Arkansas Department of Health
Office of Preparedness and Emergency Response, Section of EMS
Arkansas EMS Advisory Committee
Advisory and Recommendations

Minimum Qualifications, Core Competencies, and Responsibilities for Designation as an EMS Medical Director for an Arkansas EMS Agency

As prepared by the Clinical Practice Subcommittee

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A. Executive Summary

The Arkansas EMS Advisory Committee recommends that the Arkansas Department of Health, Section of EMS, establish minimum qualifications and defined core responsibilities for physicians designated as the Medical Director of a licensed Arkansas EMS agency. Physician medical direction is the legal and ethical foundation of EMS practice, yet the current Arkansas EMS Rules require only an active Arkansas medical license, DEA registration, and a general, yet unverified statement of familiarity with EMS systems. This gap makes it difficult for the Section of EMS, EMS agencies, and the communities they serve to ensure that medical direction is adequate, consistent, and accountable.

In developing this advisory, the EMSAC deliberately moved away from requiring any single specialty designation or board certification as a condition of serving as an EMS medical director. Several states have begun to restrict the role to emergency medicine or EMS-boarded physicians; the EMSAC does not support that approach for Arkansas. In Arkansas, a non-emergency medicine or EMS-trained physician who may be the only physician in a rural community can be an excellent medical director if they are engaged, knowledgeable, and actively working with their EMS agency, while a physician who holds a relevant board certification but is not engaged should not be considered adequately qualified. States that restrict medical direction to a single specialty have, in some cases, seen agencies contract with distant “professional” medical directors who hold the correct credential but have little to no local presence or system knowledge. The EMSAC believes local engagement and demonstrated competency better serve Arkansas’s EMS systems than a specialty requirement alone.

This advisory therefore proposes a competency-based, specialty-agnostic framework built on multiple qualifying pathways, a defined set of core clinical competencies, foundational EMS medical oversight training, and clearly stated expectations for engagement and deliverables to the agency. It is not intended to create an unfunded mandate or to

discourage physicians, particularly in rural and small-agency settings, from serving in this critical role.

B. Problem Statement

Under Arkansas law (Ark. Code Ann. § 20-13-201 et seq.) and the Arkansas EMS Rules, every licensed EMS agency must have a designated medical director, and all EMS personnel practice under that physician's license and authority. While not explicitly stated in the statute, the medical director is responsible for approving protocols and keeping them updated with evidence-based prehospital medicine, credentialing their providers, overseeing and maintaining their scope of practice and clinical competency, directing quality assurance and improvement, and ensuring that field care meets accepted standards of medical practice.

Despite this central role, the Arkansas EMS Rules currently define the ALS Medical Director only as an Arkansas-licensed MD or DO who is registered with the Department and is "familiar with the design and operation of EMS systems and experienced in pre-hospital emergency care." Beyond an active license and DEA registration, there are no required qualifications, no specified EMS medical oversight training, no minimum engagement standard, and no defined list of responsibilities. The Arkansas Medical Practice Act (Ark. Code Ann. § 17-95-208) addresses physician delegation generally but does not establish EMS medical director-specific requirements.

This is not merely a regulatory formality. As Arkansas works to advance EMS scope of practice, expand community paramedicine programs, expand treatment-in-place initiatives, develop critical care transport capability, and develop EMS into the critical healthcare resource it is intended to be, engaged and knowledgeable medical direction should not be the limiting factor for progress statewide.

C. Background and Guiding Principles

1. Specialty-Agnostic, Competency-Based Approach

The EMSAC wishes to avoid a model that would restrict EMS medical direction to only physicians who are emergency medicine or EMS board-certified. While such certifications are valuable and directly relevant, requiring them exclusively would be unnecessarily restrictive for a state where many agencies, particularly in rural areas, already struggle to recruit any medical director, let alone a specialty-boarded one. Core competency in the relevant clinical areas, not a specific specialty label, should determine eligibility.

2. Engagement is the Determining Factor

A physician who is board-certified in emergency medicine, EMS, or surgery but who is not actively engaged with their agency provides little practical benefit over any other physician. Conversely, an engaged, knowledgeable physician without a specialty board

certification can be an outstanding medical director. This advisory is built around the principle that the Section of EMS cannot move the state's EMS system forward without medical directors who are active, engaged, and responsive to their agencies. As Arkansas works to advance the EMS scope of practice and elevate EMS clinical care across communities, the lack of a qualified and engaged medical director could become a hindrance or an obstacle to this progress.

3. Avoiding Redundant Requirements

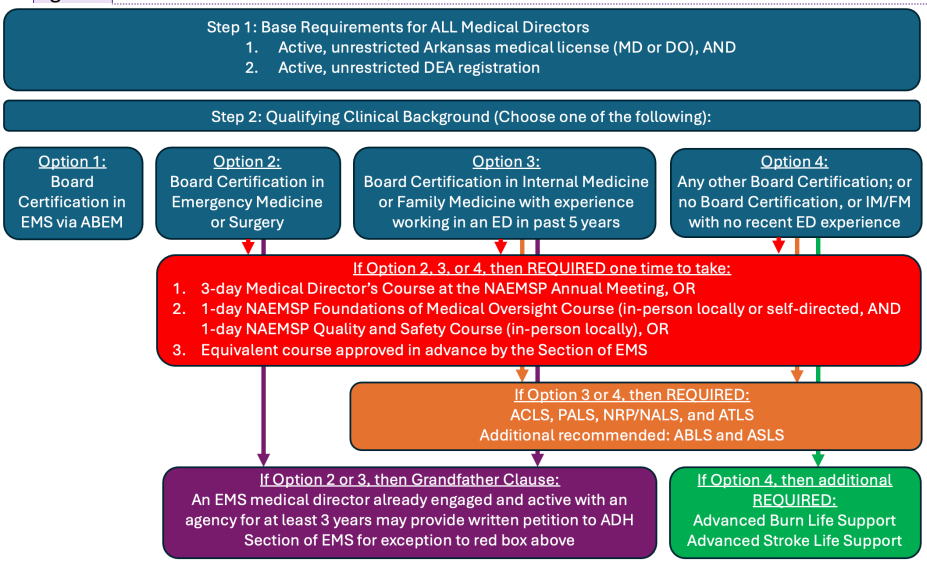
The framework below (Figure 1) is built around demonstrated competencies rather than a fixed checklist of certifications, so that physicians are not required to obtain training that duplicates what their existing residency training or board certification already covers. For example, a board certification from the American Board of Emergency Medicine supersedes certifications in card courses covering ACLS, PALS, ATLS, etc. Where an applicant's residency training, fellowship, or board certification already establishes a given competency, a separate stand-alone certificate should not be required to demonstrate it again.

D. Proposed Qualification Framework

The EMSAC recommends that the Section of EMS adopt the following framework (Figure 1) for designation as the Medical Director of an Arkansas ALS or advanced-capability EMS agency, utilizing minimum base requirements for all medical directors, followed by specific qualifying clinical backgrounds. In the absence of a specific qualifying clinical background, a medical director would be expected to achieve one or more of a combination of core clinical competencies.

Either through previous clinical training as demonstrated through board certifications, or through training beyond residency or fellowship, a medical director should demonstrate competency in the assessment and management of trauma, pediatric emergencies, high-risk obstetrics, neonatal resuscitation, STEMI, stroke, and other time-sensitive conditions relevant to their agency's patient population and scope of practice.

Figure 1. Framework for Minimum Qualifications for an Arkansas EMS Medical Director



The EMSAC also strongly recommends, but does not propose to mandate, membership in NAEMSP and its Arkansas state chapter, which provides ongoing access to relevant resources and a network of EMS physicians both within the state and nationwide available for consultation and support.

E. Demonstrated Engagement and Agency Deliverables

Rather than defining a fixed minimum number of hours, which the EMSAC believes is difficult to standardize fairly across agencies of very different size, call volume, and provider counts, this advisory instead recommends that engagement be evaluated through a defined set of deliverables the medical director provides to their agency across the domains below.

The EMSAC strongly recommends, but will not mandate, that agencies and their medical directors enter into a formal written agreement (MOU, contract, etc.), documenting the expectations of deliverables between the two parties, and how each of these deliverables will be met and evidenced. The degree of involvement is negotiable between the two parties, but should be explicitly stated up front regarding the expectations of how the medical director will meet each of the following domains of medical direction and oversight (Table 1). The involvement, whether based on hours or on objective deliverables, may be based on factors such as number of credentialed EMS providers, EMS run volume, population of the service area, or other variables.

Commented [DBM1]: Likely need to include exception for industrial EMS, medical director of training programs, and BLS agencies (paid and volunteer), and need to revise rules accordingly.

Table 1. Domains of Medical Director Engagement and Oversight

Engagement Domain	Expected Deliverables
Clinical Protocol Oversight	• Reviews and formally approves agency clinical protocols at least annually • Ensures protocols reflect current, evidence-based prehospital medicine • Approves any protocol deviations, standing orders, or off-protocol care in a timely manner
Credentialing & Scope of Practice	• Individually credentials providers for any skill, medication, or procedure beyond the state scope of practice • Approves initial credentialing of new hires and periodic re-credentialing thereafter • Authorizes and defines any expanded scope (e.g., community paramedicine, critical care transport)
Quality Assurance & Improvement	• Participates in chart review and QI activities on a regular, defined basis • Reviews high-acuity, sentinel, and protocol-deviation cases • Provides structured, documented feedback to providers and agency leadership
Training & Education	• Participates in, or oversees, ongoing provider education relevant to the agency's scope of practice • Supports skills verification, simulation, or ride-along evaluation as needed • Assists with clinical orientation of newly credentialed providers.
Availability & Clinical Consultation	• Maintains documented availability, or a defined backup physician, for real-time clinical consultation • Responds to time-sensitive clinical questions within an agency-defined timeframe
Regulatory, Administrative & System-of-Care Engagement	• Ensures the agency's DEA registration and controlled-substance protocols remain current and compliant • Signs required state EMS documentation (e.g., licensure, protocol submissions) in a timely manner • Maintains active engagement with relevant regional systems of care (trauma, cardiac, stroke, perinatal) consistent with the agency's transport patterns

F. End Goal and Recommendations

The end goal of this advisory is to establish reasonable, attainable minimum qualifications and core responsibilities for EMS medical directors in Arkansas, while

identifying accessible, low-cost resources to help physicians currently serving (or seeking to serve in this role) meet those standards. Specifically, the Committee recommends that the Section of EMS:

1. Revise the definition and requirements for "Medical Director (Advanced Life Support Services)" in the Arkansas EMS Rules to incorporate the qualifying pathways, core competencies, and foundational training described in Section D, rather than requiring a single specialty designation.
2. Develop or designate a state-specific EMS medical director orientation resource, ideally offered at no or low cost, and explore locally offering the NAEMSP one-day Foundations of Medical Oversight and Quality and Safety courses in alternating years.
3. Establish a reasonable phase-in period of 12 months and grandfather provisions up to 3 years so currently serving medical directors are not abruptly displaced and have adequate time and support to meet the new standards.

G. Implementation Considerations

1. Verification process: The Section of EMS should develop a process for verifying qualifying board certification or residency training, required certifications, and completion of foundational EMS medical oversight training, similar to existing credential-verification practices at licensure and renewal.
2. Phase-in and grandfathering: A defined phase-in period of 12 months from the date of implementation, with grandfather provisions for currently serving medical directors of at least 3 years, should be established so that agencies and physicians have adequate time to meet the new standards without disruption to ongoing medical direction.
3. Local training availability: The Section of EMS, in coordination with NAEMSP and its Arkansas chapter, should explore offering the one-day Foundations of Medical Oversight and Quality and Safety courses locally in alternating years as part of the state EMS medical directors' conference to minimize cost and travel burden for Arkansas physicians.
4. Compensation and malpractice coverage: This advisory does not establish compensation requirements. That will be between the medical director and the agency to discuss in advance. The Committee will note to agencies that compensating the medical director (hourly or via salary/contract) and providing malpractice coverage for that role is industry standard, and there is often a direct correlation between compensation and the degree of engagement of the medical director, which often results in improvement of overall quality of care within the EMS agency.
5. Engagement metrics: This advisory does not establish specific engagement metrics. That will be between the medical director and the agency to discuss, and will be dependent on the variables important to that specific agency.

H. Conclusion

Engaged, knowledgeable physician medical direction is foundational to the continued advancement of the Arkansas EMS system, and the EMSAC's review reflects a consistent theme: the limiting factor for progress across the state is not a lack of qualified physicians, but a lack of clearly defined, verifiable, and enforceable expectations for those who serve in this role. This advisory proposes a specialty-agnostic, competency-based framework that raises the floor for EMS medical direction in Arkansas without imposing an unfunded mandate or excluding the many dedicated community physicians, including those without an emergency medicine or EMS board certification, who currently serve, and should be permitted to continue serving, their communities. The Arkansas EMS Advisory Committee respectfully requests that the Arkansas Department of Health, Section of EMS, evaluate and act upon the recommendations set forth in this advisory.

I. References

1. Ark. Code Ann. § 20-13-201 et seq. – Arkansas Emergency Medical Services Act.
2. Ark. Code Ann. § 17-95-201 et seq. – Arkansas Medical Practice Act.
3. Arkansas Department of Health, State Board of Health, Section of EMS. Arkansas EMS Rules. https://healthy.arkansas.gov/wp-content/uploads/EMS-Rules_.pdf
4. National Association of EMS Physicians (NAEMSP). Position statements on EMS medical director qualifications and responsibilities. https://naemsp.org/position-statements/
5. NAEMSP. Foundations of EMS Medical Oversight Course. https://naemsp.org/foundations-of-medical-oversight-course-fomoc/
6. NAEMSP. Quality and Safety Course. https://naemsp.org/quality-and-safety/
7. US Fire Administration. EMS Medical Director's Handbook. https://www.usfa.fema.gov/downloads/pdf/publications/handbook_for_ems_medical_directors.pdf
8. National Highway Traffic Safety Administration. EMS Agenda for the Future; EMS Agenda 2050.