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).

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. When in doubt, contact medical control to determine if there is an urgent need to transport with lights and siren.

I. **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.

1. 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

Response to the scene and transport to the hospital:

MCA Selection Response to Unstable Patient Incidents and Transports

☑ Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and sirens while responding to the scene and/or transporting to the hospital

☑ Response ☑ Transport

☐ 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 and/or transporting to the hospital (per MCA selection).

☐ Response ☐ Transport

2. 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

a. Response to the scene.

MCA Selection for Response to Potentially Unstable Patients and Transports

☑ 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.

☐ 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.

b. Do not transport using lights and sirens unless the patient's condition deteriorates.

3. 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.

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

4. Dead Patients:

Priority	Description	Example(s) include, but not limited to
Dead	**Dead** patients are absent of all vital signs and do not require further medical attention, per protocol.	**See Patient Death, Termination of Resuscitation and Pronouncement Protocol**

a. 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.

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.

☑ 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.

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. Utilize 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.

. 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.

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.

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: 7/28/23 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 may transport the following (per MCA selection)
     - a. IV fluids without medications added on dial-a-flow or gravity run – peripheral site.

MCA Approval for BLS care during Interfacility transfer

☑ IV Fluids on a pump

☑ IV Antibiotics that have been infusing for at least 15 minutes prior to departure.

☑ IV Lipids/TPN

☑ 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 en route, 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**)

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.

Enhanced Paramedic Inter-Facility Patient Transfers and Critical Care Interfacility Patient Transports (MCA Optional Protocol)

Paramedic Use Only

Purpose: To expand the Scope of Practice for ALS EMS providers in the performance of Interfacility Patient Transfers through the requirement of additional education and training.

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

☑ **Enhanced Paramedic Inter-Facility Transfers**

☑ **Critical Care Inter-Facility Transfers**

ENHANCED PARAMEDIC INTER-FACILITY PATIENT TRANSFERS

A. Training:

Only personnel trained under an approved MDHHS and MCA Expanded Scope curriculum may utilize the listed medications or procedures included in this addendum during interfacility transfers without additional/accompanying staff. See **Inter-Facility Patient Transfer Protocol.**

B. Medications:

1. The following medications/fluids (to a maximum of two simultaneously) may be continued during transport by MCA approved ALS personnel. These medications may require the use of an IV infusion pump which will be supplied by the sending facility or the ALS provider. The medications may be monitored by the attending paramedic only and may NOT be titrated or started as a new infusion. Should complications arise, infusions must be discontinued, and medical control contacted. Paramedics must receive training in the use of these medications (per MCA Selection)

Enhanced Paramedic Interfacility Medications (Per MCA Selection)

- ✔ Amiodarone
- ✔ Antibiotics
- ✔ Antifungals
- ✔ Antihistamines
- ✔ Antivirals
- ✔ Beta Agonists
- ✔ Beta Blockers
- ✔ Blood
- ✔ Calcium Channel Blockers
- ✔ Calcium Gluconate
- ✔ Collids/Crystalloids/Lipids
- ✔ Electrolytes
- ✔ Glycoprotein IIa/IIIB Inhibitors
- ✔ Heparin
- ✔ Insulin Pumps (closed systems)
- ✔ Lidocaine
- ✔ Magnesium Sulfate
- ✔ Nexium (esomeprazole)
- ✔ Nitroglycerin
- ✔ Nitroprusside
- ✔ NSAIDs
- ✔ Oxytocin (Pitocin)
- ✔ PCA Pumps (closed systems)
- ✔ Pepcid (famotidine)
- ✔ Potassium (up to 20 mEq)
- ✔ Protonix (pantoprazole)
- ✔ Sodium Bicarbonate
- ✔ TPN (Total Parenteral Nutrition)
- ✔ Tranexamic Acid (TXA)
- ✔ Vitamins
- ✔ Zantac (ranitidine)

2. Medications used from an ALS medication bag will be recorded by the paramedic, per the appropriate medication usage form. Upon arrival at the receiving facility the medication box will be exchanged per protocol. If the receiving facility is outside the West Michigan Regional Drug Bag Exchange program participation area, replacement of the medication box is the responsibility of the sending facility.

3. EMS documentation of the interfacility transfer must include the interventions performed en-route and documentation of personnel involved in specific patient care activities.

C. Skills:

✔ **Chest Tubes/Chest Drainage Units: [C]**

Paramedics in the participating medical control authority may monitor an existing chest tube during transport. The chest tube shall be placed by the sending facility and any necessary equipment will be provided by the sending facility.

☑ **Pressors: [P]**

Paramedics in the participating medical control authority may maintain an existing infusion of a pressor medication. Any pressor infusion must be delivered via an IV pump. Agencies and sending facilities should collaborate with regards to equipment necessary for maintenance of pressor infusions. Paramedics may titrate pressor medications based on the parameters in written orders obtained from the sending facility.

☑ **tPA: [T]**

Paramedics in the participating medical control authority may transport patients receiving tPA, Tissue Plasminogen Activator (Alteplase, Activase), in the presence of acute ischemic stroke, myocardial infarction, pulmonary embolism, central venous catheter occlusion, arterial thrombus or embolism, or other medical indication. In long transports where tPA dosing changes, transition between hospital premixed bags may be performed in transit with written orders, and medication cross check prior to departure from the facility. Agencies and sending facilities should collaborate with regard to equipment necessary for continuation of tPA therapy.

☑ **Paralytics/Sedatives: [S]**

Paramedics may, to properly manage the mechanically ventilated patient, titrate sedative medications based on the parameters in written orders obtained from the sending facility, and may maintain paralytics as ordered. Agencies and sending facilities should collaborate with regards to equipment necessary for administration of medication infusions.

☑ **Ventilators: [V]**

Paramedics in the participating medical control authority may maintain, and adjust mechanical ventilation as ordered by a sending facility. Supply of a mechanical ventilator (agency-owned vs. hospital-owned) shall be determined by the medical control authority.

☑ **Insulin: [I]**

Paramedics in participating medical control authorities may administer insulin by subcutaneous injection, IV drip or closed system continuous infusion pump based on written orders obtained from the sending facility/attending physician.

Critical Care Patient Inter-Facility Transports

Purpose: To provide hospital facilities, physicians, and medical transport personnel with guidelines to facilitate inter-facility transportation of critically sick and injured patients within Advanced Life Support vehicles. Paramedics must complete and MDHHS approved critical care course.

1. Vehicle, Equipment and Staffing Requirements
    A. MDHHS Vehicle License. All vehicles conducting Critical Care Inter-Facility Patient Transports must be licensed as transporting Advanced Life Support (ALS) vehicles.
    B. Equipment. The following is the minimum equipment that will be carried by an ALS vehicle while it is providing Critical Care Inter-Facility Patient Transport, in addition to the equipment required by Part 209, P.A. 368 of 1978, as amended, and local medical control authority protocols:
        a. Waveform Capnography
        b. Portable Ventilator or staff capable of providing ventilatory support
        c. Portable Infusion Pump(s)
        d. Pressure infusion bag(s)
    C. Staffing
        a. All ALS vehicles that conduct Critical Care Inter-Facility Patient Transports will be staffed in accordance with local medical control requirements with at least one (1) paramedic trained in the Critical Care Inter-Facility Patient Transport curriculum. The trained paramedic must be in the patient compartment while transporting the patient.
        b. The above requirement for staffing does not apply to the transportation of a patient by an ambulance if the patient is accompanied in the patient compartment of the ambulance by an appropriately licensed health professional designated by a physician and after a physician-patient relationship has been established as prescribed. (PA 368, Section 20921(5)).

2. Critical Care Inter-Facility Patient Transport Physician Director/Quality Improvement
    A. Ambulance services that utilize this protocol must designate a Critical Care Inter-Facility Patient Transport Physician Director.
    B. The Critical Care Inter-Facility Patient Transport Physician Director will be responsible for:
        a. Oversight of a quality improvement program for Critical Care Inter-Facility Patient Transports

b. Oversight of the training curriculum for EMS personnel trained under this protocol.

3. Critical Care Inter-Facility Patient Transport Curriculum
   A. Curriculum must be submitted to MDHHS for approval prior to class implementation.
   B. Curriculum will include at a minimum, the following:
      a. Ventilators
      b. Chest Tubes and Drainage Devices
      c. Invasive Line Maintenance
      d. Equipment Training (IV Pumps, Ventilator, etc.)
      e. Thrombolytics
      f. Interpreting blood gases
      g. Blood products
      h. Cardiac Enzymes
      i. Vasoactive drugs
      j. Critical Care Patient Transport Protocol Review
      k. Paralytics
      l. Practical Lab
      m. Cardiac Physiology
      n. High Risk Pregnancy
      o. Antibiotics
      p. Pediatrics
      q. Critical Care Patient Transport Charting
      r. Critical Care Patient Transport Call: Start to Finish
      s. Critical Care Patient Transport Case Presentations
      t. Written and Practical Exam

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
- [ ] 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:

Applicable to all Specialist and above

☑ Practical Competency (Specialist Skills)

☐ Other MCA requirements as specified/listed below:

Applicable to all Paramedic

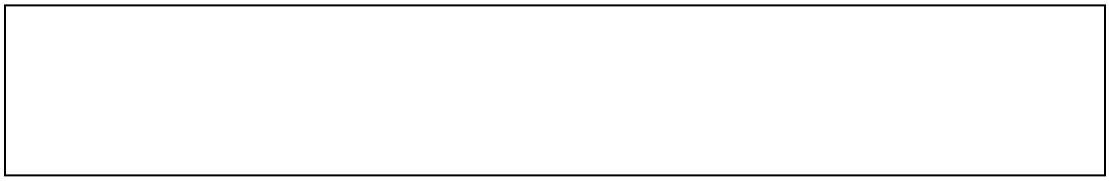
☑ Advanced Cardiac Life Support (ACLS)

☑ Pre-hospital Pediatric Certification (PALS, PEPP)

☑ Practical Competency (Paramedic Skills)

☐ Enhanced Paramedic Interfacility Care

☐ Other MCA requirements as specified/listed below:



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 likely to 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.

Initial Date: 09/2004
Revised Date: 12/27/2022 Section: 8-21

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

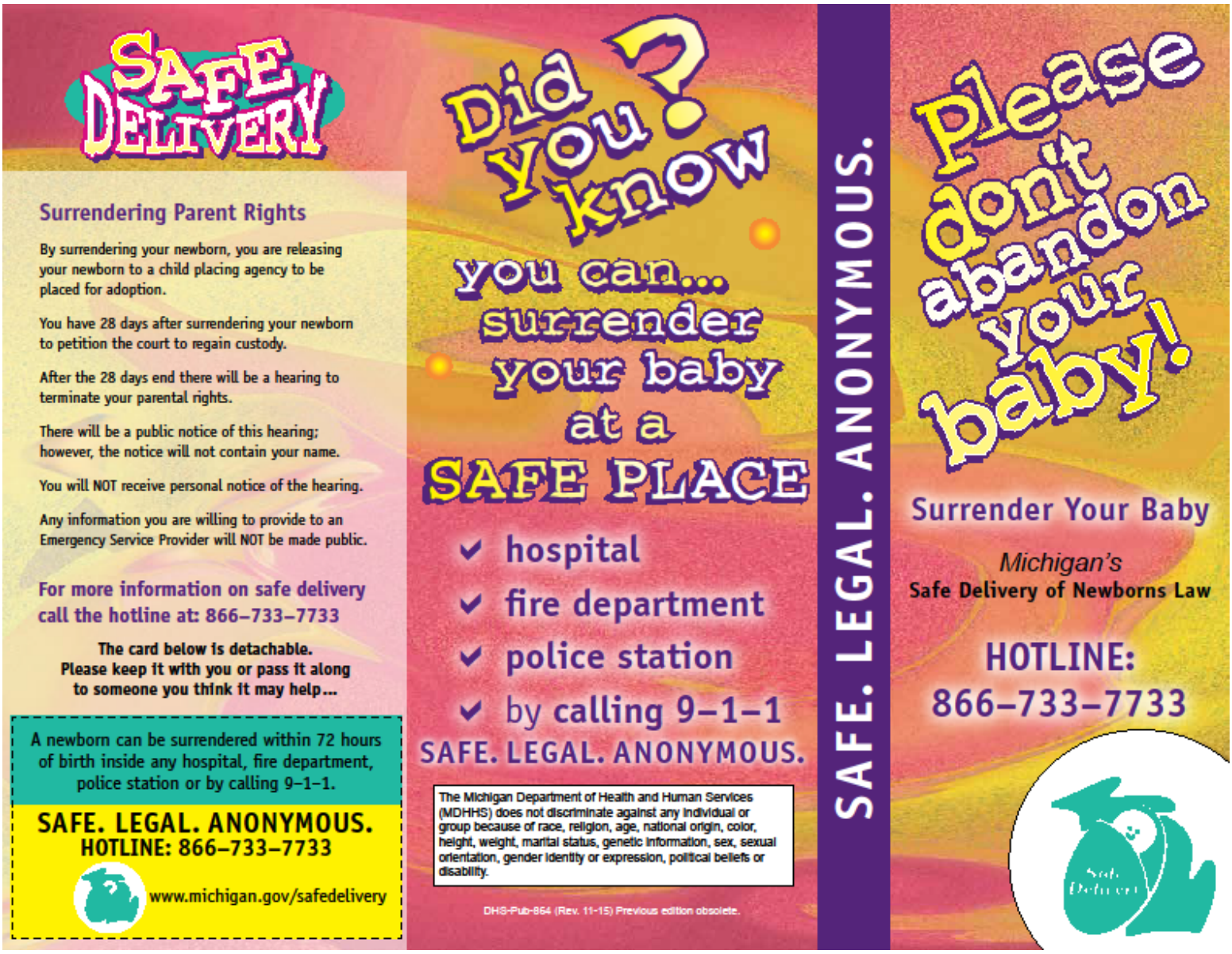
Subscribed and sworn to before me on _____ (Date), _____ (County and State)

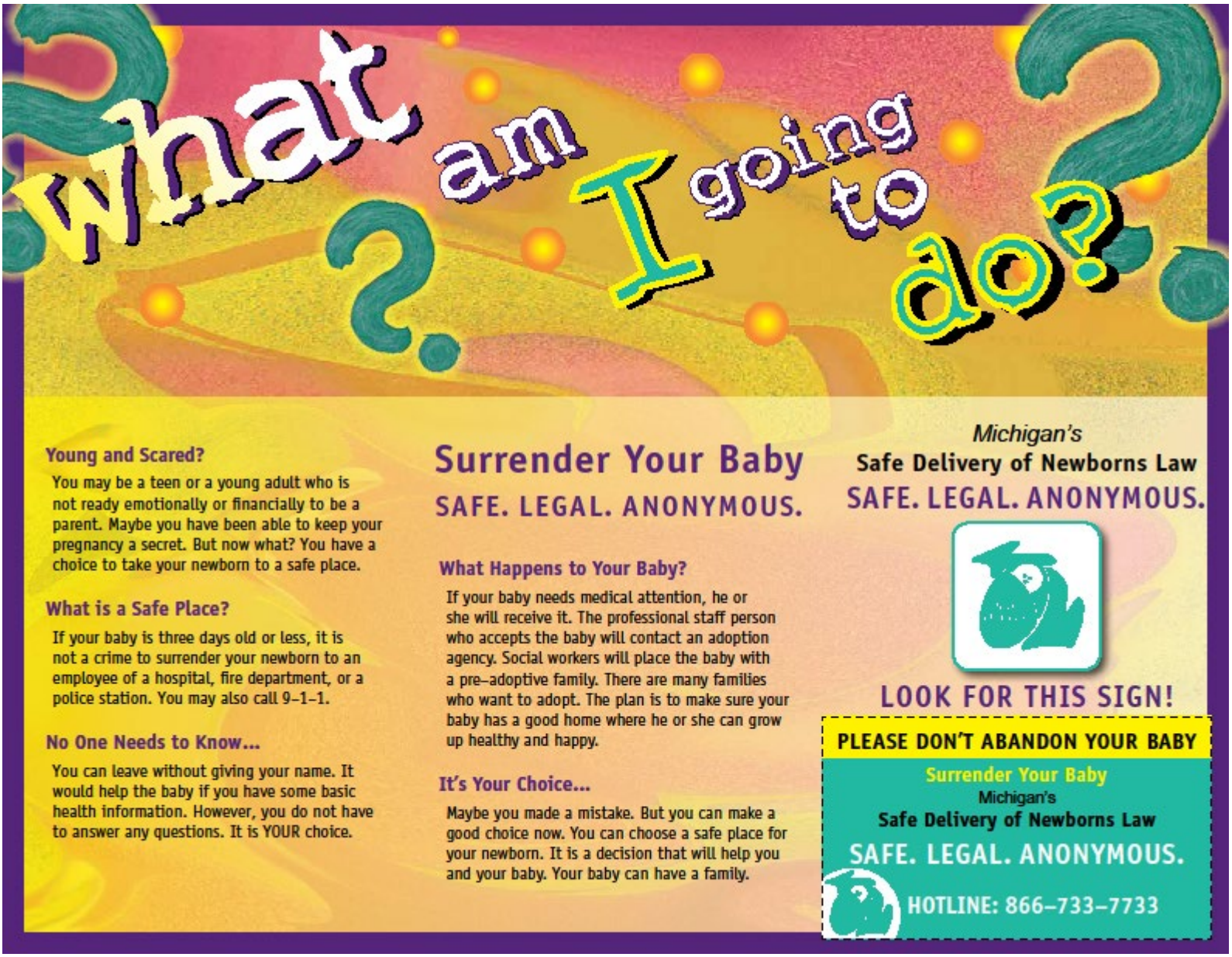
My commission expires: _____ (Date) Signature: _____

_____
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

Complaint Investigation & Resolution

Purpose: This policy is provided as a means to receive, investigate, and resolve complaints regarding licensees falling under the purview of the Medical Control Authority (MCA).

I. Definitions:

A. Allegation/Complaint Invalid:
The allegation or compliant was found to have no administrative rule or protocol violation or the protocol deviation was considered acceptable for the situation.

B. Allegation Valid Minor:
This can be viewed two ways:
1. The licensee's role in the administrative rule or protocol violation was small.
2. The result of the administrative rule or protocol violation had a minor effect.

C. Allegation Valid Serious:
This can be viewed two ways.
1. The licensee's role in the administrative rule or protocol violation was great.
2. The result of the administrative rule or protocol violation had a major effect.

D. Appeal Hearing:
A hearing to appeal an Order of Disciplinary Action. This hearing is to re-examine any new facts and/or review the incident to ensure due process has been followed.

E. Order of Disciplinary Action (ODA):
An Order of (ODA) is a written document developed by the MCA and sent to a subject licensee for the purposes of clearly and plainly identifying the findings of the MCA, any disciplinary action and any required remediation.

F. Complaint:
For the purpose of this policy, a complaint shall be defined as any notification of dissatisfaction or concern regarding medical care rendered by the MCA licensed EMS provider/agency, or any issues that involve the performance of the EMS system in whole or in part.

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

H. Formal Inquiry:
Formal inquiry means that a complaint has been found to either be valid, or that more detailed inquiry is necessary to determine the validity of the complaint; either of which will require that the subject licensee (individual/agency) be notified of the specific complaint. A formal inquiry may involve the gathering of incident reports which provide explanations for care rendered or justification for actions, as well as subject/witness interviews. Some information gathering may not necessitate a formal inquiry.

I. Just Culture Guidelines:
A just culture policy is a high-level statement of the values and commitment of an organization to treat healthcare workers and agencies fairly in all complaint investigations.

J. Licensee:
A licensee is defined as an individual or an agency (fire department, rescue squad, life support agency, etc.) holding a valid State of Michigan Medical First Responder, Emergency Medical Technician, Specialist, Paramedic, or agency licensed to operate within the Medical Control Authority service area. Said individual licensee shall be an employee of a provider licensed to operate within the Medical Control Authority.

K. Privileged Documents:
Privileged documents are those which are collected by the Professional Standards Review Organization (PSRO) of the MCA.

L. Quality Improvement Action:
An action taken to remediate a valid complaint to the MCA.

M. Sentinel Event:
A sentinel event is any complaint which involves at least one single level I infraction, a violation of Michigan or Federal laws, EMS rules, or 2 or more level II infractions, as described in the Medical Incident Review and Corrective Action Policy.

N. Subject Licensee:
The individual provider that is the subject of the complaint received by the MCA

II. Complaints Received:

A. Complaints may be received at the MCA directly, at life support agencies or by individuals. Those in receipt of a complaint which involves violations of protocols, statutes, or administrative rules shall inform the MCA. The MCA will determine if further investigation is necessary.

B. The complainant for a case should be asked if they would like to be contacted by the agency/individual that is the subject of the complaint. This will allow the complainant the opportunity to voice a request to remain anonymous or to allow their information to be provided to the subject of the complaint.

C. All complaints, in order to be considered for action by the MCA, shall meet the following Inclusion Criteria:

1. A complaint may be submitted either verbally or in writing. Hearsay or "second hand" complaints may not be accepted or investigated by the MCA.
2. The complainant must provide the MCA with his/her name, address, and telephone number. A request for anonymity by a complainant shall be honored by the MCA to the extent possible.

3. The complaint must be directed toward a licensee (individual or agency) within the MCA.
4. The complaint must include a potential violation of Michigan or Federal laws, EMS rules, or MCA protocol
    i. All complaint reviews will be based on MCA approved protocols that were approved and active on the date of the EMS call for service.

D. Complaints That Might Not Be Considered
1. Complaints regarding conduct of a licensee, exclusive of medical practice or actions bearing upon medical practice, may be referred to the employer of the individual. These complaints may also be referred to the PSRO for investigation at the discretion of the MCA.
2. MCA reserves the right to retain the complaint investigation.

III. Complaint Delegation:

A. Complaints directed toward an individual acting while employed by an agency outside of the jurisdiction of the MCA shall not be accepted or investigated but will be forwarded, or the complainant directed to, the MCA/agency under whose jurisdiction it does fall.

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

C. Complaints more appropriately investigated at the agency or operational level may be turned over to the life support agency or hospital involved. Investigation results should be reported to the MCA.

IV. Investigation of Complaints:

A. Once a complaint is received by the MCA, the complaint will be assigned to the PSRO.
1. The person(s) charged with complaint investigation will gather information to determine the validity of the complaint, if valid:
    i. The investigator will utilize the following list to determine if the complaint is a formal inquiry or sentinel event. These criteria are for example purposes and do not form an all-inclusive list of potential violations. Violations that are substantively similar in type or severity will fall under the closest, most appropriate classification category.
        1. The following categories of incidents are defined as Level I incidents:
            a. Willful neglect of a patient

b. Abandonment of a patient
c. Failure to obey medical control physician's legitimate orders either by omission or commission in the presence of good communications.
d. Improper and inappropriate care which may result in compromise of wellbeing of the patient.
e. Conviction of a felony or misdemeanor
f. Two or more Level II offenses in any six-month period *
g. Breach of Confidentiality
h. Intentional falsification of EMS documentation, including patient care records.
i. Found to be under the influence of drugs or intoxicants while involved with patient care.
j. Violation of the EMS statute and its attendant rules and regulations, including care outside the scope of practice, as defined by protocol.
k. Practicing in the MCA without a current Michigan EMS provider license.
l. Practicing in the MCA without current privileges on two separate occasions within a single licensure period. Certifications required by the MCA in order to maintain privileges are identified in the **Medical Control Privileges Protocol.**
m. Any other patient care offense resulting from violation of policies, protocols and procedures of similar severity not listed above at the discretion of the EMS Medical Director.
n. Failure to complete prescribed Quality Improvement Actions from a previous incident. (Or see (n) of LEVEL II)
o. Arrest or criminal charges for criminal sexual conduct of any degree, violent crime, drug diversion or illegal possession or distribution of controlled substances.
p. Failure to notify the MCA of a criminal charge, arrest or conviction within 1 business day
q. Gross negligence or willful misconduct

* Time measured from the time of occurrence of the initial incident to the time of occurrence of the succeeding event.

2. The following categories of incidents are defined as Level II incidents:
    a. Failure to adhere to system protocols, policies and procedures that had the potential to negatively impact patient care, as determined by the EMS Medical Director.
    b. Failure of personnel or agency to respond within 96 hours of receipt of requests for information or documentation regarding an incident under investigation by the MCA. A response shall be submitted in writing and with a signed delivery receipt to MCA staff within the allotted time period.
    c. Abuse and/or loss of system equipment due to neglect.
    d. Significant documentation errors
    e. Failure to accurately perform procedures as defined in protocols, policies and procedures.
    f. Failure to check and maintain functional equipment necessary to provide adequate patient care at the level of licensure, the failure of which may lead to an inability to communicate with medical control, inability to administer appropriate medications, or otherwise negatively affecting the ability of the personnel to function at his/her level of training in the field. This includes verification that a sealed drug and IV box, functional monitor/defibrillator, functional airway equipment, etc. are present on the unit.
    g. Improper or unprofessional medical communications including, but not limited to, any violation of Federal Communications Regulations, and falsification of identification during medical communications.
    h. Failure to appear before the EMS Medical Director, designated PSRO committee or MCA Governing Body when so requested by the MCA, as defined in the Complaint Investigation, Quality Improvement and Disciplinary Action Policies.
    i. Furnishing of information known to be inaccurate in response to any official request for information relative to quality improvement activities or other investigations subsequent to this policy.
    j. Two or more orders of disciplinary action within a 6-month period **

k. Any other patient care offense resulting from violation of policies, protocols and procedures of similar severity not listed above at the discretion of the EMS Medical Director.
l. Practicing in the MCA without current credentials required in order to maintain privileges, as identified in the Authorization for Medical Control Privileges Policy.
m. Medication error, which has a negative impact on patient care.
n. A determination by the designated PSRO Committee of failure to complete prescribed Quality Improvement Actions within the prescribed time frame.

** Time measured from the time of occurrence of the initial incident to the time of occurrence of the succeeding event.

ii. Will communicate with the employing agency of the subject licensee or agency involved in the complaint.
iii. The PSRO may request copies of documents, incident reports, video and audio recordings relating to a complaint without formal notification of the complaint to the subject licensee and/or agency.
iv. All requests for information will be documented in the investigation notes or with attached documentation/emails.
v. The agency and/or the individual will have 96 hours to turn over the requested documentation or provide statements the MCA.
vi. The MCA will redact all PHI prior to sending it to the PSRO for review.

2. Complaints found to be invalid will be closed as unsubstantiated; notification to the individual or the agency of the closure will only occur if prior knowledge of the complaint was provided to, or exists with, the involved individual/agency.
3. Formal notification of the subject licensee will occur if MCA Quality Improvement Actions, formal inquiry, or sentinel are indicated. A copy of the initial complaint, or a complaint summary (if the initial complainant requested anonymity), may be provided upon request.

B. Documentation

The documentation of the investigation of a complaint may include, but is not limited to, the following:

1. The name, address, and telephone number of the complainant (if known)
2. A copy of the stated complaint
3. The date and time of the receipt of the complaint
4. A copy of the complaint acknowledgement, if appropriate.
5. A copy of the notice to the subject licensee, if appropriate.
6. A copy of the pertinent protocol(s) and/or policy/policies.

7. Written statements of witnesses including notes from telephone interviews
8. Copies of pertinent reports, transcriptions of audio tapes; video recordings and copies of other pertinent documents or emails.

V. Due Process:

This policy establishes the initial steps of Due Process. A complaint will be investigated for validity and severity. Subject licensees and agencies shall be notified of formal or sentinel reviews.

A. The MCA will provide at least 4 business days notice to affected providers and agencies prior to convening PSRO meetings to which they must attend.
B. The MCA will provide a copy of the Complaint Investigation Protocol to the subject licensee(s) of the complaint.
C. Subject licensee(s) and agencies of a complaint will be provided with copies of all, complaint/investigation related materials at the time of the meeting with the exception of materials that would reveal the identity of an individual that provided information under the condition of anonymity. The subject licensee or agency may request the complaint/investigation related materials in advance of the PSRO meeting.
D. Based on the complaint information and/or evidence the MCA Medical Director may temporarily suspend the privileges of a subject licensee or agency pending a sentinel event meeting.
    1. Any MCA suspension enacted as a measure to ensure the safety of the community or patients shall remain in effect pending sentinel event review and disposition.
    2. In the event of criminal charges being filed against a provider or agency related to acts of violence, diversion of medications, illegal possession of controlled substances, criminal sexual conduct, or other practice which may pose a threat to the community or patients, the MCA may act with suspension of MCA privileges without convening a sentinel event 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 considered to be revoked.
        c. If found not guilty of charges, the individual or agency must provide copies of court documents, including transcripts, to the MCA.
        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 should occur at a sentinel event meeting.
E. A subject licensee or agency may request a postponement of up to thirty (30) calendar days of a PSRO meeting appearance in order to prepare his/her individual or agency response to the complaint. The subject licensee must submit

a copy of all supporting documentation to the MCA at least one week (5 business days) prior to the postponed review meeting.

F. The MCA is not a hiring entity and is not subject to collective bargaining. Union representation during MCA PSRO reviews is not permitted.
G. The MCA's PSRO investigates incidents, complaints, personnel and agencies. While a deed or misdeed may be civil or criminal in nature, the MCA's PSRO is not an adjudicating body for either of these conditions. The PSRO is not subject to the rules and statutes which govern civil or criminal adjudication; as such, attorneys and legal representatives are not permitted in PSRO reviews.
H. Recording, monitoring, or any manner of duplicating a PSRO review is not permitted unless conducted by the PSRO entity and expressly for PSRO purposes.
I. Disclosure of confidential PSRO materials[1] by individuals or agencies both before and after review shall be cause for possible suspension or revocation of MCA privileges, as well as possible statutory violations.
J. The MCA may disclose non-specific information relating to discipline of individuals or agencies. Care must be taken to not compromise any confidential information.[2]
K. Subject licensees or agencies may have agency representation at PSRO reviews provided PSRO standards are maintained.
L. Subject licensees or agencies failing to appear for PSRO reviews waive their right to representation and are subject to the summary findings of the review body. Failure to appear also constitutes a violation as defined in the Incident Classification Section.
M. The following steps shall be taken in the complaint review process for Formal Inquiries where the allegations could lead to an Order of Disciplinary Action be prescribed by the PSRO and ALL Sentinel Events:
    1. The violation of policy or protocol shall be defined.
    2. The impact on patient outcome will be evaluated.
    3. The subject licensee shall be given time to speak on the issue of the complaint including the opportunity to present supporting documentation.
    4. Counseling, remedial, and/or disciplinary action shall be considered and/or ordered as deemed appropriate by a majority vote of the MCA or their designated and pre-established Professional Standards Review Organization/Quality Review Committee.
N. The PSRO of the MCA will review the alleged violation(s) and by majority vote of the members present decide a course of action.
    1. All alleged violations will be determined as the following for each individual subject licensee and/or agency.
        a. Invalid

[1] MCL 331.533
[2] MCL 331.533

b. Valid – Minor
c. Valid – Serious

O. All valid allegations shall be followed by a Quality Improvement Action.
P. All system failures shall be addressed by the MCA.
Q. Subject licensees or agencies shall be notified of the findings of a PSRO review. If disciplinary action results, the individual or agency will be provided with any required remediation steps/actions and a copy of the **Disciplinary Action Appeal Protocol**.
R. In the event that a complaint/investigation involves both the function of an individual and the compliance of their agency or department, the requirement for a 4-business day notice of any special meeting shall apply, unless a postponement is granted to the individual agency or subject licensee.

VI. Application 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 licensees maintain an appropriate level of clinical and operational performance.
D. MCAs should utilize Just Culture when applying or considering Quality Improvement Actions. There should be a balance between provider and system accountability.
E. The subject 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.

VII. Orders of Quality Improvement Action:

A. No Action (Warning Letter)
   1. A letter can be sent to the subject licensee or agency or individual advising them that although the incident was determined to be valid; there will be no action taken at this time.
   2. The MCA may provide recommendations to prevent future occurrences.
B. Remediation
   1. The Medical Control Authority may issue an order of remediation to correct substandard clinical performance.
   2. A defined time period for completion of remedial activity shall be stated in the order.
   3. Subject licensees or agency shall be required to perform remedial activity under the supervision of an appointed proctor to correct an identified performance shortcoming.

4. For subject licensee(s): Notice of a remedial order, or the order itself, shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
5. A subject licensee or agency shall be allowed only one opportunity for remediation of repetitive substandard performance in a twelve-month period. Subsequent episodes of substandard performance of the same nature occurring within the same twelve-month period shall be addressed under the disciplinary portion of this policy.

C. Probation which does not include a restriction of privileges:
1. A probationary letter shall be issued to a subject licensee or agency stating
   a. the details of the substandard performance
   b. the details of the probation
   c. the remedial action required
   d. the time of probationary period
   e. the consequences for repetitive noncompliance
2. Notice of probationary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).

D. Order of Disciplinary Action
1. An Order of Disciplinary Action (ODA) is a written document developed by the MCA and sent to a subject licensee for the purposes of clearly and plainly identifying the findings of the MCA, any disciplinary action and any required remediation.
2. ODAs include, but are not limited to, written reprimands, written notice of suspension, written notice of revocation, a letter of warning and a letter of reprimand.
3. The ODA must be delivered in a way that confirmed receipt by the licensee may occur.
4. The licensee that receives an ODA must provide a copy to all MCAs in which they are privileged.
5. Licensees receiving an ODA from another MCA must provide a copy of the ODA to this MCA.
6. An Order of Disciplinary Action may be accompanied by assignment of additional remedial activity.
7. Temporary Suspension of Privileges
   a. The Medical Director may temporarily suspend a licensee's privileges in cases where there is a clearly definable risk to the public health and welfare. The Medical Control Authority shall review such action within three business days after the Medical Director's determination.
   b. If a licensee's MCA privileges have been temporarily suspended from a licensee, the licensee shall not provide prehospital care until MCA privileges are reinstated.
8. Written Reprimand
   c. A written reprimand shall be issued to a licensee stating
      1. the details of the substandard performance
      2. the remedial action, if required

3. the time allowed for completion of remedial action
4. the consequences for repetitive noncompliance

d. Notice of disciplinary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
e. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

9. Probation – that includes restriction of privileges:
   a. A probationary letter shall be issued to a licensee stating
      1. the details of the substandard performance
      2. the details of the probation
      3. the remedial action required
      4. the restriction of privileges, if applicable
      5. the time of probationary period
      6. the consequences for repetitive noncompliance
   b. Notice of probationary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
   c. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
10. Suspension of Privileges - A licensee's medical privileges shall be suspended for a specified period of time.
   a. A written notice of the suspension shall be issued to the licensee stating:
      1. the details of the substandard performance
      2. the violation(s) of protocol and/or policy
      3. the term of suspension
      4. the remedial activity, if required
      5. the time allowed for the completion of the remedial activity
   b. Notice of disciplinary action shall be forwarded to the licensee's employer, if employed (or MCA board in the case of an agency provider).
   c. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
   d. If a licensee's MCA privileges have been suspended from a licensee, the licensee shall not provide prehospital care until the MCA privileges are reinstated.
   e. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.
11. Revocation of Privileges
   a. The notice of revocation shall state the violation(s) of protocol and/or policy.
   b. Notice of disciplinary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
   c. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

d. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.
e. Within one (1) business day of the removal of medical control privileges, the Medical Control Authority must notify all other Medical Control Authorities which it knows, or has reason to believe, have granted the licensee or agency Medical Control privileges.

E. A subject licensee and/or agency must notify the MCA of disciplinary action from the State of Michigan.
F. Additional Agency Quality Improvement Actions
   1. The Medical Control Authority will notify the department chief or agency official of the alleged protocol violation.
   2. If a minor protocol violation is determined by the Medical Control Authority to have occurred, a letter of warning will be sent to the EMS agency.
   3. If an initial serious violation or a second minor protocol violation within a six-month period is determined to have occurred, a letter of reprimand will be sent and the EMS agency may be required to submit, within 15 days, a written statement of actions it will take to prevent future protocol violations.
   4. At the discretion of the Medical Control Authority, notice of these actions may be made public.
   5. The MCA may assess restrictions or limitations upon a licensed life support agency for non-compliance with protocols.
   6. If a third of more frequent minor protocol violation is determined by the Medical Control Authority to have occurred within a period of 18 months, or if the violation is a second serious violation within 18 months, the Medical Control Authority may suspend or revoke its medical control oversight for the EMS agency. The EMS agency shall not provide pre-hospital care until medical control is reinstated. At its discretion, the Medical Control Authority may take any other action within its authority to prevent further protocol violations. Notice of this action shall be made public.
   7. An EMS agency may appeal a decision of the Medical Control Authority. The EMS Agency must follow the **Disciplinary Action Appeal** policy.
G. The complainant shall, to the extent allowed under confidentiality statutes, be notified of the outcome of the complaint review process.
H. Reapplication after Revocation
   1. Following revocation of an involved party's privilege to practice in the MCA, the involved party may reapply to the MCA for privileges after no less than 24 months have elapsed from the date of revocation. Those issued a permanent revocation may not reapply for privileges at any time.
I. Financial Penalties

   The MCA may not apply financial penalties to individuals, per this policy. No such prohibition exists within statute; however, the MCA wishing to establish individual financial penalties must purposely develop an addendum to this policy.

J. PSRO Communications

PSRO protected entities may share PSRO information with other PSRO entities for the following purposes[3]:

1. To advance health care research or health care education.
2. To maintain the standards of the health care professions.
3. To protect the financial integrity of any governmentally funded program.
4. To provide evidence relating to the ethics or discipline of a health care provider, entity, or practitioner.
5. To review the qualifications, competence, and performance of a health care professional with respect to the selection and appointment of the health care professional to the medical staff of a health facility.

Protocol Source/References: [1] MCL 331.532

Disciplinary Action Appeal

Purpose: This protocol is provided to define the steps a licensee must take to appeal an order of disciplinary action issued by the Medical Control Authority.

I. Procedure
   A. A licensee having received an Order for Disciplinary Action (ODA) from the Medical Control Authority (MCA) may initiate a Request to Appeal.
   B. A licensee shall notify the MCA within seven (7) days of receipt of notice of an ODA of his/her/their request to Appeal. Such notice shall be in writing.

II. Appeal Hearing
   A. Upon receipt of a Request to Appeal an ODA, the MCA shall schedule a special meeting for the purpose of hearing an appeal. This meeting shall be scheduled as soon as practicable following receipt of a Request to Appeal.
   B. The receipt of a Request to Appeal does not stay the ODA or the imposition of the discipline on the appellant licensee.
   C. The MCA shall honor a request to postpone an appeal hearing, no later than thirty (30) days past the originally scheduled hearing date, to allow the appellant licensee opportunity to assemble information bearing upon his/her/their appeal.
   D. The MCA shall hold an appeal hearing to review the appellant licensee's new information and exercise one of the following options:
      1. Uphold the original decision and subsequent ODA.
      2. Diminish the ODA to a lesser Disciplinary Action (i.e., suspension of privileges diminished to written reprimand).
      3. Revoke the ODA (revocation of an ODA shall not expunge the appellant's record of the complaint process records for a period to twelve (12) months from date of original incident).
   E. Following exhaustion of the procedure stated herein, an appellant 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). An appeal must be filed with the Department of Health and Human Services, in writing, no more than 30 calendar days following notification of the final determination by the MCA.
      1. If a decision of the MCA is appealed to the Emergency Medical Services Coordination Committee, the MCA shall make available, in writing, the information it considered in makings 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.

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