Downgrade of Response

Purpose: To allow downgrading of EMS vehicles responding to an EMS incident.

I. If information is received, while en route, that the incident is not life-threatening, then that ambulance may use that information to alter response accordingly.

II. No EMS vehicle shall be canceled, once a request for emergency assistance is received, unless one of the following occurs.

   A. A police/fire department unit reports that no person/accident can be found at the location,

   B. Any licensed EMS personnel on the scene cancels the responding EMS vehicles.

   C. A 1st party caller (the potential patient) states they no longer require a response from emergency medical services AND an EMS response is no longer requested AND there is not another indication that an emergency exists.

MCL 333.20967 If an emergency has been declared, the declaration that an emergency no longer exists shall be made only by a licensed EMS provider or a licensed health professional who has training specific to the provision of emergency medical services in accordance with protocols established by the local medical control authority.

Note: For the purposes of this protocol, a situation in which injuries or illness have not been confirmed does not constitute an “emergency” (i.e. motor vehicle crash with unknown injuries, unknown medical alarm).

Michigan SYSTEM PATIENT PRIORITIZATION AND USE OF LIGHTS AND SIRENS

Initial Date: 12/27/2022
Revised Date: 03/31/2025
Section: 8-2

Patient Prioritization and Use of Lights and Siren

This protocol is designed to provide a safe and orderly response to all requests for emergency medical care in the State of Michigan.

A. **Michigan Motor Vehicle Code** *(§257.603 and 257.653)*
The Michigan Motor Vehicle Code governs the driving of emergency vehicles. All licensed life support vehicles will abide by the Michigan Motor Vehicle Code.

1. This protocol does not supersede the Michigan Motor Vehicle Code.

B. **Authority to Require Lights and Siren Use**
Neither the patient's sending nor receiving physician has the authority to require the use of lights and siren during transport; this policy shall be followed at all times. Only the EMS transport crew can determine transport mode, based on patient priority.

C. **Use of Emergency Medical Dispatch**
Where Emergency Medical Dispatchers (EMD) and/or a tiered EMS response are/is available, the EMS Agency is encouraged to develop procedures that reduce unnecessary use of lights and sirens. The procedures may include, but are not limited to, the use of established EMD call screening protocols and evaluation of the scene/patient by first responder personnel.

D. **Prudent Use of Lights and Siren During Transport**
Lights and sirens may be used to clear traffic and then shut down, if prudent, where no obstruction or delay is present, provided both lights and siren are activated at least 500 feet before any intersection or obstruction to be cleared. When lights and siren are not in use, the vehicle must be operated as a typical non-emergency vehicle, per the Motor Vehicle Code.

E. **Returning from the transport, returning to a service area**

1. EMS units may ONLY utilize lights and sirens to return to their area IF THEY ARE RESPONDING TO AN EMERGENCY CALL.
2. Lights and sirens will **NOT** be used to return to an area when the unit is not responding to another emergency call.

F. **Education**
Life Support Agencies shall ensure MCA approved annual training surrounding the Michigan Motor Vehicle Code, safe use of lights and siren, this protocol and related agency polices.

G. **Agency and Medical Control Authority Specific Policies**
This protocol does not preclude MCAs from developing protocols and/or individual agencies from developing internal policies on this subject, as long as it includes the contents of this protocol as a minimum.

H. **Response and Transport**

Response to the scene and transport to the hospital is determined by patient priority.

1. If the on-scene patient priority is different from the dispatch priority, follow the on-scene patient priority for transport.
2. If the patient priority changes during transport follow the appropriate use of lights and sirens for the new patient priority.

I. Unstable Patients

Priority	Description	Example(s) include, but not limited to

Unstable	**Unstable** patients with a critical and immediate life-threatening illness or injury, or require time sensitive interventions	A patient that has an acutely life-threatening illness or injury and is unstable.
		• Unstable or deteriorating vital signs
		• Compromised airway that cannot be secured by EMS.
		• Severe respiratory distress/failure
		• Cardiac arrest or post cardiac arrest
		• STEMI
		• Tonic Clonic seizures unresponsive to treatment
		• Significant blunt or penetrating trauma including but not limited to:
		  ○ Airway compromised
		  ○ Respiratory distress
		  ○ Signs of inadequate perfusion

1. Response <u>to the scene</u> for unstable patient

MCA Selection for <u>Response</u> to Unstable Patient Incidents
(select only one)

(●) Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and sirens while responding to the scene

( ) Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and siren only when necessary to circumvent significant traffic delays and obstructions responding to the scene

2. Transport to the hospital for unstable patient

MCA Selection for Transport of Unstable Patients
(select only one)

- (●) Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and sirens while transporting to the hospital
- ( ) Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and siren only when necessary to circumvent significant traffic delays and obstructions when transporting to the hospital

J. Potentially Unstable Patients

Priority	Description	Example(s) include, but not limited to
Potentially Unstable	**Potentially unstable** patients that are ill or injured *without immediate* life-threatening condition and do not require time sensitive interventions	A patient that is currently stable but is felt to have a condition that may become unstable or life-threatening if not evaluated and treated rapidly. • Hemodynamically stable chest pain without signs of STEMI • Altered mental status – not acutely deteriorating • Seizure - Post-ictal not actively seizing • Hemodynamically stable abdominal pain • Hemodynamically stable >65 y/o fall with confirmed or suspicion of head injury and currently taking blood thinner medications

1. Response to the scene for potentially unstable patient

MCA Selection for Response to Potentially Unstable Patients (select only one)

- ○ Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and sirens while responding to the scene, transports without lights and siren.
- ○ Emergency Vehicles, in compliance with Michigan Vehicle Code, respond with no lights and sirens to the scene or during transport (including first responding life support vehicles).
- ◉ Only the first responding life support vehicle, in compliance with Michigan Motor Vehicle Code, responds lights and sirens to the scene. All other life support vehicles respond with no lights and sirens to the scene unless upgraded.
- ○ Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and siren only when necessary to circumvent significant traffic delays and obstructions when transporting to the hospital

2. Transport to hospital for potentially unstable patient - Do not transport using lights and sirens unless the patient's condition deteriorates.

K. Stable Patients

Priority	Description	Example(s) include, but not limited to
Stable	**Stable** patients are Ill or injured patients not fitting the above two categories who require medical attention but do not have a life-threatening condition.	A patient that does need to receive medical evaluation but does NOT have a potentially life-threatening illness or injury at the time of assessment or transport by EMS.

1. Respond to the incident and transport to the hospital using normal traffic patterns.

L. Dead Patients

Priority	Description	
Dead	**Dead** patients are absent of all vital signs and do not require further medical attention, per protocol.	**See Dead on Scene/Termination of Resuscitation Protocol and Medical Examiner Notification and Body Disposition Protocol**

1. Do not transport using lights and sirens.

Initial Date: 9/2004
Revised Date: 01/27/2023 Section: 8-3

Transport Destination and Diversion

Purpose: To define the decision-making process regarding EMS destination.

I. **Transport Destination Decisions**
   A. In matters of imminent threat to life or limb, transport to the closest appropriate facility.
      Closest appropriate is a facility capable of providing definitive care or, if definitive care is not readily available, resuscitative care for the patient's condition in consultation with on-line medical control or as defined by MCA specific protocol.
   B. Patients that are stable will be transported according to the following ranking given below unless the patient becomes unstable during transport:
      1. Patient request
      2. Family request
      3. Patient's personal physician request
   C. No other individuals are permitted to determine destination of patient without prior approval of on-line medical control: (police, fire, bystander physician, etc.)
   D. Exception: If transportation to the requested facility removes the EMS vehicle from the service area for an extended time, Consult medical control and an alternative may be considered

II. Transportation Procedure
   A. Priority 3 patients (medical or trauma): Shall be transported to an Emergency Facility of the patient's or patient's family choice
   B. Priority 1 and 2 (medical) Patients: shall be transported to the closest appropriate facility, based on the following guidelines:
   C. ST Elevation Myocardial Infarction (STEMI)
      1. Transport to a facility capable of interventional cardiac care.
   D. Return of Spontaneous Circulation (ROSC)
      1. Transport to a facility capable of interventional cardiac care. Notify receiving facility, as soon as possible and give ETA.
   E. Stroke
      1. Notify closest MCA approved stroke center as soon as possible if Cincinnati Stroke Scale or other validated MCA approved stroke scale is abnormal with "Stroke Alert" and ETA
   F. Trauma Patients – follow **Adult and Pediatric Trauma Triage-Treatment Protocol**
      1. A patient may be transported to a Provider Based Emergency department if they are:
         i. Priority 3 patient who requests transport to the Provider Based Emergency department.
         ii. A stable patient (priority 2) who has been approved by medical direction for transport to a Provider Based Emergency department.

iii. An unstable Priority 1 patient who is unstable for transport to an acute care facility where the Provider Based Emergency department can provide additional care not available in the ambulance (the primary example is a patient being transported by an ALS unit with an airway that cannot be secured or maintained by EMS personnel).

iv. A trauma patient with minor injuries such as sprains and minor fractures without deformity or without high velocity mechanism who requests transport to the Provider Based Emergency Department.

G. Documentation of destination will be the reason the facility was chosen (specialty care, trauma center). Closest facility will only be indicated when the facility is geographically the closest facility.

III. Patient Diversions

A. Once the decision is made to transport a patient to a facility, the patient may be diverted to another facility if:

1. On-line medical control for the initially selected destination requests diversion to another facility. A receiving facility may not refuse a patient unless it does not have the staff or resources to accept the patient.
2. The patient experiences an imminent threat to life or clinical deterioration and, in the medical judgment of the EMS personnel, the patient should be diverted to the closest appropriate facility.
   i. Documentation of the reason for the diversion shall be included in the EMS patient care record.

B. Immediate on-line medical direction shall be established with the newly chosen receiving facility.

C. If EMS personnel determine diversion is necessary, contact the initial receiving facility as quickly as possible to inform it of the diversion.,.

D. Patients requesting transport to a facility, which is currently on diversion, should be advised of the diversion and that the appropriate resources to care for them are not currently available at that institution. An alternative facility destination should be requested from the patient.

1. If the patient persists in the request of the facility currently on diversion, contact medical control.

Note: Each facility has the authority to develop and administer written policies concerning the temporary closing of emergency departments, however a facility on diversion must notify the MCA of the diversion status. By statute, the medical control authority, based on needs of the EMS system, may determine the destination of the patient thus overriding the diversion status.

OB High-Risk Delivery Transport Guidelines (MCA Optional Protocol)

☑ Medical Control Authorities choosing to adopt this supplement may do so by selecting this check box. Adopting this supplement changes or clarifies the referenced protocol or procedure in some way. This supplement supersedes, clarifies, or has authority over the referenced protocol.

Purpose:
This policy is to establish guidelines for transport of women with pregnancy of more than 20 weeks and less than 34 weeks gestation in active labor, as these infants may require newborn intensive care.

1. In all cases where delivery is imminent, transport will be to the closest emergency receiving facility.
2. If labor is brought on by medical illness or injury of the mother, appropriate medical treatment of the mother is the first priority. This is also the most appropriate treatment of the newborn.
3. If time allows, any woman in active labor with a gestational period of more than 20 weeks and less than 34 weeks, in anticipation of delivery of a high risk newborn, should be taken to (list facilities and instructions for where to proceed with the patient):

X Sparrow Hospital - Main Campus

NOTE: This protocol was created as a template to be used for each MCA to determine the most appropriate transport decisions for the high-risk OB patient in their individualized MCA areas.

☑ Medical Control Authorities choosing to adopt this supplement may do so by selecting this check box. Adopting this supplement changes or clarifies the referenced protocol or procedure in some way. This supplement supersedes, clarifies, or has authority over the referenced protocol.

ALS and LALS Intercept/Transfer of Care

Purpose: The purpose of this protocol is to establish indications and procedures for ALS intercept for patients being managed by a BLS or LALS unit who might benefit from ALS care or LALS intercept for patients being managed by a BLS unit when ALS is not available.

I. If a transport has begun by a Basic Life Support (BLS) unit, a rendezvous with an Advanced Life Support (ALS) unit or Limited Advanced Life Support (LALS) if available and ALS unit is not available, should be attempted at a mutually agreed upon location, if indicated and available.

II. If a transport has begun by a Limited Advanced Life Support (LALS) unit, a rendezvous with an Advanced Life Support (ALS) unit should be attempted at a mutually agreed upon location, if indicated and available.

III. Indications
- a. Patients presenting with conditions for which ALS interventions would be potentially beneficial for patients, if the intercept can be completed 10 or more minutes from the receiving facility, including, but not limited to patients with:
  - i. Chest pain with suspected cardiac etiology
  - ii. Seizure
  - iii. Uncontrolled pain
  - iv. Hypoglycemia
  - v. Altered mental status
  - vi. Worsening respiratory distress
  - vii. Major trauma
- b. Patients presenting with conditions where ALS may be needed for life saving interventions may be intercepted at any distance from the hospital:
  - i. Those with an uncontrolled airway
  - ii. Patients in cardiac arrest without a mechanical CPR device in place

III. Contraindications
- a. Low acuity patients for which advanced intervention would likely not be beneficial to the patient.
- b. Patients with time sensitive emergencies where advanced intervention would likely not be beneficial to the patient

NOTE: BLS unit may contact Medical Control for assistance with any situation as necessary.

Procedure & Documentation

1. BLS/LALS personnel are required to provide the receiving ALS (or if applicable LALS) personnel with a complete hand-off report including medical history, pertinent physical exam findings, vital signs, treatment provided and response to treatment.
    a. The hand-off procedure (i.e., verbal report, field notes, air drop, etc.) must be MCA approved.
2. ALS (or if applicable LALS) personnel will include the complete hand-off report from BLS/LALS within or attached to (i.e., scannable field note) the ALS (or if applicable LALS) patient care record.
3. Both the initial unit (BLS/LALS) and unit receiving the rendezvous (ALS or if applicable LALS) shall complete an electronic Patient Care Report (PCR) and include the following in addition to patient care information:
    a. Agency name/unit number/providers names from whom patient was received or transferred to.
    b. If both transferring and receiving units are from the same agency, all personnel should be listed as crew in both the ALS and BLS run when possible.

Dispatch

Purpose:
As mandated under Public Act 368 of 1978, as amended, Section 20919 (1)(b): "A local medical control authority shall establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region. The protocols shall be developed and adopted in accordance with procedures established by the department and shall include medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system."

Local municipalities shall determine, in accordance with the rules and regulations of their local Medical Control Authority, the level of agency licensure, as well as who will provide EMS service in their area.

Protocol

1. Public Safety Answering Points and/or Life Support Agency dispatch centers shall use Enhanced 911 technology, where available, and shall dispatch appropriate resources as quickly as possible.
2. Since ALS may provide additional medical care and delay may negatively impact patient outcome, in areas where ALS is available it shall be simultaneously dispatched to certain medical emergencies including, but not limited to:
    a. Cardiac Arrest
    b. Chest Pain
    c. Stroke
    d. Drug Overdose / Poison
    e. Altered Mental Status / Unconscious
    f. Allergic Reaction
    g. Difficulty Breathing
    h. Drowning or Near Drowning
    i. Injury with Bleeding or Immobility
    j. Seizures / Convulsions
    k. Diabetic Reactions
    l. Child Birth
    m. Burns
    n. or as determined through prioritized dispatch developed through an MCA approved EMD program.

All medical callers shall be evaluated based on symptoms provided and/or observed, and provided with pre-arrival instructions where applicable as determined through an Emergency Medical Dispatch program. Evaluation, instructions and prioritization shall be made through an Emergency Medical Dispatch program approved by the MCA which conforms to nationally recognized guidelines.

PURPOSE

To define medically appropriate EMS dispatch methods.

PROCEDURE

1.0 Definitions

1.1 Life threatening emergencies – Priority One and some Priority Two patients (per section 8-2) whose condition could reasonably be expected to worsen without immediate intervention.

1.2 Nearest available agency – EMS agency(ies) designated by the municipality to provide emergency medical services, or that EMS agency's designated mutual aid provider.

2.0 TCEMCA strongly encourages the use of a medically supervised, protocol driven EMS dispatch system that provides both pre-arrival instructions to callers and response priority data to responding units.

2.1 If response priority data is available from an EMS dispatch point, responding units shall conform their response mode to the data provided.

2.2 A request for EMS service shall not be "stacked" awaiting an available unit if that request is for a "life threatening emergency" as defined in §1.1 above. If a unit is not available within 90 seconds of receipt of the call, the call shall be referred to a mutual aid provider for response. If a unit from the initial provider becomes available after mutual aid has been requested, the initial provider should contact the mutual aid provider to coordinate response and determine the actual closest unit to the call.

2.3 If an EMS agency, or its dispatch service, receives a request to provide service to an area outside its licensed geographic service area for a "life threatening emergency", that EMS agency or its dispatch service shall notify the "nearest available agency" as defined in §1.2 above. Contractual agreements entered into by the EMS agency with other persons shall not contradict or circumvent this requirement.

2.4 The use of the "nearest available agency" is not required for "emergency" calls not meeting the definition of "life threatening" in §1.1, or for scheduled ambulance transfers.

3.0 No EMS unit shall be canceled, once a request for emergency assistance is received, unless one of the following occurs:

3.1 A police/fire department unit reports that no person/accident can be found at the location, or

3.2 Any TCEMCA authorized EMS unit on the scene cancels the responding EMS units. Canceling agency must complete and submit TCEMCA patient refusal forms.

4.0 Each EMS agency shall have written Standard Operating Procedures for their dispatch center to use when mutual aid requests are necessary.

5.0 It is the responsibility of each EMS agency director/chief to ensure compliance with this protocol.

6.0 All TCEMCA authorized agencies shall respond or ensure that a response is provided to all requests for emergency assistance originating from within the bounds of its service area and provide appropriate emergency medical services and/or transportation as necessary without regard to the patient's ability to pay for said emergency medical services and/or transportation or said patient's reimbursement status.

ALS to BLS Transfer of Care (MCA Optional Protocol)

☑ Medical Control Authorities choosing to adopt this supplement may do so by selecting this check box. Adopting this supplement changes or clarifies the referenced protocol or procedure in some way. This supplement supersedes, clarifies, or has authority over the referenced protocol.

Purpose
Patients who need or desire transport to a hospital and do NOT meet criteria for ALS interventions, may have care transferred from an ALS unit to a BLS unit if all criteria are met.

1. Criteria for transfer of care from ALS to BLS must include:
    a. Patient assessed by on scene paramedic and deemed appropriate for BLS care.
    b. Patient's airway is patent, maintained without assistance or adjuncts.
    c. Patient is hemodynamically stable with medical complaints or injuries that would be cared for at the BLS level.
    d. No imminent changes are anticipated in the patient's present condition.
    e. Patient presents at baseline mentation and GCS or if unknown, GCS ≥ 14.
    f. The EMT in attendance must be willing to accept the transfer of care given the patient's condition.
    g. ALS may consider transfer to BLS for the patients who have meet the above criteria and have had the following ALS interventions:
        i. IV placement with saline lock
        ii. Dextrose administration with return to baseline mental status
        iii. Naloxone administration with return to baseline mental status and without respiratory complaints
        iv. Analgesia administration, with no other excluding criteria and not requiring additional doses during transport.
    h. For any other patients with ALS interventions performed, contact medical control prior to ALS to BLS transfer of care.

2. Transport by the ALS unit shall be considered if the transfer of care to the BLS staffed ambulance would incur a time delay greater than the projected transport time to the intended receiving facility.

Procedure & Documentation
1. ALS personnel are required to provide BLS personnel with a complete hand-off report including medical history, pertinent physical exam findings, vital signs, treatment provided and response to treatment.
    a. The hand-off procedure (i.e., verbal report, field notes, air drop, etc.) must be MCA approved.

2. BLS personnel will include the complete hand-off report from ALS within or attached to (i.e., scannable field note) the BLS patient care record.
3. Both ALS and BLS shall complete an electronic Patient Care Report (PCR) and include the following in addition to patient care information:
    a. Agency name/unit number/providers names from whom patient was received or transferred to.
    b. If both transferring and receiving units are from the same agency, all personnel should be listed as crew in both the ALS and BLS run when possible.

Quality Improvement/Quality Assurance (QA/QI)

1. The MCA shall establish a QA/QI process for review of ALS to BLS transfers of care.

Helicopter Utilization

I. Indications for Use – in the presence of one or any combination of the following:

NOTE: These guidelines are offered as examples of patients who might benefit from helicopter transport. Additional considerations would include the physical exam, additional contributing factors such as age, mechanism of injury, the level of care available in the area, and ground service availability.

A. Trauma Patients that meet the red criteria per **Adult/Pediatric Trauma Triage-Treatment Protocol** and one or more of the following:
   1. Long transport times
   2. Poor road conditions
   3. Entrapment with prolonged extrication

B. Medical Patients
   1. If in the estimation of the paramedic, that the use of helicopter resources would be beneficial to patient outcome.

NOTE: Appropriate helicopter utilization is determined by a combination of factors with the goal of responsible resource utilization for the seriously ill or injured to reach definitive care in the least amount of time.

II. Procedure

A. Request for helicopter service response may require prior medical control approval per MCA selection:

○ **YES** - Online Medical Control pre-approval required

◉ **NO –** Online Medical Control pre-approval not required. Follow established Medical Control guidelines

B. Patient should be prepared for transport by air in the following manner:
   1. Patient should be stabilized and immobilized with ground ambulance equipment per existing protocol.
   2. Ground ambulance personnel will stay with the patient until released by the helicopter personnel.

C. Communications
   1. Communication with the helicopter dispatch should include information regarding location.
   2. Helicopter dispatch will request pertinent medical information to relay to the flight crew.
   3. Communications between the helicopter and ground ambulance shall be coordinated through dispatch and preferentially take place on AirLZ1 or AirLZ2 as dictated by local policies and procedures.

D. Landing Site
   1. Utilize trained personnel whenever possible.
   2. Locate a level, 100’ x 100’ area clear of obstacles (i.e. wires, trees)

3. Mark landing zone with a marker at each corner and one upwind.
4. Public safety vehicles should leave on flashers to assist in identifying site from the air.
5. Identify obstacles close to the landing zone and communicate all pertinent information about the landing zone to the flight crew.
6. Landing zone personnel will communicate by radio with the flight crew.

E. Safety
1. Under NO circumstances should the helicopter be approached from the rear due to the extreme danger of the tail rotor.
2. The flight crew will direct all actions around a helicopter including personnel approach/departure of the helicopter, and loading/unloading of patients and/or equipment.
3. Personnel should be in a crouched position in the vicinity of the helicopter and NEVER near the tail rotor.

F. Patient Destination
1. Patient will be transported to appropriate facility as directed by medical control.

G. Quality Assurance
1. Upon request, helicopter services will forward copies of their patient care record(s) to the Medical Control Authority. The Medical Director may review all helicopter activations for appropriateness.

Infection Control and Communicable Disease

PURPOSE: To outline procedures for infection control through personal protective equipment use and decontamination for people, equipment, and vehicles utilized in assessment, treatment, and transport of patients along with categorization and response for exposure. ALL patients are considered potentially infectious.

NOTE: Any information obtained or exchanged regarding communicable disease exposures must be handled with strict confidentiality.

I. PRECAUTIONS AND PREVENTION

A. Standard Precautions and Body Substance Isolation (BSI)

1. Purpose: To prevent the transmission of all bloodborne pathogens that are spread by blood, tears, sweat, saliva, sputum, gastric secretions, urine, feces, CSF, amniotic fluid, semen, breast milk, skin rash and open wounds.
2. Rationale: Medical history and examination cannot identify all patients infected with bloodborne pathogens.
3. Practice: Standard Precautions/BSI will be done for patient encounters in which the risk of exposure to blood or body fluid exists.

B. Respiratory Precautions

1. Purpose: To prevent the transmission of airborne infections for patients with respiratory complaints.
2. Rationale: Medical history and examination cannot fully identify all patients with transmissible respiratory pathogens. Respiratory complaints include but are not limited to dyspnea, cough, shortness of breath, etc.
3. Practice: Respiratory precautions will be used for every patient with respiratory complaints and/or receiving aerosolized treatments.

C. Precautions for patients highly suspicious communicable disease including but not limited to:

1. Fever > 100.5 F with headache or malaise or myalgia, and cough or shortness of breath or difficulty breathing.
2. Pustular, papular or vesicular rash distributed over the body (trunk, face, arms, or legs) preceded by fever with rash progressing over days (not weeks or months) and the patient appears ill.
    a. Consider the patient to be both airborne and contact contagious.
    b. Crew PPE and procedures:
        i. N95 or higher protective mask/respiratory protection
        ii. Goggles or face shield
        iii. Gowns

iv. Utilized waterless hand sanitizer between glove changes and upon removal of gloves.

c. Source Control:
   i. Patient wear a paper surgical mask if tolerated.
   ii. Cover patient with linen sheet to reduce chance of contaminating objects in area.
   iii. Patients should be encouraged to use hand sanitizer when tolerated.

d. Notify the receiving facility as soon as possible of the patient's condition to facilitate preparation of the facility and institution of appropriate infection control procedures
   i. Confirm entrance and procedure for transfer of patient into facility.
   ii. Ensure proper notification and preparation of receiving facility for inter-facility transfers.

e. Vehicles that have separate driver and patient compartments and can provide separate ventilation to these areas are preferred for patient transportation. If a vehicle without separate compartments and ventilation must be used, the outside air vents in the driver compartment should be turned on at the highest setting during transport of patient to provide relative negative pressure in the patient care compartment.

f. DO NOT REMOVE protective equipment during patient transport.

g. Discourage non-essential personnel and family members from entry or accompanying patient in ambulance.

h. Patient cohorting may occur if resources are exhausted and patients are grouped with same disease. Cohorting should only be utilized as a last resort.

i. The ambulance(s)/transport vehicle will not be used to transport other patients (or for any other use) until it is decontaminated using the CDC guidelines for decontamination.

D. Procedures

1. Handwashing will be done before and after contact with ALL patients.
2. Nonsterile disposable gloves will be worn with patients that pose a potential exposure through blood or body fluids. Gloves will be changed in-between patients and not used repeatedly.
3. Outerwear (example: gown, coveralls, turnout gear) will be worn if contact with blood or body fluids contamination may occur.
4. Face Protection (including eye protection) will be worn if aerosolization of blood or body fluids may occur (examples include but are not limited to suctioning,

insertion of endotracheal tubes, patient with excessive coughing, invasive procedures).

5. Mouth-to-mouth resuscitation: CDC recommends that EMS personnel NOT perform mouth to mouth, instead use adjunctive aids (pocket masks, face shields, BVM).
6. N95 or higher will be worn during contact with patients with respiratory complaints, during any aerosolizing treatments, and with all mechanically ventilated patients.
7. Mechanically Ventilated Patients (including bag-valve-mask)
    a. HEPA filtration of airflow exhaust shall be used, EMS provider shall don a simple face mask.
        i. If no HEPA filtration, EMS provider shall don an N95
    b. Consult ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive pressure ventilation.

II. CLEANING AND DECONTAMINATION

A. Wear gloves for ALL decontamination

B. Non-disposable contaminated articles:
1. Bag according to agency procedures.
2. Articles must be decontaminated prior to being placed back into service. Refer to manufacturer's recommendations for proper cleaning and disinfecting

C. Disposable contaminated articles
1. Articles contaminated with blood or body fluids must be bagged and discarded in accordance with MIOSHA guidelines.

D. Medication/IV Bags or Boxes shall be inspected and all contaminated waste removed prior to bag exchange. If the medication/IV bag or box is contaminated, it must be spot cleaned or laundered prior to being placed back into service.

E. Linens soiled with blood or body fluids shall be placed in appropriately marked container.

F. Needles and syringes shall be disposed of in a rigid, puncture-resistant container. Any grossly contaminated container, or one that has reached the 'fill line', should be disposed of appropriately.

G. Blood spills shall be cleaned up promptly with a solution of 5.25% sodium hypochlorite (household bleach) diluted 1:10 with water or other FDA approved disinfectant.

H. Non contaminated but utilized equipment will be disinfected after every patient encounter in accordance with MCA approved agency guidelines.

I. Vehicle surfaces will be disinfected after every patient encounter in accordance with MCA approved agency guidelines.

III. RADIO COMMUNICATIONS

A. Radio communications of any kind regarding a communicable disease should be done so in a format that ensures patient confidentiality.

IV. EXPOSURES

A. Definitions:

1. "Emergency source patient" means an individual who is transported to an organized emergency department located in and operated by a licensed hospital or a facility other than a hospital that is routinely available for the general care of medical patients.

2. Definition of Reportable Exposure:

a. Any breach of the skin by cut,needle stick, absorption, or open wound.

b. Blood/body fluid splash to the moth, nose, eye, or other parenteral route.

c. Blood/body fluid splash into non-intact skin area

B. Reporting Exposures:

1. Police, Fire or EMS personnel who, in the performance of their duty, sustain a needle stick, mucous membrane or open wound exposure to blood or other potentially infectious material (OPIM) may request, under Public Act 368, Section 333.20191, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a MDHHS Form (DCH-1179): First Responder Provider Request for HIV and/or Hepatitis B Testing of Emergency Patient.

C. Cooperating Hospitals' Responsibilities

1. Each cooperating hospital in the Medical Control region will designate an infection control contact to serve as liaison(s) with the staff of medical control and all EMS agencies for the purpose of communicating information about infectious patients or potential exposures.

2. Hospitals, upon learning that any patient has a reportable infectious or communicable disease, will check the patient chart to determine if any EMS agencies were involved with the patient prior to hospitalization. When determined that EMS may have had contact with the patient, designated individual will notify the EMS agency for further follow-up and complete the required State forms.

3. Hospitals, when requested to do so, will obtain lab tests and results on source patients when exposure to a pre-hospital provider has occurred.

a. Hospitals will report the results of testing on MDHHS Form (DCH-1179) and return to the address indicated on the form.

4. Hospitals will notify transporting agencies at the time a transfer is scheduled if any infection potential exists with the patient and the precautions necessary (standard precautions and/or mask).

D. Pre-hospital Agency Responsibilities

1. Each pre-hospital provider agency will be responsible for assuring that their personnel, trainees and students are familiar with infection control procedures, epidemiology, modes of transmission and means of preventing transmission of communicable disease per CDC guidelines and MIOSHA regulations.
2. Each pre-hospital provider agency will be responsible for supplying personnel with the appropriate personal protective equipment.
3. It is recommended that each pre-hospital provider agency ensures adequate immunizations per CDC Immunization Guidelines for Health Care Workers.

E. Follow-up Care/Counseling

1. Follow-up care and counseling of exposed personnel shall be the responsibility of the pre-hospital provider agency and shall be carried out without delay upon notification of exposure.

F. Summary of EMS Personnel Post-Exposure Procedures

1. Irrigate and wash exposed area very well.
2. Notify agency supervisor of possible exposure.
3. Each exposed individual complete section 1 and sign form DCH-1179 (E) and sign
4. If source patient is transported submit (in person or via fax) DCH-1179 (E) form at hospital receiving the source patient
5. Contact (preferably in person but may be by phone) the emergency department of the health care facility receiving the source patient and review Section 1 of DCH-1179 (E).
    a. The health care facility authorized staff member will complete Section 2 of the form and determine if an exposure did or did not occur. If determined exposure did occur, the health care facility will:
        i. Complete testing of source patient for HIV, Hepatitis B, and other pathogens, as applicable
        ii. Rapid HIV testing should be conducted
        iii. If HIV rapid testing is positive, the health care facility will coordinate appropriate post exposure prophylaxis for the exposed individual.
        iv. Section 3 of form DCH-1179 (E) will be completed
    b. If determined that an exposure did not occur, the health care facility will explain the rationale of determining that it was a non-exposure.
    c. The exposed individual, health care facility, agencies and the Medical Control Authority will comply with all parts of Public Act 368, Section 333.20191
6. The exposed personnel shall follow up with the agency occupational health in accordance with agency requirements.

7. If the patient is deceased and not transported to a hospital
    a. If the source patient remains on scene or is transported to somewhere other than a hospital, collaboration between the medical examiner's office (if applicable), EMS agency, the agency occupational health provider and/or the medical control authority should be notified to facilitate source patient testing.
8. If the source patient is living and not transported the exposed individual should work with the EMS agency, the agency occupational health provider and/or the medical control authority for potential testing of the source patient.
    a. The EMS agency may contact the individual with a request for prompt testing.
    b. The exposed personnel and EMS agency shall follow up with agency occupational health and the medical control authority.

G. Any first responders (Police, Fire or EMS personnel) who may have had an exposure should be encouraged to follow the protocol as described.

Protocol Source/References: Testing and Reporting (including HIV and STI Case Reporting Forms and Aphirm) (michigan.gov)

DCH-1179, FIRST RESPONDER PROVIDER REQUEST FOR HIV AND/OR HEPATITIS B TESTING OF EMERGENCY PATIENT

Michigan Department of Health and Human Services (MDHHS)
In Accordance with Michigan Public Act 419 of 1994 (MCL 333.20191)
(Revised 11-22)

NOTICE TO EXPOSED INDIVIDUAL:

- Test results will not be provided over the telephone.
- This request should be made before the emergency patient is released from the health care facility.
- Contact the health care facility if the interpretation of test results on the emergency patient is not received by you within ten (10) days.
- **Information contained on this form is confidential.**
- See page 3 for PA 431 and non-discrimination information.

SECTION 1 – To be completed by EXPOSED INDIVIDUAL (Please Print)

1. Name of Exposed Individual
2. Job Classification
☐ Good Samaritan

3. Home Address (Number & Street, etc.) City State Zip Code

4. Home Phone Number

5. Name of Employer
6. Employer Phone Number

7. Employer Address (Number & Street, etc.) City State Zip Code

8. Emergency Source Patient ID Number
9. Date of Exposure
10. Approximate time of Exposure
☐ AM ☐ PM

11. Route of Exposure
☐ Open Wound ☐ Mucous Membrane ☐ Percutaneous ☐ Other

12. Provide a detailed description of the exposure (attach an additional sheet as needed)

13. Personal Protective Equipment used when exposed (check all that apply)
☐ Glove ☐ Gown ☐ Eye Protection ☐ Face Mask
☐ Turnout Gear ☐ None ☐ Other **explain**

14. Based on my exposure described above, I am requesting that this source individual be tested for the following (check all that apply)
☐ HIV ☐ Hepatitis B ☐ Other **explain**

15. Where do you want the Test Results Sent to: (check all that apply)
☐ Me at my Home (Address Above) ☐ My Physician (Complete #16 below)
☐ Me at Work (Address Above) ☐ Other Health Care Professional (Complete #17 below)

16. Name of Your Physician Physician Phone Number

Physician Address (Number & Street, etc.)	City	State	Zip Code

17. Name of Other Health Care Professional	Other Health Care Professional Phone Number

Other Health Care Professional Address (No. & St.)	City	State	Zip Code

- I understand that the NAME of the source individual to be tested, and that person's test results are confidential according to Section 5131 of Michigan Compiled Laws (MCL). I understand that a person who discloses information in violation of this Section is guilty of a misdemeanor.
- I also understand that I am ultimately responsible for the payment of the charges associated with the testing of this individual to whom I have been exposed, unless an agreement has been worked out between me and my employer, or is otherwise covered by my health care or benefits plan.

18. Signature of Exposed Individual	Date

- "First Responder Provider" is defined as a police officer, fire fighter, or an individual licensed under MCL.333.20950 or 333.20952 as one of the following: medical first responder, emergency medical technician, emergency medical technician specialist, paramedic, or an emergency medical services instructor or coordinator. A lay citizen, or Good Samaritan, if they assist an emergency patient, may also be included as a pre-hospital provider (for purposes of this law).
- "Emergency source patient" means an individual who is transported to an organized emergency department located in and operated by a licensed hospital or a facility other than a hospital that is routinely available for the general care of medical patients.

SECTION 2 – EVALUATION OF EXPOSURE – To be completed by the HEALTH CARE FACILITY.

1. Name of Exposed Individual	2. Emergency Source Patient ID Number

3. Based upon the information provided
☐ Exposure DID Occur (see #4 below) ☐ Exposure DID NOT Occur (see #5 below)

4. Exposure DID Occur – The type of exposure was determined to be
☐ Open Wound ☐ Mucous Membrane ☐ Percutaneous ☐ Other

Was the emergency patient informed at the time of admission about the possibility of being tested if a first responder exposure occurred? (In accordance with MCL 333.5133)? ☐ Yes ☐ No

NOTE: The Exposed Individual **SHOULD BE** counseled and tested for HIV and Hepatitis B. Testing for hepatitis C is also recommended although it is not mentioned in the law. Prophylaxis should also be considered for the exposed individual. If appropriate, please refer the exposed individual for follow-up medical evaluation.

5. Exposure did not Occur – Explain

Print Person's Name	Job Title

Authorized Signature at Health Facility	Date

SECTION 3 – TEST RESULTS – to be completed by the HEALTH FACILITY

1. Emergency Patient was Tested for (check all that apply)

☐ HIV ☐ Hepatitis B ☐ Other **explain**

2. Test Results on Source Individual

HIV:	Rapid Test:	☐ Reactive*	☐ Non-Reactive	
	EIA:	☐ Reactive	☐ Non-Reactive	
	Western Blot:	☐ Reactive	☐ Non-Reactive	☐ Indeterminate
Hepatitis B:	HBsAG:	☐ Found	☐ Not Found	

Other **(explain)**

*HIV Rapid Tests are for screening purposes only. A reactive Rapid Test requires follow-up testing to confirm patient status.

3. Emergency Patient was NOT Tested

☐ Emergency source patient refused testing/to have blood drawn.
☐ Emergency source patient expired before test(s) could be performed.
☐ Emergency source patient was released from the health care facility before testing could be performed.
☐ Emergency source patient did not present to this facility for care.

Date Test Results were Completed | Date Test Results were Reported Out

Print Name and Title of Person Providing Test Results | Signature of Person Providing Test Results

Test Results were Mailed to (Name)

Address Results were mailed to (Number & Street) | City | State | Zip Code

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: PA 419 OF 1994 (M.C.L. 333.20191

COMPLETION: Is voluntary, but is required if testing of the source patient is desired.

Immunization & Testing

Purpose:
To allow paramedics or other Medical Control Authority (MCA) approved personnel to provide testing and vaccinations for agency personnel and the community. Community immunization and other public health applications are important duties that EMS personnel may perform as determined necessary in cooperation with the medical control authority, local hospitals, and the local public health department. Training will be approved by the EMS Medical Director and the MCA, and may be accomplished under the direction of the MCA and/or local public health department.

1. **Indications for immunization and/or testing:**
   A. Public or EMS agency personnel may be immunized or tested under guidelines developed by the public health department or MCA. Testing may include tests for infectious diseases or other diagnostic testing as needed.
   B. Age groups for immunization will be determined by the MCA or public health department as appropriate.
   C. Timing of immunizations or testing will be determined by the MCA, hospital, EMS agency and public health department to comply with public health needs or agency immunization requirements as determined by agency infection control guidance.
   D. Immunizations or testing may be performed in clinic, NEHC, mass immunization or agency setting as approved by the MCA and/or local public health department.
2. **Immunization or testing**
   A. Immunizations may be administered via intramuscular (IM), subcutaneous (SQ), or intranasal (IN) route in dosing determined by guidance provided by the MCA or local public health department as required for the agent administered.
   B. Screening will be performed as determined appropriate for the agent administered by the MCA or local health department.
   C. TB tests are intradermal and require additional training and certification in order to perform. Tests will be interpreted by paramedics performing the tests or personnel trained to review TB tests under MCA approved training programs.
3. **Training**
   A. Training for immunization will be provided by local public health department personnel or under an approved MCA program.
4. **Personnel requirements**
A. Immunizations or testing may be performed by paramedics trained by local public health department personnel or under approved MCA training programs.
5. **Record keeping**
   A. A record of public or agency personnel receiving immunizations or TB testing will be maintained by the agency performing the immunizations or TB testing as determined by the local public health department/Medical Control Authority.
   B. The Michigan Care Improvement Registry (MCIR) record keeping is required for immunizations.

Initial Date: 09/2004
Revised Date: 12/27/2022 Section: 8-12

Communications Failure

Purpose: To allow for continued patient care activities in the event of a communications failure or inability to contact medical control.

Procedure

1. With a communications failure or inability to contact medical control, EMS personnel may initiate medical treatment protocols and procedures including interventions identified after the “Post-Medical Control” section.

2. Contact medical control as soon as communications can be established and inform them of the situation, including care or procedures rendered.

3. Notification to the MCA of the communication failure will occur within 24 hours.

4. The electronic patient care record will have a protocol deviation noted and the circumstances around the communication failure described in the narrative section.

NOTE: This procedure is considered a protocol deviation and will only be used in exceptional circumstances.

Initial Date: 08/28/2020
Revised Date: 05/30/2023 Section 8-13

Electronic Records & EMS Information System

I. **Responsibility for Records**
   A. Any PCR software utilized by an EMS agency must be compliant with the National EMS Information System (NEMSIS) system and the Michigan EMS Information System (MIEMSIS) as determined by the department.
   B. All PCR are considered confidential medical records and must be treated in accordance with state and federal law.
   C. Signed electronic or paper PCR shall be maintained by the EMS agency as the official medical record for each patient treated and/or transported.
   D. All original PCR reports will be made available to the receiving facility, the MCA and the Bureau of EMS, Trauma and Preparedness, in electronic format, upon request.

II. **Submission to MIEMSIS Data Repository**
   A. All agencies must transfer data at least monthly. Reporting period begins at 00:00:01 hours on the 1st day of the calendar month, ending at midnight on the last day of the calendar month. Data must be uploaded by the 15th of the month following the close of the reporting period. MCAs may require data to be transferred more frequently.
   B. Agencies performing invasive skills (including supraglottic airways) must transfer data at least daily. PCR that include invasive skills will be available in MIEMSIS within 24 hours of incident completion.
   C. If technology permits, transfer should occur at the time of incident completion.
   D. Agencies are responsible to work with their MCA(s) and the department to ensure that the quality of the data submitted to the MIEMSIS repository is an accurate reflection of the information entered into their EMS information system. Agencies are responsible for ensuring accuracy in data element mapping, accuracy in data value coding, list compliance, and accuracy in data transfer between the vendor and the MI-EMSIS system. Agencies may access MIEMSIS to verify the submission of their records at any time.
   E. Agencies entering data from paper PCR after-the-fact are responsible for entering those PCR in accordance with the above time frames.
   F. All PCR transferred to MIEMSIS must be compliant with the Michigan Required Elements.
   G. All PCR transferred into MIEMSIS will use values from Department provided lookup lists.

III. **Utilizing Data**
   A. The MCA professional standards review organization (PSRO) will utilize data submitted by the life support agencies for the purpose of providing professional oversight and for improving the quality of medical care within the MCA region.
   B. MCAs may utilize aggregate data that does not identify the patient or agency to support EMS system and public health activities.

C. MCAs may choose to maintain its own repository and in turn submit the data to the Department of Health and Human Services.
D. The information accessed by the MCA is confidential in nature and is intended for the medical control PSRO. Data protection is critical and is provided for through 1967 PA 270, MCL 331.531 to 331.533, other applicable confidentiality laws, and use and user agreements. The MCA will:
    1. Only use or disclose data for the purposes described in Part 209 of the Public Health Code and the Michigan Administrative Code R 325.22101 through R 22217. Any other uses or disclosures will be made only as required by applicable laws.
    2. Use appropriate safeguards to prevent use or disclosure of the information other than as provided by this agreement.
    3. Limit access to the data to only those employees assigned to perform the functions under the above statute and administrative rules and who have signed a data user agreement on file with the Department.
    4. Report any actual or suspected breach, intrusion, or unauthorized use or disclosure to the Department and the affected life support agency within 10 days of becoming aware of such breach, intrusion, or unauthorized use or disclosure or such shorter time period as is reasonable under the circumstances.
    5. Mitigate the effects of any breach, intrusion, or unauthorized use or disclosure.
    6. Notify the Department when anyone with a signed user agreement and access to data systems leaves their position. Notification should occur within 24 hours.
    7. Comply with the Michigan Identity Theft Protection Act notification procedures at MCL 445.61 et seq.
    8. As a public body subject to the Freedom of Information Act (FOIA), redact all personal identifiers or other information pursuant to applicable FOIA exemptions. 1976 PA 441: MCL 15.231 et seq.

E. **CARES Data**
    1. The LSA will submit data for out-of-hospital cardiac arrest (OHCA) patients to the Cardiac Arrest Registry to Enhance Survival (CARES).
    2. If multiple agencies are on scene the transporting agency is responsible for CARES data entry.
    3. The agency completing the CARES record will collect applicable CARES dispatch elements.

F. **Confidentiality**
    1. The EMS patient care record is a confidential patient care document and is not to be released to anyone other than those involved in the patient's care or Professional Standards Review Organization, without the patient's written release of information permission.

Initial Date: 09/2004
Revised Date: 12/27/2022 Section: 8-14

Protected Health Information

Purpose:

I. To provide a standard for sharing protected health information (PHI) with entities that function in the capacity of a life support agency.

II. To promote and improve overall patient care and pre-hospital EMS activities, Medical Control Authorities shall establish patient care quality improvement programs. Patient care information will be utilized in these programs for quality improvement activities only and shall conform to all state and federal patient confidentiality and privacy laws.

Policy:

I. Medical Control Authorities and their Professional Standards Review Organization (QI Committee) will collect patient care information through retrospective review of patient care records generated and supplied by all life support agencies.

II. Patient care records will be completed on all patients where any type of care or assessment has occurred.

III. Each responding pre-hospital care provider shall complete Medical Control approved documentation, a copy of which may be forwarded to Medical Control Authority for quality improvement purposes.

IV. The Medical Control Authorities shall hold all patient care information in strictest confidence.

V. Quality Improvement within the Medical Control Authority shall be conducted under the Professional Standards Review Organization, which may be comprised of representatives from various pre-hospital agencies. No patient identifiers will be used or shared during reporting of any retrospective QI reviews of patient care.

VI. Patient outcomes may be tracked by pre-hospital agencies and/or Medical Control Authorities and may be shared among pre-hospital agencies, including Medical First Response agencies, responsible for patient care. No patient identifiers will be used or shared during reporting.

VII. Patient care audits may occur as part of the QI process. No patient identifiers will be used or shared during reporting. Aggregate data will be shared with pre-hospital agencies using no patient identifiers. This data will be used for education, remediation and overall improvement of system processes.

Initial Date: 09/2004
Revised Date: 03/03/2025 Section: 8-15

Inter-facility Patient Transfers

Purpose: The purpose of this protocol is to establish a uniform procedure for inter-facility transfers. Providers of inter-facility transfers must have MCA privileges in the MCA in which the transfer begins or ends unless otherwise indicated (per MCA selection).

MCA Approval for Inter-Facility Transfer Resource Expansion

☐ Inter-facility transfers initiated within the MCA may be carried out by providers that hold MCA privileges in an MCA other than the sending or receiving MCA.

The MCA is responsible for establishing guidelines and communications for this process and maintain a roster of providers . Providers will provide care under their originating MCA protocols unless otherwise specified.

1. Responsibility:
   - A. Patient transfer is a physician-to-physician referral. The transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility prior to the transportation. The name of the accepting physician must be included with the transfer orders.
   - B. It is the responsibility of the transferring facility to:
     - a. Perform a screening examination.
     - b. Determine if transfer to another facility is in the patient's best interest.
     - c. Initiate appropriate stabilization measures prior to transfer.
   - C. During transport, the transferring physician is responsible for patient care until arrival of the patient at the receiving facility.
   - D. It is the transferring physician's responsibility to know and understand the training and capabilities of the transporting EMS personnel.
   - E. BLS that have received training may transport the following patients with IV access (per MCA selection)

MCA Approval for BLS care during Interfacility transfer

☐ Capped peripheral/central lines without fluid or medication

☐ Isotonic IV fluids without medications on dial-a-flow (may not adjust flow rate)

☐ Isotonic IV fluids on a pump (may not adjust flow rate)

☐ IV Antibiotics that have been infusing for at least 15 minutes prior to departure (on a pump or dial-a-flow and may not adjust flow rate).

☐ IV Lipids/TPN (on a pump or dial-a-flow and may not adjust flow rate)

☐ PCA Pump

F. Additional/Accompanying Staff (Non-EMS personnel) assigned for transfer by physician:
    a. The transferring physician is responsible for ensuring the qualification of accompanying staff.
    b. Accompanying staff will render care to the patient under the order of the transferring physician.
    c. It is the responsibility of the transferring facility to arrange for the return of staff, equipment, and medications.

2. Transportation
    A. Pre-transport
        a. Care initiated by the transferring facility that requires continuation during transport, along with additional treatment(s) will be determined by the transferring physician.
        b. Orders for treatment shall be provided in writing to the EMS personnel prior to initiation of the transport by the transferring Physician.
            1. A mutually agreed upon primary form of communication with the transferring physician for the duration of the transfer.
        c. Ordered medications not contained within the EMS System Medication Box must be supplied by the transferring hospital.
        d. EMS personnel must be trained in all the equipment, procedures, and medications being used in the patient's care during the transfer. see **ENHANCE PARAMEDIC INTERFACILITY CARE/CRITICAL CARE PROTOCOL**
        e. Patient care, procedures, equipment, or medications that exceed EMS personnel training require additional/accompanying staff (see section 1.F. above).
        f. EMS personnel have the right to decline transport that is outside their scope of practice and/or training when additional/accompanying staff is unavailable.
        g. The following information should accompany the patient (but not delay the transfer in acute situations):
            1. Copies of pertinent hospital records
            2. Written orders during transport
            3. Any other pertinent information including appropriate transfer documents.
    B. During Transport
        a. Hospital supplied medications not used during transport must be appropriately tracked, wasted and documented.
            1. All controlled substances and Propofol must have a documented chain of custody.
        b. The concentration and administration rates of all medications being administered will be documented on the patient care record.
        c. Interventions performed enroute, and who performed them, will be documented on the patient care record.

d. Intervention beyond the written orders provided by the transferring Physician, require contact with the transferring Physician.

e. Order of operation for care and communication when unable to contact the transferring physician.
    1. Follow Medical Control approved Protocols under which the EMS agency has Medical Control privileges and initiate contact with:
        a. Receiving physician
        b. On-line Medical Control Physician from the sending facility.
        c. On-line Medical Control Physician from the receiving facility
        d. Closest appropriate on-line Medical Control facility.

3. Special Treatments

A. Interfacility High Flow Nasal Oxygen (HFNO) (per MCA selection)

Interfacility High Flow Nasal Oxygen Included?
(●) Yes ( ) No

a. See **Interfacility High Flow Nasal Oxygen-Procedure Protocol**
b. Ensure adequate supply of oxygen is available for transport.
    1. Calculate amount of oxygen needed prior to departure.
    2. Must have minimally two times the amount of oxygen calculated.

Medication Custody Form

Patient Name _____

EMS Staff Receiving Medication _____ (**Name**) _____ (**Signature**)

Hospital Staff Sending Medication _____ (**Name**) _____ (**Signature**)

Medication	Amount Received From Hospital	Administered	Wasted

EMS Staff Wasting Medication _____ (**Name**) _____ (**Signature**)

Hospital Staff Witnessing Waste _____ (**Name**) _____ (**Signature**)

Licensure Level Requirement of Attendant during Transport (MCA Optional Protocol)

☑ Medical Control Authorities choosing to adopt this supplement may do so by selecting this check box. Adopting this supplement changes or clarifies the referenced protocol or procedure in some way. This supplement supersedes, clarifies, or has authority over the referenced protocol.

Purpose: To provide a protocol to fulfill the requirement that allows for EMS personnel to transport patients up to their individual licensure level in the event that the vehicle is licensed at a higher level as set forth in Michigan Administrative Code Part 3, Ambulance Operations R325.22133 (f).

Michigan Administrative Code Part 3. Ambulance Operations R 325.22133 (f) states: that an individual whose license is at least equal to the level of vehicle license is in the patient compartment when transporting an emergency patient, or consistent with department approved medical control authority protocols.

I. Patient care transport level is to be determined by the individual(s) whose license is at least equal to the level of the vehicle license. This individual will perform a patient assessment to determine the level of patient care transport. The electronic patient care record must reflect this assessment both as a procedure and in components of the assessment.
   A. EMT-Basic may attend in the patient compartment during transport on a patient deemed to be within the scope of practice for an EMT-Basic as defined by the State of Michigan.
   B. EMT-Specialist may attend in the patient compartment during transport on a patient deemed to be within the scope of practice for an EMT-Specialist as defined by the State of Michigan.
   C. EMT-Paramedic may transport a patient at any level.

II. Ambulance(s) must maintain minimum staffing in accordance with Public Health Code Act 368 of 1978 Section 333.20921:
   (3a) If designated as providing basic life support, with at least 1 emergency medical technician and 1 medical first responder.
   (3b) If designated as providing limited advanced life support, with at least 1 emergency medical technician specialist and 1 emergency medical technician.
   (3c) If designated as providing advanced life support, with at least 1 paramedic and 1 emergency medical technician.

III. An appropriate licensed health professional, designated by a physician with an established patient relationship may be present in the patient compartment of the ambulance in place of EMS staffing, according to 333.20921 (6).

Medical Control Privileges

Purpose: To establish minimum requirements for licensees applying for and retaining medical privileges within the jurisdiction of this medical control.

I. Minimum requirements for providers
   A. EMS personnel shall possess a valid State of Michigan license.
   B. EMS personnel shall possess a valid BLS Healthcare Provider card.
   C. Personnel licensed at EMT-Basic and above are subject to other MCA specific requirements as outlined below

II. Minimum Life Support Agency Requirements
   A. Valid State of Michigan license.
   B. Medical Control approved electronic documentation tool for submitting patient care records.
   C. Responsibility for their EMS personnel meeting the requirements of this and other applicable protocols.
   D. Compliance with protocols.
   E. Notification of the medical control authority if they are unable to meet or comply with any protocol, statutory or regulatory requirement.
   F. Compliance with the minimum staffing and equipment requirements as defined in P.A. 368 of 1978, as amended.

III. Scope of Privileges
   A. A licensee's scope of medical privileges shall be granted to the equivalent of those granted his/her employer agency operating within the jurisdiction of this medical control authority.
   B. In circumstances where a licensee is dually employed, he/she may exercise privileges to the limit of his/her employer agency of the moment (i.e., a paramedic who is employed by an advanced life support agency and a medical first responder agency may only practice to the level of privileges granted to the agency on whose behalf he/she is acting).

IV. Disciplinary Notifications
   A. A licensee must inform the MCA within (1) business day of any suspensions or revocations of MCA privileges in any other MCA in which the licensee has privileges.
   B. A licensee must inform the MCA within (1) business day of the receipt of an MDHHS issued Notice of Intent to Suspend (NOIS), Notice of Intent to Revoke (NOIR), Emergency Order (of any kind), or Compliance Order.

IV. Training Standards Required by MCA: mark and specify as applicable

Applicable to all EMT and above

- [x] Written Exam
- [x] ICS 100
- [x] ICS 700
- [x] MCA Orientation
- [ ] Pre-hospital Trauma Certification (PHTLS, ITLS, FTC)
- [x] Practical Competency (EMT Skills)

☑ Upon application for MCA privileges the licensee must disclose to the MCA disciplinary actions pending or within the past 12 months, received from any Michigan MCA and/or MDHHS involving a Level 1 or Level 2 infraction.

☑ Other MCA requirements as specified/listed below:

Must notify the MCA of any State, MCA or Tribal territory suspension or revocation of their pre-hospital privileges or license. Must be authorized by each employer currently employed by within TCEMCA utilizing TCEMCA EMS Provider Authorization request and other documents.

Applicable to all Specialist and above

☑ Practical Competency (Specialist Skills)

☑ Other MCA requirements as specified/listed below:

Must notify the MCA of any State, MCA or Tribal territory suspension or revocation of their pre-hospital privileges or license. Must be authorized by each employer currently employed by within TCEMCA utilizing TCEMCA EMS Provider Authorization request and other documents.

Applicable to all Paramedic

☑ Advanced Cardiac Life Support (ACLS)

☐ Pre-hospital Pediatric Certification (PALS, PEPP)

☑ Practical Competency (Paramedic Skills)

☐ Enhanced Paramedic Interfacility Care

☑ Other MCA requirements as specified/listed below:

Must notify the MCA of any State, MCA or Tribal territory suspension or revocation of their pre-hospital privileges or license. Must be authorized by each employer currently employed by within TCEMCA utilizing TCEMCA EMS Provider Authorization request and other documents.

V. Specialty Care Privileges

☑ Enhanced Paramedic Interfacility Care (EPIC)

A. Trained according to Enhance Paramedic Interfacility Care Protocol
B. Access to necessary equipment for Enhanced Paramedic Interfacility Care Protocol

☑ Critical Care Interfacility Transport

A. Trained according to MCA approved standards
B. Access to necessary equipment at time of transport

☑ Community Integrated Paramedicine

A. Trained according to CIP Program Policy Protocol
B. Access to necessary equipment for MCA approved CIP protocols

Responsibilities of the Participants in the Medical Control Authority System

Purpose:

This protocol defines the responsibilities of each administrative segment of the Medical Control Authority system. These segments include the Medical Control Authority itself; the hospitals and freestanding emergency departments (FSED) providing on-line medical direction; and the EMS agencies providing direct EMS services to the public.

I. Responsibilities of the Medical Control Authority
   - A. The Medical Control Authority is responsible for providing medical oversight for EMS. Hospitals are responsible for administering the Medical Control Authority.
   - B. The Medical Control Authority will issue protocols, with Department approval, as defined by Part 209 of P.A. 368 of 1978, as amended, that reflect current medical practice and address issues as necessary to assure quality pre-hospital patient care.
   - C. In cooperation with the EMS agencies, the Medical Control Authority will coordinate training to implement protocols not included in initial EMS education.
   - D. Ensure that all significantly affected parties in the MCA will have sixty-days' notice for protocol changes (aside from emergency protocols).
   - E. The Medical Control Authority will establish a Professional Standards Review Organization (PSRO).
     - a. PSRO will implement a system wide Continuous Quality Improvement program.
     - b. PSRO will provide an impartial, fair and medically appropriate peer review process.
   - F. The Medical Control Authority will forward to the Department within (1) business day any ODA issued to a licensee that restricts their ability to practice (i.e., suspension or revocation of MCA privileges)

II. Responsibilities of Participating Hospitals and Free Standing Emergency Departments (FSED) Providing On-Line Medical Direction
   - A. A hospital or FSED within the Medical Control Authority system providing on-line medical direction to EMS providers will assure that any physician or physician designee authorized to providing such direction:
     - a. Has access to the current MCA approved protocols
     - b. Provides medical direction consistent with MCA approved protocols.
   - B. Each hospital or FSED providing on-line medical direction will encourage the participation of a representative of its Emergency Department physician staff with the Medical Control Authority.
   - C. Hospitals or FSEDs will promptly inform their Emergency Department physicians and staff of Medical Control Authority policy and protocol changes.

III. Responsibilities of EMS Agencies

A. Agencies will operate under the Medical Control Authority and comply with Department approved protocols.
B. Assure only persons currently authorized to do so by the Medical Control Authority will provide pre-hospital patient care.
C. Each EMS agency will assure that their personnel have current training and certifications as required by **Medical Control Privileges Protocol**.
D. Each EMS agency will immediately notify the Medical Control Authority and the Department if the EMS agency is unable to provide staffing at the level required by its State license.
E. Licensed EMS vehicles will be equipped with all Medical Control Authority required equipment, if applicable, in addition to that equipment required by the State of Michigan.
F. EMS agencies will promptly inform their EMS personnel of Medical Control Authority policy and protocol changes.
G. EMS agencies will provide an annual listing of EMS personnel. This listing shall note the license and Medical Control Authority authorization status of each individual.
H. If an employee of an EMS agency is found to be in violation of a Medical Control Authority protocol, the EMS agency will cooperate with the Medical Control Authority in addressing the violation and taking corrective measures.
I. Assure training and competency of personnel in the case of new or expanding department approved protocols.

IV. Accountability

A. The Department designates the Medical Control Authority for a specific geographic area. As such, the Medical Control Authority is accountable to the Department in the performance of its duties.
B. The hospitals and possibly the FSEDs within the Medical Control Authority system collectively administer this Medical Control Authority. Each individual hospital and FSED that receives emergency patients by ambulance is accountable to the Medical Control Authority to meet the responsibilities listed above. Failure to meet those responsibilities may result in a termination of the ability of a hospital or FSED to provide on-line medical direction or receive emergency patients (by ambulance).
C. EMS agencies within the Medical Control Authority system are accountable to the Medical Control Authority, as detailed and defined in protocol. Failure to comply with approved protocols may result in sanctions against that EMS agency.

On-Scene Physician Interaction

The EMS system will be available at all times to provide support for health professionals in emergency medical settings. It is ready to assume responsibility for patient care upon request of a physician who has initiated treatment of a patient with whom he has an established physician-patient relationship.

The EMS system On-Line Medical Control Physician is considered the highest medical authority at the scene of a medical emergency with a patient unattended by a physician. An on-scene physician who does not have an established physician-patient relationship and wishes to assume responsibility must seek permission from the Medical Control physician in order to do so.

EMS Personnel are to receive orders for interfacility patient care from the referring physician provided those orders are consistent with the training of the paramedic and the **Interfacility Patient Transfer Protocol**. If the patient's condition changes to the point that the sending facilities orders did not meet the needs of the patient, the patient will become the responsibility of the EMS system. Appropriate treatment will be performed based on the MCA protocols or from an on-line medical direction.

Procedure:

A. Physician's Office, Clinic or Ambulatory Patient Care Facility
   1. Physician Office, Clinic or Ambulatory Patient Care Facility to hospital transfers are considered scene calls unless a physician-to-physician transfer is designated by the Physician Office, Clinic or Ambulatory Patient Care Facility. EMS personnel will take responsibility for the patient as if the patient were coming from a prehospital scene.
   2. EMS personnel should obtain pertinent history, from the patient and physician (or designee).
      a. If no destination chosen, follow MCA transport protocol
      b. If physician to physician destination decision has been determined, honor that established agreement when possible.

         i. If a valid reason exists to not honor the established transport agreement, contact Medical Control.

B. Free Standing Emergency Department (FSED) to Hospital Transfers
   1. FSED is defined in the MCA Transport Protocol.
   2. A FSED to hospital transfer is considered a physician-to-physician interfacility transfer.
   3. EMS personnel responding to a FSED should receive a patient report from the treating physician (or designee). This report should include the physician's assessment, the requested destination, name of the person who accepted the transfer, care to be given during transport, and any potential problems felt likelyto occur in route.
   4. If EMS personnel do not agree with the destination or proposed orders, they

should discuss this with the transferring physician. If an agreement is not reached, medical control should be contacted to determine the destination and care to be given by EMS personnel in route to the hospital.

5. The scope of practice for EMS when performing a FSED to Hospital transfer is determined by the **Interfacility Patient Transfer Protocol**.
6. At the discretion of the FSED physician, the FSED physician or designated facility staff may treat and accompany the patient during transport with the assistance of the EMS system.
7. Upon departure from the scene, contact Medical Control as would be done for any EMS scene patient.

C. Physician On-scene

1. As time and patient condition permit, EMS personnel should make a reasonable effort to establish the identity or credentials of anyone at the scene of a medical emergency (not a covered by previous sections of this protocol) who professes to be a Michigan licensed physician who expresses an interest in participating in patient care activities.
2. An on-scene physician must identify themself and verify to Medical Control either the fact of an established physician-patient relationship with the patient, or willingness to assume responsibility for the patient and to accompany the patient to the hospital. The Medical Control physician may allow the on-scene physician to provide on-scene Medical Direction and then not accompany the patient to the hospital. Should this occur the Medical Control physician re-assumes responsibility for the patient during transport.
3. The Medical Control physician will verify over the radio his delegation of responsibility to the physician on-scene and the nature of that delegation.
4. A physician on-scene may participate with paramedic(s) in the resuscitation of a patient with permission of Medical Control without assuming full responsibility for the patient. This responsibility will, in this case, remain with the Medical Control physician and the ALS system.
5. It should be noted that responsibility for the patient at the scene rests with the on-line medical control physician. Decisions releasing medical care responsibility to another physician should be considered carefully.
6. If an on-scene health care professional has identified themself, and obstructs efforts of the paramedic(s) to aid a patient for whom they are called, or who insists on rendering patient care inconsistent with the system standards and resists all invitation to function appropriately to the point where his continued intervention will result in obstruction to rendering good and reasonable patient care, EMS personnel should:
   a. Request Public Safety Officers become involved, if necessary, so that the team members can continue to provide patient care according to system protocol.
   b. Communicate the situation promptly to On-Line Medical Control.
   c. Document the behavior of the on-scene health care professional on the patient care record.

D. For on scene interaction with Emergency Medicine Residents, Fellows, Medical Control Physicians, and the EMS Medical Director: MCAs may have an optional protocol specific to programs within their area.

Protocol Deviation

I. It is acknowledged that there are situations in which deviation from the protocols, policies and procedures may be needed in the interest of patient care.

   A. In those situations, EMS personnel should request permission for deviation from on-line medical direction whenever possible.

   B. Unavailability of on-line medical direction and the immediacy of patient care needs may, in very rare instances, prohibit such requests, but those situations should occur rarely.

II. All instances of protocol deviation must be documented in the EMS patient care record, noting the deviation which occurred and the reason for that deviation.

III. All deviations performed without online medical control approval must be reported to the MCA with 24 hours.

IV. All reported deviations will be reviewed within the MCA Professional Standard Review Organization.

Violent/Chemical/Hazardous Scene

Note: This policy applies to any situation, which may expose EMS personnel to known or potentially violent (e.g., shooting, stabbing, assault, other violent crimes) or other known or potentially hazardous (e.g., hazardous material, chemical, biological) situations.

The medical component of the response to a violent or hazardous incident will operate under the Incident Command System.

I. Procedure
   A. Upon notification of a known or potentially violent situation, the EMS personnel will determine through dispatch, the nature and location of incident and:
      1. Violent Situations
         a. Is assailant/weapon present?
         b. Assure law enforcement notification?
         c. Is scene secure?
      2. Hazardous materials situation
         a. Is scene secure?
         b. Nature and identification of material?
         c. Assure FD/Hazmat Team notification?

NOTE: The above information should be communicated to responding crews.

II. If the scene is not secured:
   A. EMS personnel will stage an appropriate distance away from the scene to protect themselves from danger.
   B. In hazardous material situations stage upwind, uphill and upstream.
   C. In violent situations EMS personnel will NOT enter a potentially unsecure scene until coordinated by law enforcement command and MUST maintain law enforcement protection.

III. Once on the scene, if the situation changes posing an immediate life or limb threat to EMS personnel:
   A. Attempt to safely exit scene.
      1. Exit scene with patient, if possible.
      2. Medical treatment protocols may be limited or deferred to assure safety of EMS personnel and patient.
   B. Notify the dispatcher of the assistance needed.
   C. Provide any additional information available – e.g., number of assailants, weapons present/involved, any additional information.

Special Considerations: For those patients, who have been contaminated in a hazardous material incident, refer to **Hazard Contaminated Patient-Special Operations Protocol**.

Medical Examiner Notification and Body Disposition (MCA Optional Protocol)

The intent of this policy is to establish standards for proper and respectful disposition, handling, and notifications for a deceased person.

- Refer to **Dead on Scene & Termination of Resuscitation-Procedure Protocol** for determination of when and when not to initiate CPR, and when to terminate efforts.

I. Out of hospital death – Notification of the Medical Examiner

A. The Medical Examiner's office shall be notified for any out-of-hospital death under the following circumstances:
   1. The individual dies by violence
   2. The individual's death is unexpected
   3. The individual dies without medical attendance by a physician, or the individual dies while under home hospice care without medical attendance by a physician or registered nurse, during the 48 hours immediately preceding the time of death, unless the attending physician, if any, is able to determine accurately the time of death.
   4. If the individual dies as a result of an abortion, whether self-induced or otherwise.
   5. Death of a prisoner in a jail or prison.

B. Responsibility to notify the Medical Examiner
   1. If a patient is transported to a hospital from the scene, having met the above criteria, EMS shall notify the hospital of the criteria which requires notification. Responsibility for the notification of the Medical Examiner resides with the hospital.
   2. If a patient meeting the above criteria is pronounced dead without being transported to the hospital, the responsibility for notification of the Medical Examiner is shared between law enforcement and EMS personnel having authority for the management of the patient.
   3. Patients who do not meet the above criteria and who are pronounced dead outside of a hospital do not require notification of the medical examiner.
      a) Any patient who is attended by a physician or registered nurse at the time of death (nursing home)
      b) Any patient who was under home hospice care and had medical attendance by a physician or registered nurse within the 48 hours immediately preceding the time of death (hospice patient either at home or in hospice facility)

II. Out of Hospital Death – Management, Handling and Movement of Body

A. A body shall not be moved from the location of death if any mandatory Medical Examiner reporting criteria are present, **unless the ME's office provides**

official notification that an autopsy or external examination will not be performed and that the body will be released to the funeral home.

B. Alternately, the body of a person who has unexpectedly died in a public location may be moved by EMS only after approval from the ME's office. Such approval shall not be requested if there is any indication of violence, criminal activity or if the physical environment may contain evidence related to a cause of death or an injury pattern.

C. **A situation which does not require notification of the ME's office does allow for movement of the body pending retrieval by the funeral home.**

D. Bodies must remain attended in the case of an unexpected death. Police should take custody of the body in the instance of an ME case. If there is a significant delay of the funeral home, the body may be left with the family.

E. Medical devices utilized during care by EMS may be removed from the patient if the body is released by the ME's office to the funeral home (IV's, advanced airways, defibrillation pads, etc.)

F. Medical devices utilized during care by EMS must remain in place if the ME's office advises that an autopsy of examination will be performed.

G. If there is evidence of suspicious, violent, or unusual cause of death, caution should be taken to avoid contamination of the scene.

1. In the instance of a scene resuscitation and termination, the identification may be removed from the body. No other personal items may be removed.
2. Bodies may be covered with a sheet when the body is visible to the public or bystanders.

H. If a body is moved, as permitted in the prior criteria, the location should be to a private, secure and nearby location pending retrieval by the funeral home or the ME's staff.

I. Bodies must be handled with care and respect for the deceased, the family and the public.

III. Death in an Ambulance – termination of care

A. Patients with valid DNR orders being transported for any reason, whether due to an emergency condition or during an interfacility transfer, who experience cardiac or respiratory arrest shall have the DNR honored unless, before arresting, the patient expressly withdraws their DNR.

B. Patients for whom transport was initiated but who, during transport, meet the criteria for either Dead on Scene or Termination of Resuscitation protocols, and for whom On-line Medical Control (OLMC) has approved a termination of resuscitation (as required by those protocols respectively), may have care terminated while still en route to the hospital.

IV. Death in an Ambulance – transportation of body

A. In the event of a patient death in an ambulance, the body shall be transported to the original destination hospital if the call was originally from a scene to a hospital or from a facility to a hospital (transfer).
   1. The patient's body shall be brought to the Emergency Department
   2. The patient will be registered to accommodate both the transfer of custody and for preservation of evidence, if indicated
   3. The Medical Examiner shall be contacted by the hospital and the disposition of the body shall be according to the direction of the ME.

B. If a patient is being transferred to a nursing home or to their home, immediately following discharge from a hospital, and death is determined, the body should be brought back to the hospital from which they were discharged, unless the patient is a hospice patient.
   1. If the patient is a hospice patient and hospice will be meeting you at the destination, or the destination is a hospice facility, you may continue on to the destination and relinquish the body to hospice personnel. This is permitted, without notification of the Medical Examiner, since the patient was both a hospice patient and received medical attendance within the 48 hours immediately preceding the time of death. However, if the death was unexpected, the Medical Examiner must be notified.
   2. If the patient is a hospice patient, and hospice personnel will not be meeting you at the destination, continue on toward the destination, contact a supervisor from your agency and evaluate the situation. Where you ultimately go is dependent on how far you are from the destination, if family was intending to meet you at the destination, if the death was unexpected and any confounding factors. The body may not be left without there being a custodial transfer from EMS to an appropriate healthcare provider.
      a) Consider contacting the hospice care provider
      b) Consider consultation with online medical control
      c) If the death was unexpected, contact the Medical Examiner

C. If a patient is being transferred from a facility to an appointment, or vice versa, where neither the starting or ending destination was a hospital:
      a) If no DNR exists, treat and transport the patient to a hospital
      b) If a DNR exists but the patient is not a hospice patient, determine death, honor the DNR, and transport the body to a hospital
      c) If a DNR exists and the patient is a hospice patient, determine death; honor the DNR, refer to IV(B)(1) and (2) above.

Safe Delivery of Newborns

Purpose

According to Public Act 488 of 2006 and Public Acts 232, 233, 234, and 235 or 2000, parents may surrender their newborn child to any hospital, fire department, police station, or call 911 from any location and remain anonymous. This protocol outlines steps to be taken in this circumstance. ***IMPORTANT* While there is opportunity for information gathering through forms, the surrendering parent has the option of remaining completely anonymous and disclosing no information.**

Definitions

Newborn: A child who a physician reasonably believes to be not more than 72 hours old.

Emergency Service Provider (ESP): A uniformed or otherwise identified employee or contractor of a fire department, hospital, or police station when such an individual is inside the premises and on duty. ESP also includes a paramedic or an emergency medical technician (EMT) when either of those individuals is responding to a 9-1-1 emergency call.

Surrender: To leave a newborn with an emergency service provider without expressing an intent to return for the newborn.

Procedures

1. The surrender of the infant must occur inside the fire department, police station or in response to a 9-1-1 emergency call to paramedics or EMT.
2. In the instance of a parent attempting to surrender a newborn to a staffed ambulance, not on an emergency call, immediately notify dispatch and establish an emergency call.
3. To protect the parent's right to anonymity/confidentiality, the EMS agency responding to a 9–1–1 emergency call from a parent(s) wanting to surrender a newborn, should not use the vehicle sirens or flashing lights.
4. The firefighter, police officer, paramedic or EMT personnel cannot refuse to accept the infant and must place the infant under temporary protective custody.
5. Fire departments, police stations, paramedics and EMTs have statutory obligations under the law, including:
    a. Assume that the child is a newborn and take into temporary protective custody.
    b. Ask surrendering person(s) if they are the biological parent(s). If they are not the biological parent(s) the newborn cannot be surrendered under the Safe Delivery of Newborns law.
    c. Make a reasonable effort to inform the parent(s) that:
        i. By surrendering the newborn, the parent(s) is releasing the newborn to a child placement agency to be placed for adoption.
        ii. He or she has 28 days to petition the Circuit Court, Family Division to regain custody of the newborn.

iii. There will be a public notice of this hearing and the notice will not contain the parent(s) name.
iv. The parent(s) will not receive personal notice of the hearing.
v. Information the parent(s) provides will not be made public. A parent(s) may contact the Safe Delivery of Newborns hotline for information. The toll-free number is: **866-733-7733**

6. Provide the parent(s) with written material from the Department of Health and Human Services that includes:
    a. Safe Delivery Program FACT Sheet (DHHS Pub 867)
    b. What Am I Going To Do? (DHHS Pub 864) Optional
7. Make a reasonable attempt to:
    a. Reassure parent(s) that shared information will be kept confidential.
    b. Encourage parent(s) to identify him/herself.
    c. Encourage the parent(s) to share any relevant family/medical background, Voluntary Medical Background Form for a Surrendered Newborn (DHHS Form 4819).
    d. Inform the parent(s) of the newborn he or she can receive counseling or medical attention.
    e. Inform parent that in order to place the child for adoption the state is required to make a reasonable attempt to identify both parents. Ask for the non-surrendering parent's name. Do not press if the name is refused.
    f. Inform the parent(s) that he or she can sign a release for the child that could be used at the parental rights termination hearing, Voluntary Release for Adoption of a Surrendered Newborn (DHHS Form 4820).
8. Fire and Police may contact emergency medical services (EMS) to transport newborn to hospital. ESP will accompany newborn to the hospital to provide hospital with any forms completed by the parent(s) and to transfer temporary protective custody.
    a. Note: Temporary protective custody cannot be transferred to EMS. A representative of the fire department or police station must go to the hospital to transfer temporary protective custody to the hospital.
9. The responding EMS crew will transport the newborn to closest appropriate facility, according to the MCA transport protocol, provide any forms completed by parent(s) and transfer temporary protective custody to hospital staff.

* For Safe Delivery purposes EMS is defined as a paramedic or emergency medical technician.

Michigan's

Safe Delivery of Newborns Law

FACT Sheet

SAFE. LEGAL. ANONYMOUS.

Background:

Michigan lawmakers passed the Safe Delivery of Newborns law to end the tragedy of unwanted newborns being hidden and left to die in unsafe places. More than 100 newborns were surrendered in the first 10 years the law was in effect, with the majority of these infants adopted by loving families.

What the law provides?

- Unharmed newborns, up to 72 hours old, can be taken to an Emergency Service Provider (ESP), meaning a uniformed or otherwise identified employee or contractor of a fire department, hospital or police station who is inside the building and on duty. ESP includes a paramedic or EMT when either responds to a 9-1-1 call. The parent(s) has the choice to leave the infant without giving any identifying information to the ESP.
- The ESP is authorized to accept the infant and provide whatever care may be necessary.
- The ESP will make a reasonable effort to provide the parent(s) with the following information:
  1. A written statement of the parent's rights following surrender of the infant.
  2. Information about other confidential infant placement options, as well as information about the availability of confidential medical and counseling services, such as Public Health, Community Mental Health, Family Planning Clinics, Adoptions Agencies.

What are the rights of the surrendering parent?

- To be informed that by surrendering the newborn, the parent is releasing the newborn to a child placing agency to be placed for adoption.
- To petition the court to regain custody of the newborn within 28 days of surrender or notice of surrender.
- Any information the parent(s) provides the ESP will **not** be made public.
- A criminal investigation shall not be initated solely on the basis of a newborn being surrendered to an ESP.
- To file a consent to release identifying information with the Adoption Central Registry.

CONFIDENTIAL
VOLUNTARY MEDICAL BACKGROUND FORM FOR A SURRENDERED NEWBORN
Michigan Department of Human Services

Preference for Child's Name	Date of Birth
Where was the child born?	Sex

SURRENDERING PARENT BACKGROUND (Optional)

Name	Marital Status ☐ S ☐ M ☐ D	Date of Birth	Phone Number
Address			
Race	Affiliated with American Indian Tribe ☐ YES ☐ NO	Identify Tribe	
Height	Weight	Hair Color	Eye Color

Any Family History of:	Yes	No		Yes	No	
Sickle Cell Disease	☐	☐	Cancer	☐	☐	If Yes Type
Heart Disease	☐	☐	Genetic Disease	☐	☐	If Yes Type
Diabetes	☐	☐	Family History of Mental Illness	☐	☐	If Yes Explain
HIV	☐	☐	Drug Usage	☐	☐	If Yes Explain
Hepatitis	☐	☐	Alcohol Usage	☐	☐	If Yes Explain
Other						

Surgical History

OTHER PARENT BACKGROUND (Optional)

Name	Marital Status ☐ S ☐ M ☐ D	Date of Birth	Phone Number
Address			
Race	Affiliated with American Indian Tribe ☐ YES ☐ NO	Identify Tribe	
Height	Weight	Hair Color	Eye Color

Any Family History of:	Yes	No		Yes	No	
Sickle Cell Disease	☐	☐	Cancer	☐	☐	If Yes Type
Heart Disease	☐	☐	Genetic Disease	☐	☐	If Yes Type
Diabetes	☐	☐	Family History of Mental Illness	☐	☐	If Yes Explain
HIV	☐	☐	Drug Usage	☐	☐	If Yes Explain
Hepatitis	☐	☐	Alcohol Usage	☐	☐	If Yes Explain
Other						

Surgical History

INFORMATION ABOUT THE PREGNANCY

Length of Pregnancy	Weight Gain Lbs.	Drug or Alcohol Use During Pregnancy ☐ Yes ☐ No, If yes, Explain

EMERGENCY SERVICE PROVIDER OBSERVATIONS

Comments

ESP Signature	Date	Phone Number
Address:	City	State / Zip Code

DHS-4819 (Rev. 4-11) Previous edition obsolete. MS Word 1

VOLUNTARY RELEASE FOR ADOPTION OF A SURRENDERED NEWBORN BY PARENT

Michigan Department of Human Services

In the matter of _____, a newborn child.

1. I, _____, DOB ___/___/_____ am the ☐ mother ☐ father of the above child, who was born on ___/___/_____ at _____ (place).

2. I understand that I have parental rights to this child and that by signing this release, I voluntarily release all of my parental rights to my child. (Subject to number three below.)

3. I understand that I have 28 days after surrendering my newborn child to petition the court to reclaim custody of my child.

4. I understand that I will not receive notice of any hearings.

5. Understanding the above provisions, I release completely and permanently my parental rights to my child, and release my child to a child placing agency for the purpose of adoption.

6. I acknowledge receipt of the following:
   ____ Fact Sheet (Pub 867)

Date ___/___/_____ Parent Signature _____

Address _____

City _____ State _____ Zip _____

Witnessed by _____
Name (type or print)

on _____ (Date), at _____ (Agency and Address)

_____
Signature

IF A NOTARY IS AVAILABLE: Notary Public

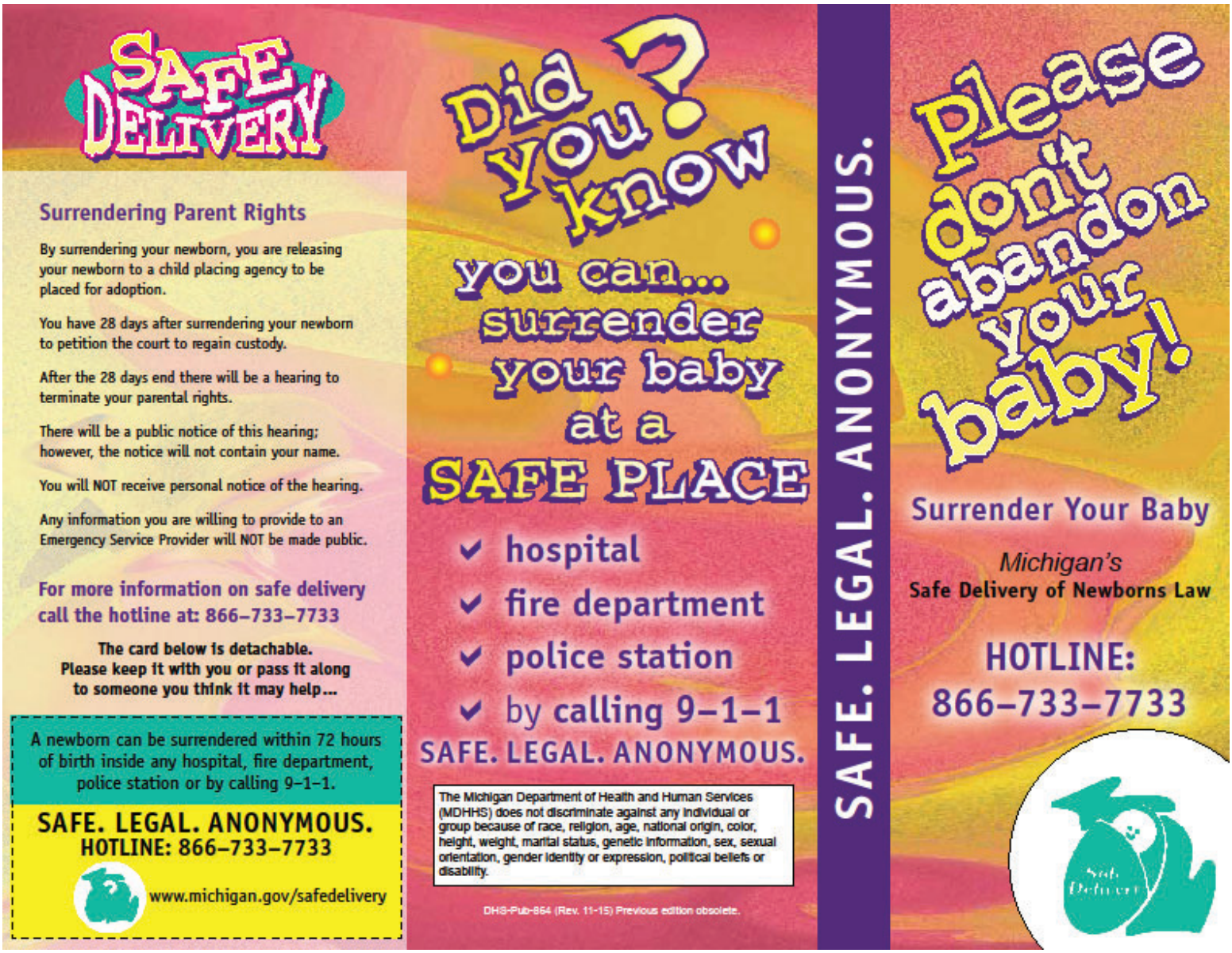
Subscribed and sworn to before me on _____ (Date), _____ (County and State)

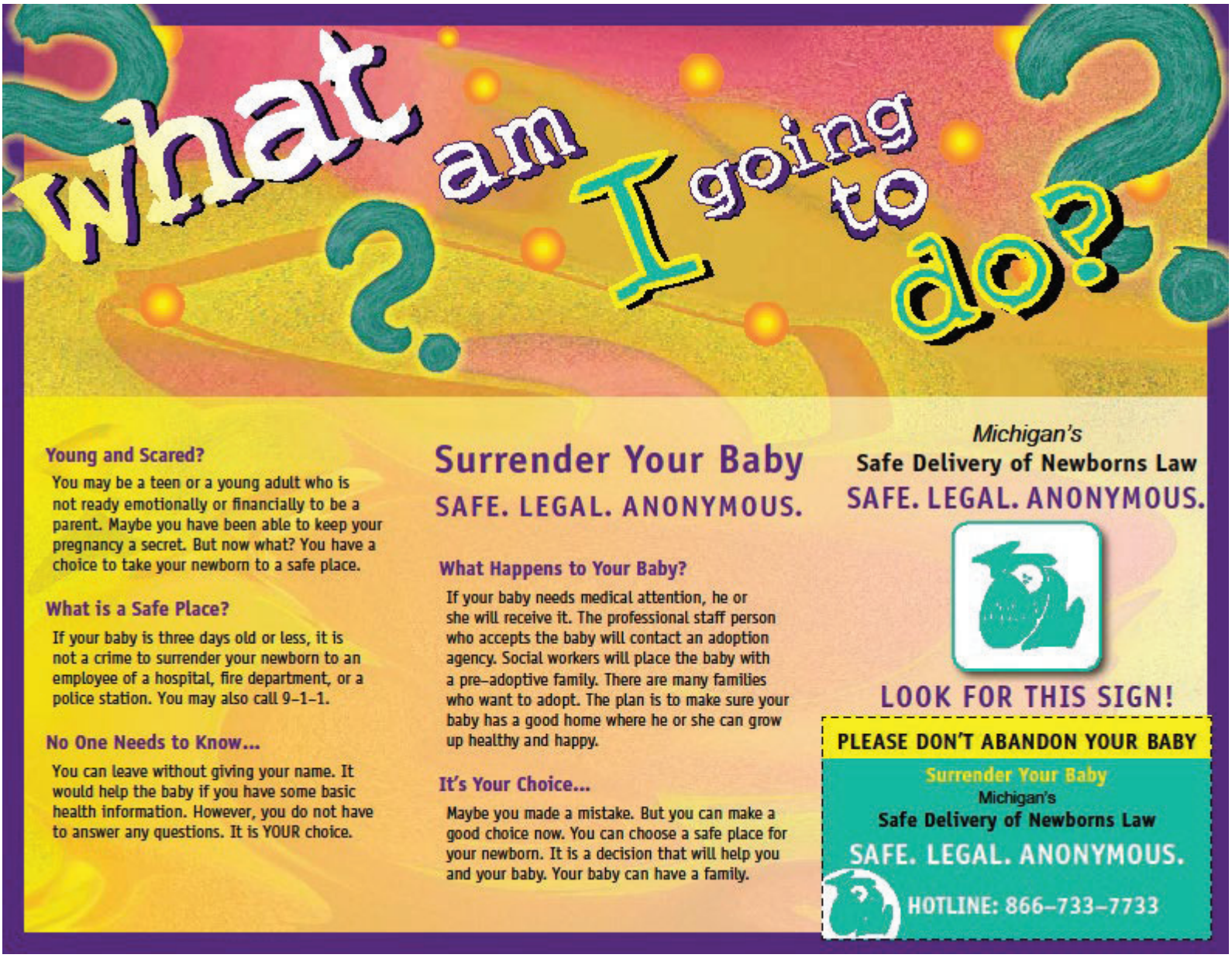
My commission expires: _____ (Date) Signature: _____

_____
Name (type or print)

AUTHORITY: State P.A. 232 of 2000 RESPONSE: Voluntary PENALTY: None	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

DHS-4820 (Rev. 5-07) MS Word


SAFE DELIVERY
Surrendering Parent Rights
By surrendering your newborn, you are releasing your newborn to a child placing agency to be placed for adoption.
You have 28 days after surrendering your newborn to petition the court to regain custody.
After the 28 days end there will be a hearing to terminate your parental rights.
There will be a public notice of this hearing; however, the notice will not contain your name.
You will NOT receive personal notice of the hearing.
Any information you are willing to provide to an Emergency Service Provider will NOT be made public.
For more information on safe delivery call the hotline at: 866-733-7733
The card below is detachable.
Please keep it with you or pass it along to someone you think it may help...
A newborn can be surrendered within 72 hours of birth inside any hospital, fire department, police station or by calling 9-1-1.
SAFE. LEGAL. ANONYMOUS.
HOTLINE: 866-733-7733
www.michigan.gov/safedelivery
Did you know
you can... surrender your baby at a SAFE PLACE
hospital
fire department
police station
by calling 9-1-1
SAFE. LEGAL. ANONYMOUS.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
DHS-Pub-864 (Rev. 11-15) Previous edition obsolete.
SAFE. LEGAL. ANONYMOUS.
Please don't abandon your baby!
Surrender Your Baby
Michigan's
Safe Delivery of Newborns Law
HOTLINE:
866-733-7733


what am I going to do?
Young and Scared?
You may be a teen or a young adult who is not ready emotionally or financially to be a parent. Maybe you have been able to keep your pregnancy a secret. But now what? You have a choice to take your newborn to a safe place.
What is a Safe Place?
If your baby is three days old or less, it is not a crime to surrender your newborn to an employee of a hospital, fire department, or a police station. You may also call 9-1-1.
No One Needs to Know...
You can leave without giving your name. It would help the baby if you have some basic health information. However, you do not have to answer any questions. It is YOUR choice.
Surrender Your Baby
SAFE. LEGAL. ANONYMOUS.
What Happens to Your Baby?
If your baby needs medical attention, he or she will receive it. The professional staff person who accepts the baby will contact an adoption agency. Social workers will place the baby with a pre-adoptive family. There are many families who want to adopt. The plan is to make sure your baby has a good home where he or she can grow up healthy and happy.
It's Your Choice...
Maybe you made a mistake. But you can make a good choice now. You can choose a safe place for your newborn. It is a decision that will help you and your baby. Your baby can have a family.
Michigan's
Safe Delivery of Newborns Law
SAFE. LEGAL. ANONYMOUS.
LOOK FOR THIS SIGN!
PLEASE DON'T ABANDON YOUR BABY
Surrender Your Baby
Michigan's
Safe Delivery of Newborns Law
SAFE. LEGAL. ANONYMOUS.
HOTLINE: 866-733-7733

PSRO Complaint Investigation & Resolution

Purpose: To provide a consistent framework for how to receive, investigate, and resolve allegations regarding EMS clinicians, or Life Support Agencies (LSA), under the purview of the Medical Control Authority (MCA) that fosters a just culture process focused on producing safer patient outcomes, identifying root causes, and outlining expected behaviors by EMS clinicians and Life Support Agencies.

NOTE: Terms contained in Section X. Definitions, on page 11, are underlined the first time they appear in this document for ease of identification.

I. Allegation Intake:

A. An allegation may be received at the MCA directly, at life support agencies, hospitals, or by the Department.
B. Those in receipt of an allegation which involves violations of protocols, statutes, or administrative rules must inform the MCA in writing.
C. The MCA will conduct an assessment to determine if further review is required.
D. The complainant for a case should be asked if they would like to remain anonymous or to allow their information to be included in the record of the allegation.
   1. The complainant must provide the MCA with his/her name, address, and telephone number. A request for anonymity by a complainant must be honored by the MCA to the extent possible.
E. Allegations considered for action by the receiving MCA, must meet the following criteria:
   1. The allegation must be directed toward an EMS clinician, or a Life Support Agency (LSA), or involve issues of performance of the EMS system within the jurisdiction of the MCA.
   2. The allegation must include a potential violation of Michigan law, Federal law, Michigan EMS administrative rules or local MCA protocols.
   3. An allegation must be in writing or transcribed if by telephone.
   4. Notable deviations from quality improvement projects may be considered for investigation at the recommendation of the Medical Director.
   5. Near misses reported by the EMS system may be accepted for review to determine root causes to develop improvements for system shaping factors.
F. Allegations that will not be considered for action by the receiving MCA include the following:
   1. Hearsay or “second hand” allegations will not be accepted or investigated.
   2. MCA Quality Improvement initiatives will be reviewed through the MCA Quality Improvement process and normal deviations will not be considered allegations.

3. Allegations regarding the conduct of an EMS clinician or LSA not related to medical practice or actions bearing upon patient care, unless covered by MCA protocol. These will be referred to the employer of the EMS clinician, or LSA.
4. Allegations directed toward an individual acting while employed by a Life Support Agency outside of the jurisdiction of the MCA must not be accepted or investigated but will be forwarded, or the complainant directed to, the MCA/agency under whose jurisdiction it does fall.
   a. These allegations may also be retained by the MCA for investigation by the PSRO committee at the discretion of the MCA.

II. Allegation Delegation:

A. MCAs may cooperate on investigations which overlap jurisdictional boundaries. For the purposes of Quality Improvement Actions, the MCA granting Medical Control privileges to the provider or agency where the primary action, or actions being investigated took place must be considered the jurisdictional MCA.

B. Allegations more appropriately investigated at the agency or operational level may be turned over to the life support agency or hospital involved. Investigation results are to be reported back to the MCA for review within 30 calendar days.
   1. Noncompliance by partnering agencies to complete reviews within assigned timeframe will be returned to the PSRO committee for investigation and determination of both the original incident and any subsequent violation(s) by the agency.

III. Investigation of Allegation:

A. Initial Investigation Process:
   1. Once an allegation is determined to meet the criteria, the allegation will be assigned to the Professional Standards Review Organization (PSRO) committee, or an MCA designee for investigation.
   2. All allegation investigations will be based on Department approved MCA protocols, administrative rules, or statutes that were active on the date of the EMS call for service.
   3. The member(s) of the PSRO, or MCA designee, charged with the allegation investigation, will initiate a preliminary review of the allegations and gather information to determine its validity.
   4. To determine validity of the allegation(s), the PSRO or MCA designee may request and review copies of documents, patient care reports, incident reports, video and audio recordings, or other materials relating to the allegation without formal notification to the named EMS clinician or LSA.

a. The EMS clinician, and/or the LSA, will have five (5) business days to provide the requested documentation or statements to the MCA.
b. This timetable may be extended by the PSRO, or MCA designee, based on the circumstances of the case.

5. To determine validity of the allegation(s), the PSRO, or MCA designee, charged with the allegation investigation may conduct fact finding interviews with EMS clinicians, or other individuals involved in the response.
6. The PSRO, or MCA designee, charged with the allegation investigation will then present the findings to the MCA Medical Director, or the PSRO committee, for determining subsequent actions.

B. Disposition of Allegations after initial investigation process:
1. The Medical Director, or PSRO committee, may choose from the following actions based on the initial investigation:
a. **NO ACTION** is required against the EMS clinician or LSA.
1. In this circumstance the Medical Director, or PSRO committee may choose that No MCA action is appropriate when:
a. The allegation was unproven, not factually accurate, or unfounded,
b. The MCA Medical Director supports the LSA's quality improvement plan,
c. There was an identified system shaping factor that created the situation that was outside of the control of the EMS clinician or LSA.
b. The incident was caused by **human error** or **at-risk behavior**.
1. In this circumstance the Medical Director, or designated committee, may issue a Letter of Remediation based on the review of the case after meeting with the EMS clinician or LSA.
2. Specific case circumstances may need increased quality improvement actions (i.e. Order of Disciplinary Action). These cases are to be referred to the PSRO committee for a formal review.
a. Justification must be included to support the decision.
3. Repetitive infractions by the EMS clinician or LSA may constitute a reason to increase the designation and require a formal review by the PSRO.
c. The incident was caused by **justifiable risk**.
1. In this circumstance the Medical Director must refer the situation to the PSRO committee for review to determine the root cause and discuss potential system improvements.
a. No action will be taken against the EMS clinician or LSA when a finding that a system shaping factor created a justifiable risk, or a near miss event performed in the manner documented.

d. The incident was caused by **reckless behavior** or a **substantial and unjustifiable risk**.
    1. In this circumstance the Medical Director may choose from the following:
        a. An immediate Emergency Suspension of MCA privileges when there is a definable risk to the public health and welfare, pending a full review by the designated PSRO committee.
            i. Possible situations where the Medical Director may consider this action appropriate:
                a. Criminal Behavior
                b. Severe Clinical Misconduct
                c. Substance Abuse
                d. Unfit to practice
                e. Violation of medical standards
                f. Insubordination
            ii. Refer to the Emergency Action section of this protocol for process.
        b. Refer the case to the designated PSRO committee for review and decision on outcome.

2. Allegations deemed valid due to **reckless behavior**, or **substantial and unjustifiable risk** by the Medical Director, must:
    a. The MCA must provide formal notice to the EMS clinician or LSA requesting participation at an upcoming Professional Standards Review Organization (PSRO) meeting to discuss the event.
        1. For an EMS clinician, notice will be provided to both the individual EMS clinician and the LSA administrator.
        2. For a LSA, notice will be provided to the agency administrator.
    b. The notice must include, but is not limited to:
        1. A description of the alleged violation.
        2. A list of protocols impacted by the alleged violation, including the Complaint Investigation and Resolution and any other protocols that will be used in the investigation and instructions on how to access.
        3. Instructions detailing any required actions of the subject EMS clinician or LSA (e.g., appearance dates, times, and locations or documentation requests).
    c. Notice must also be provided to individuals requested to appear before the PSRO as witnesses, including those asked to participate in interviews or provide testimony to the full body of the PSRO.
    d. For all nonemergency action reviews, the MCA will provide at least three (3) business days of advanced notice to affected individuals and agencies prior to convening PSRO meetings for which they must attend.

3. Any action issued directly by the Medical Director without the involvement of the PSRO committee must be reported at the next scheduled PSRO meeting for review and to ensure awareness and the identification of system trends.

IV. Emergency Action – Temporary Suspension of Privileges:

A. If the MCA Medical Director believes there is a definable threat to public health, safety, or welfare, they may immediately act by temporarily suspending privileges pending a further review.
   1. In the event the emergency action is related to criminal charges being filed against an EMS clinician or LSA related to acts of violence, diversion of medications, illegal possession of controlled substances, criminal sexual conduct, or other situations which may pose a direct threat to the community or patients, the MCA may act with a suspension of MCA privileges without convening a special PSRO meeting.
      a. The subject licensee or agency shall be notified in writing of the suspension.
      b. If found guilty in a court of law, MCA privileges will be revoked.
      c. If found not guilty of charges, the individual or agency must provide copies of court documents, including transcripts, to the MCA for review and determination of suspension.
      d. If a court case is dismissed based on procedural failings or errors, the MCA may decline to extend privileges if the conduct of the individual or agency may pose a threat to the community or patients. This determination is to occur during a PSRO meeting where the individual or agency is present to provide information relevant to the situation.

B. Formal notification to the EMS clinician or LSA by the MCA of the immediate suspension of privileges as well as the allegations for which the action is based on will be provided by the end of the business day.
   1. The LSA must be included on all communications with the EMS clinician.
   2. Medical Control Authority must notify the Department within one (1) business day of the removal of medical control privileges from an EMS clinician, or LSA.

C. The Medical Control Authority PSRO committee must convene a special meeting within three (3) business days of the Medical Director's decision to review the case and decide the outcome of the case.

D. The EMS clinician or LSA may request, prior to the scheduled date, a one-time postponement of the PSRO meeting of up to thirty (30) calendar days to prepare their response to the allegations.
   1. This request for postponement must be received in writing within one (1) business day prior to the scheduled meeting time.

E. The PSRO committee must provide a written decision to the EMS clinician or LSA following the meeting and within three (3) business days of the emergency action being taken.
   1. If the PSRO committee needs additional time to deliberate, the meeting may be adjourned and additional meeting(s) scheduled.
   2. If additional meetings are needed, a final decision still must be issued to the EMS clinician or LSA by the PSRO committee within three (3) business days of the emergency action being taken.

F. If an EMS clinician or LSA's MCA privileges have been suspended, the EMS clinician or LSA must not provide prehospital care within the MCA until the PSRO committee has made their decision.

V. Due Process:

A. Notice
   1. The EMS clinician or LSA have the right to be informed of all allegations made against them. Formal notification by the MCA to the subject of an allegation will occur if a formal Quality Review Inquiry is opened.
   2. If the subject of a Quality Review Inquiry is an EMS clinician, notification will also be made to the subject's applicable employing LSA at the same time.
   3. Reference to all applicable investigation protocols and instructions regarding how to access them must be included with notification of a Quality Review Inquiry.
   4. The MCA will provide at least three (3) business days of advanced notice to affected clinicians and agencies prior to convening any PSRO meetings to which they must attend.

B. Opportunity to be heard
   1. The subject has the right to present their side of the case, respond to evidence against them, and challenge witness statements or allegations. The subject must be given the opportunity to respond to the allegations, including the opportunity to present supporting evidence.
   2. The subject must be provided with copies of all relevant investigation related materials for review.
   3. The subject will be afforded reasonable time to review such materials prior to being interviewed by the PSRO committee.
   4. The subject may request the related materials in advance of the interview with the PSRO committee. The MCA will make reasonable efforts to accommodate such requests at the discretion of the Medical Director.
   5. Materials that would reveal the identity of an individual that provided information under the condition of anonymity are exempt from this provision.
   6. All investigation materials must be reviewed at a special meeting of the PSRO

called for that purpose and must not be removed or otherwise distributed without the express permission of the Medical Control Authority.

C. Impartial Decision Making
   1. All PSRO complaint investigation committees must be comprised of decision-makers who are able to remain impartial during the review.

D. Representation
   1. Subjects of a PSRO review may have agency representation at proceedings of the PSRO provided PSRO standards are maintained.
   2. The MCA is not a hiring entity and is not subject to collective bargaining. Union representation during proceedings of the PSRO is not permitted.
   3. The MCA PSRO is not an adjudicating body for either civil or criminal investigations and is not subject to the rules and statutes which govern civil or criminal adjudication. Attorneys and legal representation are not permitted in PSRO committees.

E. Determination
   1. The PSRO committee must provide notice to the EMS clinician or LSA within fourteen (14) business days of the committee meeting.
      a. If the decision of the committee is to issue an ODA, it must be provided to the EMS clinician or LSA within three (3) business days of the committee's meeting.
   2. If the PSRO committee needs additional time to deliberate, the meeting may be adjourned and additional meeting(s) scheduled.
      a. A final decision must be issued by the PSRO committee within three (3) business days of the initial meeting's date for all ODAs.
      b. A final decision must be issued by the PSRO committee within fourteen (14) business days of the initial meeting's start date for all other quality improvement actions.
   3. The EMS clinician, or LSA will have seven (7) business days from the date of receipt of the ODA to request an appeal of the decision of the PSRO committee. The EMS clinician or LSA must follow the **Order of Disciplinary Action Appeal** protocol.

F. Americans with Disabilities Act (ADA)
   1. Non-Discrimination:
      The MCA prohibits discrimination based on disability in all aspects, including quality reviews. No individual must be subjected to discrimination or retaliation based on disability.
   2. Reasonable Accommodations:
      Reasonable accommodation will be provided, when possible, for individuals with disabilities to ensure equal access to the investigation and review process.

Reasonable accommodations may include, but are not limited to, providing auxiliary aids, modifying policies or procedures, or adjusting scheduled interviews or proceedings.

3. Communication:
   Investigators must communicate effectively with individuals with disabilities during the investigation process. This may involve using alternative formats, allowing interpreters, or utilizing assistive technology to ensure effective communication.
4. Confidentiality:
   Information related to an individual's disability obtained during the investigation process must be treated as confidential and shared only with those who have a legitimate need to know. Confidentiality safeguards will be implemented in accordance with applicable laws and organizational policies.

VI. Order of Disciplinary Action (ODA) Notification

A. The Medical Control Authority must notify the Department within one (1) business day of the issuance of an ODA to an EMS clinician, or LSA.
B. Once the ODA is issued and any appeals are completed, the EMS clinician or LSA to which the ODA is issued must provide a copy of the ODA to all MCAs in which they are privileged for the other MCA's review.
C. The Medical Control Authority must notify all other Medical Control Authorities which it knows, or has reason to believe, have granted the EMS clinician or LSA Medical Control privileges within one (1) business day.

VII. Disposition of Quality Improvement Action:

A. A primary function of Quality Improvement Action is to ensure the protection and safety of the community and patients.
B. The application of the Quality Improvement Action is intended to promote improvement in clinical and operational performance.
C. The MCA shall engage in a process to ensure that EMS clinicians and LSAs maintain an appropriate level of clinical and operational performance.
D. MCAs should utilize a just culture approach when applying or considering Quality Improvement Actions to create a balance between provider and system accountability.
E. The licensee's agency will be notified of any Quality Improvement Action prescribed by the PSRO.
F. Quality Improvement Actions may or may not be ascending in severity. In cases where misconduct (by action or omission), regardless of where the misconduct occurred, is determined to be reckless, willful, or criminal, ascending discipline may be bypassed with a more severe disciplinary action imposed.

VIII. PSRO Quality Improvement Determinations

A. No Action –
   1. Allegation Unsubstantiated
      a. The MCA PSRO committee, or Medical Director, will compose a letter to the individual alleging the concern that the incident was reviewed through the MCA's confidential Professional Standards Review Organization.
      b. If the MCA PSRO committee, or Medical Director, discusses the allegation with the involved EMS clinician(s), or Life Support Agency, as part of the preliminary review, then the MCA PSRO committee, or the Medical Director should provide verification that the incident was reviewed as part of the MCA's PSRO quality review process and those involved were found compliant with the current standards.
   2. Cause was due to system design factors
      a. The MCA PSRO committee, or Medical Director, will compose a letter to the individual alleging the concern that the incident was reviewed through the MCA's confidential Professional Standards Review Organization.
      b. If the MCA PSRO committee, or Medical Director, discusses the allegation with the involved EMS clinician(s), or LSA, as part of the preliminary review, then the MCA PSRO committee, or Medical Director, should provide confirmation that the incident was reviewed as part of the MCA's PSRO quality review process.
      c. These cases are to be referred to the appropriate MCA committee for review and to develop a system improvement plan to mitigate a reoccurrence.
      d. These plans, and cases, must then be reviewed by the MCA Board to assess and implement actions that are available to improve the EMS system.
   3. No Action – support of LSA quality improvement plan
      a. The MCA PSRO committee, or Medical Director, will compose a letter to the individual alleging the concern that the incident was reviewed through the MCA's confidential Professional Standards Review Organization.
      b. If the MCA PSRO committee, or Medical Director, discusses the allegation with the involved EMS clinician(s), or Life Support Agency, as part of the preliminary review, then the MCA PSRO committee, or Medical Director, should provide confirmation that the incident was reviewed as part of the MCA's PSRO quality review.

B. Letter of Remediation
   1. The Letter of Remediation is a written quality improvement action plan for an EMS clinician or LSA which includes a timeline, SMART goals, and a plan to assess desired outcome.

2. This quality improvement action may include:
   a. Requiring the EMS clinician to work with a provider at an equal or higher level of licensure, for a certain period. i.e. complete a field training program, or work with a supervisor for oversight.
   b. Additional education that does not restrict the EMS clinician's or LSA's privileges within the MCA.
   c. A probationary period with additional remediation requirements as deemed appropriate.
3. The Medical Control Authority may choose to issue a Letter of Remediation, when the actions of the EMS clinician's or LSA's were determined to be contributing factor and related to simple human error.

C. Order of Disciplinary Action
1. An Order of Disciplinary Action (ODA) is a written document developed by the MCA and sent to a subject EMS clinician or LSA for the purposes of clearly and plainly identifying the findings of the MCA.
2. Disciplinary actions available for inclusion in an ODA:
   a. Restriction of privileges:
      i. May entail reducing the EMS clinician's or LSA's level of privileging to a lower level, i.e. from Paramedic to AEMT.
   b. Suspension of Privileges:
      i. An EMS clinician's or LSA's medical privileges are suspended for a specified period within the local MCA.
      ii. If an EMS clinician's or LSA's MCA privileges have been suspended, the EMS clinician or LSA must not provide prehospital care until MCA privileges are reinstated.
   c. Revocation of Privileges:
      i. An EMS clinician's or LSA's medical privileges are revoked within the MCA and will require the provider to reapply for privileges after a minimum of one (1) year.
3. The ODA must include the following provisions:
   a. Details of the violation of Michigan law, Federal law, Michigan EMS administrative rules or local MCA protocols,
   b. The restriction of local medical control privileges determined by the PSRO committee,
   c. Any additional remediation activities that may be required of the EMS clinician or LSA prior to resolution of the ODA,
   d. The timeframe assigned to complete the PSRO Committee's requirements.

e. Copies of, or detailed instructions on how to access referenced protocols as well as the **PSRO Investigation & Resolution** and **ODA Action Appeal** protocols.
f. The MCA must demonstrate good faith to ensure that an ODA is received by the EMS clinician or LSA in a timely manner.
g. Notice of disciplinary action must be forwarded to the EMS clinician's employer, or board in the case of an LSA.

D. Emergency Action – Temporary Suspension of Privileges
1. The Medical Director may temporarily suspend an EMS clinician or LSA's privileges in cases where there is a definable risk to the public health and welfare.
2. The Medical Control Authority's designated PSRO committee must convene a special meeting within three (3) business days of the Medical Director's decision to decide the outcome of the review as outlined in the Emergency Action and Due Process sections.
3. A final decision must be issued to the EMS clinician or LSA by the PSRO committee within three (3) business days of the emergency action being taken.
4. If an EMS clinician or LSA's MCA privileges have been temporarily suspended, the EMS clinician or LSA must not provide prehospital care within the MCA until the designated PSRO committee has made their decision.

IX. Special Circumstances

A. EMS Clinician, or Life Support Agency, practicing in the MCA without a current Michigan EMS license.
1. These cases are to be referred to local law enforcement agencies and the Department for investigation.

X. Definitions

A. Allegation:
For this policy, an allegation must be defined as any notification of dissatisfaction or concern regarding medical care rendered by an EMS clinician or LSA within the MCA, or any issues that involve the performance of the EMS system in whole or in part.

B. Allegation Unsubstantiated:
The allegation or compliant was found to have no administrative rule or protocol violation or the protocol deviation was considered acceptable for the situation.

C. At-risk behavior:
Describes a situation where an action, or activity, has the potential to be harmful or dangerous, where risk is not perceived or mistakenly believed to be justified.

D. Due Process:
A course of formal proceedings carried out regularly and in accordance with established rules and principles.

E. Emergency Action:
Situations where the MCA Medical Director believes there is a definable threat to public health, safety, or welfare of the community.

F. EMS Clinician:
One who has a current EMS patient care license in the State of Michigan.

G. Human error:
Describes a situation where an action, or activity, when an unintended sequence of actions does not achieve its intended outcome. Could be considered a slip, lapse of judgment or mistake.

H. Just culture:
A just culture process is a high-level statement of the values and commitment of an organization to treat EMS clinicians and agencies fairly in all investigations.

I. Justifiable choice/deviation:
Describes a situation where an action, or activity, when there is a deviation from protocol, process, or procedure due to the circumstances and change in expected process is deemed safer than if the accepted process was followed.

J. Letter of Remediation:
This is a written defined quality improvement plan for an EMS clinician or LSA which includes a timeline, SMART goals, and a plan to assess desired outcomes.

K. Life Support Agency (LSA):
Refers to an agency and/or the employer of an EMS clinician against which an allegation has been received.

L. Near miss:
Describes a situation where an action, or activity, has the potential to lead to an error occurring, however, due to a system, process, or procedure the situation was identified prior to the error occurring and remedied.

M. No action:
The allegation or complaint did not warrant action by the MCA against the EMS clinician or LSA. This could be because no administrative rule or protocol violation or the protocol deviation was found, the MCA supported the action of the LSA, or there were factors outside of the control of the EMS clinician or LSA.

N. Order of Disciplinary Action (ODA):
This is a quality improvement action taken by an MCA that meets one of the following criteria and must be reported to the Department within one (1) business day:
1. Revocation of MCA privileges of a licensee, or
2. Suspension of MCA privileges of a licensee, or

3. Restriction of MCA privileges of licensee (i.e., paramedic licensee restricted to working as an EMT or required to complete training prior to returning to the original licensure level within the MCA).

M. Quality Improvement Action:
An action taken to produce safer patient outcomes, identifying root causes, and outlining expected behaviors by an EMS clinician and/or a Life Support Agency.

N. Reckless behavior:
Describes a situation where an action or activity, when there is a conscious decision to disregard approved MCA protocol(s), statue, or Administrative Rules that leads to unjustifiable risk.

O. Repetitive human error:
Describes a situation where an action, or activity, when there is continued human errors which occur by an EMS clinician or LSA after remediation actions have been attempted without correcting actions. Errors may or may not be related.

P. Repetitive at-risk behavior:
Describes a situation where an action, or activity, when there is continued at-risk behavior which occurs by an EMS clinician or LSA after remediation actions have been attempted without correcting actions. At-risk behaviors may or may not be related.

Q. Root Cause Analysis:
Describes a wide range of tools used to improve system performance which uncovers the cause of situations that allowed for an unintentional outcome.

R. SMART goals:
A framework for setting and achieving goals by ensuring they are Specific, Measurable, Achievable, Related (or Realistic), and Time-bound.

S. Substantial or unjustifiable risk:
Describes a situation where an action, or activity, is determined to be intentional and the risk of harm outweighs any benefit.

T. System Shaping Factors:
Describes variables that can impact an EMS clinician or LSA and system performance.

Order of Disciplinary Action Appeal

Purpose: This protocol is provided to define the steps an EMS Clinician or Life Support Agency (LSA) must take to appeal an Order of Disciplinary Action (ODA) issued by the Professional Standards Review Organization Committee (PSRO) and the Medical Control Authority (MCA).

I. EMS Clinician or LSA Appeal Request Procedure:
   A. The EMS clinician or LSA who received an ODA from the MCA may initiate a Request to Appeal if one, or more, of the following apply:
      1. New evidence: There is new material information relevant to the review that was not available, or known, during the original review of the incident.
      2. Procedural Errors: There was a procedural violation of the **PSRO Investigation and Resolution** protocol.
      3. Fraud or Misrepresentation: The decision was influenced by false statements or fraudulent conduct.
      4. Improper Application: The decision was inconsistent, or based on an incorrect interpretation, with the applicable MCA's protocols, Statute or Administrative Rules.
   B. The MCA must be notified, in writing, within seven (7) business days of receipt of the ODA that the recipient is requesting to appeal. The appeal must include:
      1. A detailed explanation of the reasons for the appeal.
      2. Any relevant material or supporting documentation.
   C. The submission of a Request to Appeal does not stay the provisions of the ODA.

II. MCA Procedure
   A. Upon receipt of a Request to Appeal an Order of Disciplinary Action, the MCA Board chair, in conjunction with the MCA staff, must review the appeal to determine if the appeal meets the requirements outlined in Section I.
      1. If it is determined that the appeal does not meet the requirements for an appeal, the appeal will be returned to the EMS Clinician/LSA requesting the appeal with an explanation why the appeal is being rejected within three (3) business days.
      2. If the EMS Clinician/ LSA decides to resubmit the appeal, they must do so within three (3) business days and include additional justifications as needed to address the MCA's reasons.
      3. Upon receipt of a resubmitted appeal, the appeal will be reevaluated in full.
   B. The MCA Board chair will assign the appeal to the appropriate committee based on the category of the appeal:
      1. If the appeal is based on the presentation of New Evidence, or an allegation of Fraud or Misrepresentation, the incident is remanded back to the PSRO

committee that conducted the medical review for reevaluation of the committee's determination.

a. A new PSRO meeting must occur within three (3) business days of the MCA Board chair's decision.

2. If the appeal is based on an allegation of a Procedural Error, the allegation will be referred to the MCA Board, as a formal body, to determine if there was a procedural violation of the **PSRO Investigation and Resolution** protocol.
   a. If the MCA board finds there are procedural violations in how the medical review was conducted, then the MCA Board must perform one of the following:
      i. Make a determination on the appeal during the appeal meeting.
      ii. Assign a new PSRO committee, made up of new decision-making membership, to conduct a new medical review as outlined in **the PSRO Investigation and Resolution** protocol.
         a) The new PSRO meeting must occur within three (3) business days of MCA Board decision.
3. If the appeal is based on an allegation of Improper Application. The appeal will be referred to the MCA Board, as a formal body, for determination.
4. If the appeal is based on multiple categories:
   a. The appeal will be referred to the MCA Board for determination of assignment and resolution utilizing the process above.

C. If the appeal is assigned to the MCA Board will:
1. The MCA Board, functioning as a PSRO review committee, must schedule a meeting for the purpose of hearing the appeal. This meeting must be scheduled not less than three (3) business days and not more than thirty (30) business days following receipt of the Request to Appeal.
   a. Once scheduled the EMS clinician or LSA may request a one-time postponement of up to thirty (30) business days to assemble information pertinent to the appeal.
   b. This request for postponement must be received in writing within three (3) business days prior to the scheduled meeting time.
2. Conduct a fair and thorough review.
   a. During an open session of the MCA Board appeal meeting:
      i. The EMS clinician, LSA, or their designee may present information supporting their reason for appeal ensuring protected health information is not disclosed.
      ii. The MCA Board may ask clarifying questions related to the appeal.
   b. The MCA Board may move into a closed session to review protected information for the purposes of:
      i. Reviewing the PSRO committee's decision.
      ii. Reviewing the grounds for the appeal and evaluate whether the MCA protocols were properly followed.
      iii. Reviewing the decisions that resulted in the issuance of the ODA are consistent with the standards applicable to the disciplinary action.
3. Determine the outcome of the appeal.

a. The MCA Board must return from the closed session into an open session to make a final determination regarding the appeal, choosing only one of the following:
   i. To affirm the ODA.
   ii. To revoke the ODA.
   iii. Diminish the ODA to a lesser disciplinary action (i.e. a suspension of privileges diminished to a written reprimand).
   iv. To suspend the ODA.
b. If the MCA Board needs additional time to deliberate, the appeal meeting may be adjourned and additional meeting(s) scheduled in accordance with the Open Meetings Act.
   i. A final decision must be issued by the MCA Board within fourteen (14) business days of the appeal meeting's start date.

D. The final decision must be provided by the MCA Board in writing to the EMS clinician or LSA within fourteen (14) business days of the appeal meeting's start date.
E. If, during the appeal process, new information is discovered that leads to additional allegations, a new investigation must be conducted and the **PSRO Complaint Investigation & Resolution** process followed.

III. Appeal to the EMS Coordinating Committee (EMSCC)

A. Following exhaustion of the procedure stated herein, an EMS clinician or LSA may appeal the decision of the MCA to the State of Michigan Emergency Medical Services Coordination Committee as defined in Part 209 of P.A. 368 of 1978, as amended Section 20919(4).
B. The appeal will be to determine whether the actions, or decisions, of the Medical Control Authority were in accordance with their Department approved protocols, statue, or Administrative Rules.
   1. Specific facts regarding the underlying case that lead to the issuance of the ODA will not be evaluated and are not to be included in the request for appeal.
C. An appeal must be filed with the Department of Health and Human Services, in writing, no more than 30 business days following the written notification to the EMS clinician or LSA of the final determination by the MCA.
D. If a decision of the MCA is appealed to the Emergency Medical Services Coordination Committee, the MCA must make available, in writing, the information it considered in making its decision.

EMS Provider Criminal Charges and Convictions

Purpose:

The purpose of this policy is to provide the parameters for EMS licensure related to criminal charges and convictions.

Definitions:

Charge: any formal accusation made by a governmental authority asserting that somebody has committed a criminal misdemeanor or felony (anything other than a civil infraction).

Conviction: any plea of nolo contender, a guilty plea, or plea agreement, including deferments, as well as conviction(s) after a trial.

Policy:

Failure to disclose a criminal conviction or withholding of any material information regarding such conviction on any application for licensure will be considered a violation of Section 20958(1)(a) of the Public Health Code.

An EMS license or licensed EMS provider at any level may be denied, suspended, or revoked, or other appropriate action taken with respect to a felony or misdemeanor criminal charge or conviction under either Section 20958(1) or Section 20168 of the Public Health Code. Applicants that have a criminal charge, may have their license suspended until resolution of the criminal matter.

Procedure:

1. An EMS provider shall notify all their employers and all Medical Control Authority(s) in which they hold MCA privilege(s) in writing within one business day of being charged and/or convicted of a felony or criminal misdemeanor.
2. The Medical Director shall make a determination whether to temporarily suspend privileges within the respective MCA.
3. The Medical Control Authority PSRO will review and make a recommendation regarding the subject licensee's privileges to practice EMS within the MCA.
4. The Medical Control Authority PSRO will notify the MDHHS and the subject licensee of the results.

Protocol Source/References: Michigan Public Act 368 of 1978 Public Health Code, as amended. Parts 201 and 209. Retrieved April 19, 2021, from the Michigan Legislature website.

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Revised Date: 01/24/2025 **Section: 8-26a**

Authorization to Function as EMS Personnel in TCEMCA

It is the purpose of this policy to establish a method by which the Medical Director can be assured that EMS personnel have sufficient knowledge of TCEMCA protocols, general EMS treatment principles, and are proficient in practical skills.

It is the policy of TCEMCA that all EMS personnel must have the valid "authorization" of the Medical Director prior to providing pre-hospital emergency medical care within the Counties of Clinton, Eaton, and Ingham. Authorization means "the provision of Medical Control oversight" as defined by MCL 333.20919. This authorization may be withdrawn by the Medical Director, if he/she determines that an individual's EMS care is a danger to the public health, safety, or welfare; or violates approved protocol. The Medical Director may also ask the State of Michigan to act against the license of an individual for being a danger to the public health, safety, or welfare; or, for violation of approved protocol. Appeal of a decision of the Medical Director may be made following the Disciplinary Action Appeal Protocol 8-25 processes. The most current TCEMCA Authorization form will be utilized, and submitted, for this purpose. The authorization form can be signed by an instructor coordinator (IC), Chief or Director, or a designated person. A designated person is a person the agency designates, on file, with TCEMCA office, to sign the authorization form. The EMS Practical Skills Evaluation shall be completed and signed by a licensed IC. The authorization and skill forms submitted must be complete and accurate. Any falsification of these forms may lead to discipline, up to an including termination of authorization or loss of medical licensure from the state. Forms are submitted through email to: Authorizations@tcemca.org

Authorizations are valid as soon as the email is sent containing the proper authorization forms with the following exemption. Providers applying for authorization who have had, or have, their privilege to provide pre-hospital care, suspended or revoked by any MCA, State of Michigan, or any other state, must indicate this on the Tri-County Authorization Form. Any case where privileges are or were suspended or

revoked by an MCA or state, will be reviewed by the MCA, possibly PSRO, and Medical Director for final determination of TCEMCA Authorization. Providers are required to submit, in letter form, an account of the events leading to their suspension and or revocation to provide pre-hospital care. A completed and signed TCEMCA release form may be required to release all records or information surrounding the suspension or revocation as needed.

The Medical Director shall establish, monitor, and revise as necessary a process to evaluate the competency (as described above) of all EMS personnel wishing to function within the TCEMCA boundaries. This process may include testing of knowledge and skills, requirement for outside currency such as ACLS, BLS and/or other methods of determining competency to practice, at the discretion of the Medical Director. The Medical Director shall consider the economic impact of any requirements placed on EMS personnel, per MCL 333.20919(5).

It is the responsibility of the EMS agency's Chief/Director to authorize all personnel under their employ or control, providing Pre-Hospital care, through their department, by TCEMCA to provide pre-hospital care. This includes practical skills (described below), written exam, valid BLS Card, and valid ACLS card per licensure level. TCEMCA authorizations are valid for the department/agency in which personnel are under their employ or control, providing Pre-Hospital Care. If the provider's employment or control is terminated the providers TCEMCA Authorization with that employer is immediately terminated. Providers may possess multiple TCEMCA authorization cards depending on employment status.

Authorization is approved by the Medical Director for TCEMCA providers.

TCEMCA may provide an authorization card for each provider that is authorized to provide pre-hospital emergency medical care within Clinton, Eaton, and Ingham County. The TCEMCA authorization card expires with the expiration of the provider's State EMS license with no "grace period" allowed after printed expiration date. The authorization card is required to

be returned to the TCEMCA office upon request. Agencies may request TCEMCA not to provide an authorization card to their providers. Authorization and Skills evaluation forms can be found at: TCEMCA.org

Practical Skills Evaluated

MFR, EMT, EMT-S, Paramedic
- Glucometer Usage (if agency equipped)
- Basic Airway Opening Techniques
- Narcan Administration (if agency equipped)
- Epinephrine Administration (if agency equipped)
- Spinal Precautions
- Advanced Supraglottic Airway Management (if agency equipped)
- Capnography (All levels, MFR only if using I-Gel Airways)
- Airway Suctioning
- Assessment of Lung Sounds
- Report Writing
- MI-MEDIC Card understanding/usage

EMT, EMT-S, Paramedic
- CPAP (if agency equipped)

EMT-S, Paramedic
- IV insertion
- Verifying Proper ET Tube placement

Paramedic
- Endotracheal intubation
- Cricothyrotomy, needle or surgical
- Intra-Osseous Insertion
- EKG Interpretation
- Drug Box Inventory/Exchange Process

Practical skills shall be evaluated by a licensed I/C and can be evaluated all at one time, or throughout the license period.

Guidelines for IC's EMS Practical Skills Evaluation

Airway Suctioning---Demonstrates basic knowledge of suctioning techniques.
Basic Airway Opening Techniques---Demonstrates various methods of manually opening an airway (Jaw Thrust, Head Tilt, etc.)
Assessment of Lung Sounds---Within the scope of their license level and training, is able to recognize and describe normal and abnormal lung sounds, and their meaning.
Spinal Precautions---Demonstrates proper techniques of spinal immobilization using backboards. Demonstrates ability to use "Spinal Injury Assessment" protocol and when c-collar only should be applied. This should require a "hands-on", detailed demonstration of skills.
Report Writing---Demonstrates the ability to write a complete yet concise report of findings and treatment given. For providers renewing their authorization, base this evaluation on actual reports written. For new providers seeking authorization, their discussion of the subject with the I/C will suffice.
Advanced Supraglottic Airway Management---Applies to MFR/EMT/ EMT-S/Paramedic levels; Demonstrates the ability to correctly insert the supraglottic airway, ensure its proper position in the patient, and ensure the patient is being adequately ventilated by the supraglottic airway.
IV Insertion---Demonstrates competency in actual performance of this skill. Ideally, this will be determined by actual field data such as a review of the "success rate" of the applicant in starting IV's. While there is no "magic number" specified, an I/C should give serious thought to certifying competence of a person if, historically, their IV "success rate" is less than 70%. If no historical data is available, such as with a newly licensed person, then competency may be demonstrated on a manikin.
Intra-Osseous Insertion---Demonstrates knowledge of the technique and the special equipment needed.

Endotracheal Intubation---Demonstrates ability to quickly and correctly intubate a patient. It is preferred that this evaluation be based on actual field intubation data and experience, if available. Competency in intubation of manikins will suffice if actual patient experience is not available.
Verifying Proper ET Tube Placement---Demonstrates knowledge of various methods of verifying tube placement. These would include breath sounds, patient color, pulse oximetry, end-tidal CO_2 monitoring, etc.
Cricothyrotomy---Demonstrates knowledge of the techniques used for both needle and surgical cricothyrotomy. Is familiar with the special equipment needed for each and knows landmarks for proper placement.
EKG Interpretation---Demonstrates the ability to correctly interpret both static and moving EKG rhythm strips. The common "ACLS" type rhythms should be covered.
Naloxone Administration---Demonstrates the ability to identify indications for Naloxone administration, including appropriate dosage and administration route.
igel®-- Demonstrates the ability to correctly insert the igel® airway, ensure proper placement, and verify the patient is receiving adequate ventilation**.**
Glucometer--- Demonstrates appropriate capillary skin puncture and collection procedure. Ability to identify critical values. Knowledgeable in proper disposal of lancet and bio-hazardous material**.**
MI-MEDIC---Review understanding of usage, location, Braselow tape location at agency.
Drug Box Exchange Process---Review process of drug box exchange, report or drug box exchange form must be included inside drug box, narcotic box red tagged if used, drug box red tagged, complete inventory every time drug box used prior to exchange.
Epinephrine Administration---Demonstrates the ability to indicate when needed, contraindications, process for drawing up, and administration. Review the 6 Rights of Medication Administration.

Tri-County Emergency Medical Control Authority

Serving Clinton, Eaton, and Ingham County

EMS Provider Authorization Request

("Authorization" means the below named individual has met the standards required to function within the TCEMCA region, under the medical oversight of TCEMCA)

Name:_____
(PLEASE --- Type or Legibly Print)

EMS Agency / Company_____

License Level:

- ☐ **MFR**
- ☐ **EMT-B**
- ☐ **EMT-S**
- ☐ **Paramedic**

MDHHS Lic. #_____

MDHHS Lic. Expiration_____

For Agency Use

- ☐ New TCEMCA Provider
- ☐ Renewal
- ☐ New to Agency but in TCEMCA already
- ☐ Remove provider from Agency

BCLS Expiration Date: _____(All)

ACLS Expiration Date: _____ (Paramedic Only)

TCEMCA Written Protocol Test Date: _____(All)

TCEMCA Skills Evaluation Date: _____(All)

TCEMCA Use

Received: _____

Issued: _____

Agency #: _____

Initials: _____

Card Completed: Yes

Certifications:

I have read and understand the current TCEMCA out of Hospital patient treatment protocols and agree to provide patient care only under those protocols and TCEMCA direct (on-line) medical control. Please check the box below to indicate if your MCA Authorization or medical license is or ever has been suspended/revoked from any MCA, the State of Michigan, or by any other state. ***If yes, your authorization is not automatic, and you are unable to practice until the circumstances have been reviewed and authorization approved by the TCEMCA Medical Director.***

☐ Yes.
MCA/State:_____
Dates:_____
☐ No.

_____
EMS Provider Signature Date

As an agency we have administered the TCEMCA Written Protocol Review and Practical Skills test to the above applicant and certify that, to the best of our knowledge and belief, the applicant meets the standards established by TCEMCA for those persons wishing to provide EMS care in the TCEMCA region.

_____
IC/Chief-Director/Designated person License # Date

Note: This authorization is not intended to be used as a pre-employment screening tool, or as an ongoing assessment of an individual. Each EMS agency is responsible to assess and monitor the abilities, knowledge, and skills of its employees.

Developed	5/18/2018	Updated	7/23/2024	Implemented	9/1/2023	Approval	BP	Form ID	F-004

Tri-County Emergency Medical Control Authority

Serving Clinton, Eaton, and Ingham County

EMS PRACTICAL SKILLS EVALUATION

Provider_____Agency_____Date_____

Licensure level	Provider Initials
MFR, EMT, EMT-S, Paramedic	
Glucometer Usage (if agency equipped)	_____
Basic Airway Opening Techniques	_____
Narcan Administration (if agency equipped)	_____
Epinephrine Administration (if agency equipped)	_____
Spinal Precautions	_____
Advanced Supraglottic Airway Management (if agency equipped)	_____
Capnography (all levels, MFR if using I-Gel Airways)	_____
Airway Suctioning	_____
Assessment of Lung Sounds	_____
Report Writing	_____
Mi-Medic Card understanding/usage	_____
EMT, EMT-S, Paramedic	
CPAP (if agency equipped)	_____
EMT-S, Paramedic	
IV insertion	_____
Verifying Proper ET Tube placement	_____
Paramedic	
Endotracheal Intubation	_____
Cricothyrotomy, needle or surgical	_____
Intra-Osseous Insertion	_____
EKG Interpretation	_____
Drug Box Inventory/Exchange Process	_____

My signature below certifies that the above-named provider has met the EMS practical skills standards, as defined by TCEMCA in “Guidelines for IC’s”, in the performance of the above listed EMS skills.

I/C Signature_____Date_____IC License #_____

Developed	7/23/2024	Updated		Implemented		Approval	BP	Form ID	F-004

2127 University Park Drive, Suite 370 · Okemos, MI 48864 · (517) 699-2888 · Fax (517) 699-2922
www.tcemca.org

Initial Date: September 2004
Revised Date: 6/8/2017 Section: 8-27

Quality Improvement Policy

Purpose: The purpose of this policy is to establish the requirement for a defined Quality Improvement process within the Medical Control Authority (MCA) and with agencies holding medical control privileges. This policy provides a means for evaluation and improvement of protocol and EMS system components and design.

I. Confidentiality Assurance

Information obtained for the purpose of Quality Review will be used to determine if the current protocols in the MCA are being appropriately followed and to improve the protocols and the EMS system. Data is protected under P.A. 270 of 1967, MCL 331.531 to 331.533.

In specific cases where EMS providers may require corrective actions, the emergency medical services personnel names may be given to the agency to address at the agency level.

II. Professional Standards Review Organization

A. The Professional Standards Review Organization (PSRO) of the MCA is a review entity that is provided information or data regarding the physical or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or the qualifications, competence, or performance of a health care provider. The PSRO is a committee established by the MCA for the purpose of improving the quality of medical care and oversight of appropriate protocol compliance within the EMS system.

B. Agencies shall develop institutional PSROs for the purpose of internal review and improvement. For the purpose of this protocol, PRSO is meant to refer to the PSRO of the MCA.

C. The MCA's designated PSRO shall perform the duties and functions related to complaints, investigations or quality improvement activities, both prospective and retrospective.

D. The PSRO may be comprised of members of the board(s), MCA employees and contract staff, EMS agency staff, hospital staff, committee members, and other designated individuals when acting on behalf of, or at the direction of the MCA when performing PSRO tasks.

E. All Quality Improvement activities shall be performed by the PSRO, and all documents collected for Quality Improvement activities shall be held by the PSRO subject to Michigan's peer review privilege.[1]

[1] MCL 331.531 *et seq*.

III. Data Collection

A. Electronic Patient Care Reports (EPCR)
The MCA is authorized to obtain access to EPCR originating within their service area; this includes all scene responses, interfacility transfers and critical care transfers. The Medical Control may elect to receive reports on request.

B. MI-EMSIS Data Collection
1. Providers and agencies are required to report per **Electronic Records & EMS Information System Protocol** and **Documentation and Patient Care Records-Procedure Protocol**.
2. Agencies shall work in cooperation with the MCA, under PSRO, to ensure the quality, consistency and accuracy of data submitted through MI-EMSIS.
3. The MCA shall maintain access to the MI-EMSIS data and ensure that agencies are accountable for the submission of data.
4. MI-EMSIS data should be utilized as a tool for the evaluation of performance and function as a driving mechanism for quality improvement.

C. Other Electronic Data Collection
The MCA is authorized to obtain electronic data and voice recordings from any and all EMS agencies and/or departments, and dispatch agencies with interaction with callers requesting a medical response within the MCA service area. This includes mutual aid responses into the MCA service area. Data will be provided to the MCA's PSRO on a monthly basis or when individual records, recordings and reports are requested. The Medical Control may elect to receive electronic reports on a more frequent schedule.

D. Ownership of Records
Any documents or data relating to requests for service, records of provided services, records of refused services, dispatch reports and incident reports including all aggregated reports for benchmarking and analysis which are submitted to the PSRO of the MCA, or generated by the PSRO, are privileged. The MCA's PSRO holds ownership of only protected Quality Improvement documents. The submitting agency maintains ownership of any and all original records generated by their agency and personnel.

E. Incident Report Collection
1. Incident reports and requests for additional information directed to an individual provider or to an EMS agency/department requested by the MCA/PSRO must be submitted to the MCA/PSRO within 96 hours.
2. The MCA may establish an online reporting system.

IV. Data Review

A. Agency PSRO Responsibilities

Each agency, or department licensed to provide prehospital care, within the MCA area must develop and maintain a PSRO subgroup that reviews, either through a peer evaluation group or individuals tasked with peer review functions, and conducts audits requested by Medical Control.

B. Special Studies
All EPCR that include the use of equipment, skills, techniques or procedures that are currently under special study will be reviewed.

C. Unusual Occurrences
Any EPCR that are unusual and possibly one-time situations that may serve as a learning tool for other services in the future may be reviewed.

D. Problem Identification
1. Potential concerns in patient care may be brought to the attention of the PSRO of the MCA.
2. Topic quality improvement reviews will be performed with results reported to the Medical Control Authority.

E. Sentinel Event Reporting
1. The Medical Control Authority may designate specific items that must be reported.
2. Any intervention where it is reasonable to believe that harm to the patient may have occurred must be reported.

VI. Quality Review Criteria

A. Medical Control Authority Protocols
1. The current protocols in place at the time of the event will be used to review the EPCR selected.
2. Any changes in protocols will not be used for evaluation until the changes are approved and distributed.

B. Dispatch Policies
The review of the EPCR may address dispatch, location, response time, or mutual aid/multi-agency problems.

VII. Quality Improvement Actions

The PSRO, the Medical Director or his/her designee will determine the severity of the incident and develop an action plan to address the matter. The action plan may include:

A. Revision of policies/procedures
B. Remediation of individuals involved
C. Education recommendations for the system
D. Referral to Due Process and Disciplinary Procedures Protocol
E. Modification of clinical privileges
F. Continued monitoring

Evidentiary Blood Draw Protocol (MCA Optional Protocol)

This protocol is for specialist/AEMT and paramedic use only

☑ Medical Control Authorities choosing to adopt this supplement may do so by selecting this check box. Adopting this supplement changes or clarifies the referenced protocol or procedure in some way. This supplement supersedes, clarifies, or has authority over the referenced protocol.

MCAs will be responsible for maintaining a roster of the agencies choosing to participate and will submit roster to MDHHS.

Purpose

In order to effectively utilize the resources of the Medical Control Authority, licensed Life Support Agencies may allow Paramedics working for them to draw a sample specimen of blood as allowed under the delegation of the Medical Control Authority EMS Medical Director, a licensed physician by the State of Michigan, pursuant to PA 368 (1978) MCL 333.16215 (Public Health Code) and PA 300 (1940) MCL 257.625a (Michigan Vehicle Code) and subsequent amendments reference these Public Acts. This shall be considered a Priority 3 level of service. However, if a patient presents with a medical condition, the General Pre-hospital Care protocol will be initiated.

Definitions

Consent to Search: Permission given by a person authorizing a law enforcement officer to make a seizure or conduct a search.

Implied Consent: A requirement under Michigan Law; all drivers are to have given their consent for a chemical test upon being arrested for Operating While Intoxicated as part of their application and issuance of a driver's license.

Medical Environment: Any area not within a freestanding medical facility(e.g., booking area, jail, or other scene where the paramedics may provide medical care).

Warrant: A precept or writ issued by a competent judge or magistrate authorizing a law enforcement officer to make a seizure or conduct a search.

Procedure

A paramedic may draw a blood specimen if one of the listed criteria is met:

1. When requested by a law enforcement officer, who provides verbal or written verification from the subject who is in custody, that the subject is voluntarily submitting to an Evidentiary Blood Draw as required by Implied Consent under PA 300 (1940) MCL 257.625a (Michigan Vehicle Code).
2. When requested by a law enforcement officer, who is in possession of a consent to search form duly signed by the subject in custody.

3. When requested by a law enforcement officer, who is in possession of a search warrant duly signed by a magistrate or judge.

This procedure is done at the delegation of the Medical Control Authority EMS Medical Director, a licensed physician, and under the supervision and at the direction of medical control, to draw blood for the purposes of determining the presence of alcohol and/or drugs as allowed for in PA 368 (1978) MCL 333.16215 (Public Health Code) in a Medical Environment.

Pre-Radio
PARAMEDIC

1. Obtain a full set of vital signs.
2. Obtain blood draw kit from law enforcement officer and use the provided contents within the kit for collection.
3. Sample shall be obtained in the presence of a law enforcement officer.
4. Do not use alcohol or alcoholic solutions to sterilize skin surface, needle or syringe.
5. In the presence of a law enforcement officer tell the subject that no alcohol was used in sterilizing the skin surface, needle, or syringe; then draw two tubes of venous blood from subject and upon completion of obtaining the specimen, slowly invert blood collection tube(s) several times to distribute the sodium fluoride/potassium oxalate preservative.
6. Complete blood specimen label(s) by entering name of subject, date and time of blood collection, and your name in ink.
7. In the presence of subject, hand tube(s) of blood and label(s) to law enforcement officer for signing, packaging, and transfer to the laboratory.
8. If the patient has no medical or trauma complaints and the vital signs are within normal limits consider this a treat and release from care.
9. If the patient has a medical or trauma complaint and/or vital signs are outside normal limits, transport the patient to the hospital.
   a. If officer refuses transport, contact medical control.

Hospital Communications

1. The use of the patient priority assignment system:

   Priority One (1):

   An unstable patient having an airway, breathing or circulation problem, which is uncontrolled or deteriorating. An EMS unit is requesting immediate availability of the frequency for physician medical direction.

   Priority Two (2):

   A stable patient in which an EMS unit anticipates medical direction.

   Priority Three (3):

   A stable patient in which the EMS unit does not anticipate receiving medical direction. The primary reason for radio transmission is to notify the destination hospital of the EMS unit's arrival time and patient's needs upon arrival.

2. ---The preferred communication system for any patient priority and all levels of EMS service is the "UHF MED Channel", including the Ingham County Hospital talk groups, where applicable.. TCEMCA has a UHF radio system, which makes use of six repeater sites, giving full coverage over the entire three County area. All TCEMCA affiliated hospitals are connected to this system.
   ---Landline and cellular telephone communications may be utilized for all priority levels, as a backup communication method.
   ---The HEAR radio system (155.34 MHz) should be reserved for those situations when communication cannot be achieved by other means**.**

   Radio communications should not be utilized for inter-facility transfers or direct admits. Telephone communication to the receiving hospital will be made prior to patient transport. Radio communications may be used if a change in patient status warrants further communications with the receiving hospital.

   "On-Line Medical Control", for purposes of these protocols, is defined as the attending ED physician (or designee) at the anticipated TCEMCA receiving facility.

PRIORITY ONE AND TWO PATIENTS:

1. EMS unit identifies itself and the hospital it is attempting to contact.
2. Hospital acknowledges transmission and hospital personnel identify themselves.
3. EMS personnel give their last name and level of licensure.
4. **ETA**
5. **Patient priority assignment**.
6. **Chief complaint**
7. BREAK (if necessary, the hospital would divert at this point.)
8. (If no diversion) Receiving hospital asks EMS unit to continue.
9. **Age and sex of patient**.
10. **Vital signs.**
11. BREAK (Receiving hospital may ask pertinent questions at this time.)
12. Receiving hospital asks EMS unit to continue.
13. **Treatment provided by EMS unit.**
14. **EMS personnel requests orders.**
15. BREAK.
16. Receiving hospital confirms or gives additional orders.
17. EMS unit clears.
18. Hospital clears.

PRIORITY THREE PATIENTS:

1. EMS unit identifies itself and the hospital it is attempting to contact.
2. Hospital acknowledges transmission and hospital personnel identify themselves.
3. EMS personnel give their last name and level of licensure.
4. **Age and sex of patient**.
5. **ETA.**
6. **Patient priority assignment**.
7. **Chief complaint**.
8. BREAK (if necessary, the hospital would divert at this point.)
9. (If no diversion) Receiving hospital asks EMS unit to continue.
10. Vital signs. **(ONLY IF HOSPITAL REQUESTS).**

Professional Standards Review Organization & Committees

Purpose: To establish a policy for appointing a Professional Standards Review Organization (PSRO) and committees by the Medical Control Authority and to define its authorities, composition, roles, and responsibilities.

I. Authority:

A. 1978 PA 368 (the "code"), MCL 333.20919(1)(g) requires that the Medical Control Authority (MCA) establish written protocols to ensure that a quality improvement program is in place within the medical control authority and that it provides data protection as defined in 1967 PA 270, MCL 331.531 to 331.534.
B. The Professional Standards Review Organization (PSRO) of the medical control authority is a "review entity" as defined in 1967 PA 270, MCL 331.531.
C. As a "review entity," the PSRO must be provided information or data regarding:
   1. The physical or psychological condition of a person/patient.
   2. The necessity, appropriateness, or quality of health care rendered to a person/patient.
   3. The qualifications, competence, or performance of a health care provider.

II. Policy

A. Medical control authorities must appoint a Professional Standards Review Organization (PSRO) as defined in this protocol, in accordance with section 20919(1)(g) of the code and administrative rules R 325.22202[1] and R325.22207[2].
B. All meetings of the PSRO are closed meetings.
C. For the purposes of this protocol, PRSO is meant to refer to the PSRO of the MCA.

III. Powers

A. The PSRO has full authority granted in accordance with 1978 PA 368, MCL 333.20919, and associated regulations, to request and compel the disclosure of all pertinent records, information, data, recordings, or other materials related to the practice of EMS within the jurisdiction of the MCA from all participating members of the MCA.
   1. This includes all EMS personnel, life support agencies, hospitals, and prehospital telecommunication centers.
B. All requests for such materials must be honored in accordance with the MCAs statutory obligations and must be turned over in a timely manner, unless otherwise prohibited by law.

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[1]R 325.22202(1)(f) a medical control authority shall appoint a professional standards review organization to monitor and improve the quality of medical care.
[2]R 325.22207(1)(i)(ii) Data must be reviewed by the professional standards review organization of the medical control authority and protected in accordance with section 20919(1)(g) of the code.

IV. Composition

A. The purpose of the committee(s) is to ensure a system level peer review perspective of prehospital care within the Medical Control Authority.
B. To assist in this purpose, the PSRO committee(s) must include at least one licensed prehospital EMS clinician and one Life Support Agency representative currently participating within the local MCA system, representative(s) of the MCA Board and/or MCA staff, and a representative from a participating MCA hospital.
C. Individuals with expertise in medical care, quality assurance, and relevant areas of EMS and healthcare practice may be included at the discretion of the MCA Board.
D. Members of the PSRO should possess the necessary qualifications and experience to effectively contribute to the review and improvement process.

V. Confidentiality

A. All records, data, and knowledge obtained for or by individuals assigned a professional review function of the PSRO are confidential and must not be made public, nor available for subpoena, and are protected from disclosure under Michigan law, including 1967 PA 270, MCL 331.20919(1)(g).
B. All members of the PSRO, including the subject of a PSRO Inquiry, are subject to confidentiality obligations regarding the materials and discussions that are reviewed.
C. All participants are prohibited from removing materials from a meeting of the PSRO and from discussing or disclosing any aspect of the materials or discussions with anyone outside of the PSRO without appropriate prior authorization.
D. The PSRO may disclose deidentified, aggregate data for review by other committees of the MCA, its stakeholders, and the public.

VI. MCA Roles and Responsibilities

A. The MCA Board is responsible for ensuring that all duties and functions related to complaints, investigations, and quality improvement activities are performed by the PSRO committee including:
    1. Request and review EMS patient care reports, hospital charts, data, audio, video, professional credentials, and other materials relevant to professional practice within the EMS system.
    2. Assess adherence to applicable statutes, administrative rules, and protocols governing the practice of emergency medical services within the MCA's jurisdiction.
    3. Review and make recommendations on professional standards and practices outlined in protocols.

4. Incident Reviews
   a. To assess, investigate and make recommendations to the MCA Board pertaining to unusual circumstances, complaints and/or allegations posed by any person(s) regarding EMS activities in the MCA.
   b. Incidents that must be reviewed
      i. Unusual Occurrences
      ii. Protocol Required Reviews
      iii. Complaints / allegations
         a. Any complaint will follow the **PSRO Investigation and Resolution Protocol**.
5. Quality Improvement activities
   a. Identify needs and make recommendations for training and development to enhance professional competencies.
6. Data Collection
7. Mi-EMSIS
   a. The MCA must maintain access to the Mi-EMSIS data and ensure that agencies are accountable for the submission of data.
   b. Mi-EMSIS data should be utilized as a tool to assist in the evaluation of performance and function for quality improvement.
8. Research projects
9. Special Studies
10. Audits

B. MCAs may choose to have PSRO committees which have specific responsibilities based on content expertise. Potential committees could include:
   1. Quality Review Committee, focusing on prehospital quality review inquiries,
   2. Systems of Care,
   3. Emergency Medical Dispatching,
   4. Others as determined by the MCA Board.

C. PSRO committee members are responsible for attending professional training activities as determined by the local MCA Board, or the Department.

VII. LSA Responsibilities for PSRO

A. Each life support agency licensed to provide prehospital care within the MCA must develop and maintain a PSRO subgroup that reviews, either through a peer evaluation group or individuals tasked with peer review functions, and conducts audits requested by MCA.

B. Each life support agency licensed to provide prehospital care within the MCA must ensure all staff are trained and provided current MCA protocols.

TRI COUNTY EMERGENCY MEDICAL CONTROL AUTHORITY
SYSTEMS PROTOCOL
ACTIVE VIOLENCE INCIDENT ENTRY

Purpose:

The purpose of this protocol is to acknowledge the use of specialty trained and equipped EMS personnel in our Medical Control Authority working alongside with Law Enforcement during an active violence incident (AVI). EMS personnel who have trained with law enforcement are allowed to enter into the warm zones.

When responding to these types of incidents, the trained and equipped EMS personnel will respond along with a State licensed EMS unit from their Agency, licensed at an appropriate level. If requested outside of the EMS Agency's response area, an additional ambulance from the local jurisdiction shall be dispatched as well.

This protocol does not provide liability coverage as prescribed under the EMS law for tactical teams that originate and/or operate out of a ***non-life support*** EMS Agency, i.e. police departments, sheriff departments; SWAT teams.

Procedure:

EMS agencies that seek to utilize trained EMS personnel will ensure their personnel have the following: State of Michigan EMS licensure, a valid TCEMCA Authorization Card and training with law enforcement. It will be the agency's responsibility to provide appropriate training, equipment, and deployment of resources for response to these events, including rostering of those personnel.

All EMS personnel should have training in AVI response and treatment guidelines. The first arriving rescuers will be the one's entering with a law enforcement escort once it is declared a warm zone and reasonably safe to enter. SWAT Teams and Tactical Paramedics are unlikely to be on scene fast enough to provide care in a reasonable time frame, hence requiring every responder to be trained and familiar with AVI response.

1. Only trained and equipped EMS personnel will be allowed to enter the warm zone, in coordination with law enforcement, to provide immediate patient care. EMS personnel will wait until law enforcement is ready to escort them into the warm zone to begin patient care. The goal is to provide life-saving interventions and prevent patients from sustaining further complications by providing minimal trauma care intervention. i.e. control and treat hemorrhage, opening and protecting airway. EMS personnel will provide care only within their licensed scope of practice.

2. Any patient may be the suspect/perpetrator, therefore, check all patients for weapons before rendering care. If any weapons are found, the EMS personnel should immediately retreat to safety and advise law enforcement of the situation. If law enforcement individuals are part of the casualties, be sure to have appropriate personnel secure their weapons.

3. Non-tactical EMS personnel may enter the area once it is declared safe/clear by law enforcement, to provide further care. These EMS personnel should be escorted by law enforcement into the safe/cleared area. Appropriate protective gear should be provided to the EMS personnel.

4. Once casualties are removed from the warm zones, EMS personnel working under unified incident command will provide triage, treatment, and transport as outlined in the TCEMCA MCI protocol, section 6-20.

Tactical Emergency Medical Service Team (TEMS*)*

The purpose of this protocol is to allow for the use of tactical EMS paramedics, within the Tri-County Emergency Medical Control Authority, during police-related activities and training in which their presence would be advantageous.

This protocol does not provide liability coverage as prescribed under the EMS law, for tactical teams that originate and /or operate out of a ***non-life support*** EMS Agency, i.e. police departments, sheriff departments, SWAT teams.

Procedure:

Any ALS agency that seeks to utilize a TEMS team will provide personnel with, at a minimum, paramedic-level licensure in the State of Michigan, a valid TCEMCA Authorization Card, and training in tactical scenarios.

When responding to a tactical scene, the TEMS paramedic team will respond along with an EMS unit from their Agency, licensed at the ALS level.

If requested outside of the EMS Agency's response area, an ambulance from the local jurisdiction should be dispatched as well. In the event a patient arises out of the tactical situation, the TEMS paramedic(s) will provide a comprehensive verbal report upon transferring patient care to the transporting unit. *If the transporting unit is not ALS, or when it is deemed necessary, the TEMS paramedic(s) will accompany the patient to the hospital as to maintain or optimize patient care initiatives.*

The TEMS paramedic team will be comprised of TCEMCA authorized and State of Michigan licensed emergency medical personnel. The TEMS paramedic(s) will follow the Tri-County Emergency Medical Control Authority protocols. The TEMS paramedic(s) will have radio capabilities which allow them to reach their respective dispatch center, as well as TCEMCA hospitals for the purpose of accessing on-line medical control.

1. In tactical situations where it is not possible to contact medical control, *all post-medical control orders will become pre-medical control orders*; medical control will be contacted as soon as it becomes possible.

2. In the event of a TEMS activation, police personnel will contact their respective dispatch center and advise them of the need for TEMS personnel to respond to a situation.

3. TEMS personnel will contact the incident commander on scene for a situation report. The TEMS personnel will size-up the situation and request additional resources as needed.

TCEMCA Paramedic Drug Box

1. If a TCEMCA Paramedic Drug Box is utilized by the TEMS paramedic team, they are to exchange it for the sealed drug box on the ALS transporting unit; this is to transpire upon the transfer of patient care as to ensure the operational integrity of both entities.

2. The transporting ALS unit will use the open drug box for any additional medication administration. The ALS transport unit will be responsible for documenting any and all medication administered in the electronic patient care report; including that which was administered by the TEMS paramedic team. Upon arrival at the hospital, the ALS unit will follow the standardized TCEMCA protocol for the exchange of the drug box.

3. The TEMS paramedic will complete an Electronic Patient Care Report for each patient in which they provide treatment; these reports are to be comprehensive in nature and will contain any and all interventions provided prior to the transfer of patient care to the ALS transport unit.

IV Kits/Fluids

1. The TEMS paramedic team will carry one (1) IV kit, one (1) saline lock, and (1) 1000 ml bag of Normal Saline; each of which are to be TCEMCA approved.

2. The TEMS paramedic team will replace any of its used IV supplies and fluids from the standard allotment on the ALS transporting unit. In the event the TEMS paramedic(s) accompanies the patient to the hospital, the standardized protocol for IV supply/fluid exchange will apply.

3. The ALS transporting unit will replace IV supplies and fluids in a manner consistent with TCEMCA protocol.

TRI COUNTY EMERGENCY MEDICAL CONTROL AUTHORITY
SYSTEMS PROTOCOL
OPTIONAL EMS HEMOSTATIC DRESSING

ALL LEVELS

Indications:

Only to be used in severe wounds where blood loss from traumatic injury is present and when primary means, i.e. direct pressure and or tourniquet, to stop bleeding is ineffective.

Contraindications:

- Avoid contact with eye injuries.

Approved Hemostatic Dressings:

- Quick Clot, HemCon, and Celox

Procedure:

1. Open the package and remove.
2. Sterility of the dressing must be maintained.
3. Open clothing around wound. Remove excess pooled blood from wound with sterile gauze.
    a. Preserve any clots already in the wound to aid with the clotting process.
    b. When the source of the bleeding is located, pack the wound tightly with hemostatic dressing.
    c. Use as much of the hemostatic dressing as needed to stop the blood flow. Remainder of the dressing can be used to cover top of wound.
4. Quickly apply pressure until the bleeding stops. Estimated time is 3-5 minutes of continuous pressure.
5. Leave hemostatic dressing in place and wrap area with kerlix or ace bandage to secure wound and dressing
6. Do not remove bandage or hemostatic dressing, elevate the injury if possible.
7. Reassess the wound and patient for any changes and document them.
8. Transport patient to appropriate trauma hospitals.
9. Make sure that empty package is attached to or sent with patient. Removal instructions are on the package for emergency room staff.

Key Points

- Reassess your patient for any changes that may occur and document for report.
- Document the time and location where the hemostatic dressing was applied.
- Avoid leaving hemostatic dressing in sunlight for extended periods of time.
- Quick Clot is for external use only. **DO NOT** use for vaginal bleeding
- Quick Clot is **NOT** to be used in eye injures.
- Contact receiving hospital with the patient information including the status of the patient and wound.

Initial Date: 3/10/2025
Revised Date: **Section 8-37**

PURPOSE:

To establish a system to exchange expiring or used medication kits, medication bags, medication boxes and to conduct a bi-annual account of all medications provided to EMS Agencies authorized by TCEMCA. A Pharmacy Accountability Inventory will occur in June and December each year. This inventory includes pharmacies, and agencies authorized by TCEMCA that carry or stock medications for use in TCEMCA. Inventory will include medication kits, medication bags, and medication boxes. The medications utilized in TCEMCA are the property of the MCA participating hospitals, and all bags or boxes are property of TCEMCA.

Bi-annual Pharmacy Accountability Inventory is mandatory for all agencies authorized by TCEMCA that carry medications. Non-Compliance of the bi-annual Pharmacy Accountability Inventory or carrying/using expired medications may result in the termination of the agency's MCA privileges (ability to provide care within TCEMCA).

First Offense:	A letter of non-compliance will be sent to the Agency and placed in the agency file at TCEMCA.
Second Offense:	If non-compliance continues the Agency will be requested to appear before the Professional Standards Review Organization (PSRO) Committee to review the Agency's non-compliance status with this protocol. This will follow all applicable protocols concerning PSRO and any actions taken.

Medication kits, medication bags, and medication boxes shall be signed out by EMS personnel at the pharmacy. Each agency is responsible for the medication(s) they sign out, carry and utilize in TCEMCA.

Agencies shall ensure they never carry or use expired medications.

PROCEDURE: Used medication kits, medication bags, and medication boxes

Medication Kits

1. Complete the exchange paperwork inside each kit.
2. Bring the completed paperwork to the pharmacy, preferably the pharmacy at the hospital the patient was transported to.
3. Sign out the new medication kit on pharmacy provided form.

Medication Bags

1. Complete the exchange paperwork inside each medication bag.
2. Bring the medication bag with any unused medications, and the completed paperwork to the pharmacy. Preferably this will be the pharmacy at the hospital the patient was transported to.
3. Sign out a new, sealed, medication bag on pharmacy provided form.

Medication Boxes

1. Exchange with the hospital pharmacy that the patient was transported to.
2. Inventory medication box prior to exchange.
3. Place copy of the patient EPCR or TCEMCA Paramedic Drug Box Exchange Form inside the used medication box.
4. Seal medication box with red tag.
5. Sign out a new, green tagged, medication box on pharmacy provided form.

Narcotic Box inside Medication Box

1. If <u>not</u> used, it remains green tagged in bottom of medication box.
2. If used, inventory the narcotic box, seal with red tag and place back in bottom of the medication box that will also be red tagged for exchange.

PROCEDURE: Expiring medication kits, medication bags, and/or medication boxes

A medication kit, medication bag or medication box may be exchanged up to 3 months prior to expiration at the agencies designated pharmacy Monday-Friday. The exchange paper included inside each medication kit and medication bag shall be used when exchanging expiring kits or bags.

Agencies will note "EXPIRING MEDICATION" for the patient's name on the exchange paper and place inside the medication kit or medication bag being exchanged.

Medication boxes being exchanged due to expiring medication will have a paper placed inside stating "EXPIRING MEDICATION," the agency name, and paramedic exchanging name, as well the expiring medication box will be red tagged.

All new medication kits, medication bags, and medication boxes shall be signed out from the pharmacy when exchanging on pharmacy provided form.

PROCEDURE: Bi-Annual Pharmacy Accountability Inventory

Pharmacy Accountability Inventory is a designated Wednesday in June and December at which time all medication kits, medication bags, and medication boxes are accounted for, and if needed, exchanged with our pharmacies for any updates or changes as advised by TCEMCA.

Pharmacy Accountability Inventory forms utilized are located at TCEMCA.ORG website. The forms are to be completed and emailed by agencies to TCEMCA between 8-10am the morning of Pharmacy Accountability Inventory day. For proper processing, the agency name must be indicated on all Pharmacy Accountability Inventory forms and emailed to: pharmacy@TCEMCA.ORG

MFR Agencies - Saturday to Saturday before Pharmacy Accountability Inventory Wednesday, record required information on the TCEMCA Pharmacy Accountability Inventory form(s). Email completed form(s) to TCEMCA office for each type of medication kit your agency has.

If advised to bring all medication kits in for Pharmacy Accountability Inventory, bring the medication kit(s) in for exchange with your designated pharmacy at your agencies designated time or as close as possible to the time. The medication kit(s) are exchanged, un-opened. If the agency has multiple medication kits, try exchanging them in smaller groups to assist the pharmacies with being able to exchange in a timely manner.

BLS Agencies - Saturday to Saturday before Pharmacy Accountability Inventory Wednesday, record required information on the TCEMCA Pharmacy Accountability Inventory form(s). Email completed form(s) to TCEMCA office for each type of mediation kit or medication bag the agency has.

If advised to bring all medication kits or medication bags in for Pharmacy Accountability Inventory, bring the medication kit(s) and/or the medication bag(s) in for exchange with your designated pharmacy at your agencies designated time or as close as possible to the time. The medication kit(s) and/or medication bag(s) are to be exchanged un-opened. If the agency has multiple medication kits or medication bags, try exchanging them in smaller groups to assist the pharmacies with being able to exchange in a timely manner.

LALS/ALS Agencies - On Pharmacy Accountability Inventory Wednesday, record required information on the TCEMCA Pharmacy Accountability Inventory form(s). Email completed form(s) to TCEMCA office for each type of medication kit, medication bag, and/or medication box your agency has.

If advised to bring all medication kits, medication bags and/or medication boxes in for Pharmacy Accountability Inventory, bring the medication kit(s), medication bag(s), and/or medication box(s) in for exchange with your designated pharmacy at your agencies designated time or as close as possible to the time. The medication kit(s), medication bag(s, and/or medication box(s) are to be exchanged un-opened. If the agency has multiple medication kits, bags, or boxes, try exchanging them in smaller groups to assist the pharmacies with being able to exchange in a timely manner.

NOTE: Do not wait for a Pharmacy Accountability Inventory Wednesday to exchange any expiring medication kit, medication bag or medication box. It is the responsibility of the agency to ensure they are not carrying or utilizing expired medications.

AGENCIES WITH MEDICATIONS ON RESERVE VEHICLES OR STORED SECURELY OFF VEHICLES:

The medication kit, medication bag or medication box will be rotated with frontline licensed response vehicles every thirty (30) days to ensure use in the system. It is the responsibility of the agency to ensure they are not holding, carrying, or utilizing expired medications.

Initial Date: 3/10/2025
Revised Date: **Section 8-37**

PROCEDURE: Pharmacy Accountability Inventory process for Hospital Pharmacies

Pharmacies will report inventory of medication bags and medication boxes on Pharmacy Accountability Inventory Wednesday between 8-10am to TCEMCA office.

When there is a need to change/alter/modify any medication kits, medication bags or medication boxes all medication kits, medication bags, and/or medication boxes will be required to be exchanged with an agency's designated pharmacy. At that time, the change/alteration/modification will occur, and labels will be updated on or within the medication kits, medication bags or medication boxes. The outside of the medication bag or medication box may be temporarily marked to indicate the change has been made by the pharmacy.

Tri-County Emergency Medical Control Authority
Systems Protocols
APPLICATION TO PROVIDE SERVICE/UPGRADE LEVEL OF SERVICE IN TRI-COUNTY EMERGENCY MEDICAL CONTROL AUTHORITY

Initial Date: 6/1/2017
Revised Date: **Section: 8-38**

Agencies desiring to provide emergency medical services in Clinton, Eaton, or Ingham Counties or wishing to upgrade their existing licensure level must satisfactorily complete the application process as outlined below. Applying agency must meet all licensing requirements as set forth by the State of Michigan, including the State required equipment/supplies. The applying Agency must also meet all additional requirements listed in TCEMCA protocol.

1. Submit letter of application indication the specific geographic area to be served, the desired level of licensure, the proposed station(s) location, type of service (transporting or non-transporting), and the number of ambulances being licensed with their licensure level.
2. Submit documents related to the official types of legal organization of the service, stating whether it is an individual proprietorship, partnership, corporation, or subsidiary of any other corporation or unit of government.
3. Submit your plan to communicate with the 9-1-1 Dispatch Centers. If dispatching will not be occurring through the 9-1-1 Dispatch Centers, include documentation of agencies dispatching method, including: dispatch training requirements, records, pre-arrival instructions and computer aided dispatch capabilities.
4. Submit proof of electronic report capabilities, and vendor of choice.
5. Submit a personnel roster which included the EMS personnel's license number and licensure level. Within the roster, indicate names of Instructor Coordinators for agency.
6. EMS Personnel must meet requirements outlined in the "Responsibilities of Participants Protocol" Responsibilities of EMS providers, Section 6-34. After application approval, prior to operation in the MCA, personnel must complete the TCEMCA authorization process.
7. For any proposed transporting or non-transporting service at the Advanced Life Support, Limited Advanced or Basic Life support service, describe the clinical need for the new service.
8. If your agency is currently licensed in the State of Michigan, provide a complete list of Medical Control Authorities, which you have provided service in the last five years, and permission to contact them for references.
9. Include any other factors you wish the TCEMCA Board to consider when reviewing this application.

10. Include the Agency's completed State application both Part 1 and Part 2 of the application, and the TCEMCA application form (page 4 of this protocol).
11. If all the conditions stated above in items one through ten are met, the application will be accepted.

The application packet must be presented in the order stated above. The applying agency must submit two copies of the application for review by the Tri County Emergency Medical Control Authority (TCEMCA) Board of Directors. The completed application must be submitted no later than two weeks prior to the meeting date of the Tri County Emergency Medical Control Board. Meetings ae held on the second Wednesday of January, March, May, July, September and November.

The Medical Control Board will review the completed application and may direct a reference review and investigation. The Board may withhold support of the application based upon adverse findings in the investigations process. The Board or designated representative will advise the applicant of the Board's final determination.

All new agencies will be placed on probation from the first day of operation for a period of 1-year. During probation, in 90-day intervals, the agency will meet with the Medical Director and Manager of Operations. This meeting will serve as a progress report, and if necessary include a performance improvement plan. A report of this meeting will be presented by the Medical Director or Manager of Operations at the TCEMCA Board Meeting.

APPLICATION FEE:

A non-refundable fee must accompany this application.

New Agency Fee Schedule:

$2,500.00 for Advanced Life Support

$1,500.00 for Limited Advanced Life Support

$1,000.00 for Basic Life Support

$500.00 for Medical First Responders

Agency Upgrade Fee Schedule:

$1,250.00 for Advanced Life Support

$750.00 for Limited Advanced Life Support

$500.00 for Basic Life Support

The application fee must be in the form of a certified check made payable to:

Tri-County Emergency Medical Control Authority

Mail the completed application packet and check to the address below:

Tri County Emergency Medical Control Authority
2127 University Park Dr., Suite 370
Okemos, MI 48864

Initial Date: 6/1/2017
Revised Date: **Section: 8-38**

NEW SERVICE / AGENCY UPGRADE APPLICATION FORM

DATE _____

NAME OF SERVICE _____

MAILING ADDRESS _____

_____

_____

CONTACT PERSON _____

PHONE NUMBER _____

FAX NUMBER _____

E-MAIL _____

_____

SIGNATURE OF AGENCY CHIEF EXECUTIVE OFFICER

The above signature expresses a willingness to comply with all TCEMCA protocols, procedures, directives, and provides a release to obtain reference information. Misrepresentation of any item on the application will disqualify the service from consideration for a period of six-months.

Emergency service workers, by virtue of their own profession, are faced with certain events that have the potential to create a significant stress reaction. These events have been termed "critical incidents". A critical incident is any situation that causes unusually strong emotions and has the potential to overwhelm one's ability to cope.

PURPOSE: This is an informational protocol that is for resource purposes and is voluntary.

CAPTIAL AREA PEER SUPPORT HELPLINE – 989-372-6664 (call or text) IMMEDIATE ASSISTANCE

The Capital Area Peer Support (CAPS) Helpline is staffed by trained emergency services personnel. It exists for all first responders in the Capital Region of Michigan, and their family members, to speak with a peer about any concerns they may have. Peers will provide support and referrals as needed.

STATE OF MICHIGAN ROUTED SUICIDE & CRISIS LIFELINE – DIAL 988

The 988 Suicide and Crisis Lifeline, formally known as the National Suicide Prevention Lifeline (NSPL), is a 24/7 toll-free nationwide hotline, made up of a network of independently operated and funded local call centers (200+) across the country where compassionate care and accessible support is available.

Lifeline call centers are free and confidential.

FRONTLINE STRONG TOGETHER (FST5) – 1-833-34-STRONG

COMMUNITY MENTAL HEALTH AUTHORITY OF CLINTON, EATON, and INGHAM COUNTIES - 517-346-8460 or 1-800-372-8460 – Crisis Hotline

LISTENING EAR CRISIS CENTER – 517-337-1717

DEFINITIONS

Critical incident stress - A strong emotional, cognitive, or physical reaction that has the potential to interfere with daily life, including physical and emotional illness, loss of interest in the job, personality changes, marital discord, and loss of ability to function.

Critical Incident Stress Debriefing (CISD) - A standardized approach using a group format to provide education, an atmosphere and opportunity for emotional release

through discussion, and support for members who are involved in emergency incidents under conditions of extreme stress. CISD is not a diagnostic or treatment process like that provided in counseling sessions by a mental health professional. Instead, it is a service that provides education and support.

Critical Incident Stress Management (CISM) - Critical Incident Stress Management is a method of helping first responders and others who have been involved in critical incidents that leave them emotionally and /or physically affected by those incidents. CISM is a process that enables peers to help their peers understand problems that might occur after an event. The process also helps people prepare to continue to perform their services or, in some cases, return to a normal lifestyle.

Critical Incident Stress Management team member - A member of a debriefing team that has been trained by the Michigan Crisis Response Association Network (MCL 333.20981), following the ICISF model.

Peer Support - Emotional assistance provided by a trained individual or group of first responders.

CISD PROGRAMS

A CISD program should include pre-incident, on-scene, and post-incident activities, including education, diffusion of emotional reactions, and debriefing. The purpose of the program is to minimize the impact of stress on first responders following major incidents.

Ideally, CISD/CISM should incorporate the services of both peer support personnel and trained professionals, such as physicians, psychologists, or counselors.

The following are examples of incidents that may initiate a CISD response:

- Major disaster or mass casualty incidents
- Severe injury, death, or suicide of an emergency service provider
- Severe injury or death of a civilian resulting from emergency service operations.
- Death of a child or similar incident involving a profound emotional response
- Any incident that attracts unusually heavy media attention
- Loss of life following an unusual or extremely prolonged expenditure of emotional and physical energy by emergency services personnel

- Any unusual incident that produces an extreme, immediate, or delayed emotional response
- Cumulative trauma from multiple incidents

A CISD/CISM Team can provide debriefing services within 48-72 hours following a critical incident. In addition, the teams can provide on-scene support and defusing during a major incident. These teams may also provide educational seminars on stress as an on-going educational program.

Any time it has been determined that a critical incident has occurred, or that responders are requesting assistance, a CISD/CISM process should be initiated. The request may be made either directly to peer support personnel, through the agencies EAP, regional CISM networks or state CISM networks.

Depending on the type and magnitude of the incident and services that may be needed, the CISD may be activated either during or immediately after a critical incident.

All responders are responsible for recognizing incidents that may need a CISD. Once an incident has been identified as a critical incident, a CISD should be initiated as soon as practicable.

Debriefing may be conducted anywhere there is ample space, privacy, and freedom from distractions. Consideration should be given to including responders from other agencies who were involved in the incident including but not limited to communications personnel, law enforcement officers, paramedics or ambulance personnel, and hospital personnel.

Any first responder is encouraged to take advantage of peer support services, or seek professional help as needed.

DEBRIEFING

The form of CISD utilized should depend upon how early the intervention is activated and the nature of the incident. The use of one format does not preclude the use of others for the same critical incident.

Common formats for CISD include:

(a) On-scene debriefing: Peer support personnel or mental health professionals respond to the scene and are advisers to watch for the development of acute reactions. They may offer encouragement and support, check on the well-being of personnel, and allow for individual discussion of feelings and reactions.

(b) Initial defusing: This usually takes place within a few hours of the incident and is generally facilitated by peer support personnel. It is an informal process encouraging open and free expression of feelings without a critique of the incident. The purpose is to stabilize involved members so they can go home or return to service.

(c) Formal debriefing: Debriefing led by a CISD/CISM program mental health professional and peer support personnel that usually takes place 24 to 48 hours after the conclusion of the incident. Members involved in the critical incident are given the opportunity for free expression of feelings. This expression should be met with acceptance, support, and understanding.

(d) Follow-up debriefing: If deemed necessary, follow-up may be facilitated by the CISD/CISM mental health professional and/or peer support personnel several weeks or months after a critical incident. The main purpose is to resolve any issues or problems that may not initially been resolved. The follow-up debriefing may include the entire group or a portion of those originally involved.

Regardless of the type of debriefing, CISD is not a critique of agency operations at the incident. The CISD provides a setting in which members can discuss their feelings and reactions to reduce the stress resulting from exposure to critical incidents. Performance issues should not be discussed during the debriefing.

No one has rank during a debriefing process. Everyone is equal.

Following any intervention, should members feel a need for additional assistance, contact peer support personnel or a CISD/CISM team member to obtain information regarding a referral.

Only those involved in the incident and CISD/CISM team members should be present. Members directly exposed to the traumatic aspects of an incident are strongly encouraged to participate in CISD/CISM.

CONFIDENTIALITY

TCEMCA considers all CISD interventions, regardless of type, as strictly confidential. Notes, other than those specifically identified in this protocol, are prohibited. No audio or video recording may be made without the express consent of all participants (MCL 333.20982). Reference State of Michigan Senate Bill No. 444, Part 209A Critical Incident Stress Management Services, Section 20982 regarding communications with a CISM team as being confidential and private.

The only exceptions to confidentiality should be when:

(a) There is reasonable evidence to assume a risk of harm to the member or to others. If the risk is to another person, that person is identifiable, and there are means to contact the person.

(b) Participants divulge information that falls under any applicable state mandatory reporting duties or enacted law, bill, or statute.

ADDITIONAL RESOURCES

ResponderStrong – Improving mental health supports for emergency responders and their families

FST5 is here to help first responders - Frontline Strong Together

CEI Community Resources 23.pdf (msu.edu)

State of Michigan 98th Legislature of 2016 Senate Bill No. 444

State of Michigan 100th Legislature of 2020 House Bill No. 4862

Agencies and Departments are encouraged to have Emergency Action Plans (EAP) and services for all employees to assist with their mental wellbeing.

Initial Date: 2/27/2025
Revised Date: **Section 8-40**

PURPOSE:

This optional protocol does not change the requirements set by the agency's license from the state. Agencies must first complete, sign, and submit to TCEMCA the Optional use of BLS Ambulances for 911 response attestation letter. TCEMCA will maintain a roster of agencies that are approved to participate in this protocol.

To allow approved TCEMCA agencies the ability to respond Basic Life Support (BLS) Ambulances for medical dispatched 911 priority 3 & 4 requests for service within TCEMCA. This protocol will continue to require an Advanced Life Support (ALS) response to Priority 1 and 2 EMS incidents.

Furthermore, in the event that an ALS ambulance is not readily available (including via in- or out-of-county mutual aid), it will be permissible to respond a BLS ambulance. An ALS intercept shall be considered for patients who are in need of ALS-level care and where the transport time to the hospital is longer than the time to ALS intercept. However, for time-critical conditions in which ALS care is not likely to change outcomes and would likely result in delayed access to definitive care (e.g., stroke), ALS intercept may not be appropriate.

TCEMCA EMS AGENCY REQUIREMENTS:

Provide a signed BLS Ambulance for 911 response attestation letter to TCEMCA prior to implementing this protocol. Fulfill all requirements indicated in this protocol including all CQI requirements. An agency will be excluded from this protocol in the event they are unable to or fail to maintain the requirements set forth in this protocol.

Agencies not utilizing this optional protocol will always respond at the level of the agency state license regardless of the priority of the patient given by the public safety telecommunicator.

PUBLIC SAFETY ANSWERING POINT MANDATORY REQUIREMENTS:

TCEMCA has approved using Emergency Medical Dispatcher (EMD) medical protocols through the International Academies of Emergency Dispatch (IAED). All Public Safety Answering Points (PSAP) within TCEMCA area that processes/dispatch medical calls must use the latest approved version of the medical priority dispatch system from IAED. Public Safety Telecommunicators must be trained, certified, and maintain IAED EMD certification to process/dispatch medical calls. An IAED-Certified EMD telecommunicator shall directly supervise a trainee telecommunicator.

PSAP CALL PROCESSING:

EMS priority indicators, priority 1, 2, 3, or 4 will be used by the EMD telecommunicator when dispatching EMS calls for service. EMS priority indicators shall be determined from the determinate descriptors within the IAED EMD program, without alteration, unless approved by the TCEMCA medical director. The determinate code is assigned based on the answers provided to the EMD telecommunicator during call processing using the approved IAED protocols. The crossover from IAED determinate codes to EMS priority indicators will be as follows:

- Alpha (A) and Bravo (B) IAED determinate codes will be referred to as Priority 3 or 4 for EMS dispatching. Priority 3 & 4 requests may receive a Basic Life Support (BLS) response.
- Charlie (C), Delta (D), Echo (E) IAED determinate codes will be referred as Priority 1 & 2 for EMS dispatching. Priority 1 & 2 requests will receive an Advanced Life Support (ALS) response.

If an EMD telecommunicator is unable to provide a priority level for a patient, the EMS agency shall respond at the level of the agency's state license.

EMS AGENCY & EMD TELECOMMUNICATOR PROCEDURES:

I. Use of BLS Ambulance as Sole Ambulance Response to Priority 3 & 4 request for service. (Determinate Code Alpha or Bravo)

A. It is permissible to dispatch a BLS ambulance to Priority 3 & 4 requests for service. (Determinate Code Alpha or Bravo) - BLS Response.
   1. An ALS ambulance, if available, will be dispatched after initial BLS dispatch if the PSAP receives additional information that identifies a Priority 1 or 2 patient, or as requested by a responding EMS unit.
   2. An ALS ambulance shall be requested by BLS or MFR personnel on scene if patient(s) found to need ALS interventions.

B. ALS will be requested by BLS when the patient fails to meet the criteria for BLS transport as noted in TCEMCA protocol **8-7 – ALS to BLS Transfer of Care** and below.
   1. Patient's airway is patent, maintained without assistance or adjuncts.
   2. Patient is hemodynamically stable with medical complaints or injuries that would be cared for at the BLS level.

3. No imminent changes are anticipated in the patient's present condition.
4. Patient presents at baseline mentation and GCS or if unknown, GCS ≥ 14.
5. Patient does not require cardiac monitoring, or pain management (e.g., chest pain, dyspnea, syncope, pain)

- **Examples of patients appropriate for BLS transport.**
- Minor trauma without concerning mechanism of injury or special trauma considerations (e.g., pregnant, blood thinners), and not needing ALS medications (e.g., analgesia)
- Opioid overdose with successful reversal with narcotic antagonist medication and with stable vital signs and normal level of consciousness.
- Suspected alcohol intoxication with stable vital signs, alert, normal blood glucose, alert, no recent seizure, no evidence of trauma, no concern for co-toxins
- Behavioral health condition with patient with stable vital signs, alert, and fully cooperative who have not required (or anticipated to need) physical or pharmacologic restraint.
- Patient found hypoglycemic, has received ALS care resulting in normal level of consciousness, and not taking oral or long-acting anti-hyperglycemic medications.
- Patients who have received analgesia (e.g., fentanyl IV/IN) and otherwise meet criteria.
- Note: Patients who meet above criteria who have a saline lock in place or IV fluid infusing at TKO who otherwise meet the above criteria may be transported by BLS

II. Use of BLS Ambulance, when ALS is not readily available, for Response to a Priority 1 & 2 request for service (determinate code Charlie, Delta, Echo).

A. An ALS response is the standard for all priority 1 & 2 EMS requests.

B. If **NO ALS unit** is available to respond (including in- and out-of- county mutual aid) to an ALS incident, priority 1 & 2 request, a BLS ambulance shall be used to respond to the incident.

C. BLS Responsibilities for sole response to ALS call

1. Provide BLS care consistent with TCEMCA protocols with an EMT providing care in patient compartment.
2. Determine if an ALS intercept is indicated considering patient acuity and transport time to the hospital. ALS intercept should only be considered if ALS arrival is faster than ED delivery by BLS unit.

3. In the event of an unanticipated medical emergency warranting ALS care, request an ALS intercept or continue to destination hospital alerting them as to change in condition (whichever provides most timely access to ALS care) NOTE: Cardiac Arrests occurring while in transport to the hospital should be managed in a stationary ambulance supported by closest ALS unit.
4. Provide verbal and/or written (may use TCEMCA EMS Field Notes) hand-off to hospital personnel.
5. Document EMS encounter (including ALS component if any) per protocol in EPCR.

*If ALS is on scene, and patient <u>does not meet</u> criteria for ALS interventions, care may transfer from the ALS unit to a BLS unit following protocol **8-7 – ALS to BLS Transfer of Care**.*

III. Continuous Quality Improvement (CQI)

A. All BLS responses occurring under this protocol shall be reviewed by the EMS agency and reported bi-weekly to TCEMCA. A BLS911 CQI form will be utilized to report these responses to TCEMCA, through email at: BLS911@TCEMCA.ORG

B. All BLS responses to Priority 1 or 2 incident without ALS or to a Priority 3 & 4 incident resulting in a need for ALS care, and/or emergency transport to the hospital will be considered to be a sentinel event and must be reported to TCEMCA by the agency (along with EPCR uploaded to MIEMSIS) within 24 hours of the incident. Reporting to TCEMCA shall utilize the BLS911 CQI form and email through the BLS911@TCEMCA.ORG email.

Protocol Reference: Kalamazoo County Medical Control Authority (KCMCA) – 8.16a Use of Basic Life Support Ambulances for 911 Responses, Version: 07/20/2023, MDHHS Approval: 07/20/2023