and health) before we will not be able to offer full-time ambulance service coverage.

— Ambulance service director

In this chapter, we examine Minnesota ambulance services’ challenges to maintain adequate staffing and financial sustainability, drawing primarily from interviews and our survey. We conclude with a recommendation to address ambulance services’ sustainability challenges.

¹ We surveyed directors of all 258 ground ambulance services licensed to respond to 911 calls in Minnesota as of August 2021. We received responses from 186, for a response rate of 72 percent.

Staffing

Without trained staff, ambulance services cannot operate. Not only are staff needed to drive ambulances, but staff play critical roles in assessing patient needs, providing treatment, and determining what medical facility destination will best meet patient needs.

Ambulance services face persistent staffing challenges across the state, but especially in outstate Minnesota.

A majority of ambulance service directors responding to our survey reported their services had difficulty staffing shifts at the level needed to adequately respond to 911 calls in the preceding month. Staffing shortages were particularly acute in outstate Minnesota.² Sixty-one percent of directors with services located outstate reported difficulty staffing shifts in the previous month, while 31 percent of directors with



There is a chronic issue with appreciating the value of Minnesota's rural volunteer services. The [COVID-19] pandemic has put an additional strain on all ambulance services and volunteers within the state.... There is great difficulty finding qualified personnel willing to sacrifice their time...and possible health/wellbeing. As it currently is, we cannot offer those volunteers something as simple as reliable, sustainable retirement for their years of service.

— Ambulance service director

services in the Twin Cities metropolitan region reported difficulty. The percentage of outstate service directors reporting staffing difficulties was virtually the same among services employing paid staff and those relying on volunteers.

Although economic and social disruptions associated with the COVID-19 pandemic have exacerbated the situation for some services, many have been dealing with staffing challenges for years. Nearly 50 percent of outstate service directors and 12 percent of metropolitan service

directors responding to our survey said they have had difficulty staffing ambulance shifts for at least five years.

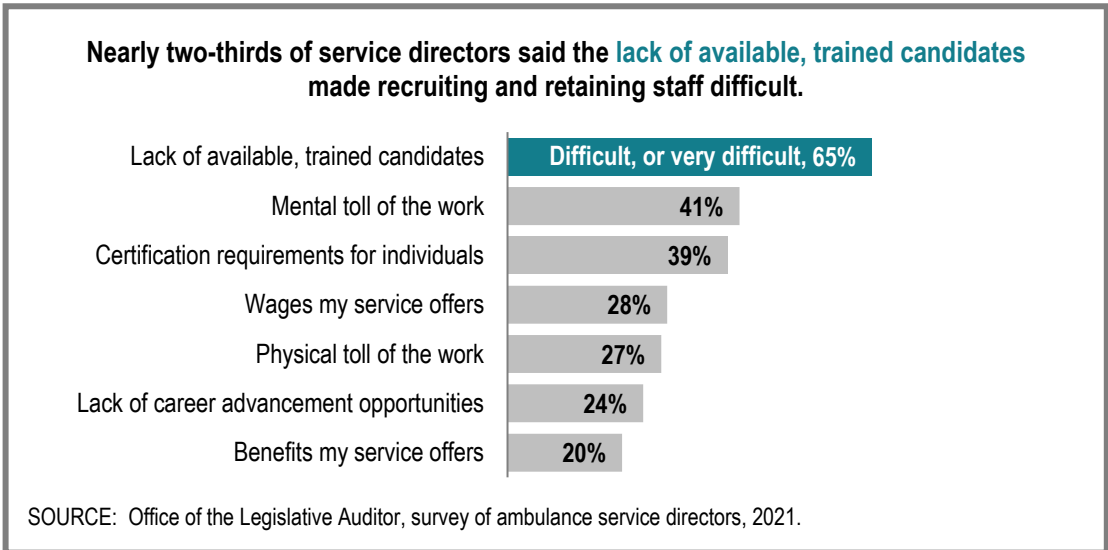
Our evaluation is not the first study to highlight staffing challenges for ambulance services in outstate Minnesota or in rural areas more generally. Studies conducted by the Minnesota Department of Health's Office of Rural Health and Primary Care in 2002 and 2016 identified critical staffing concerns among rural ambulance services.³ A federally funded report by the Rural Policy Research Institute in 2021 concluded that "A rural [emergency medical services] volunteer workforce is no longer sustainable due to demographic, economic, and other factors."⁴

² In this chapter, we use "outstate" to refer to the areas of the state outside of the Twin Cities metropolitan emergency medical services region. The metropolitan region includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, and Washington.

³ Minnesota Department of Health, Office of Rural Health and Primary Care, *A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk* (St. Paul, 2002), 32, <https://www.lrl.mn.gov>, accessed February 17, 2022; and Minnesota Department of Health, Office of Rural Health and Primary Care, *2016 Rural EMS Sustainability Survey Results* (St. Paul, n.d.), 5-6, <https://www.health.state.mn.us/facilities/ruralhealth/flex/pubs.html>, accessed December 7, 2021.

⁴ A. Clinton MacKinney, et. al., *Characteristics and Challenges of Rural Ambulance Agencies—A Brief Review and Policy Considerations* (Iowa City: University of Iowa, College of Public Health, 2021), 10.

A majority of ambulance service directors who responded to our survey cited the lack of available, trained candidates in the workforce as a key factor driving staffing shortages. Sixty-five percent of service directors said that a lack of candidates made it difficult or very difficult to recruit and retain staff. Other factors that made recruitment and retention difficult for at least a third of respondents included the mental toll of the work and certification requirements for individuals.



Some services have resorted to creative measures to improve recruitment and retention. One ambulance service director we interviewed described a program her service has developed with local schools to use high school students as ambulance drivers. Students leave school when 911 calls come in and drive ambulances while EMTs provide patient care. The students are trained as emergency drivers and receive high school credit for their ambulance work.

Another outstate service developed a program to send staff to respond to disasters elsewhere in the country, such as to Louisiana in response to Hurricane Ida in 2021. The service director said that this disaster response program was designed as a recruitment and retention tool, but said that recently his service has not had sufficient personnel to both staff the service and send personnel out-of-state.

Broader factors may negatively affect rural ambulance staffing.

Our interviews with ambulance service directors, medical directors, and others suggest that a variety of broader factors outside the control of ambulance services have had effects on staffing, particularly the volunteer staffing models common among rural services. These include:

- **Changing rural employment patterns.** Increasingly, individuals who live in rural areas drive long distances to their place of work; the U.S. Census Bureau estimated that commuting times for residents outside of urban areas increased

by about 10 percent between 2006 and 2019.⁵ As a result, it may be difficult for some individuals to volunteer in their home communities during regular work hours. According to the Minnesota Department of Health’s 2016 survey of rural ambulance services in Minnesota, many rural services reported great difficulty staffing daytime weekday hours.⁶

- **Long ambulance trips.** Some patients’ needs cannot be met by local hospitals in rural areas. In some instances, an ambulance crew may bypass a local hospital and transport a patient directly to a hospital that can provide a higher level of care, often located in major population centers like Duluth, Fargo, or the Twin Cities. In other instances, the patient is transported to a local hospital for evaluation and stabilization before being transported again to another hospital for more advanced care. In some regions of the state in Fiscal Year 2021, more than 15 percent of interfacility transports took more than four hours to complete (from when the vehicle was en route until it was back in service).

Long ambulance trips can strain volunteer crews and create long periods when an ambulance and its crew is not available to respond to another emergency, further exacerbating staff shortages. Some outstate service directors and medical directors said their ambulance crews have traveled particularly long distances for patients needing treatment for mental health crises.

- **Increased training needs.** Advances in medical practice have led to increased training needs for ambulance crews. Rural services that make relatively few ambulance runs may have greater training needs; when ambulance crews only rarely have the opportunity to practice skills in the field, additional training is necessary to keep skills sharp.

Minnesota is not alone in facing staffing challenges; officials from ambulance regulatory agencies in other states told us services in their states are also experiencing staffing problems.⁷ For example, rural ambulance services have closed in parts of Michigan, and a state agency representative told us that no one is willing or able to provide ambulance care and transportation in some areas, including in sections of the Upper Peninsula. Agency officials from Massachusetts, Michigan, Pennsylvania, and Wisconsin told us that services are struggling to maintain staffing because ambulance personnel have opportunities to earn higher wages or receive better benefits in other jobs.

⁵ U.S. Census Bureau, *Travel Time to Work in the United States: 2019* (Suitland, MD, 2021), 5, <https://www.census.gov/library/publications/2021/acs/acs-47.html>, accessed December 18, 2021. We use “urban areas” to refer to the U.S. Census Bureau’s definition of micropolitan and metropolitan statistical areas.

⁶ Minnesota Department of Health, Office of Rural Health and Primary Care, *2016 Rural EMS Sustainability Survey Results*, 5-6.

⁷ We spoke with officials from ambulance regulatory agencies in four other states: Massachusetts, Michigan, Pennsylvania, and Wisconsin. We selected states similar to Minnesota in the proportions of uninsured or publicly insured residents, the number of primary care providers compared to population needs, the number of 911 calls per 100,000 residents, and range of driving distances to hospitals.

Severe staffing shortages have sometimes led ambulance services to be unable to respond to calls from their primary service areas.

When facing staffing challenges, large services may be able to modify shift schedules and deploy backup resources to maintain coverage for 911 calls. However, at small ambulance services, staffing shortages can mean that the local service is simply not available to respond when individuals call 911.

When an ambulance service has no staff to respond, neighboring services generally provide coverage under “mutual aid” agreements. Mutual aid is intended to enable ambulance services to support one another when too many calls come in at once to the same service. However, some services have used mutual aid in circumstances where there is no ambulance available at all. Ten percent of outstate ambulance service directors responding to our survey said that at least one-half of the mutual aid runs provided in their areas over the previous year were to cover situations where their ambulance service did not have enough staff available to run a single ambulance.

In a few instances, dispatch staff or service directors told us that some ambulance services occasionally have had no one at all on duty—not even a person monitoring radio traffic who could tell 911 dispatchers that the ambulance service could not handle a call. One ambulance service director described her experience when a neighboring service had no one on duty—a situation that had occurred more than once. She explained that she was monitoring the emergency services radio frequency and heard the 911 dispatcher page the neighboring service multiple times without an answer. After the second unanswered page, she contacted her own on-call staff to prepare backup coverage for her service area in case one of her ambulances needed to leave and provide mutual aid support to the neighboring service. After a third unanswered page, the dispatcher transferred the call to her service for response. She pointed out that ten minutes had passed between the initial request for an ambulance and her crew’s departure—and her crew had a longer travel time to reach the scene because it was outside of their primary service area.

We could not quantify exactly how often ambulance services in Minnesota are unable to respond to calls due to a lack of staff, nor how often ambulance services fail to respond altogether. The data collection system used by the Emergency Medical Services Regulatory Board (EMS RB) contains information about ambulance runs that actually occur; it was not designed to collect information about calls that go unanswered.

RECOMMENDATION**EMS RB should explore reporting mechanisms that would enable it to track nonresponse by ambulance services.**

We think EMS RB should be aware of every instance in which an ambulance service fails to respond at all to a request for service, even if the call is subsequently transferred to a neighboring service for mutual aid support. We recommend that EMS RB explore how it might best obtain such information. If it can track nonresponses through its

existing authority to regulate ambulance services, it should do so. However, if it would be best to obtain information about nonresponses directly from 911 dispatching centers, EMSRB should determine whether it needs additional statutory authority to do so and advise the Legislature accordingly.

Revenue

In addition to staffing challenges, many service directors told us that their services have had increasing difficulty making ends meet.

As we noted in Chapter 1, ambulance services combine both public safety and health care functions, but are funded more like health care providers. Unlike fire and police services, ambulance services typically are not primarily supported by taxes. Instead, individual patients are billed for the services they receive at a flat rate (known as the “base rate”) plus a charge per mile traveled.



The looming problem that no one in government seems to realize is simple math: my input costs keep going up, and with this year's inflation, they are going up even more. The amount we get reimbursed by government and third-party payors is going down (or at least not following inflation). Therefore, the only thing I can do is pass along my costs to those patients who can, and will, pay.

— Ambulance service director

Ambulance services must pay fixed costs to have an ambulance available at any time. They have to procure vehicles, equipment, and supplies, and keep them in good working order. Employees are often paid hourly regardless of whether ambulance calls come in on a particular shift. Most services that use volunteers pay them a stipend, often a small amount for on-call time and a higher rate for the time spent on ambulance runs. Most services also pay for their employees' continuing education expenses.

Ambulance services with low numbers of ambulance runs may not receive enough revenue from billing patients to cover their costs.

Because fixed costs associated with running an ambulance service cannot be easily reduced, the financial stability of ambulance services rests on the number of their ambulance runs. In highly populated areas, the large volume of ambulance runs may enable services to cover all fixed costs with revenue from billing patients.⁸



The state needs to take accountability to help consolidate, fund, and provide exceptional EMS care to Greater MN. This is a crisis of intense magnitude. Due to the complexity of the medical care, the specialized equipment, the cost to provide the service, and so much more, it is not something that the small cities and townships can adequately fund.

— Ambulance service director

However, when ambulance services have small run volumes, it can be difficult to cover fixed costs. Such services generally rely on external subsidies in addition to revenue from billing patients. Many ambulance services with low numbers of runs rely on volunteers, and their work subsidizes the cost of staffing ambulances. In our survey, 35 of the 42 ambulance services that had less than

⁸ According to our survey, a majority (14 out of 26) of directors of ambulance services in the Twin Cities metropolitan region said that 99 or 100 percent of their revenues in the previous 12 months were from billing patients alone.

1,000 ambulance runs in fiscal years 2017 through 2021 had only volunteer personnel.⁹ In addition, many services—both those with volunteers and those with paid staff—receive funding from local units of government. One-half of services in our survey with fewer than 1,000 runs in fiscal years 2017 through 2021 received at least some local government funding in the previous year.

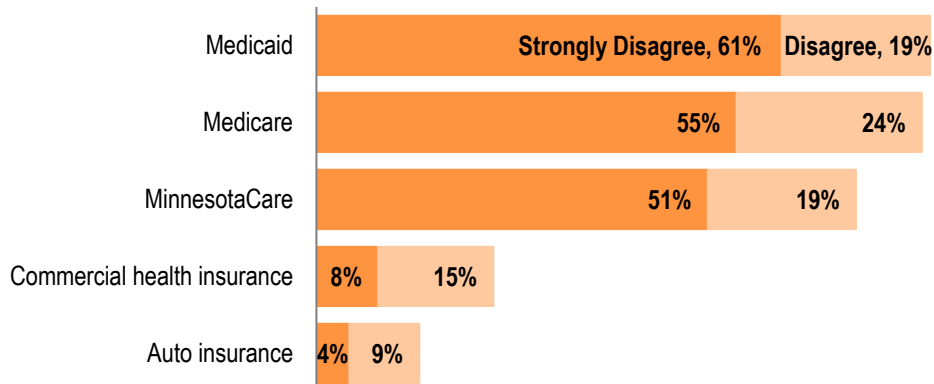
Ambulance service directors overwhelmingly said that Medicare and Medicaid reimbursements are insufficient to cover costs.

Many ambulance services in Minnesota receive a majority of their revenue from public health insurance programs such as Medicare or Medicaid. Over 40 percent of ambulance service directors responding to our survey said that more than one-half of their service's total revenue in the past 12 months came from public payors.

However, an ambulance run covered by Medicare or Medicaid can generate less revenue for an ambulance service than a similar run covered by another type of insurance. In our survey, 80 percent of all respondents disagreed or strongly disagreed that Medicaid reimbursement rates adequately cover the cost of ambulance runs. A similar proportion disagreed or strongly disagreed that Medicare reimbursement rates were adequate. In comparison, 23 percent of service directors disagreed or strongly disagreed that commercial health insurance rates adequately cover the cost of ambulance runs.

Service directors reported that public health insurance programs do not adequately cover the cost of ambulance runs.

To what extent do you agree or disagree that the reimbursement rates from the following programs adequately cover the cost of ambulance runs?



SOURCE: Office of the Legislative Auditor, survey of ambulance service directors, 2021.

⁹ Twenty-three percent of services in our survey had less than 1,000 ambulance runs during fiscal years 2017 to 2021, including interfacility transports and runs in response to 911 calls.

Minnesota’s Medicaid base rates represent only a fraction of the median base rates reported by ambulance service directors who responded to our survey.¹⁰ As the table below shows, the Medicaid base rate for emergency basic life support (BLS) care in Minnesota is about one-third the median BLS base rate charged by ambulance services for BLS-level care.¹¹

Medicaid base rates are often far below billed charges.			
Level of Care	Median Base Rates Reported by Survey Respondents	Medicaid Base Rate	Percentage Reimbursed
BLS	\$1,199.00	\$430.03	36%
ALS-1	\$1,870.00	\$430.03	23%
ALS-2	\$2,214.00	\$639.09	29%

NOTES: Base rates shown here do not include mileage costs; Medicaid reimbursements may be adjusted for factors such as the ambulance service’s location. ALS-1 and ALS-2 are different levels of ALS care recognized by Medicaid, but not used in Minnesota’s licensing structure.

SOURCES: Minnesota Department of Human Services fee schedule for transportation services; and Office of the Legislative Auditor, survey of ambulance service directors, 2021.

Some ambulance runs do not result in any payment at all to the service. For example, when ambulance crews determine that no immediate hospital visit is necessary or if a patient refuses transportation, Medicare does not allow reimbursement of ambulance charges because no transport occurred.¹² According to the National EMS Advisory Council, many insurers follow suit, only reimbursing ambulance services for trips that result in a patient transport.¹³ A federal pilot initiative is testing new Medicare payment options to reimburse services for treating patients at the scene or transporting them to nonhospital medical facilities, if appropriate.¹⁴

Discussion

Serious long-term staffing and revenue challenges threaten the sustainability of many outstate ambulance services in Minnesota. These problems have not risen suddenly as a result of the COVID-19 pandemic, but instead have persisted for years. In some

¹⁰ A “base rate” is a flat rate an ambulance service bills a patient depending on the level of care the patient received. It does not include costs reflecting the number of miles traveled.

¹¹ As we explained in Chapter 1, Basic Life Support (BLS) care can include personnel delivering oxygen, providing intravenous fluids (without medication), placing devices to assist breathing into the mouth and pharynx, or administering a limited set of medications. Advanced Life Support (ALS) care can include personnel administering more medications than BLS care—including narcotics—or performing more sophisticated procedures, such as advanced heart monitoring or insertion of a breathing tube directly into the trachea (windpipe).

¹² Centers for Medicare and Medicaid Services, *Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services* (Baltimore, revised 2018), sec. 10.

¹³ The National EMS Advisory Council, *EMS System Performance-based Funding and Reimbursement Model* (Washington, DC, revised September 2019), 1-2, 10, and 16, <https://www.ems.gov/recommendations.html>, accessed December 11, 2021.

¹⁴ Centers for Medicare and Medicaid Services, “Emergency Triage, Treat, and Transport (ET3) Model,” <https://innovation.cms.gov/innovation-models/et3>, accessed January 11, 2022.

communities, ambulances are already not available at times they are needed, requiring neighboring services to respond from long distances away.

Some state programs and organization-led initiatives aim to support struggling ambulance services. The Minnesota Department of Health provided grant funding to support the formation of the Minnesota Rural EMS Resource Center in 2019. According to a September 2021 presentation by the Center's director, it is currently collecting and sharing information about resources available for improving rural ambulance service sustainability.¹⁵ Dual training grants provided through a partnership between the Department of Labor and Industry and the Office of Higher Education can be used by ambulance services to train EMTs to become paramedics.¹⁶ Emergency medical services regional boards can seek EMSRB funding to reimburse ambulance personnel for continuing education costs that are not covered by their services or other funding sources.¹⁷ EMSRB occasionally offers "rural ambulance assessments" to individual rural services. State law also allows local governments to establish special taxing districts to support ambulance services in their areas.¹⁸

RECOMMENDATION

The Legislature should explore options for improving ambulance service sustainability in Minnesota, potentially through pilot programs or other trial programs.

Despite the initiatives listed above, staffing and funding challenges persist statewide. Several service directors and other stakeholders have recommended large-scale changes to improve the sustainability of ambulance services in Minnesota. These recommendations include creating or modifying programs to improve compensation for ambulance staff,

implementing direct state funding of rural services, and consolidating struggling services into regional organizations, among others.

However, we are hesitant to endorse any specific recommendations at this time. Many proposals reflect a desire for change but are largely untested. Sustainability problems affecting Minnesota's ambulance services are likely caused by several overlapping factors, including services' reliance on volunteers, local economic conditions, total run



Rural ambulance services are in a dire situation. We are trying to keep our volunteers as well as trying to stay financially afloat. Our equipment is aging, our patients are aging, our demands are higher, our call volumes are higher, volunteers are few and far between, and it feels like no one notices. EMS has become something that people forget about until they need it. State funding of rural EMS would be a welcome relief.

— Ambulance service director

¹⁵ Minnesota Rural EMS Resource Center, "Resources for Rural EMS Sustainability" (presentation, Alexandria, MN, September 11, 2021), <https://www.mnems.org/other-useful-links>, accessed December 30, 2021.

¹⁶ Minnesota Department of Labor and Industry, "Minnesota Dual-Training Pipeline: Health Care Services," <https://www.dli.mn.gov/business/workforce/health-care-services>, accessed January 18, 2022.

¹⁷ *Minnesota Statutes* 2021, 144E.52.

¹⁸ *Minnesota Statutes* 2021, 144F.01, subd. 2. There were 21 special emergency medical services taxing districts in Minnesota for which taxes were payable in 2021, 18 of which were located in Polk County. The Legislature revised the law on emergency medical services special taxing districts in 2021 (*Laws of Minnesota* 2021, First Special Session, chapter 14, art. 6, sec. 1).

volumes within primary service areas, and health insurance reimbursement rates.¹⁹ Moreover, it is unclear how the disruptions to health care and the broader economy caused by the COVID-19 pandemic could limit the effectiveness of proposed solutions.

Nonetheless, the Legislature should act to address services' sustainability challenges. We recommend that the Legislature convene a task force—but not to study the problem, which is already well defined. Instead, the task force should identify specific strategies that the Legislature and EMSRB could attempt. Because potential outcomes are unclear, we believe it would be appropriate to implement strategies on a trial basis. Depending on the approach, the Legislature could pilot some programs with a small number of services, or implement a statewide program for a short time period with a plan to assess its effectiveness.

Whatever approaches it adopts, the Legislature should direct EMSRB to evaluate the success of the strategies it chooses and report back to the Legislature on whether the strategies should be continued, expanded, or ended.

¹⁹ Current state laws target some of these areas. For example, the 2016 Legislature increased Minnesota's Medicaid reimbursement rates for ambulance services by 5 percent for services located outside of the seven-county Twin Cities metropolitan area; outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or within a municipality with a population of less than 1,000 (*Laws of Minnesota* 2016, chapter 189, art. 19, sec. 10, codified as *Minnesota Statutes* 2021, 256B.0625, subd. 17a(b)).

Chapter 6: EMSRB

Thousands of people rely on Minnesota ambulance services each year to help them through difficult situations. To ensure these individuals receive quality care, the Legislature authorized the Emergency Medical Service Regulatory Board (EMSRB) to regulate the emergency medical services industry.¹

EMSRB is responsible for licensing and inspecting ambulance services, registering and certifying emergency medical service personnel, and investigating complaints against emergency medical services providers.² In this chapter, we examine the extent to which EMSRB has fulfilled some of its key responsibilities. We make a number of recommendations to the Legislature and to EMSRB throughout the chapter, and conclude by discussing changes the Legislature should consider making to the EMSRB board and Minnesota’s statutes governing ambulance services.

Key Findings in This Chapter

- EMSRB has been largely ineffective in its regulation and support of ambulance services in Minnesota.
- EMSRB has failed to carry out some of its core functions, in part due to insufficient staffing.
- The EMSRB board has failed to provide sufficient oversight of the agency’s activities.
- Although statutes require that EMSRB board members represent a variety of interests, nearly two-thirds of the board’s voting members as of September 2021 had professional ties to ambulance services.

Systemwide Leadership

EMSRB—composed of a 19-member governing board, an executive director, and several staff—is the primary entity in Minnesota responsible for ensuring that ambulance care is delivered by licensed ambulance services and certified personnel. In addition to its regulatory responsibilities, the Legislature also created EMSRB to serve in a broad support role for emergency medical services in the state. In the legislation creating EMSRB, the Legislature found that “the emergency medical services (EMS) system and the critical public health needs it addresses would be greatly enhanced by establishing an independent governing body that has the responsibility and authority to ensure the efficient and effective operation of the system.”³

Further, EMSRB is statutorily authorized to address “issues affecting the statewide delivery system” and is directed to “make recommendations to the legislature on improving the access, delivery, and effectiveness of the state’s emergency medical

¹ *Minnesota Statutes* 2021, 144E.01, subd. 6(a)(1); 144E.10; 144E.275; and 144E.28.

² *Minnesota Statutes* 2021, 144E.01, subd. 6(a)(4); 144E.10; 144E.18; 144E.27, subd. 2; and 144E.28, subd. 1.

³ *Laws of Minnesota* 1995, chapter 207, art. 9, sec. 56.

services delivery system.”⁴ Since its inception, EMSRB has been instructed to use grant funds for “promoting systematic, cost-effective delivery of emergency medical care throughout the state” and “identifying common local, regional, and state emergency medical system needs and providing assistance in addressing those needs.”⁵

EMSRB has been largely ineffective in its regulation and support of ambulance services in Minnesota.

EMSRB’s stated mission is “To protect the public’s health and safety through regulation and support of the EMS [emergency medical services] system.”⁶ However, EMSRB has not effectively fulfilled this mission for several years.

- **EMSRB has not created or implemented a plan for emergency medical services in Minnesota.** Statutes state that EMSRB “may prepare an initial work plan, which may be updated biennially,” which may include preparation of “an emergency medical services assessment which addresses issues affecting the statewide delivery system.”⁷ The board chair told us that EMSRB last developed a work plan about seven years ago, but the plan was limited to the operations of EMSRB and did not address the state’s emergency medical services as a whole.

Several other states create and periodically update statewide emergency medical services plans. For example, the Pennsylvania Department of Health is required to prepare and revise a statewide emergency medical services system plan, which must specify

performance measures, strategies for achieving the performance measures, and methods for evaluating the strategies.⁸ The Virginia Board of Health is also required to triennially publish a plan that outlines strategies to improve the effectiveness and efficiency of Virginia’s emergency care system.⁹ Its plan for 2020-2022 includes actions the health department and others could take to develop and implement initiatives to recruit and retain emergency medical services personnel, promote and facilitate emergency medical service research, and coordinate the emergency medical services system’s response to natural disasters and public health emergencies, among other things.



[Emergency medical services] is on the verge of collapse and what has the EMSRB done to assist?

— Ambulance service director

⁴ *Minnesota Statutes* 2021, 144E.01, subd. 6.

⁵ *Minnesota Statutes* 2021, 144E.50, subd. 2.

⁶ Emergency Medical Services Regulatory Board, *EMSRB Mission and Values*, <https://mn.gov/emsrp/about/missionvalues/>, accessed December 30, 2021.

⁷ *Minnesota Statutes* 2021, 144E.01, subd. 6(b).

⁸ 35 *Pennsylvania Consolidated Statutes*, sec. 8111.

⁹ *Code of Virginia*, sec. 32.1-111.3 (2021).

- **EMSRB has taken limited action to address staffing and sustainability issues in Minnesota as a whole.** As we discussed in Chapter 5, ambulance services reported to us that they are facing significant personnel and revenue challenges that affect their ongoing operations. Staffing and sustainability concerns have persisted for decades, and several individuals expressed to us frustration that the Legislature and EMSRB have taken little action to address them.



The EMSRB should be a driving force in improving EMS in Minnesota, and at this time they are failing. However, with the right people in place and the right support, I think that they could help move Minnesota's EMS system into the future.

— Regional emergency medical services organization director

While the regional emergency medical services organizations, nonprofit organizations, and other state agencies can play a role in addressing ambulance staffing and sustainability issues, EMSRB has important responsibilities.¹⁰ As we noted above, one of EMSRB's statutory duties is to "make recommendations to the legislature on improving the access, delivery, and effectiveness of the state's emergency medical services delivery system."¹¹

Despite some calls from board members to address staffing and sustainability issues, the board took no action to address these issues at a statewide level during any of its meetings in 2015 through 2021.

Aside from answering questions and providing informal coaching, the only effort EMSRB has undertaken to address sustainability challenges has been its "rural ambulance assessments." In such assessments, EMSRB staff typically examine an individual ambulance service's management, staffing, medical direction, and financial practices. At the end of the assessment, EMSRB staff produce a report intended to help the service make changes. However, EMSRB only conducts these assessments when it has staff available, and generally only when ambulance services request them. EMSRB staff told us that the agency did not conduct any assessments in 2019, and completed only two full assessments over the subsequent two years. Although directors of regional emergency medical services organizations told us that EMSRB's rural ambulance assessments had helped services in their regions, they said that far more services need assistance than EMSRB can reach at its current rate of conducting assessments.



The EMSRB lacks strong leadership, funding, and support of the State Government. Our EMS systems are vital to the communities they serve, yet our elected officials and EMSRB officials seem absent and unsupportive in addressing the staffing challenges faced by all ambulance services. EMSRB has not helped improve reimbursement rates nor acted as a strong advocate on behalf of EMS services.

— Ambulance service director

¹⁰ As we noted in Chapter 1, Minnesota has eight emergency medical services regions. The regional organizations use grant funds distributed by EMSRB to promote the delivery of emergency medical care, identify regional needs, and establish and maintain training standards for ambulance crews in their regions.

¹¹ *Minnesota Statutes* 2021, 144E.01, subd. 6(a)(3).



It is time for the EMSRB to get with what is needed for the patients of this state. This means a massive shift in ideas and priorities of EMS. You just have to look at other states to see that we [are] starting to fall behind when it comes to pre-hospital evidence-based care. If the EMSRB doesn't regulate and push what is best for a patient and EMS service in the state, then what is it that they exactly do?

— Ambulance service director

- **EMSRB has not updated emergency medical services regulations to account for changes in technology and service provision.** Despite having broad statutory authority to promulgate rules, EMSRB has not made any changes to its rules since 2001. Some rules that establish standards for ambulance services are outdated. For example, one section of rules, which deals with radio frequencies, dates from at least the early 1980s and has not been updated to account for modern communications technology.

The EMSRB board chair told us that EMSRB has believed it could not afford the rulemaking process and that it would be better to try to change statutes than to change rules. As a result, the board has simply left the rules in place and allowed services to ignore them.

- **Even though primary service areas were first created 40 years ago and EMSRB has been in existence since 1996, EMSRB has never published maps of the state's primary service areas.** EMSRB staff told us that the text-based primary service area boundary information on EMSRB's website was last updated over six years ago and would not guarantee its accuracy. When we used up-to-date files EMSRB provided to us to map primary service areas, we found dozens of gaps, inadvertent overlaps, and other obvious errors.

Further, EMSRB has not used commonly familiar landmarks to designate primary service area boundaries, such as municipal and county boundaries, highways, and rivers. Instead, EMSRB has relied on public land survey township and section numbers—a system of specifying land area that dates back to the 19th century. EMSRB's use of public land survey township and section numbers does not provide stakeholders with transparent information about what locations are actually in a given ambulance service's area.

- **EMSRB has not implemented a financial data collection system mandated by statute.** Statutes require EMSRB to establish a financial data collection system for all licensed ambulance services.¹² The 1997 Legislature created this requirement and appropriated \$52,000 to EMSRB to implement it.¹³ According to EMSRB staff, the agency does not currently collect financial data from ambulance services. The board chair and vice chair—both of whom have served on the board for about a decade—told us they had never seen the statute prior to our inquiry.

¹² *Minnesota Statutes* 2021, 62J.49, subd. 1.

¹³ *Laws of Minnesota* 1997, chapter 203, art. 1, sec. 6; and art. 2, sec. 1, codified as *Minnesota Statutes* 2021, 62J.49.

Recommendations

RECOMMENDATION

The Legislature should require EMSRB to create and periodically update a statewide emergency medical services plan, and report regularly on its progress toward achieving the goals outlined in the plan.

The Legislature should mandate that EMSRB complete a statewide emergency medical services plan as part of its duty to seek improvements to the state's emergency medical services delivery system. A statewide plan could help EMSRB, legislators, and other state leaders plan for and strategically respond to changes in the emergency medical services and health care industries. A statewide plan could also aid efforts to respond to the significant staffing and sustainability challenges currently facing Minnesota ambulance services.¹⁴

A statewide emergency medical services plan should include:

- Broad, long-term goals for Minnesota's emergency medical services system.
- Specific actions that EMSRB and other entities need to take to achieve the goals.
- The entity or entities responsible for implementing the actions.
- Target dates by which the actions will occur.
- Strategies for measuring the effectiveness of the specified actions in meeting the goals.

When requiring a statewide emergency medical services plan, the Legislature should consider how EMSRB should involve the state's regional emergency medical services organizations, other state agencies, industry representatives, and members of the public in the planning process. The Legislature should also specify how often EMSRB should report on its progress meeting the goals outlined in the plan and how frequently EMSRB should update the plan.

RECOMMENDATION

EMSRB should update its administrative rules.

The board should act to revise its outdated rules. Rules regarding communications, vehicles, medications, and training should all be updated to match currently accepted industry best practices. Additionally, updating rules would provide EMSRB a means to develop meaningful standards by which it could assess ambulance services, as we discussed in Chapter 4.

¹⁴ In Chapter 5, we recommended that the Legislature explore options to address Minnesota ambulance services' revenue and staffing challenges.

As we noted above, the board chair told us that EMSRB has not revised its rules because it believed it could not afford to undertake rulemaking. We acknowledge that state agencies can spend tens of thousands of dollars on rulemaking processes.¹⁵ However, as a rulemaking agency, EMSRB should plan and budget for such costs. Further, as we describe in the next section, EMSRB returned money to the General Fund at the end of several recent biennia.

RECOMMENDATION

EMSRB should improve its documentation and publication of primary service area boundaries.

Although primary service areas have been in place for 40 years, EMSRB has never published maps of the state's primary service areas. Primary service areas are a core component of the ambulance service system in Minnesota, and one of EMSRB's primary responsibilities is to regulate ambulance services.

EMSRB should produce up-to-date maps of primary service areas, post them on its website, and keep them up-to-date. It should also work with the Minnesota Information Technology Services' (MNIT's) Geospatial Information Office to produce and publish geographic information system data for use by local governments, state agencies, and other stakeholders. In addition, given the widespread use of geographic information system software in the administration of public safety programs, we do not see any reason for EMSRB to continue using public land survey township and section numbers as its formal means of defining primary service areas. When EMSRB revises primary service area boundaries, it should instead delineate service areas in the same way that fire and police services often do—by using commonly familiar geographical lines such as county, city, and township boundaries, and highways, railroads, lakes, and rivers.

RECOMMENDATION

Unless the Legislature decides to repeal the statutory requirement for a financial data collection system, EMSRB should develop and implement this system.

We were unable to determine whether EMSRB ever created a financial data collection system as the 1997 Legislature directed it to do. Regardless, the requirement still exists in statutes, and EMSRB should follow the law.

That being said, the statute's wording is vague, and current EMSRB staff and board members are unfamiliar with the Legislature's original intent. The Legislature should consider amending the statute to provide greater clarity regarding the data it wishes EMSRB to collect. If the Legislature no longer sees a need for this requirement, it should repeal this statutory language.

¹⁵ For example, see the cost estimates in Patricia Winget, ed., *Minnesota Rulemaking Manual* (St. Paul, August 15, 2020), 282, www.health.state.mn.us/rules/manual/, accessed January 21, 2022.

EMSRB Operations

As we noted above, statutes require EMSRB to conduct a number of activities to regulate ambulance services and personnel.¹⁶ Two key components of EMSRB’s regulatory authority are its responsibility to conduct inspections and investigations.

- During onsite **inspections** of ambulance services, EMSRB staff review documents and inspect ambulances to determine whether ambulance services comply with state licensing requirements. As we explained in Chapter 3, EMSRB conducts inspections before approving new ambulance service licenses. Statutes also allow EMSRB to inspect ambulance services “as frequently as deemed necessary.”¹⁷
- EMSRB **investigates** complaints against ambulance services and personnel. Members of the public and ambulance services may submit complaints. When EMSRB receives such complaints, EMSRB investigators collect documents, interview individuals associated with the complaint, and write reports detailing their findings.¹⁸ A committee of the EMSRB board then reviews the investigation and makes a recommendation to the board on the outcome of the case.¹⁹ For example, the committee may recommend that the board revoke an emergency medical technician’s (EMT’s) certification.

EMSRB has failed to carry out some of its core functions, in part due to insufficient staffing.



The EMSRB has been unresponsive to complaints filed and it’s taken several prompts to have complaints made 2+ years ago investigated. The complaints made involved controlled substance diversion and no follow-up was done by the EMSRB after the complaint was made. Finally, after 2 years and several phone calls to the main [St. Paul] office, I received a call from an investigator.

— Ambulance service director

When EMSRB began operating in July 1996, it had 17 full-time staff; in late 2018 and early 2019, it had as few as 3 full-time staff. Prior to 2020, EMSRB had no

investigators on staff to handle the complaints it received against ambulance services and personnel. And, from mid-2018 to mid-2019, there was only a single EMSRB staff person available to inspect all ambulance services in the state. As of January 2022, more than half of EMSRB’s ten staff had worked at the agency less than two years.

¹⁶ See, for example, *Minnesota Statutes* 2021, 144E.01, subd. 6; 144E.10; 144E.18; 144E.27; and 144E.28.

¹⁷ *Minnesota Statutes* 2021, 144E.18.

¹⁸ Statutes require licensed ambulance services to report to EMSRB certain situations involving their personnel, such as when the service dismisses an employee or when the service reasonably believes that an employee is unable to provide adequate care due to illness, a mental or physical condition, or use of drugs or alcohol (*Minnesota Statutes* 2021, 144E.305, subd. 2).

¹⁹ The committee may also directly refer an individual to the state’s Health Professional Services Program. The Health Professional Services Program provides services—such as referrals for evaluation and treatment—to licensed health professionals who are unable to perform their jobs due to illness or alcohol, drug, or chemical use.

An EMSRB staff person told us that many complaints EMSRB received from about 2017 to 2020 were not investigated, in part because EMSRB did not have sufficient numbers of staff.²⁰ Some complaints that EMSRB received and reviewed in that time remained open until 2021. Further, while states are required to submit data to a federal database on disciplinary actions taken against emergency medical services providers, a staff person told us that no one from EMSRB logged into the federal system between 2017 and mid-2021.²¹ As a result, nearly 400 disciplinary actions taken since 2017 had not been reported. It is possible that some individuals with substantiated complaints against them could have been approved to practice in another state without the other state knowing about disciplinary action EMSRB had taken.



[One individual] was fired for diverting narcotics from another agency, and applied at our agency. The theft had occurred two years earlier, and nothing was shown on the state for issues or discipline as the matter was still in an open investigation, two years later. Our agency would never have known this except for the fact that one of the people on the hiring committee worked with this individual at the other agency, and was part of the initial investigation.

— Ambulance service director

Additionally, EMSRB staff told us they aim to inspect ambulance services every two years. However, of the 277 services licensed as of July 2021, EMSRB had only inspected 13 percent in the previous two years, largely due to a lack of staff.²² One ambulance service director told us his service had not been inspected in 12 years.



We have not seen anyone from the EMSRB for at least 7 years. I have had a new truck since 2016 and have not had it inspected by anyone. We still operate under a temporary [authorization] until inspection. We are currently adding two new trucks and still cannot get inspections of these trucks. We have not had a base inspection for at least 10 years.

— Ambulance service director

A number of respondents to our survey of ambulance services indicated that they had not been inspected for five or more years.²³

EMSRB's staffing shortage was not due to a lack of money. Between the 2012-2013 biennium and the 2020-2021 biennium, the biennial appropriation for EMSRB operations grew from about \$2.5 million to \$3.8 million in inflation-adjusted 2020 dollars.

EMSRB did not spend all of its operations appropriation during the three most recent biennia. At the end of the 2016-2017 biennium, EMSRB returned to the General Fund about \$227,000 of unspent funds dedicated for its operations. At the end of the 2018-2019 biennium, EMSRB forfeited

²⁰ An EMSRB staff person told us that as of early February 2022, EMSRB investigators had conducted at least some investigatory work on each of the outstanding complaints and had closed them all.

²¹ 45 *CFR*, sec. 60.9 (2020), requires states to report to the National Practitioner Data Bank adverse licensure or certification actions taken against health care practitioners.

²² Between March 2020 and June 2021, many statutes regulating ambulance care and transportation were suspended by a peacetime emergency declaration related to the COVID-19 pandemic. As a result, EMSRB determined it would not conduct routine ambulance service inspections. However, for the 18 months immediately preceding the COVID-19 pandemic, EMSRB only had one staff person available to inspect ambulance services. An EMSRB staff person told us that during this time, the agency focused on inspecting only the services where problems had been reported, or the services applying for new types of licenses.

²³ We surveyed directors of all 258 ground ambulance services licensed to respond to 911 calls in Minnesota as of August 2021. We received responses from 186, for a response rate of 72 percent.

about \$1.2 million dedicated for its operations, and at the end of the 2020-2021 biennium, EMSRB forfeited \$703,000.

Ambulance service directors who responded to our survey had differing experiences with EMSRB. A majority of ambulance service directors indicated that they were satisfied with some aspects of EMSRB's work, including its certification of individuals and licensing of ambulance services. However, one in five survey respondents indicated that they were dissatisfied with EMSRB's inspections of vehicles and equipment and one in four said they were dissatisfied with EMSRB's administration of grant funds.²⁴

We make a recommendation related to EMSRB's failure to carry out some of its core functions in the next section.

Board Oversight

The EMSRB board is ultimately responsible for overseeing the operations of the agency as a whole. The board directs and oversees the work of the executive director, who in turn directs and oversees the work of the staff.

The EMSRB board has failed to provide sufficient oversight of the agency's activities.

EMSRB's failure to provide systemwide leadership and perform some of its basic responsibilities—which we discussed above—indicates that the board has not adequately overseen the agency for some time. The board's Internal Operating Procedure states that the board's executive committee "is responsible for appraising the performance of the executive director at least annually."²⁵ However, the board has not conducted a performance appraisal of the executive director in many years. The last documentation of a performance appraisal we found was in 2016.



[EMSRB has] not been able to maintain a consistent Executive Director that maintains the focus on the mission of the EMSRB. The focus should be to ensure EMS agencies are compliant with regulations, and provide support and guidance to services that may be struggling.

— Ambulance service administrator

The current board chair told us about a number of questionable decisions made by former executive directors.²⁶ According to the board chair, EMSRB's former executive director had authorization from the board to hire more staff and did not do so. Additionally, the former executive director signed a ten-year lease for office space that is much bigger than EMSRB needs, at more than double the cost of the lease for its former office space. The board chair told us this decision limits EMSRB's ability to hire additional staff in the coming years. The board chair also told us that after the most recent

²⁴ EMSRB provides grants to Minnesota's eight regional emergency medical services organizations to broadly support ambulance services and to reimburse individuals for out-of-pocket training costs; it also provides grants directly to ambulance services to fund volunteer EMT training.

²⁵ Emergency Medical Services Regulatory Board, *Internal Operating Procedures*, revised September 2015.

²⁶ Between June 2011 and June 2021, EMSRB had one interim and two permanent executive directors. The agency did not have an executive director between June 2021 and January 2022.

executive director left, he discovered that nearly all EMSRB staff had been assigned state cars. Some staff were using them to commute to work from home, which violated state law.²⁷ Finally, according to the board chair, former executive directors have been asked to appear at or attend legislative hearings and have simply chosen not to go. The executive directors did not inform the board that their attendance had been requested.

In June 2021, the most recent former executive director's appointment was discontinued. This decision followed the board's receipt of a May 2021

report by an outside attorney that concluded that the former executive director "hired other employees and contractors with whom he had a previous personal relationship" and "failed to complete various tasks in a timely manner," among other things.²⁸

EMSRB's board chair acknowledged to us that the board has done very poorly in its oversight of the executive director the entire time he has been on the board (nearly a decade).



The EMSRB has not been filling the positions needed. When the EMSRB was fully staffed, regional staff members were a great asset ensuring local inspections were done. They also helped local leaders identify required paperwork and offered advice and direction to help with recruiting and retention. As time has gone on, those positions were alleviated or combined with more coverage focused on the Twin Cities metro area, leaving greater Minnesota to fend for itself or not receive any assistance. My service has not had a regional representative for the EMSRB or an inspection in excess of 5 years.

— Ambulance service director

Recommendations

RECOMMENDATIONS

The EMSRB board should:

- **Improve its oversight of the executive director.**
- **Ensure that the organization fulfills its responsibilities and maintains adequate staff to do so.**

The EMSRB board is responsible for ensuring that the agency fulfills its mission to regulate and support emergency medical services within Minnesota. As a result, it is important that the board ensures that the executive director provides strong leadership to the organization and fills vacant positions so that EMSRB can fulfill its responsibilities. While our evaluation was underway, the EMSRB board revamped some of its internal processes to address some of the issues described above. It is too soon to evaluate the effects of these changes.

²⁷ *Minnesota Statutes* 2021, 16B.55, subd. 2.

²⁸ Christian R. Shafer, *Emergency Medical Services Regulatory Board Investigation Report* (Minneapolis: Ratwik, Roszak & Maloney, P.A., May 24, 2021), 5.

RECOMMENDATION

The Legislature should require the EMSRB board to regularly evaluate the executive director's performance.

As we stated above, the board's executive committee is responsible for appraising the executive director's performance annually under internal agency policies. However, the board has not held itself accountable to this standard, and the agency's performance has suffered. As a result, we think the Legislature should mandate in law that the EMSRB board regularly evaluate the executive director's performance.

Board Membership

EMSRB has a 19-member board, with 17 voting members and 2 ex-officio, nonvoting members. As the box below shows, statutes require that the EMSRB board include representatives with many different backgrounds.

Although statutes require that EMSRB board members represent a variety of interests, nearly two-thirds of the board's voting members as of September 2021 had professional ties to ambulance services.



Statutes specify that the EMSRB board include:

- One emergency physician
- One representative of Minnesota hospitals
- One representative of fire chiefs
- One full-time firefighter who serves as an emergency medical responder and who meets other criteria
- One volunteer firefighter who serves as an emergency medical responder
- One EMT or paramedic working at a licensed ambulance service
- One ambulance director for a licensed ambulance service
- One representative of sheriffs
- One member of a community health board
- Two representatives of regional emergency medical services organizations, one of whom must be from the Twin Cities metropolitan region
- One registered nurse currently working at a hospital emergency department
- One pediatrician with experience in emergency medical services
- One family practice physician involved in emergency medical services
- One public member
- The commissioners of health and public safety or their designees
- One state representative (nonvoting member)
- One state senator (nonvoting member)

— *Minnesota Statutes 2021, 144E.01, subds. 1(a) and 2*

Statutes require representation on the EMSRB board from many different stakeholder groups, including nurses, firefighters, hospitals, and sheriffs. Based on the statutory requirements, only two of EMSRB's voting board members must work for an ambulance service. In September 2021, however, 10 of the board's 16 voting members either worked or volunteered for ambulance services.

For example, both the board member representing hospitals and the board member representing fire chiefs were deputy chiefs of large ambulance services based in the Twin Cities metropolitan area. The board member representing sheriffs was a volunteer paramedic, and one of the board members representing regional emergency medical services organizations was the medical director for two ambulance services in Hennepin County.

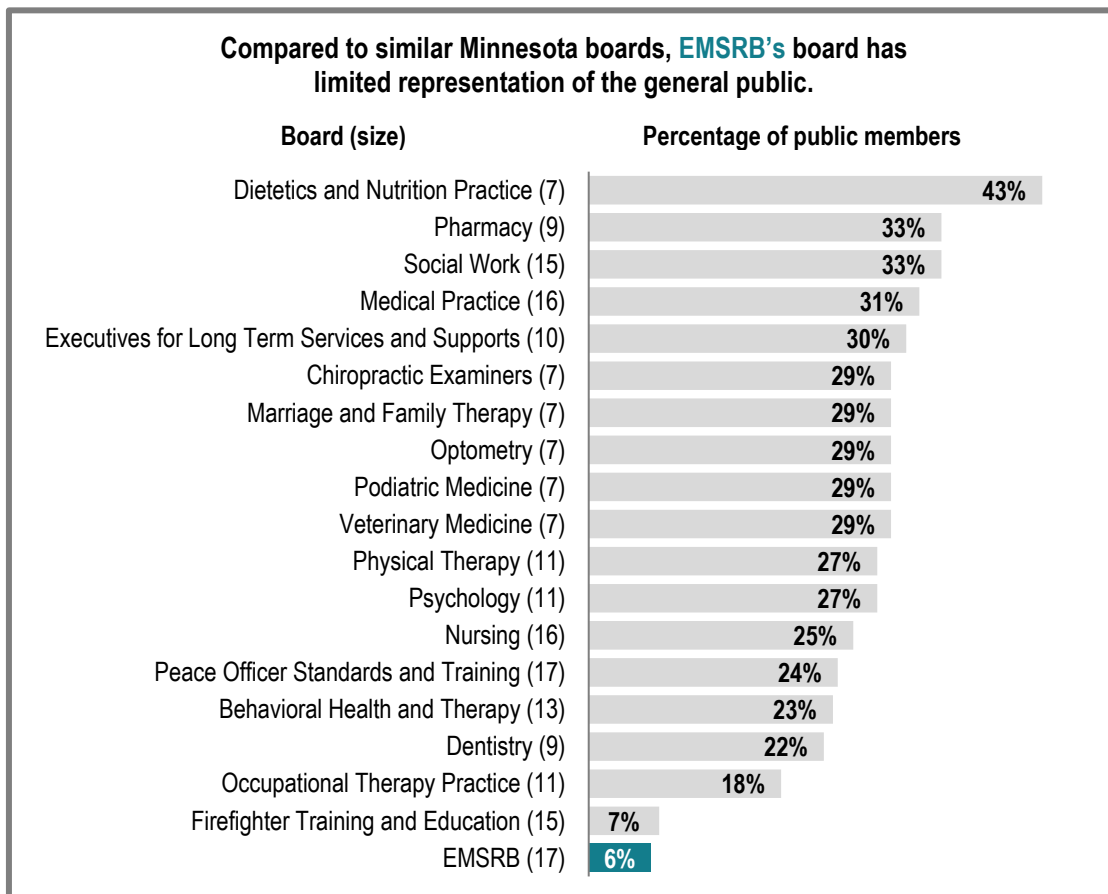
Several individuals shared with us concerns about the number and types of representatives that make up the EMSRB board. Some people told us that the board's composition gives the appearance that the

board is biased and does not represent certain types of ambulance services, such as rural ambulance services. Others told us that the board has too many members.

EMSRB's board has few members who represent the general public.

As we noted above, the EMSRB board is largely composed of individuals who are connected to the emergency medical service industry. Only 1 of the board's 17 voting members (6 percent) must be a member of the general public. This member is the only member on the board who has a singular allegiance to the interests of the public; all other board members inherently represent other interests, such as ambulance services, physicians, and firefighters.

As the chart below shows, all of the comparable Minnesota boards we reviewed had greater representation of members of the general public than did the EMSRB board. All 16 of the health-related licensing boards that we reviewed, as well as two public safety licensing boards—the Minnesota Board of Firefighter Training and Education and the Minnesota Board of Peace Officer Standards and Training—had more public members or smaller board sizes so that the single public member's position carried greater weight.²⁹



²⁹ We reviewed 16 health-related licensing boards as defined in *Minnesota Statutes* 2021, 214.01, subd. 2. One additional health-related licensing board—the Minnesota Office of Unlicensed Complementary and Alternative Health Care Practice—does not oversee medical professionals, so we omitted it from our analysis. EMSRB is not defined in statute as a health-related licensing board.

EMSRB's board composition and unique responsibilities create risks for conflicts of interest that are not adequately addressed by statutes or board policies.

As we explained above, many EMSRB board members have professional ties to ambulance services—the businesses they are responsible for regulating. However, as several observers expressed to us, these relationships can create an appearance of conflicts of interest. The board's sole public member, who has served for 12 years, has publicly stated that the board's composition creates “an unacceptable risk of opportunities for the (a) reduction of regulatory effectiveness, (b) need of board members to recuse themselves from significant policy discussions and decisions, (c) existence of conflicts of interest, and (d) potential for self-dealing.”³⁰ A conflict of interest occurs when a person derives personal benefit from actions or decisions they make in their official capacity, as we explain in the box below.

Unlike most of the similar state boards we reviewed, EMSRB regulates businesses. All but 1 of the 16 health-related licensing boards we reviewed only license or certify individuals.³¹ Similarly, two public safety licensing boards—the Minnesota Board of Firefighter Training and Education and the Minnesota Board of Peace Officer Standards and Training—license individuals and do not license fire or police departments, respectively. Statutory language pertaining to conflicts of interest by members of these licensing boards generally focuses on relationships board members may have with the individuals they regulate.



A person in a public position has a **potential conflict of interest** when they have a relationship or affiliation that would create an inappropriate influence *only if* the person is called on to make a decision or recommendation that would affect one or more of those relationships or affiliations.

An **actual conflict of interest** occurs if the person actually makes a decision or recommendation.

The **appearance of a conflict of interest** occurs if a “reasonable person” believes the person's relationships or affiliations would inappropriately influence their decision-making.

Statutes and the board's Internal Operating Procedure define conflicts of interest narrowly, and do not take into account EMSRB's unusual circumstances. Statutes state that “No member of the Emergency Medical Services Board may participate or vote in board proceedings in which the member has a *direct* conflict of interest, financial or otherwise.”³² EMSRB's legal counsel told us that a key criterion for determining whether a “direct” conflict of interest exists under the law is whether a decision could *personally* benefit or penalize that board member—for example, whether the board member could gain or lose money as a result of the board's decision. However, EMSRB's board chair told us that board members almost never have a direct conflict of

³⁰ Michael Jordan, written testimony to Minnesota House Health and Finance Policy Committee, January 25, 2021.

³¹ The Minnesota Board of Pharmacy licenses a number of pharmaceutical entities, including pharmacies and manufacturers.

³² *Minnesota Statutes* 2021, 144E.01, subd. 7; emphasis added. The board's Internal Operating Procedure contains a similar statement and generally reflects the process outlined in *Minnesota Statutes* 2021, 10A.07, specifying how public officials should disclose potential conflicts of interest and act to mitigate them.

interest under this definition because the salaries board members receive from ambulance services would be unaffected, even if the board’s decision caused their employer to gain or lose money.

We did not observe any instances in EMSRB board minutes from fiscal years 2020 and 2021 where a board member declared a potential conflict of interest but did not recuse themselves from a vote. However, we saw several instances in which board members abstained or recused themselves from discussions and votes for reasons other than “direct” conflicts of interest. For example, the board discussed a controversial licensing decision and voted on various aspects of the license during three board meetings held in 2020 and 2021. Even though no member of the board likely had a direct conflict of interest (because their salaries would be unaffected by the outcome), four board members either abstained or recused themselves from at least one of the votes.

Recommendations

Several of our findings in the sections above reflect concerns raised in a 1997 assessment by the National Highway Traffic Safety Administration, completed a year after EMSRB began its existence. For example, that assessment recommended that EMSRB “address visionary and strategic issues,” review primary service areas and establish policies to define relationships in overlapping areas, and update the state’s emergency medical services plan.³³ The fact that these issues are still evident after 25 years suggests that EMSRB has been unable to resolve them through successive boards and executive directors.



We look to the EMSRB for guidance on many issues, but find ourselves not getting what is really needed, leadership.

— Ambulance service director

RECOMMENDATION

The Legislature should consider whether to make structural changes to the EMSRB board or EMSRB’s responsibilities.



In my experience, when an organization is consistently unable to retain key leadership, it usually reflects a problem with that organization more than with the leader. Is the Board’s composition, structure, special interests, etc. preventing leadership from being successful?

— Former ambulance service director

The Legislature can take several different approaches when an agency has not met its responsibilities. For example, it can mandate the agency undertake certain activities, or require the agency to report to the Legislature on its work and the resulting outcomes. Throughout this report, we have made several recommendations that the Legislature take such actions. However, the Legislature can also go beyond such directives and make structural changes to an agency’s leadership, organization, or funding. Our findings are serious enough and broad enough that the Legislature should consider whether to make more fundamental changes.

³³ National Highway Traffic Safety Administration, Technical Assistance Team, *State of Minnesota: A Reassessment of Emergency Medical Services* (Washington, DC, 1997), 8 and 10.

Below, we present several structural changes the Legislature should consider. We present them as policy options without a recommendation. We cannot state with confidence that any of the problems we describe above were *caused* by structural weaknesses of EMSRB; we also cannot promise that implementing any of the options below will solve the problems we identified.

- 1. Change board membership.** One approach the Legislature could take is to increase the proportion of EMSRB's board members who are public members relative to the individuals representing ambulance services or other industries. A higher representation of public members could result in a board that has more independence from the industry it regulates and could help alleviate concerns about conflicts of interest.

The Legislature could increase the proportion of board members who are public members either by adding more public members, reducing the size of the board, or both. We note, however, that EMSRB has an unusually large board, one that some observers have suggested is too large. The EMSRB board has more members than each of the 16 health-related licensing boards that license medical professionals, as well as the Minnesota Board of Firefighter Training and Education and the Minnesota Board of Peace Officer Standards and Training.

The Legislature might also consider limiting the number of board members that are owners, directors, or managers of licensed ambulance services. The Legislature has specified that "it is desirable for boards composed primarily of members of the occupations so regulated to be charged with formulating the policies and standards governing the occupation."³⁴ However, because EMSRB regulates businesses as well as occupations, it is fundamentally different from other licensing boards.

- 2. Establish term limits for board members.** Statutes do not limit the number of terms board members may serve. Establishing term limits could make it easier to ensure representation of diverse perspectives and help avoid a concentration of power within a small group of people. As of September 2021, over one-third of EMSRB voting board members had served on the board for more than eight years.³⁵ Three members had served for 12 years, and one for 13 years. The statutes governing 5 of the 16 health-related licensing boards we reviewed limit member's terms to two consecutive four-year terms.³⁶
- 3. Give some or all of EMSRB's functions to another state agency.** For example, the Legislature could consider whether it would be more appropriate for an executive branch agency—such as the Minnesota Department of Health—to license ambulance services, while EMSRB regulates emergency medical services personnel.

³⁴ *Minnesota Statutes* 2021, 214.001, subd. 1.

³⁵ On that date, 16 of the 17 voting positions were filled.

³⁶ The five boards are the Minnesota Board of Dentistry, Minnesota Board of Dietetics and Nutritionist Practice, Minnesota Board of Medical Practice, Minnesota Board of Nursing, and Minnesota Board of Psychology.

EMSRB is unusual when compared to other states' emergency medical services regulatory agencies. In most states, emergency medical services laws are administered and enforced by agencies with broader authority, such as a department of health. We identified only three other states where the regulation and enforcement of emergency medical services is an agency's singular authority.³⁷

4. **Make no changes beyond the recommendations in this report.** The board has already begun making changes, and the Legislature could wait and see if it needs to take additional actions. For example, the board has hired a new Grants and Financial Analyst and a new Compliance Analyst to address concerns about grants and investigations, and it has assigned specific board members to serve as liaisons to staff in an effort to increase its oversight of the agency. However, if the Legislature chooses this option, it should closely monitor EMSRB's performance and its implementation of the recommendations in this report.

RECOMMENDATION

The Legislature should clarify what constitutes a conflict of interest for EMSRB board members.

Statutes and EMSRB policies provide an overly narrow definition of conflicts of interest, considering the composition of the board and the nature of the industry it regulates. Regardless of whether the Legislature makes structural changes to EMSRB, we recommend that the Legislature clarify its intention about what constitutes a conflict of interest for EMSRB board members, given EMSRB's unique structure and responsibilities.

Inconsistent Statutes

Several sections of the statutes regulating ambulance services are contradictory; other sections have not kept pace with changes in the emergency medical services field.

In this report, we have identified some instances where EMSRB has not met its statutory responsibilities. However, the law itself contains numerous contradicting and confusing clauses. For example:

- **There are two different processes for ambulance services to initiate primary service area changes.** One section of statutes indicates that ambulance services wishing to expand their primary service area must go through the initial licensure process, a process that provides an opportunity for public input and state oversight.³⁸ Another section allows services to make

³⁷ The states were Kansas, Maine, and Maryland.

³⁸ *Minnesota Statutes* 2021, 144E.11, subd. 1.

primary service area changes to eliminate overlaps or cover unassigned territory through a less rigorous process.³⁹

- **Requirements for ambulance drivers are confusing.** Ambulance services in most of outstate Minnesota may staff their basic life support ambulance crews with one EMT, who must accompany the patient, and one registered emergency medical responder (EMR) driver.⁴⁰ A separate section of statutes specifies requirements for an ambulance “driver,” but none of the requirements include being registered as an EMR.⁴¹
- **The law’s use of “ambulance service” often does not reflect the statutory definition.** The formal statutory definition of “ambulance service” is “transportation and treatment” provided to ill or injured persons or expectant mothers.⁴² However, many statutes governing ambulances clearly intend that “ambulance service” refer to an organization that holds a license.
- **There are two different definitions of “volunteer.”** One section of statutes defines a volunteer ambulance attendant as an individual whose annual stipend does not exceed \$6,000 annually.⁴³ Another section of law, which specifies eligibility for a retirement award for volunteer ambulance personnel, indicates that the \$6,000 figure should be adjusted for inflation (in December 2021, an individual’s annual earnings would have been capped at about \$8,800 for eligibility for the award).⁴⁴

Additionally, some ambulance statutes have not kept pace with changes in how emergency medical services are delivered. For example, statutes require all ground ambulance services to have associated primary service areas.⁴⁵ However, EMSRB has not required some services with specialized licenses to have primary service areas because these services only provide interfacility transports or other special care. Since they do not respond to 911 calls, the law’s requirement that these services have a primary service area does not make sense.

As another example, rules indicate that ambulance services must have a “base of operations” in their primary service area; both statutes and rules define “base of operations” as “the address at which the physical plant housing ambulances, related

³⁹ *Minnesota Statutes* 2021, 144E.07, subd. 1.

⁴⁰ *Minnesota Statutes* 2021, 144E.101, subd. 6(e). Advanced life support (ALS) services in most of outstate Minnesota are allowed to staff their ambulances with one paramedic and one EMR driver under certain circumstances. See *Minnesota Statutes* 2021, 144E.101, subd. 7(f) and 7(g). We described EMRs in Chapter 1.

⁴¹ *Minnesota Statutes* 2021, 144E.101, subd. 10.

⁴² *Minnesota Statutes* 2021, 144E.001, subd. 3.

⁴³ *Minnesota Statutes* 2021, 144E.001, subd. 15.

⁴⁴ *Minnesota Statutes* 2021, 144E.41(b)(4).

⁴⁵ *Minnesota Statutes* 2021, 144E.10, subd. 1.

equipment, and personnel is located.”⁴⁶ However, an internal report by an EMSRB workgroup has found that bases of operations are “obsolete, or at least geographically meaningless.”⁴⁷ Many larger ambulance services have shifted to “dynamic deployment” models. Ambulance services using these models do not station ambulances at a single location, but rather move ambulances from location to location within the service area to react to changing circumstances. For example, if the ambulances originally stationed in one portion of the service area are busy responding to calls, the ambulance service will direct its remaining ambulance crews to change their locations so the service can provide the best possible coverage of the entire area with its remaining ambulances.

RECOMMENDATION

The Legislature should revise *Minnesota Statutes* 2021, 144E, to clarify contradictory or unclear language.

The Legislature should identify places where statutes contradict or do not reflect current practices or technologies in the emergency medical services industry, including those outlined above. The Legislature should revise these sections of statutes after considering input from stakeholders.

⁴⁶ *Minnesota Rules*, 4690.0100, subp. 3; and 4690.3400, subp. 1, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021; and *Minnesota Statutes* 2021, 144E.001, subd. 4. Ambulance services may also have “substations,” which rules define as locations “from which ambulances and personnel operate to provide ambulance service which is supplementary to that provided from the base of operation” (*Minnesota Rules*, 4690.0100, subp. 33, <https://www.revisor.mn.gov/rules/4690/>, accessed June 15, 2021).

⁴⁷ Brian Edwards, *EMS Base of Operations and Substations: A Workgroup Report For The Minnesota Emergency Medical Services Regulatory Board* (unpublished EMSRB document, 2020), 7.

List of Recommendations

- The Legislature should retain primary service areas, but it should restructure how they are created, modified, and overseen. (p. 24)
- The Legislature should create processes for modifying primary service area boundaries.
 - The Legislature should create a process for reviewing and revising primary service area boundaries on a periodic basis to address demographic and other societal changes.
 - The Legislature should authorize EMSRB to administratively resolve overlaps and gaps in primary service area coverage—if necessary, without the consent of the ambulance services involved. (p. 25)
- The Legislature should establish a process through which local units of government have input into which services provide ambulance care and transportation in their areas. (p. 26)
- The Legislature should adopt more stringent statutory requirements for renewal of ambulance service licenses. (p. 35)
- EMSRB should ensure that ambulance services meet requirements in law. (p. 35)
- The Legislature should require ambulance services to go through the initial licensure process whenever there is a change in ownership or provider. (p. 37)
- The Legislature should direct EMSRB to develop and enforce performance standards for ambulance services. (p. 48)
- EMSRB should work with the Legislature to ensure it has sufficient authority to implement performance standards. (p. 49)
- EMSRB should explore reporting mechanisms that would enable it to track nonresponse by ambulance services. (p. 55)
- The Legislature should explore options for improving ambulance service sustainability in Minnesota, potentially through pilot programs or other trial programs. (p. 59)
- The Legislature should require EMSRB to create and periodically update a statewide emergency medical services plan, and report regularly on its progress toward achieving the goals outlined in the plan. (p. 65)
- EMSRB should update its administrative rules. (p. 65)
- EMSRB should improve its documentation and publication of primary service area boundaries. (p. 66)

- Unless the Legislature decides to repeal the statutory requirement for a financial data collection system, EMSRB should develop and implement this system. (p. 66)
- The EMSRB board should:
 - Improve its oversight of the executive director.
 - Ensure that the organization fulfills its responsibilities and maintains adequate staff to do so. (p. 70)
- The Legislature should require the EMSRB board to regularly evaluate the executive director's performance. (p. 71)
- The Legislature should consider whether to make structural changes to the EMSRB board or EMSRB's responsibilities. (p. 74)
- The Legislature should clarify what constitutes a conflict of interest for EMSRB board members. (p. 76)
- The Legislature should revise *Minnesota Statutes* 2021, 144E, to clarify contradictory or unclear language. (p. 78)

Appendix: Primary Service Area Maps

On the following pages, we present maps of the primary service areas for ambulance services in Minnesota, separated into the areas served by the eight regional emergency medical service organizations. The Emergency Medical Services Regulatory Board (EMS RB) maintains information about primary service area boundaries using public land survey township and section numbers, but has never published maps of the state's primary service areas.

These maps show the areas where ambulance services are *legally* obligated to provide ambulance coverage. As we discussed in Chapter 2, these may not reflect the *actual* service areas in use at the local level. As far as we are aware, no reliable statewide dataset of actual ambulance service area boundaries exists.

The ambulance service names shown are based on those recorded in EMS RB's licensing system. However, we frequently abbreviate names to conserve space.

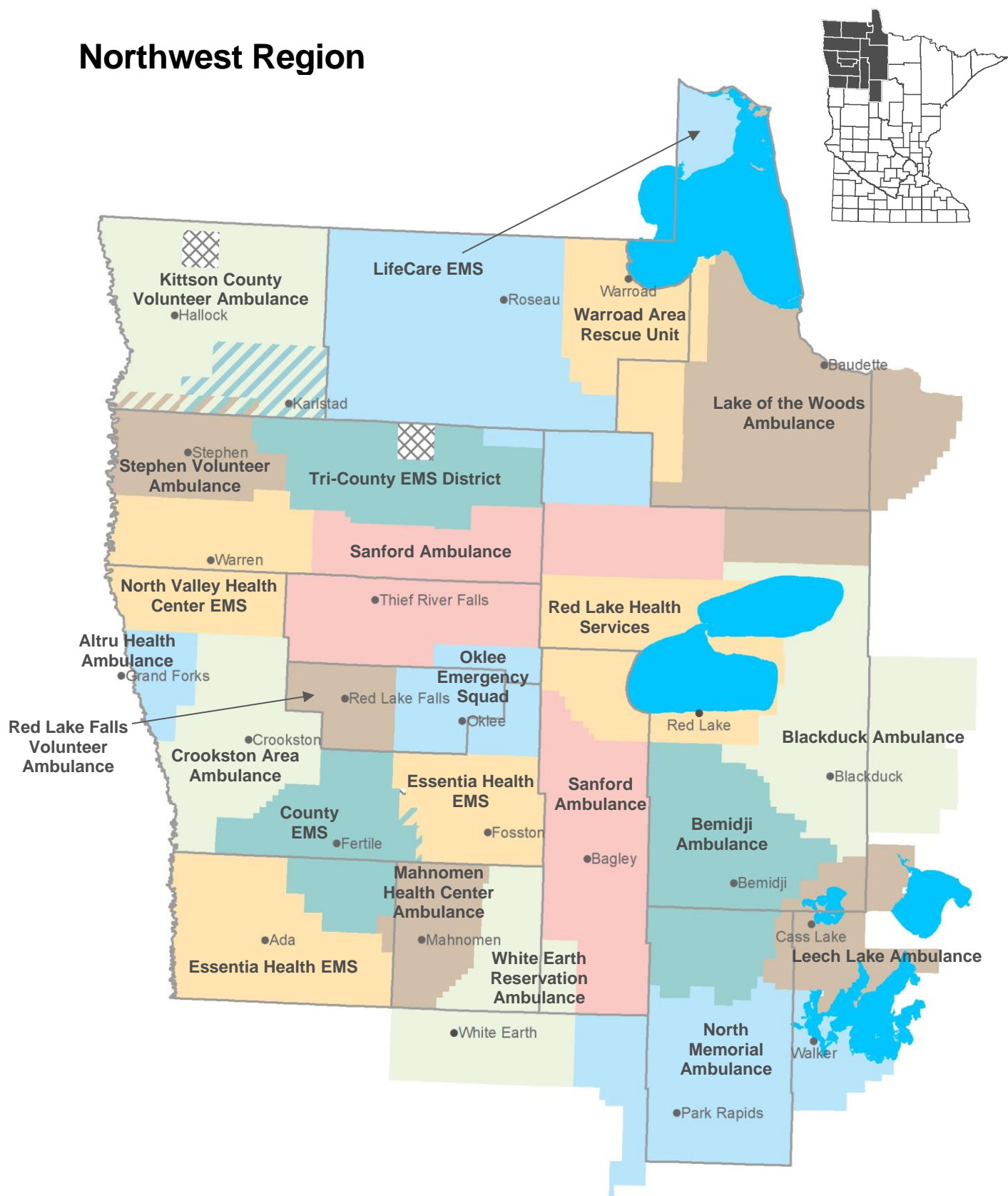
The colors in the maps have no significance; we use them to differentiate primary service areas. We do not show a boundary where the same organization provides service in bordering areas; for example, in the northwest region map, we do not display a boundary between North Memorial Ambulance's Walker-based service and its Park Rapids-based service.

Many of the maps contain gaps and overlaps. Most gaps and some overlaps are probably the result of poor recordkeeping. However, many overlaps stem from the Minnesota Department of Health's decision to allow overlaps when it first created the primary service areas in the 1980s; they have persisted since that time. Overlapping service areas are shown using diagonal lines with alternating colors. Areas with no assigned service are displayed using a grey crosshatched pattern.

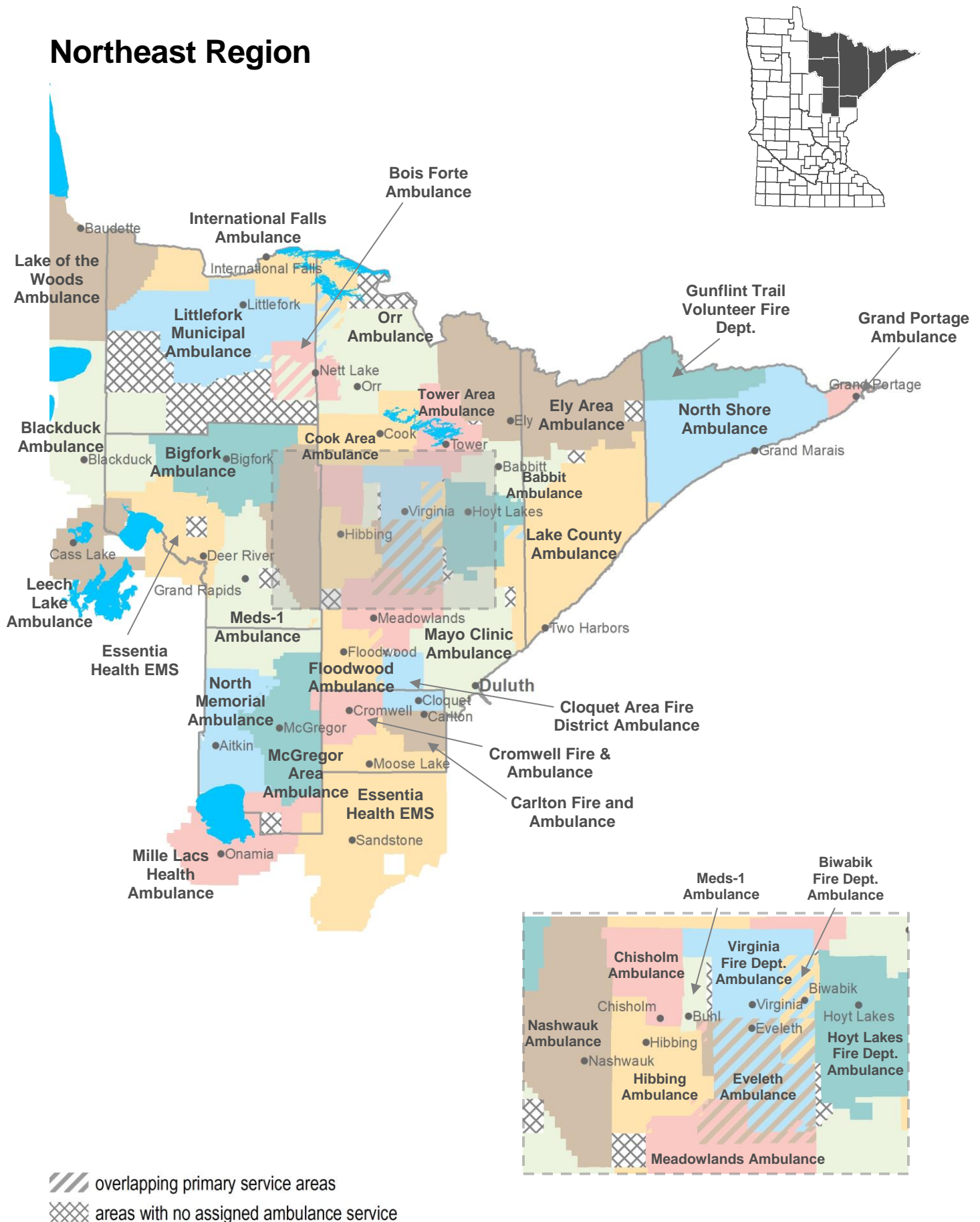
The maps are accurate to the individual public land survey section, which is one square mile of territory. We did not attempt to map service area boundaries that ran through the middle of a section; in such instances, we arbitrarily assigned the section to one area or the other.

The maps reflect data provided to us by EMS RB staff in August 2021, except that we have accounted for the merger of Preston Emergency Service and Lanesboro Ambulance Service, which occurred in November 2021.

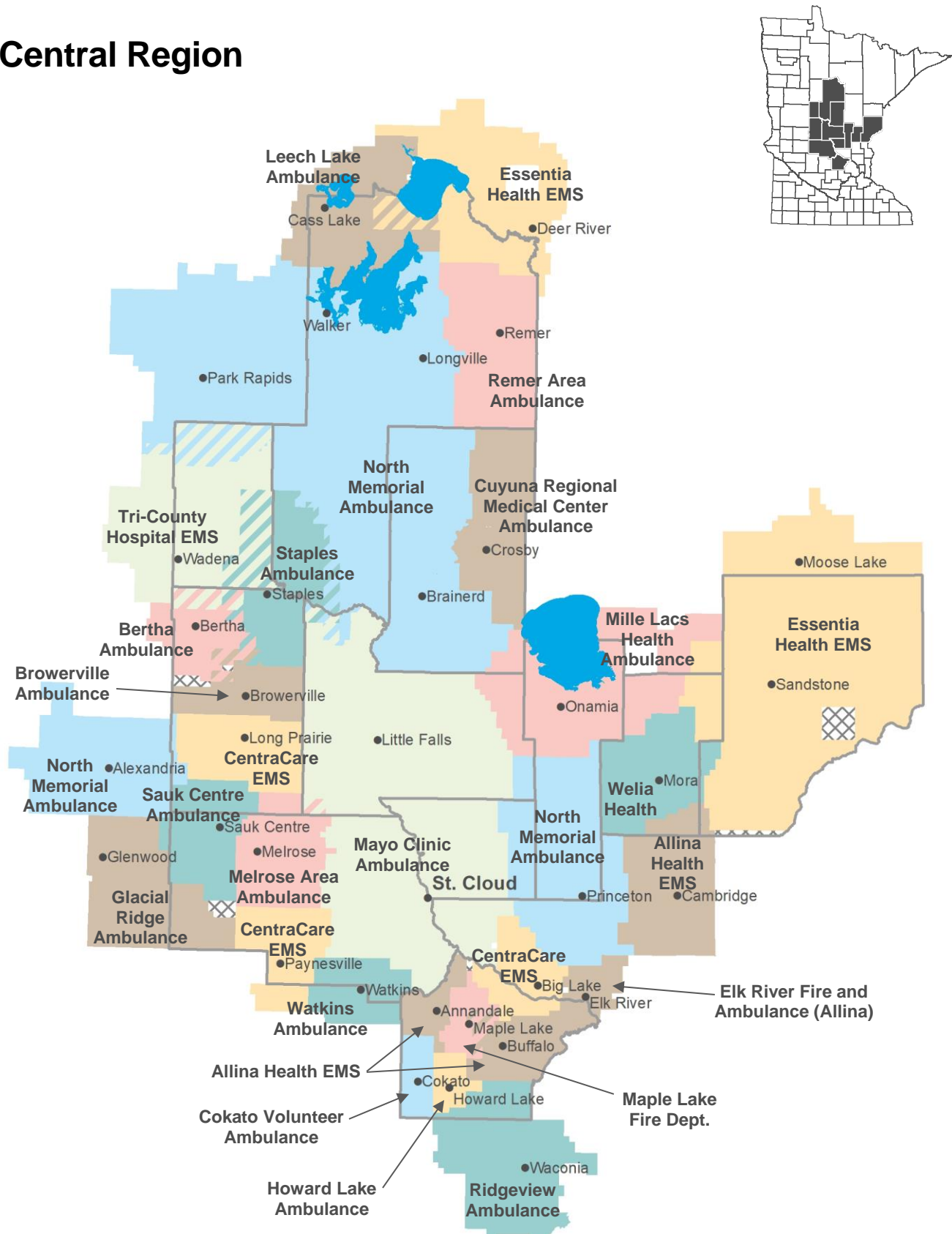
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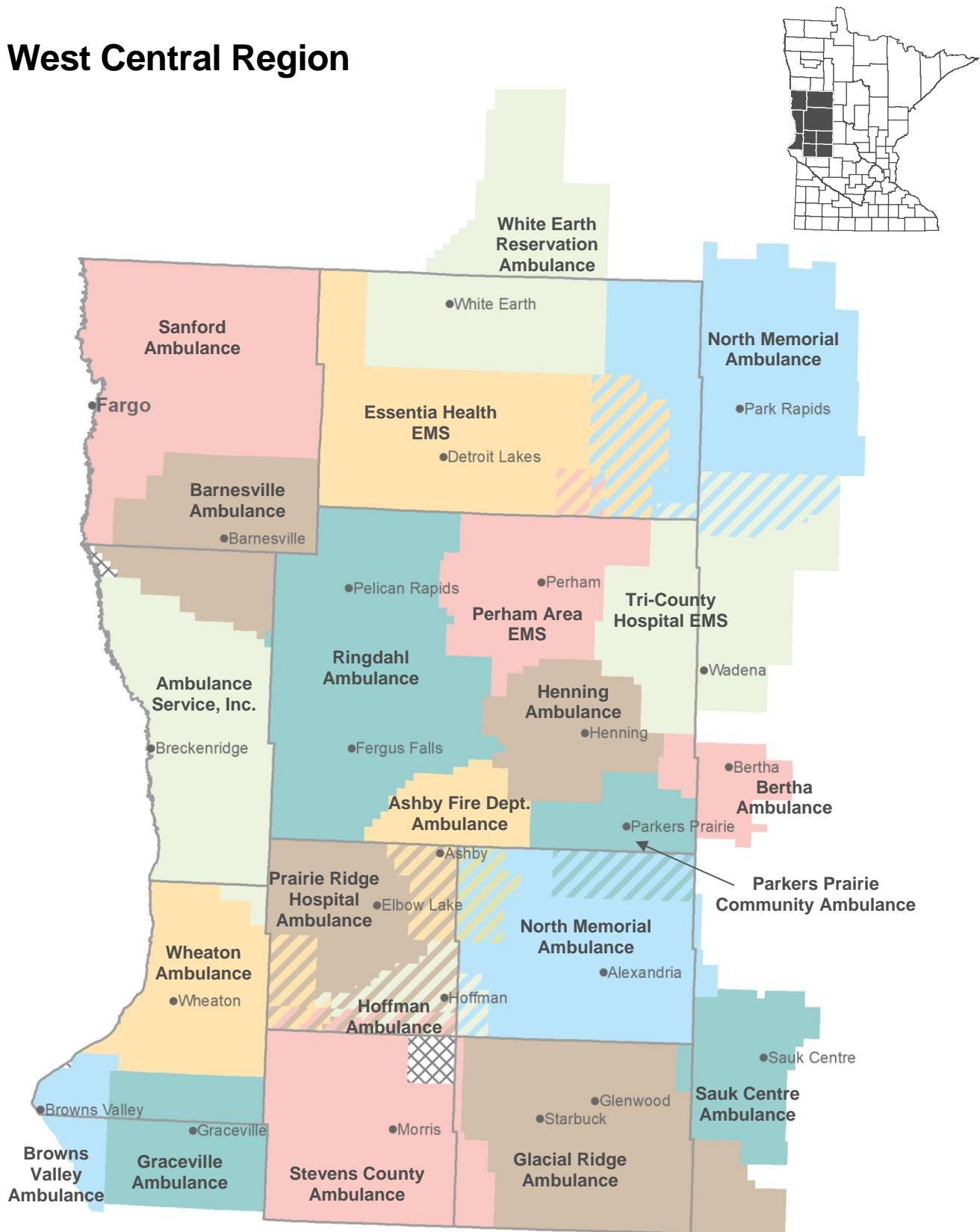
Northeast Region



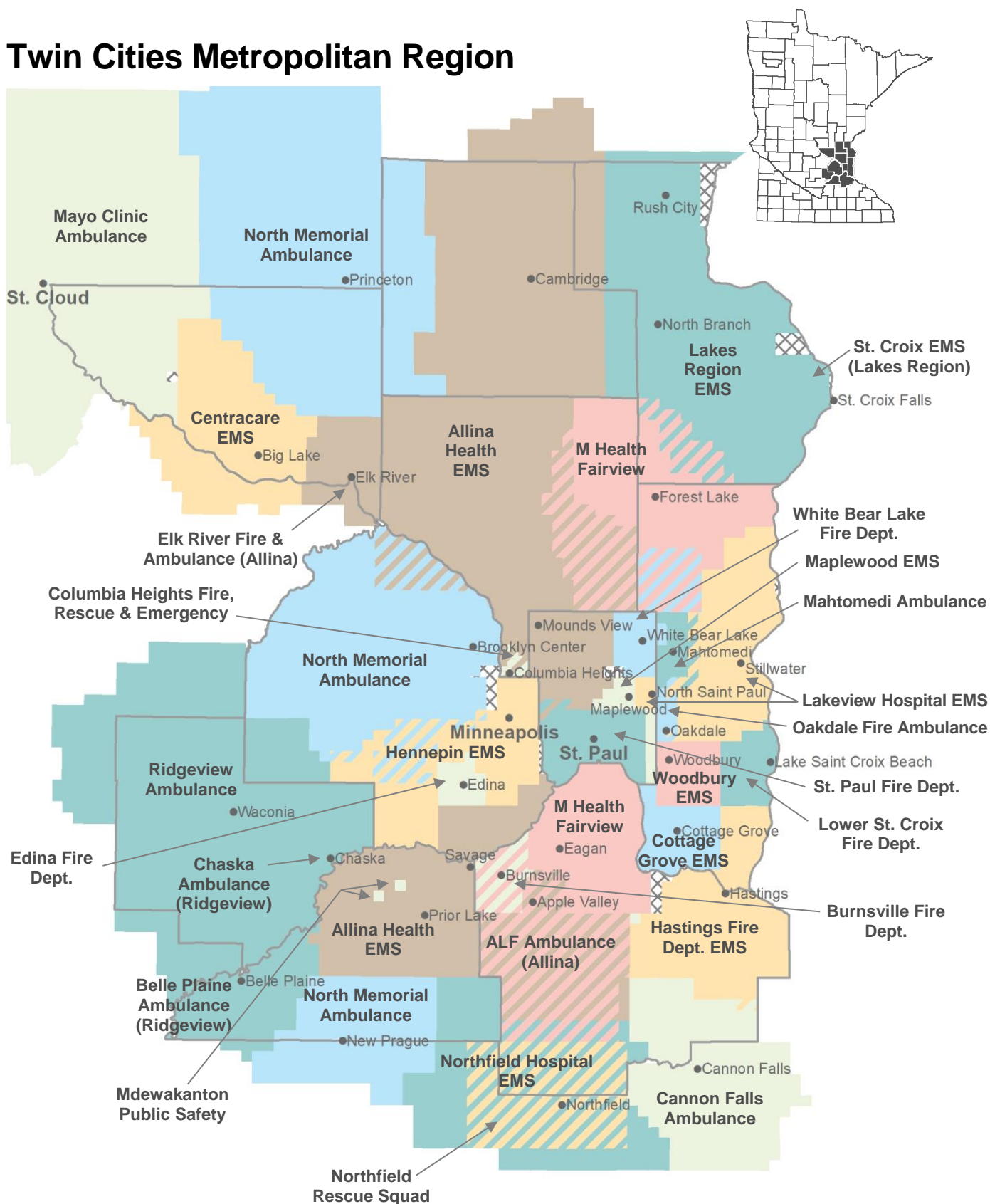
Central Region



West Central Region

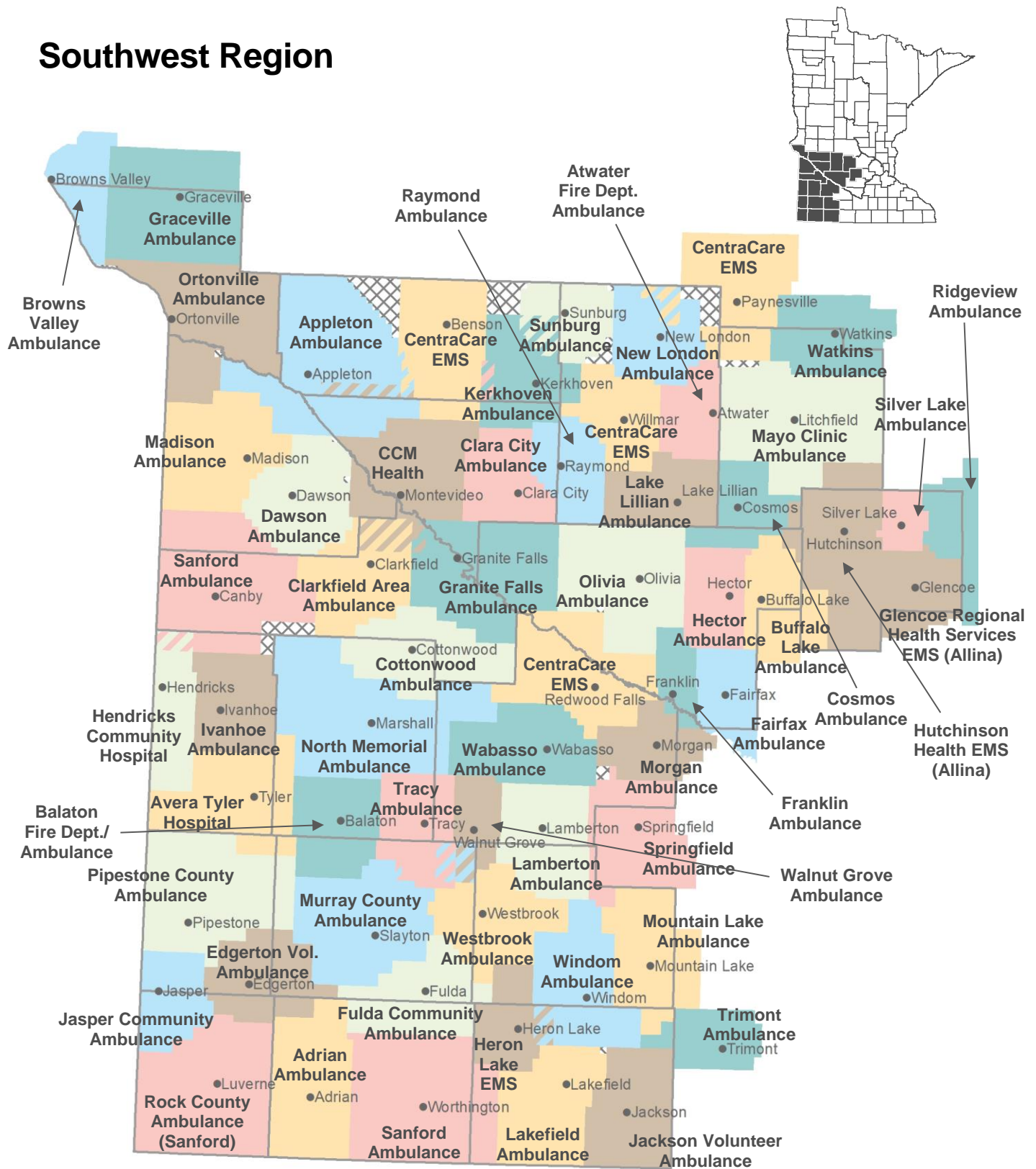


Twin Cities Metropolitan Region

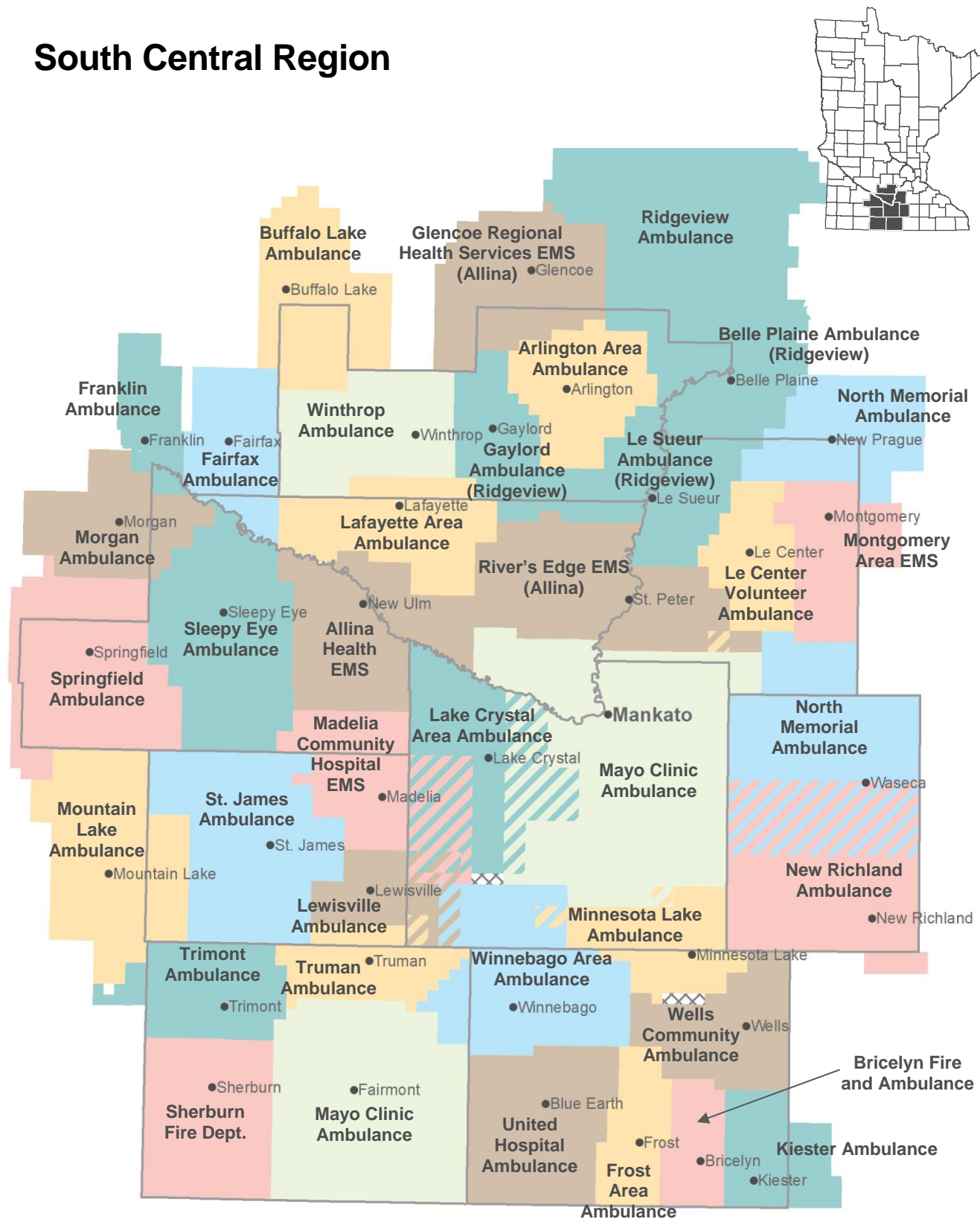


NOTE: We do not display five primary service areas in portions of Anoka, Dakota, Hennepin, Ramsey, and Washington counties associated with BLS licenses held by Allina Health EMS and M Health Fairview. Both companies told us they do not use these licenses to answer 911 calls.

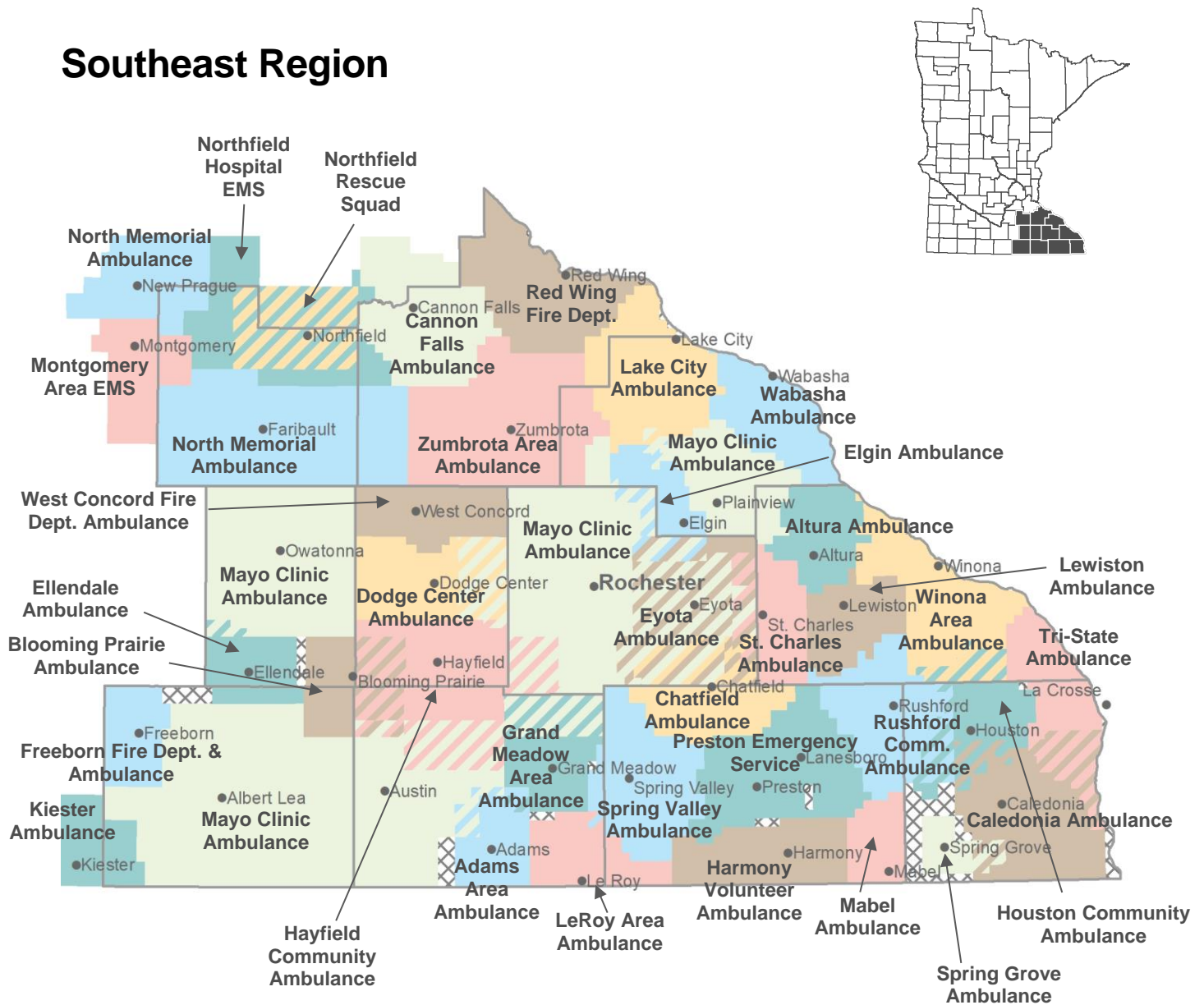
Southwest Region



South Central Region



Southeast Region





OLA

Friday February 18, 2022

Judy Randall
Legislative Auditor
Minnesota Office of the Legislative Auditor
658 Cedar Street
Room 140 Centennial Building
St. Paul, MN 55155-1603

Dear Auditor Randall:

Thank you for the opportunity to review the Office of the Legislative Auditor's evaluation report on Emergency Ambulance Services in Minnesota. On behalf of the Emergency Medical Services Regulatory Board (EMSRB), the EMSRB is aware of multiple challenges and issues facing local communities, EMS agencies, and the overall EMS system at large. It is readily apparent that there are multiple opportunities for improvement that the EMSRB can implement to improve both the administration of Minnesota's EMS system and the quality of pre-hospital care.

Your thorough evaluation raises several serious and important issues, and we are thankful for the diligent work of your team. We understand that due to the evaluation timeline, certain findings and recommendations reflect the state of the EMS system and the EMSRB that existed as of April 2021. We are pleased to report that we have already begun to make urgently needed progress on many of the issues raised by the evaluation. We are committed to working diligently and collaboratively with a broad range of stakeholders, including the Minnesota Legislature, to continue the process in implementing recommendations contained within this report.

Responses to Recommendations by the Office of the Legislative Auditor

1. The Legislature should retain primary service areas, but it should restructure how they are created, modified and overseen (Chapter 2)

EMSRB Response: The EMSRB agrees that there are multiple pathways to updating the overall administration of the Primary Service Area (PSA) process, all of which would require statutory changes to existing legislation. Empowering the EMSRB to establish procedure(s) related to the PSA process would help reduce or eliminate the possibility of creating situations in the future that the

EMSRB would be unable to reconcile, as is evidenced by the present condition. Furthermore, the EMSRB stands ready to assist the Legislature in providing consultation in the revision of the PSA process to ensure that there remains universal access to ambulance service across the state.

2. The Legislature should create processes for modifying primary service area boundaries (Chapter 2)
 - a. The Legislature should create a process for reviewing and revising primary service area boundaries on a periodic basis to address demographic and other societal changes (Chapter 2)
 - b. The Legislature should authorize EMSRB to administratively resolve overlaps and gaps in primary service area coverage—if necessary, without the consent of the ambulance services involved (Chapter 2)

EMSRB Response: The EMSRB would welcome having the statutory and regulatory tools necessary in addressing PSA overlaps. Additionally, where possible, the EMSRB asks to be empowered and given the tools needed to establish board processes to address updating the overall PSA process. Overly prescriptive statutory processes risk the consequence of unusual situations which may not be envisioned during the legislative process.

3. The Legislature should establish a process through which local units of government have input into which services provide ambulance care and transportation in their areas (Chapter 3)

EMSRB Response: The EMSRB agrees that local units of government should be provided the opportunity to participate in PSA reviews, as should all other applicable stakeholders including but not limited to the public, municipalities, townships, tribal governments, and Public Safety Answering Points. We believe that this can be accomplished by empowering the EMSRB to hold public listening sessions and allowing the EMSRB to apply weight to that testimony in addition to the other critical factors of the PSA process.

4. The Legislature should adopt more stringent statutory requirements for renewal of ambulance service licenses (Chapter 3)

EMSRB Response: The EMSRB agrees that there may be some opportunities to review the ambulance license renewal process. The agency is mindful to the overall impacts that additional renewal requirements could impose upon smaller EMS agencies in greater Minnesota. Any adoption of more stringent statutory requirements should be balanced against limiting factors of the EMS system including staff shortages, shifting workforce demographics, call volume, and the significant effects of the COVID-19 pandemic on EMS agencies across the state. Further, stringent statutory requirements should give due regard to what is reasonable given the circumstances of the individual ambulance service.

5. EMSRB should ensure that ambulance services meet requirements in law (Chapter 3)

EMSRB Response: The EMSRB agrees that ambulance services must meet the requirements as outlined in section 144E and Chapter 4690. Related to this recommendation and the OLA's key finding in Chapter 3 pertaining to a lack of meaningful oversight under Minnesota law, we encourage the Legislature to require inspection of ambulance services on a regular basis.

Historically EMSRB staff have inspected ambulances on a biennial basis to ensure compliance. While there are operational improvements that the EMSRB has and will continue to make, the EMSRB feels compelled to highlight that due to budget constraints, the number of available staff to perform this regulatory function has fallen from 6 FTE to 1 FTE before restructuring and obtaining 3 FTE as of February 2022. This previously existing condition paired with the COVID-19 pandemic and ensuing emergency response responsibilities has slowed progress in overcoming these logistical challenges. While we agree that this is a critical function of the agency, we request all due consideration for the needed statutory and fiscal support.

6. The Legislature should require ambulance services to go through the initial licensure process whenever there is a change in ownership or provider (Chapter 3)

EMSRB Response: While on general principle the EMSRB agrees with this recommendation, the agency wishes to highlight some potential concerns. A change in ownership can take multiple forms and can affect to varying degrees the type and quality of service provided within a given licensee's PSA. For example, if Hospital A held a specific PSA, and Hospital A was purchased by Hospital B, and Hospital B was already a licensed EMS agency it may not be in the best interest of the EMS system overall to require comportment to the initial licensure process. The initial licensure process can cost several thousand dollars. In certain areas of Minnesota such a cost and time commitment could introduce the possibility of EMS agencies being unwilling to engage in the process and as a result cause an unintended consequence of gaps in ambulance coverage. The staff of the EMSRB would recommend the following:

"In the event that an ownership change occurs between two (2) licensed EMS agencies, implementation of the initial licensure process may not be required so long as it is determined by the board that there are no substantial changes to operations related to the level of service and that there is not any additional expansion of the PSA at the time of the ownership change."

In instances where there would be substantial changes inconsistent with the proposed language above, or if the entity gaining ownership was not already a Minnesota licensed EMS agency the EMSRB supports implementation of the complete initial licensure process.

7. The Legislature should direct the EMSRB to develop and enforce performance standards for ambulance services (Chapter 4)

EMSRB Response: The EMSRB agrees with this recommendation. The implementation of performance standards should be part of a broader quality assurance/quality improvement process.

Many EMS agencies throughout Minnesota have developed their own performance standards for internal use in consultation with their EMS agency medical director. The EMSRB since late 2021 has been reviewing different options for the development of performance standards. Areas of consideration for performance standards include workforce, operational, and clinical measures. The EMSRB would appreciate additional statutory support for the development of performance measures and the expectations for the agency of how to respond in instances where those measures are not met. The EMSRB further recognizes the need to tailor certain types of performance measures to the available resources that may be available within a given EMS system (urban vs rural vs frontier).

8. EMSRB should work with the Legislature to ensure that it has sufficient authority to implement performance standards (Chapter 4)

EMSRB Response: The EMSRB agrees with this recommendation. There have been conflicting interpretations pertaining to the EMSRB's authority to establish various performance measures. Upon questioning related to performance measures, the EMSRB immediately began to investigate the implementation of different types of performance measures. The EMSRB concludes that additional interaction and guidance from the Legislature would be helpful, particularly related to the desired action(s) when those performance measures are not consistently met.

9. EMSRB should explore reporting mechanisms that would enable it to track nonresponse by ambulance services (Chapter 5)

EMSRB Response: The EMSRB agrees with this recommendation. Existing data sources available to the agency are generated from activity that is actually conducted by a licensed EMS agency. The agency has begun to examine if it is possible to identify from existing sources if there is a way to reliably track nonresponse. However, preliminary evaluation has indicated that the data would be largely incomplete and difficult to access.

As a result, the EMSRB believes that local Public Safety Answering Points would be the most appropriate entity from which the EMSRB could obtain this information. The agency would request legislative support by way of statutory revision to require that this data be provided to and in a manner prescribed by the EMSRB.

To conclude, despite existing pathways and requirements to report ambulance nonresponse, the EMSRB anecdotally has found that there are many EMS agencies who fail to report their neighboring services nonresponses, out of fear of being labeled a bad neighbor. The EMSRB additionally notes that there are some EMS agencies who will reach out to the agency and seek assistance and technical assistance from the EMSRB.

The EMSRB agrees that a coordinated EMS system can only occur when all stakeholders are aware of the available EMS resources on any given day. If given the appropriate tools, the EMSRB would welcome this change as we believe that it truly serves the public interest.

10. The Legislature should explore options for improving ambulance service sustainability in Minnesota, potentially through pilot programs or other trial programs (Chapter 5)

EMSRB Response: The EMSRB agrees with this recommendation. Using its existing authority, the EMSRB has worked to pilot various clinical and operational practice changes through the existing waiver and variance process in accordance with the law and EMSRB policy. However, the EMSRB's fundamental legislative mandate is to regulate through existing rule and statute. Areas such as service sustainability, recruitment, and retention are not statutorily required, and require significant resources. We agree that these are serious challenges and would look for legislative support to address accordingly.

From a financial and sustainability perspective, the agency previously submitted funding requests in late 2021 specifically intended for recruitment and retention of emergency medical services personnel. Unfortunately, due to a lack of available funding and competing priorities the EMSRB's request was ultimately not accepted.

The EMSRB implores in the strongest of terms for the Legislature to consider additional funding sources for emergency medical services in both the short term, and to assist in identifying sustainable funding solutions for the intermediate and long terms to ultimately ensure the viability of critical public health and public safety services across Minnesota. The EMSRB feels that with our renewed commitment to the support of the EMS system, we have a deep understanding of the specific challenges facing EMS services across Minnesota and as such are in the best position to administer this funding from a state perspective.

Based in no small part to the key findings pertaining to staffing and funding in Chapter 5 of this report, there should be consideration for prioritization of those funds for recruitment and retention purposes. Ambulance service staffing shortages, while not unique to Minnesota, have been realized here for over a decade. However, repeated requests by both the industry and the EMSRB for workforce funding have gone unheeded and has contributed to the present state. Funding issues coupled with other societal and cultural changes have adversely impacted not only paid EMS providers, but also nearly every type of organization that relies on volunteers.

11. The Legislature should require the EMSRB to create and periodically update a statewide emergency medical services plan, and report regularly on its progress toward achieving the goals outlined in the plan (Chapter 6)

EMSRB Response: Regularly, the EMSRB has put forth a plan of goals and objectives for the board to complete within a given year. Additionally, section 144E.01, subdivision 6(b), permits the EMSRB to establish a work plan targeting different areas. In response to these findings, EMSRB staff have already begun to evaluate EMS plans from different states. Additionally, a resource analysis is currently underway to identify what supports might be required in the creation and ultimate implementation of such a plan. Given recent structural changes made by the EMSRB, there is a greater focus on components related to leadership and sustainability. The agency feels that implementation of this recommendation would help demonstrate that renewed commitment.

12. EMSRB should update its administrative rules (Chapter 6)

EMSRB Response: The EMSRB agrees with this recommendation and has already begun to review existing regulations, while simultaneously assessing the projected budgetary needs for administrative rules revision. The EMSRB had previously received inconsistent and erroneous information related to costs that prevented implementation of this strategic priority.

As the report highlights funding does remain a concern for the agency. However, the EMSRB commits to avail itself of all available resources, and to strongly consider updates and revisions to Chapter 4690.

13. EMSRB should improve its documentation and publication of primary service area boundaries (Chapter 6)

EMSRB Response: The EMSRB agrees with this recommendation. Since early 2021 the agency has been working collaboratively with MNIT, in the creation of Geographic Information System (GIS) mapping of Minnesota's PSAs and is investing \$100,000 towards the project. While the project has incurred delays due to available program and IT resources, the project continues to be a priority of the EMSRB. Most recently the board chair along with EMSRB staff had a very productive meeting with MNIT on February 17th.

The EMSRB is hopeful that more readily available GIS information will help address inconsistencies in functional service boundaries versus the actual legal primary service area boundaries as outlined as a key finding in Chapter 2 of this report. The EMSRB has come across multiple situations where a Public Safety Answering Points may have established its own dispatch areas, and may not have been aware of the legally defined PSA.

14. Unless the Legislature decides to repeal the statutory requirement for a financial data collection system, EMSRB should implement this system (Chapter 6)

EMSRB Response: The EMSRB agrees with this recommendation. The agency requests the Legislature to take special note of the non-traditional location of this EMS related statute within 62J. That fact notwithstanding, the agency realizes and accepts its responsibility for ensuring implementation of all relevant pieces of legislation.

At this point, the EMSRB would recommend that the Legislature repeal the statutory requirement, related to EMS financial data collection outlined in section 62J. This is largely in part due to current cost collection efforts that are underway by the federal Center for Medicare Services (CMS). However, now that the EMSRB is aware of the requirement, if it is not ultimately repealed the agency will in a timely fashion work towards compliance with the statute.

In response to this finding, agency staff conducted an exhaustive search and review of the Minnesota Revisor to identify any other existing statutes or regulation in alternate locations that impose responsibilities on the EMSRB. This information was presented to the EMSRB legislative workgroup on February 14, 2022.

Finally, the EMSRB with the appointment of its new executive director and under the direction of the EMSRB is focusing on developing stronger relationships with our legislative colleagues. The EMSRB looks forward to working collaboratively with the Minnesota Legislature to ensure awareness and continuity in the creation, passage, and ultimately implementation of EMS related legislation.

15. The EMSRB board should

- a. Improve its oversight of the executive director (Chapter 6)
- b. Ensure that the organization fulfills its responsibilities and maintains adequate staff to do so (Chapter 6)

EMSRB Response: The EMSRB agrees with this recommendation. The board has made multiple fundamental changes to the agency overall. Some of these structural changes include the establishment of board liaisons to agency staff to ensure that there is continuity and an adequate flow of information and communication to the board as a whole. This change was implemented by the board in its meeting on November 18, 2021. Additionally, the expectations for the position of the executive director were revised in August of 2021 prior to the initiation of a search for the then open position of executive director, by way of an updated position description.

The Board has established an internal operating procedure (IOP) workgroup to update and revise all board IOP's, with a special emphasis on the procedure, manner, and instrument of evaluation of the EMSRB's Executive Director. The timing of all these actions have been carefully choreographed and have intentionally been implemented in line with the hiring of the new executive director.

16. The Legislature should require the EMSRB board to regularly evaluate the executive director's performance (Chapter 6)

EMSRB Response: As with recommendation 15 above, the EMSRB agrees that it needs to improve the oversight of the role of executive director. The board has already convened a working group of members to update IOP's including those specific to evaluation of the executive director. The EMSRB is unaware of any other instance in state law where there is a statutory requirement for the evaluation of a specific position or individual. Additionally, with the installation of a new executive director, this has brought an opportunity to reframe priorities and set fresh expectations related to performance for an individual holding that role. The EMSRB would ask the Legislature for the opportunity to make rapid improvements to the area of Executive Director evaluation before taking legislative action on this recommendation.

17. The Legislature should consider whether to make structural changes to the EMSRB board or EMSRB's responsibilities (Chapter 6)

EMSRB Response: Consistent with other recommendations in this report, significant revisions to 144E have not been undertaken in recent years. An evaluation and broad discussion of various sections of 144E including board composition as outlined in 144E.01 Subd. 1 would be welcomed by the agency.

The EMSRB feels that the type of responsibilities currently charged to the board are appropriate. Despite their composition or their placement within a state's organizational structure, most state EMS offices across the country are responsible for the EMS system overall including both agency licensure and provider credentialing. This dynamic exists due to the limited size of a statewide EMS system when compared relatively to the operations of other healthcare entities. Additionally, in previous recommendations of this report the OLA has asked the EMSRB to take a more forward and direct role related to sustainability of the EMS system as a whole

Furthermore, as this report notes EMS is truly in a unique position where it operates at the intersection of public health and public safety. This is a reality that neither other health licensing boards nor other public safety boards must navigate with any significant frequency, and EMSRB operates without licensing or tax-based revenue.

Finally, while this report has identified needed changes, to which the EMSRB has already begun and will continue to address, we feel that the EMSRB is best positioned to serve as the states lead EMS agency with a sole focus on EMS priorities. We approach each of these recommendations as an opportunity and with a renewed commitment to providing visibility of and leadership to a system designed to save the lives of our fellow Minnesotans.

18. The Legislature should clarify what constitutes a conflict of interest for EMSRB board members (Chapter 6)

EMSRB Response: The EMSRB agrees with this recommendation. The EMSRB takes conflicts of interest very seriously. The OLA noted EMS is operated in a variety of manners. Ambulances may be municipal, not for profit, hospital based, or for-profit agencies. This can produce unique challenges. However, as outlined in this report, the OLA noted multiple instances of board members recusing or abstaining from votes, even in instances where a strict interpretation of existing law would not require as such.

The agency would welcome additional clarification from the Legislature pertaining to this matter given the unique nature of the EMSRB. It is our intent to be open, transparent, and to take all appropriate action(s) related to any identified conflict in accordance with the law. The EMSRB, however, would suggest that any clarification should not define a conflict of interest too broadly such that it prohibits a wide array of members from participating or voting on an attenuated matter or inhibits a quorum.

19. The Legislature should revise Minnesota Statutes 144 E to clarify contradictory or unclear language

EMSRB Response: The EMSRB agrees with this recommendation. For over three years the EMSRB put forth requested legislation that would have addressed inconsistencies and other matters of statutory incongruity. The EMSRB feels that previously there has not been meaningful collaboration between the agency and the Legislature related to proposed bills impacting emergency medical services. As discussed in previous responses this may have been due to various structural issues that the agency

has since addressed. The EMSRB stands ready to collaborate and offer any and all feasible assistance to the Minnesota Legislature in the vein of advancing Minnesota's EMS system.

We are pleased with the early progress, and some of the fundamental changes currently underway within the EMSRB even as we recognize that significant work remains. Protecting the health and safety of Minnesotans by ensuring the universal availability of an ambulance in times of emergency remains in our grasp, if EMS providers, policymakers, and regulators all take swift and appropriate actions. The EMSRB remains fully committed to continuing this essential work, and we thank you for the thorough evaluation and clear recommendations you have provided.

Sincerely,

A handwritten signature in black ink, appearing to read "Dylan J. Ferguson".

Dylan J. Ferguson
EMSRB Executive Director

A handwritten signature in blue ink, appearing to read "J.B. Guiton".

J.B. Guiton
Board Chair



OLA

Forthcoming OLA Evaluations

Minnesota Department of Education's Role in Addressing the Achievement Gap

Unemployment Insurance Program: Efforts to Prevent and Detect the Use of Stolen Identities

Recent OLA Evaluations

Agriculture

Pesticide Regulation, March 2020

Agricultural Utilization Research Institute (AURI), May 2016

Agricultural Commodity Councils, March 2014

Criminal Justice and Public Safety

Driver Examination Stations, March 2021

Safety in State Correctional Facilities, February 2020

Guardian ad Litem Program, March 2018

Mental Health Services in County Jails, March 2016

Health Services in State Correctional Facilities, February 2014

Law Enforcement's Use of State Databases, February 2013

Economic Development

Minnesota Investment Fund, February 2018

Minnesota Research Tax Credit, February 2017

Iron Range Resources and Rehabilitation Board (IRRRB), March 2016

Education (Preschool, K-12, and Postsecondary)

Collaborative Urban and Greater Minnesota Educators of Color (CUGMEC) Grant Program, March 2021

Compensatory Education Revenue, March 2020

Debt Service Equalization for School Facilities, March 2019

Early Childhood Programs, April 2018

Perpich Center for Arts Education, January 2017

Standardized Student Testing, March 2017

Minnesota State High School League, April 2017

Minnesota Teacher Licensure, March 2016

Special Education, March 2013

Environment and Natural Resources

Petroleum Remediation Program, February 2022

Public Facilities Authority: Wastewater Infrastructure Programs, January 2019

Clean Water Fund Outcomes, March 2017

Department of Natural Resources: Deer Population Management, May 2016

Recycling and Waste Reduction, February 2015

DNR Forest Management, August 2014

Conservation Easements, February 2013

Sustainable Forest Incentive Program, November 2013

Financial Institutions, Insurance, and Regulated Industries

Department of Commerce's Civil Insurance Complaint Investigations, February 2022

Government Operations

Office of Minnesota Information Technology Services (MNIT), February 2019

Mineral Taxation, April 2015

Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014

Health

Emergency Ambulance Services, February 2022

Office of Health Facility Complaints, March 2018

Minnesota Department of Health Oversight of HMO Complaint Resolution, February 2016

Minnesota Health Insurance Exchange (MNsure), February 2015

Minnesota Board of Nursing: Complaint Resolution Process, March 2015

Human Services

DHS Oversight of Personal Care Assistance, March 2020

Home- and Community-Based Services: Financial Oversight, February 2017

Managed Care Organizations' Administrative Expenses, March 2015

State-Operated Human Services, February 2013

Medical Assistance Payment Rates for Dental Services, March 2013

Jobs, Training, and Labor

State Protections for Meatpacking Workers, 2015

State Employee Union Fair Share Fee Calculations, July 2013

Miscellaneous

Board of Cosmetology Licensing, May 2021

Minnesota Department of Human Rights: Complaint Resolution Process, February 2020

Public Utilities Commission's Public Participation Processes, July 2020

Economic Development and Housing Challenge Program, February 2019

Minnesota State Arts Board Grant Administration, February 2019

Board of Animal Health's Oversight of Deer and Elk Farms, April 2018

Voter Registration, March 2018

Minnesota Film and TV Board, April 2015

Transportation

MnDOT Workforce and Contracting Goals, May 2021

MnDOT Measures of Financial Effectiveness, March 2019

MnDOT Highway Project Selection, March 2016

MnDOT Selection of Pavement Surface for Road Rehabilitation, March 2014

MnDOT Noise Barriers, October 2013



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