Cancellation/Downgrade of Call Policy

Purpose: To allow cancellation or 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,

or

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

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).

Use of Emergency Lights and Sirens during Transport

Procedure

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.

B. **Transporting a Patient**
1. EMS units may transport patients using lights and sirens when:
   2. The patient's condition meets Priority One prioritization level **AND** the condition is unstable or deteriorating **AND** there is a need to circumvent significant traffic delays and obstructions
   OR
   3. The patient's condition requires immediate lifesaving intervention which cannot be accomplished by EMS personnel, with approved equipment **AND** there is a need to circumvent traffic delays or obstruction

2. Non-emergency patients will **NOT** be transported with the use of lights and siren.

C. **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.

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**
Transporting Life Support Agencies shall ensure annual training surrounding the Michigan Motor Vehicle Code, safe use of lights and siren, this policy and related agency polices.

G. **Agency Specific Policies**
This policy does not preclude individual agencies from developing internal policies on this subject, as long as the policy includes the contents of this policy as a minimum.

Destination and Diversion Guidelines

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

1. **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 protocol.

   B. In matters which are not a threat to life or limb, the patient will be taken to the closest appropriate facility or facility of his/her choice, unless:

      a. The patient is a minor, or incompetent, the family or guardian may choose the destination facility.

      b. Transportation to the chosen facility removes the EMS vehicle from the service area for an extended time. Consult medical control and an alternative may be considered.

   C. No other individuals are permitted to determine destination of patient without prior approval of on-line medical control: (police, fire, bystander physician, etc.)

2. **Patient Diversions**

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

      a. On-line medical control requests diversion to another facility. The facility may not deny the individual access unless it does not have the staff or resources to accept the patient.

      b. The patient experiences an imminent threat to life or clinical deterioration and, in the medical judgment of the EMS personnel, the patient may be transported to the closest appropriate facility.

      c. 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 receiving facility.

C. Contact with the initial receiving facility shall be made as quickly as possible to inform it of the diversion.

D. Patients requesting transport to a facility, which is currently on diversion, should be notified of that diversion and the fact 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. 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. By statute, the medical control authority, based on needs of the EMS system, may determine the destination of the patient regardless of the diversion status (open or closed) of the local facilities.

High-Risk Delivery Transport Guidelines

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

1. In all cases where delivery is imminent, transport will be to the closest emergency receiving facility.

2. If labor is brought on by medical illness or injury of the mother, appropriate medical treatment of the mother is the first priority. This is also the most appropriate treatment of the newborn.

3. If time allows, any woman in active labor with a gestational period of more than 20 weeks and less than 34 weeks, in anticipation of delivery of a high risk newborn, should be taken to (list facilities and instructions for where to proceed with the patient):

   ☐ Click here to enter text.
   Click here to enter text.

   ☐ Click here to enter text.
   Click here to enter text.

   ☐ Click here to enter text.
   Click here to enter text.

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

Intercept Policy (Optional for all ALS Systems)

Purpose: The purpose of this policy is to ensure that Advanced Life Support/Limited Advanced Life Support ambulances are dispatched, when available, to patients requiring Advanced Life Support/Limited Advanced Life Support levels of care.

I. Procedure
If a transport has begun by a Basic Life Support (BLS) unit, a rendezvous with an Advanced Life Support (ALS) (Limited Advanced Life Support if ALS unit not available) unit should be attempted at a mutually agreed upon location. Rendezvous is indicated if it will occur at a point which is greater than five (5) minutes from the receiving hospital. For patients in cardiac arrest being transported in BLS units, ALS intercept is indicated at any point during the transport.

A. Indications for ALS Intercept
1. All priority 1 & 2 patients

B. Indications for LALS
1. All Priority 1 patients & some Priority 2 patients as indicated by Medical Control.

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

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 provided with complaint evaluation and prioritization, along with pre-arrival instructions through an Emergency Medical Dispatch program approved by the MCA. Pre-arrival instructions should conform to nationally recognized guidelines.

Lights and Sirens Response to the Scene

I. Medical Priority Response
   A. Priority One – Life-Threatening or Potentially Life Threatening Emergencies Response
      1. Life support vehicles, in compliance with Michigan Motor Vehicle Code, use lights and sirens while responding to the scene.
   B. Priority Two – Response Per MCA Selection

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

☐Emergency Vehicles, in compliance with Michigan Vehicle Code, respond with no lights and sirens to the scene

OR

☐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.

   C. Priority Three - Non-Life Threatening Emergency Response
      1. Life support vehicles, in compliance with Michigan Motor Vehicle Code, respond with no lights and sirens to the scene

Patient Prioritization

1. Priority 1
    A. Critically ill or injured patient with an immediate life-threatening condition.
    B. Examples include, but are not limited to:
        1. Unstable or deteriorating vital signs
        2. Compromised airway
        3. Severe respiratory distress/failure
        4. Cardiac arrest or post cardiac arrest
        5. Stroke or STEMI
        6. GCS ≤ 10
        7. Significant blunt or penetrating trauma including but not limited to:
            a. Airway compromised
            b. Respiratory distress
            c. Signs of inadequate perfusion
        8. Actively seizing patient

2. Priority 2
    A. Seriously ill or injured patient without immediate life-threatening Condition.
    B. Examples include, but are not limited to:
        1. GCS 11-14
        2. Medical conditions such as chest pain, suspected sepsis, respiratory distress without immediate threat to life.
        3. Altered level of consciousness, responding to verbal or painful stimuli
        4. Significant mechanism of injury in patient with stable vital signs

3. Priority 3
    A. Ill or injured patients not fitting the above two categories who require medical attention and do not have a life-threatening problems.

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 and the level of care available in the area.

A. Trauma Patients
   1. Priority I patient
   2. Long transport times
   3. Poor road conditions
   4. Entrapment with prolonged extrication

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

II. Procedure

A. Request for helicopter service response may be approved by medical control or by medical control pre-approved guidelines.

B. Requests for helicopter by medical control or dispatch procedure.

C. 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.

D. Communications
   1. Communication with the helicopter dispatch should include information regarding location, identifying marks or vehicles and landing sites.
   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.

E. Landing Site
   1. Locate a level, 100’ x 100’ area clear of obstacles (i.e. wires, trees)
   2. Mark landing zone with a marker at each corner and one upwind.
   3. Public safety vehicles should leave on flashers to assist in identifying site from the air.
   4. Identify obstacles close to the landing zone and communicate all pertinent information about the landing zone to the flight crew.
   5. Landing zone personnel will communicate by radio with the flight crew.

F. Safety
   1. Under no circumstances should the helicopter be approached unless signaled to do so by the pilot or flight crew.

2. Always approach the helicopter from the front. Under no circumstances should the helicopter be approached from the rear due to the extreme danger of the tail rotor.
3. Loading and unloading of the patient is done at the direction of the flight crew.
4. Crews should crouch down when in the vicinity of the main rotor blades.

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

H. Quality Assurance
1. Helicopter services will forward copies of their patient care record to the Medical Control Authority for each scene call upon request. The Medical Director may review all helicopter activations for appropriateness.

Communicable Disease

NOTE: The EMS provider must recognize that any patient that presents with one of the following may be potentially infectious, and must take the necessary precautions to avoid secondary exposure. These precautions include following this protocol.

- A skin rash
- Open wounds
- Blood or other body fluids
- A respiratory illness that produces cough and/or sputum

Exposure Defined:

An exposure is determined to be any breach of the skin by cut, needle stick, absorption or open wound, splash to the eyes, nose or mouth, inhaled, and any other parenteral route.

Reporting Exposures:

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 or 419, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a Bureau of EMS, Trauma and Preparedness Form J427 (MDCII Form J427). The exposed individual should also report the exposure in accordance with their employer's policies and procedures.

Follow appropriate infection control procedures.

1. If a patient presents with one of the following symptom complexes, then follow the remainder of this protocol.

    A. Fever > 100.5 F with headache or malaise or myalgia, and cough or shortness of breath or difficulty breathing.

    B. Pustular, papular or vesicular rash distributed over the body in the same stage of development (trunk, face, arms or legs) preceded by fever with rash progressing over days (not weeks or months) and the patient appears ill.

2. Consider the patient to be both airborne and contact contagious. Crew will don the following PPE:

    A. N95 or higher protective mask/respiratory protection

    B. Gloves

    C. Goggles or face shield

DO NOT REMOVE protective equipment during patient transport.

3. Positive pressure ventilation should be performed using a resuscitation bag-valve mask. If available, one equipped to provide HEPA or equivalent filtration of expired air should be used. Also see the section in this protocol “Mechanically Ventilated Patients".

4. Patient should wear a paper surgical mask to reduce droplet production, if tolerated.

5. Notify the receiving facility, prior to transport, of the patient's condition to facilitate preparation of the facility and institution of appropriate infection control procedures.

6. Hands must be washed or disinfected with a waterless hand sanitizer immediately after removal of gloves. Hand hygiene is of primary importance for all personnel working with patients.

7. 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.

8. Patients should also be encouraged to use hand sanitizers.

9. Unless critical, do not allow additional passengers to travel with the patient in the ambulance.

10. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival at destination and disposed of in accordance with the direction from the hospital personnel.

MECHANICALLY VENTILATED PATIENTS

PARAMEDIC

1. Mechanical ventilators for potentially contagious patient transports must provide HEPA filtration of airflow exhaust.

2. EMS providers should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive pressure ventilation.

CLEANING AND DISINFECTION

Cleaning and Disinfection after transporting a potentially contagious patient must be done immediately and prior to transporting additional patients. Contaminated non-reusable equipment should be placed in biohazard bags and disposed of at hospital. Contaminated reusable patient care equipment should be placed in biohazard bags and labeled for cleaning and disinfection according to manufacturer's instruction.

INTER-FACILITY TRANSFERS

1. Follow the above precautions for inter-facility transfers.

2. Prior to transporting the patient, the receiving facility should be notified and given and ETA for patient arrival allowing them time to prepare to receive this patient.

3. Clarify with receiving facility the appropriate entrance and route inside the hospital to be used once crew has arrived at the receiving facility.

4. All unnecessary equipment items should be removed from the vehicle to avoid contamination.

5. All transport personnel will wear the following PPE:

    A. Gloves

    B. Gown

    C. Shoe Covers

    D. N-95 (or higher) protective mask

6. Drape/cover interior of patient compartment and stretcher (utilizing plastic or disposable sheets with plastic backing).

7. Place disposable surgical mask on patient

8. Cover patient with linen sheet to reduce chance of contaminating objects in area.

9. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival the receiving destination and disposed of in accordance with the direction from the hospital personnel.

10. 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.

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

Infection Control

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

I. Standard Precautions and Body Substance Isolation (BSI)

A. 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, and breast milk.

B. Rationale: Since medical history and examination cannot reliably identify all patients infected with HIV, or other bloodborne pathogens, blood and body fluid precautions shall be consistently used for all patients. This approach, previously recommended by the CDC, shall be used in the care of all patients. This is especially important in the emergency care settings in which the risk of blood or body fluids exposure is increased and the infection status of the patient is usually unknown.

1. Standard Precautions/BSI shall be done for every patient if contact with their blood or body fluid is possible, regardless of whether a diagnosis is known or not. This includes but is not limited to starting IVs, intubation, suctioning, caring for trauma patients, or assisting with OB/GYN emergencies.

C. Procedures

1. Handwashing shall be done before and after contact with patients regardless of whether or not gloves were used. Hands contaminated with blood or body fluids shall be washed as soon as possible after the incident.
2. Nonsterile disposable gloves shall be worn if contact with blood or body fluids may occur. Gloves shall be changed in-between patients and not used repeatedly.
3. Outerwear (example: gown, Tyvek® suit, turnout gear) shall be worn if soiling clothing with blood or body fluids may occur. The protection shall be impervious to blood or body fluids particularly in the chest and arm areas.
4. Face Protection (including eye protection) shall be worn if aerosolization of blood or body fluids may occur (examples of when to wear include: suctioning, insertion of endotracheal tubes, patient who is coughing excessively and certain invasive procedures).
5. Mouth-to-mouth resuscitation: CDC recommends that EMS personnel refrain from having direct contact with patients whenever possible, and that adjunctive aids be carried and utilized. These adjunctive aids include pocket masks, face shields or use of BVM.
6. Contaminated Articles: Bag all non-disposable articles soiled with blood or body fluids and handle according to agency procedures. Wear gloves when handling soiled articles. Bloody or soiled non-disposable articles shall be decontaminated prior to being placed back into service. Refer to manufacturer's recommendations for proper cleaning and disinfecting. Non-disposable equipment shall be decontaminated appropriately prior to reusing.

Bloody or soiled disposable equipment shall be carefully bagged and discarded.

7. Drug/IV Bags shall be inspected and all contaminated waste removed prior to bag exchange. If the bag is contaminated, it must be spot cleaned or laundered prior to being placed back into service.
8. Linens soiled with blood or body fluids shall be placed in appropriately marked container. Gloves shall be worn when handling soiled linens.
9. Needles and syringes shall be disposed of in a rigid, puncture-resistant container. Any grossly contaminated container, or one that is within 1" of the top, should be disposed of appropriately.
10. 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. Wear gloves when cleaning up such spills.
11. Routine cleaning of vehicles and equipment shall be done. Cleaning and disinfecting solutions and procedures shall be developed by provider agencies following manufacturer's guidelines and CDC recommendations.

D. Respiratory Isolation
   1. In the event of a suspected or confirmed TB patient, an appropriate HEPA mask must be worn, in accordance with MIOSHA regulations.
   2. Decontamination of equipment and vehicle after exposure to a patient with a known or suspect respiratory route of transmission shall be carried out following manufacturer's recommendations and CDC guidelines or as described in the text Infection Control Procedures for Pre-Hospital Care Providers.

II. Radio Communications
   A. Anytime the unit and/or dispatcher is made aware of the potential for any communicable disease, that information should be communicated in a format that ensures that patient confidentiality is adhered to.

III. EMS Personnel Exposure to a Communicable Disease
   A. Definition of a Reportable Exposure
      1. Contaminated needle or sharp instrument puncture
      2. Blood/body fluid splash into mucous membrane including mouth, nose, and eye
      3. Blood/body fluid splash into non-intact skin area
   B. 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 the form DCH-1179(E) 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).

C. 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.

D. 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.

E. Summary of EMS Personnel Post-Exposure Procedures
   1. Wash exposed area very well.
   2. Affected personnel may notify ED staff of potential exposure, but ED staff may choose not to test patient until potential exposure confirmed by Medical Control.
   3. Notify agency supervisor of possible exposure.
   4. Fill out form DCH-1179(E) and forward to Medical Control.
   5. Supervisor contacts Medical Control to request source patient testing.
   6. Medical Control contacts hospital personnel to request source patient testing.
   7. Provider obtains exposure evaluation and counseling.
   8. Medical Control reviews form DCH-1179(E) for completeness and forwards to hospital infection control office.
   9. Hospital infection control office returns form with tests results to EMS agency supervisor.

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. A written report describing the situation, actions taken, and description of the communication failure shall be provided to the medical control within 24 hours.

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

Initial Date: 09/2004
Revised Date: 10/25/2017 Section: 8-13

Waiver of EMS Patient Side Communication Capabilities

The State of Michigan requires advanced life support (ALS) units to have the capability of communicating by radio with medical control when away from the ALS vehicle at the patient's side. This requirement may be waived when State-approved protocols permit time-dependent medical interventions to be performed without the need to obtain on-line permission from medical control. The EMS Medical Director must indicate that local state approved protocols permit these interventions to be performed without online medical control authorization either directly in protocol, or through the **Communications Failure Protocol**.

By adopting and implementing this protocol, both the medical director and alternate medical director stipulate that life-saving interventions listed in protocol are permitted to be performed by providers without on-line medical control authorization as defined by protocol.

Health Insurance Portability Accountability Act (HIPAA)

Purpose:

I. To provide a guideline 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.

Inter-facility Patient Transfers and Critical Care Patient Transports (Optional)

Purpose: The purpose of this policy is to establish a uniform procedure for inter-facility transfers.

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. If unanticipated events occur during patient transport, and contact with the transferring physician is not possible, then on-line Medical Control will serve as a safety net.
    E. It is the transferring physician's responsibility to know and understand the training and capabilities of the transporting EMS personnel.

2. Transportation
    A. Pre-transport
        a. Care initiated by the transferring facility may need to be continued during transport. The transferring physician will determine the method and level of transport and any additional treatment(s), if any, that will be provided during the course of transport.
        b. Orders for treatment, including medications for ALS transfers, or other orders shall be provided in writing to the EMS personnel prior to initiation of the transport by the transferring Physician.
        c. For ALS transfers, ordered medications not contained within the EMS System Medication Box/Bag must be supplied by the transferring hospital.
        d. EMS personnel must be trained in all the equipment being used in the patient's care or appropriately trained staff must accompany the patient.
        e. Should the patient require care and/or equipment above and beyond the normal scope of practice and training of the EMS personnel, the transferring facility shall provide appropriate staff or consider other appropriate means of medical transportation.
        f. The paramedic has the right to decline transport if he/she is convinced patient care is outside their scope of practice and training or, alternatively, to insist a hospital staff member accompany them on the transfer or consider other appropriate means of medical transportation.
        g. If additional staff accompanies the patient, the transferring physician is responsible for ensuring their qualifications. This staff will render care to the patient under the orders of the transferring physician. It will be the

responsibility of the transferring facility to provide arrangements for the return of staff, equipment, and medications.

h. 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. 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. In the event that a patient's condition warrants intervention beyond the written Physician orders provided by the transferring Physician, the EMS personnel will contact the transferring Physician. If that is not possible, the EMS personnel will follow local Medical Control Protocols and initiate contact with the on-line Medical Control Physician from either the sending or receiving facility or, if not able to contact those facilities, the closest appropriate on-line Medical Control facility.

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**)

Critical Care Patient Inter-Facility Transport (OPTIONAL) Additional Requirements

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.

1. Vehicle and Staffing Policy
    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
        e. 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.
        f. 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

CRITICAL CARE PATIENT INTER-FACILITY TRANSPORT CURRICULUM

COURSE OUTLINE

1. Ventilator patient concerns (4 hours total)
    A. Types of ventilators
    B. IPPB, SIMV, PEEP, CPAP
    C. Use of transport ventilators
    D. Complications
    E. Use of Pulse Oximeter/Capnography
2. Chest Tubes and Pleurovac (1 hour)

    A. Principles of pleural cavity evacuation
    B. Maintaining chest tubes
    C. Review various systems
    D. Pleurovac Practical Lab
3. Maintenance of invasive lines (2 hours)
    A. Types of hemodynamic monitoring
        a. Various equipment
        b. Insertion sites
        c. Maintaining infusions
        d. Complications
4. Equipment Training Videos (1 hour)
    A. IV Pumps
    B. Ventilator
    C. 12 Lead Monitoring
5. Thrombolytics (1 hour)
    A. Indications, contraindications, adverse effects, and administration
        a. Streptokinase
        b. tPA
        c. Retavase
        d. TNKase
        e. Heparin
        f. Lovenox
6. Interpreting blood gases (1 hour)
    A. The use of ABGs in ventilator managements
7. Blood products (1 hour)
    A. Whole blood/Packed RBCs/Plasma
8. Cardiac Enzymes (1 hour)
    A. Cardiac physiology and the meaning of enzyme abnormalities
9. Vasoactive drugs (2 hours)
    A. Indications, contraindications, adverse effects, and administration
        a. Dopamine
        b. Epinephrine
        c. Dobutamine
        d. Levophed
        e. Amrinone/Milrinone
        f. Nitroglycerin
        g. Nitroprusside

h. Esmolol
i. Labetalol

10. Critical Care Patient Transport Protocol Review (1 hour)
    A. Protocol review and miscellaneous drugs
        a. Indications, contraindications, adverse effects, and administration
            1. Aminophylline
            2. Mannitol
            3. Phenytoin
            4. Insulin
            5. Propofol
            6. Oxytocin and related drugs
11. Paralytics (1 hour)
    A. Indications, contraindications, adverse effects, and administration
        a. Non-depolarizing neuromuscular blockers
        b. Sedatives during paralytic maintenance
        c. RSI indications during critical care patient transport
    B. Administer with Medical Control
12. Practical Lab (1 hour)
    A. IV Pumps
        a. Various tubing
        b. Maintaining a drip while changing to the pump
    B. Ventilator
    C. 12 Lead
    D. CO2 detector
13. Cardiac Physiology/12-Lead ECG (4 hours)
    A. Cardiac physiology and cardiac drug review
        a. Indications, contraindications, adverse effects, and administration
            1. Lidocaine/Procainamide
            2. Potassium
            3. Morphine
            4. Cardizem
            5. Amiodarone
14. 12-Lead AMI Recognition (2 hours)
15. High Risk Pregnancy (1 hour)
    A. Indications, contraindications, adverse effects, and administration
        a. Magnesium Sulfate
        b. Pitocin
16. Antibiotics (1 hour)
17. Pediatrics (4 hours)
    A. Pediatric Airway and Ventilation management including Ventilator Dynamics and Chest Tube Monitoring and pneumothorax recognition and treatment (1 hour)
    B. Pediatric fluid requirements including maintenance and bolus therapies (1 hour)
    C. Pain management (1 hour)
    D. Case studies, trauma specific (1 hour)
18. Critical Care Patient Transport Charting (1 hour)
19. Critical Care Patient Transport Call: Start to Finish (1 hour)
    A. General considerations
    B. Staffing and quality management considerations
    C. When to refuse a call

20. Critical Care Patient Transport Case Presentations (1 hour)
21. Daily Quizzes
    A. Ventilators, chest tubes, invasive lines
    B. Thrombolytics, ABGs, blood, enzymes, pressers, paralytics
22. Written and Practical Exam (4 hours)

Licensure Level Requirement of Attendant during Transport (Optional)

☐ Medical Control Authorities choosing to adopt this protocol may do so by selecting this check box.

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.

   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.

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 patient care record.
   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. Optional Training Standards: mark and specify as applicable

☐ Written Exam
☐ Pre-hospital Trauma Certification (PHTLS, ITLS, FTC)
☐ Practical Competency (EMT Skills)

☐ Practical Competency (Specialist Skills)

☐ Advanced Cardiac Life Support (ACLS)
☐ Pre-hospital Pediatric Certification (PALS, PEPP)
☐ Practical Competency (Paramedic Skills)

☐
☐

IV. 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).

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 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, as defined by Part 209 of P.A. 368 of 1978, as amended, that are up-to-date, 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 if not included in routine EMS education.
   D. 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.

II. Responsibilities of Participating Hospitals Providing On-Line Medical Direction
   A. A hospital within the Medical Control Authority system providing on-line medical direction to EMS providers will assure that any physician designee providing such direction is properly trained and qualified and abide by Medical Control Authority protocols.
   B. Each hospital 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 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 Division approved protocols.
   B. Only persons currently authorized to do so by the Medical Control Authority will provide pre-hospital patient care. Each EMS agency will assure that their personnel have current training and certifications as required by protocol.

C. The Medical Control Authority will be immediately notified if an EMS agency is unable to provide staffing at the level required by its State license.
D. 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.
E. EMS agencies will promptly inform their EMS personnel of Medical Control Authority policy and protocol changes.
F. EMS agencies will provide an annual listing of EMS personnel upon request of the Medical Control Authority. This listing shall note the license and Medical Control Authority authorization status of each individual.
G. 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.

IV. Accountability

A. The State of Michigan, Department of Health and Human Services, Division of EMS and Trauma, designated the Medical Control Authority for a specific region. As such, the Medical Control Authority is accountable to that agency in the performance of its duties.
B. The hospitals within the Medical Control Authority system collectively administer this Medical Control Authority. Each individual hospital 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 to provide on-line medical direction.
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.

Physician on Scene

Purpose: To provide a process for interaction between EMS personnel and physicians at the scene of a medical emergency.

I. Responsibility of Medical Control
   A. "When a life support agency is present at the scene of the emergency, authority for the management of an emergency patient in an emergency is vested in the physician responsible for medical control until that physician relinquishes management of the patient to a licensed physician at the scene of the emergency". MCL 333.20967

   B. The EMS provider is responsible for management of the patient and acts as the agent of the medical control physician.

II. Patient Management in the Presence of an On Scene Physician
   A. The EMS provider may accept assistance and/or advice of the on-scene physician provided they are consistent with medical control protocols. The assistance of an on-scene physician may be provided without accepting full responsibility for patient care, as long as there is ongoing communications and approval by the medical control physician. The medical control physician may relinquish control of the patient to the on-scene physician provided the on-scene physician agrees to accept full responsibility for the patient. Full responsibility includes accompanying the patient to the hospital and completing a patient care record. The EMS personnel should encourage the on-scene physician to communicate with the on-line medical control physician.

   B. The medical control physician may reassume responsibility of the patient at their discretion at any time.

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 must be reported to medical control.

IV. All deviations will be reviewed within the medical control quality improvement program.

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. In any situation in which the scene is not secured, EMS personnel ARE NOT TO ENTER THE SCENE until it has been secured by the appropriate agency.
   A. When responding to an unsecured scene, EMS personnel will stage an appropriate distance away from the scene to protect themselves from danger.

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/or 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 **Contaminated Patient Procedure**

Determination of Death, Death in an Ambulance and Transport of a Body

The intent of this policy is to establish standards for Determination of Death, when patients with Do-Not-Resuscitate (DNR) orders die in an ambulance, or care is terminated for a patient while in the ambulance.

I. Pronouncement/Determination of Death

A. Per the Determination of Death Act (Act 90 of 1992, MCL 333.1033), the MCA may establish which of its medical personnel may pronounce death.[1] Per this policy, paramedics holding MCA privileges, while on duty with a licensed ALS life support agency, with primary or secondary operations within this MCA or while providing mutual aid within this MCA, may pronounce the death of a patient who meets the following criteria:

1. Irreversible cessation of circulatory and respiratory functions
   a) Irreversible cessation of circulatory and respiratory functions is implied when a patient has experienced cardiac arrest and a valid DNR is in place, such that no attempt will be made to reestablish either circulation or respiratory functions.
   b) Irreversible cessation of circulatory and respiratory functions is also implied when a patient meets the criteria established under the **Dead on Scene protocol** or the termination criteria are met under the **Termination of Resuscitation Protocol**.

B. Contact with on-line medical control for the purpose of determination of death or pronouncement is not necessary unless expressly stated in the enabling protocol.

C. Contact with Dispatch for the purposes of recording the death is required.

II. 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 county or city jail.

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.

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[1] MCL 333.1033 (3) A physician or registered nurse may pronounce the death of a person in accordance with this act. This subsection does not prohibit a health facility or agency licensed under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws, from determining which of its medical personnel may pronounce the death of a person in that health facility or agency.

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)

III. 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 only after approval from the ME's office to EMS. 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 in the physical custody of the police or EMS until custody is transferred to the funeral home or the ME's office staff.
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. Police may choose to photograph or document the placement of medical devices, medical equipment, etc. in suspicious situations, prior to their movement or removal.
H. No personal items should be removed from the body with the exception of identification.
I. Bodies may be covered with a burn sheet or other sheet which does not shed fibers.
J. 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.
K. Bodies must be handled with care and respect for the deceased, the family and the public.

IV. 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.

V. Death in an Ambulance – transportation of patient's 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 V.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: 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. 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.
3. The firefighter, police officer, paramedic or EMT personnel cannot refuse to accept the infant and must place the infant under temporary protective custody.
4. 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**

5. 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
6. 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).
7. Fire and Police will 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.
8. Paramedics and EMT responding to a 9-1-1 emergency call will transport newborn to hospital, 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

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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 _____, at _____
Date Agency and Address

_____
Signature

IF A NOTARY IS AVAILABLE: Notary Public

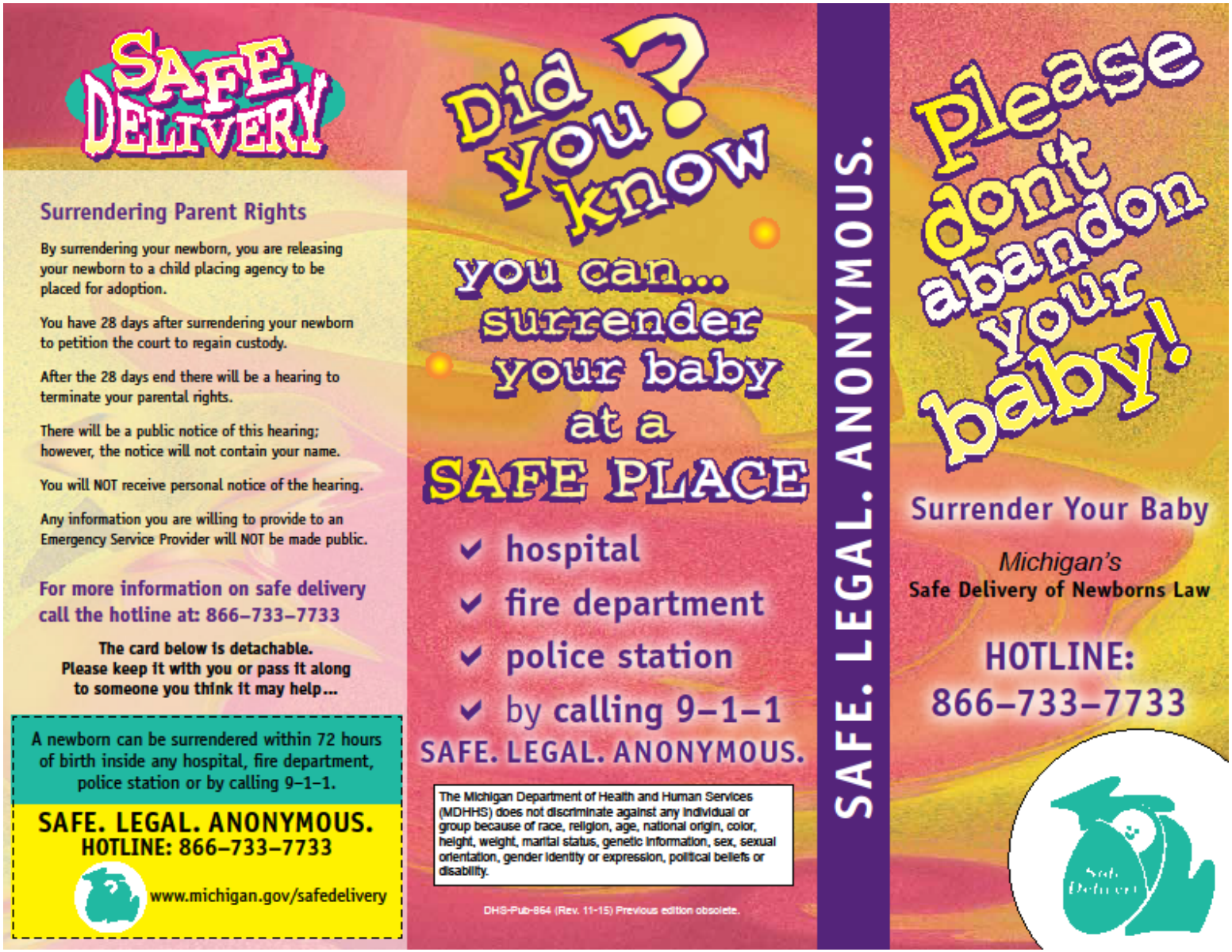
Subscribed and sworn to before me on _____, _____
Date County and State

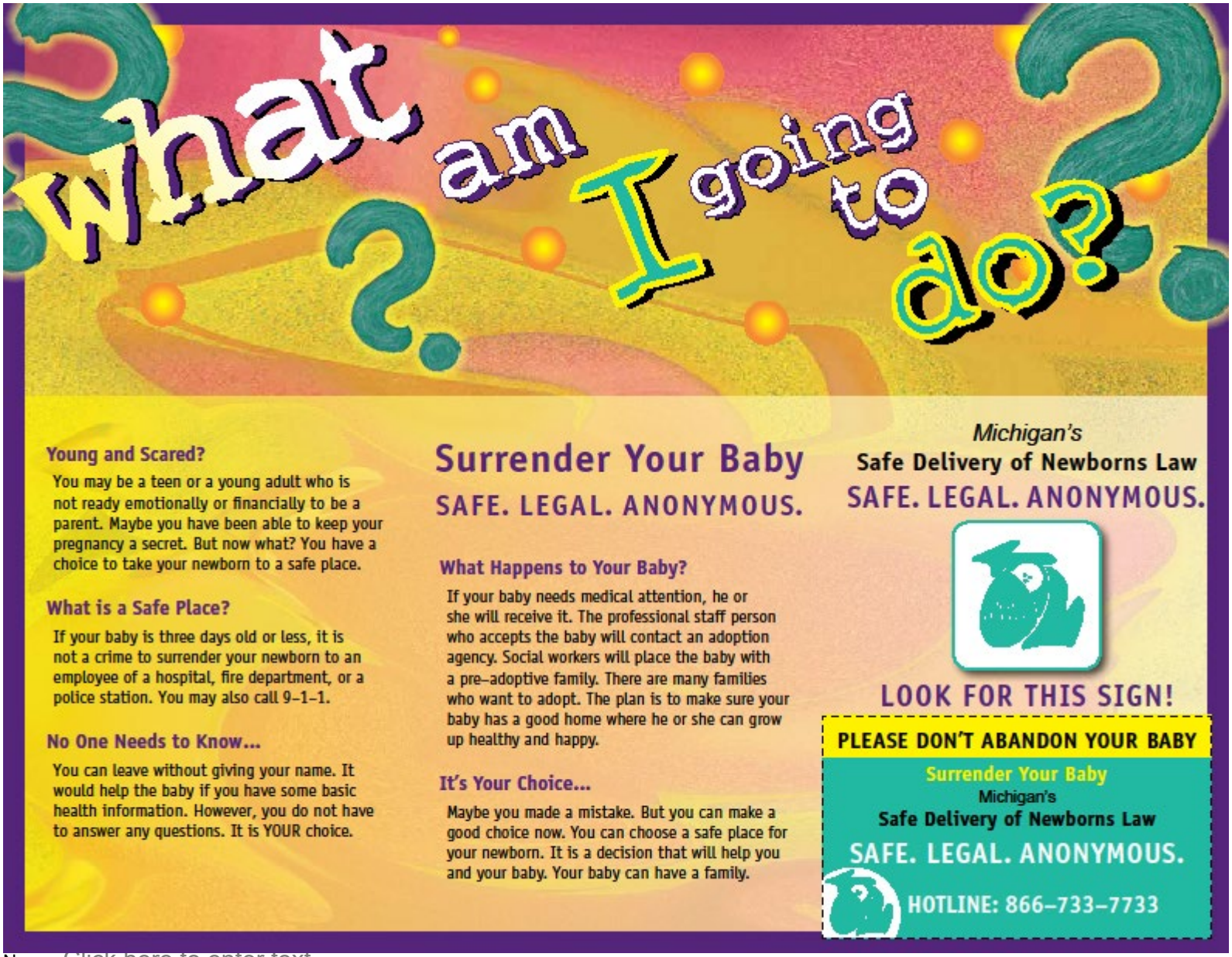
My commission expires: _____ Signature: _____
Date

_____
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. Complaint
      For the purpose of this policy, a complaint shall be defined as any notification of dissatisfaction or concern regarding medical care rendered by a MCA licensed EMS provider/agency, or any issues that involve the performance of the EMS system in whole or in part.
   B. Privileged Documents
      Privileged documents are those which are collected by the Professional Standards Review Organization (PSRO) of the MCA.
   C. 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.
   D. 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. Refer to **Incident Classification Protocol**.
   E. 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.

II. Professional Standards Review Organization of the MCA
   A. The medical control authority shall establish a PSRO to perform its duties and functions related to complaints, investigations or quality improvement activities, both prospective and retrospective.

B. 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.[1]

III. Complaints Which Will be Considered

All complaints, in order to be considered for action by the MCA, shall meet the following criteria:

A. A complaint may be submitted either verbally or in writing. Hearsay or "second hand" complaints may not be accepted or investigated by the MCA.

B. 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.

C. The complaint must be directed toward a licensee (individual or agency) within the MCA.

IV. Complaints That May Not Be Considered

Complaints regarding conduct of a licensee, exclusive of medical practice or actions bearing upon medical practice, shall 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.

V. 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 remediation or discipline, 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.

VI. Receipt of Complaints

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,

[1] MCL §331.531, (Et Seq.)

statutes, or administrative rules shall inform the MCA. The MCA will determine if further investigation is necessary.

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.

VII. Investigation of Complaints

Once a complaint is received by the MCA, the complaint will be assigned to the PSRO. The person(s) charged with complaint investigation will gather information to determine the validity of the complaint and, if valid, will communicate with the employing agency of the subject(s) involved in the complaint. 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. All requests for information will be documented in the investigation notes or with attached documentation/emails.

Formal notification of the subject licensee will occur if MCA disciplinary actions or formal inquiry are indicated. A copy of the initial complaint, or a complaint summary (if the initial complainant requested anonymity), may be provided upon request.

VIII.Documentation

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

A. The name, address, and telephone number of the complainant (if known)
B. A copy of the stated complaint
C. The date and time of the receipt of the complaint
D. A copy of the complaint acknowledgement, if appropriate.
E. A copy of the notice to the subject licensee, if appropriate.
F. A copy of the pertinent protocol(s) and/or policy/policies.
G. Written statements of witnesses including notes from telephone interviews
H. Copies of pertinent reports, transcriptions of audio tapes; video recordings and copies of other pertinent documents or emails.

IX. General Complaint Review

The complaint review process will first seek to identify the validity of each complaint. 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.

Complaints found to be valid, but of a minor or less severe nature may be handled in

cooperation with the agency's quality improvement personnel or management. These incidents may involve education and remediation but may not involve suspension, limitation or revocation of the individual's or agency's privileges to function in the MCA area.

X. Sentinel Event Complaint Review

A sentinel event complaint shall be reviewed by the PSRO at a special meeting called for that purpose. Prior to a review meeting, the subject licensee shall be provided with copies of all documentation gathered regarding the complaint with the exception of any documents that would reveal the identity of an individual who requested anonymity. The licensee will be informed if documents are withheld or summarized to maintain the anonymity of an individual.

The subject licensee (individual/agency) may request a postponement, of up to thirty (30) days, of a special meeting in order to prepare his/her/their response to the complaint. The subject individual/agency must submit copies of all supporting documentation to the PSRO at least one week prior to the review meeting.

A. Attorneys and Union representatives are not permitted in PSRO case reviews without prior expressed permission of the MCA.
B. A subject licensee may bring a representative of their life support agency, such that the agency may provide guidance for the individual, and so the agency may fairly represent themselves and their policies.
C. The following steps shall be taken in the complaint review process:
    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.
D. The complainant shall, to the extent allowed under confidentiality statutes, be notified of the outcome of the complaint review process. The employer shall be notified if one of their employees has their privileges suspended or revoked.
E. If the MCA has enacted a temporary suspension, in accord with the Due Process and Disciplinary Action Policy, and the subject licensee requests a 30-day postponement, the suspension of privileges to function shall remain in place during the postponement.

F. The PSRO shall remove all the names and addresses of patients from the record before the review entity releases or publishes a record of its proceedings, or its reports, findings, and conclusions.[2]

[2] MCL 331.533

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.

III. Appeal Hearing for an Immediate Threat
If the MCA determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control privileges can be taken immediately until the MCA has had the opportunity to review the matter at a MCA hearing. The hearing shall be held within 3 business days after the MCA's (or Medical Director's) determination to remove medical control.

Due Process & Disciplinary Procedures

Purpose: To establish a fair and equitable method of applying remediation and/or discipline to licensees found to be violation of protocol.

I. Due Process
The **Complaint Investigation & Resolution Policy** establishes the initial steps of Due Process. Under that policy, a complaint will be investigated for validity and severity. Both individuals 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 a special PSRO meeting.
B. Subjects of a complaint will be provided with copies of all, complaint/investigation related materials at the time of a special meeting with the exception of materials that would reveal the identity of an individual that provided information under the condition of anonymity. The subject individual or agency may request the complaint/investigation related materials in advance of the special meeting.
C. 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.
D. 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 special PSRO meeting.
    1. The individual or agency shall be notified of the suspension per the **Disciplinary Action and Appeal Policy**.
    2. If found guilty in a court of law, MCA privileges will be considered to be revoked.
    3. If found not guilty of charges, the individual or agency must provide copies of court documents, including transcripts, to the MCA.
    4. 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.
E. A subject licensee may request a postponement of up to thirty (30) calendar days of a special PSRO meeting 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 individuals or agencies may have agency representation at PSRO reviews provided PSRO standards are maintained.
L. Individuals 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 Policy**.
M. Subject individuals 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 Policy**.
N. 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.

II. Application of Disciplinary Action

A. A primary function of disciplinary action is to ensure the protection and safety of the community and patients.
B. The application of remediation and/or discipline 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. The review process outlined in the **Complaint Investigation Procedure** shall be utilized in assessing the remedial and/or disciplinary action required.
E. MCAs should utilize Just Culture when applying or considering disciplinary action. There should be a balance between provider and system accountability.

III. Remediation

A. The Medical Control Authority may issue an order of remediation to correct substandard clinical performance.

[1] MCL 331.533
[2] MCL 331.533

B. A defined time period for completion of remedial activity shall be stated in the order.
C. Licensees shall be required to perform remedial activity under the supervision of an appointed proctor to correct an identified performance shortcoming.
D. 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).
E. A licensee 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.
F. Disciplinary action may be accompanied by assignment of additional remedial activity.

IV. Discipline

Disciplinary action 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.

A. 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.
B. Temporary Suspension of Privileges
    1. 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.
    2. 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.
C. Written Reprimand
    1. A written reprimand shall be issued to a licensee stating
        a. the details of the substandard performance

   b. the remedial action, if required
   c. the time allowed for completion of remedial action
   d. the consequences for repetitive noncompliance
2. Notice of disciplinary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

D. Probation
1. A probationary letter shall be issued to a licensee stating
   a. the details of the substandard performance
   b. the details of the probation
   c. the remedial action required
   d. the restriction of privileges, if applicable
   e. the time of probationary period
   f. 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).
3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

E. Suspension of Privileges

A licensee's medical privileges shall be suspended for a specified period of time.

1. A written notice of the suspension shall be issued to the licensee stating
   a. the details of the substandard performance
   b. the violation(s) of protocol and/or policy
   c. the term of suspension
   d. the remedial activity, if required
   e. the time allowed for the completion of the remedial activity
2. Notice of disciplinary action shall be forwarded to the licensee's employer, if employed (or MCA board in the case of an agency provider).
3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
4. 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.
5. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.

F. Revocation of Privileges
1. The notice of revocation shall state the violation(s) of protocol and/or policy.

2. Notice of disciplinary action shall be forwarded to the licensee's employer (or MCA board in the case of an agency provider).
3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
4. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.
5. 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.

G. Financial Penalties

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

H. 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.

V. Alleged violations of administrative or operational protocol requirements by an EMS agency shall be resolved as follows:

A. The Medical Control Authority will notify the department chief or agency official of the alleged protocol violation.

B. Details of the alleged violation, and any response received from the EMS agency, will be presented to the MCA designated PSRO review body at their next meeting. The agency involved will be notified of and may attend the meeting and present any information it believes pertinent.

C. If the PSRO discussion will take place at an otherwise open meeting, the committee must go into closed session for PSRO purposes, prior to discussion. The predesignated PSRO of the MCA will then meet in closed

[3] MCL 331.532

session to perform the PSRO review. All parties not principal to the PSRO review shall be excluded from such a closed session review. No record of PSRO reviews shall be entered into the general minutes except to state that the committee entered/exited closed session for a PSRO review.

D. The PSRO of the MCA will review the alleged violation and by majority vote of the members present decide a course of action. Any sanction imposed shall follow the guidelines below:
    1. Severity of the violation will determine the level of sanction to be imposed.
        a. A violation is considered "minor" if it involves administrative infractions, including but not limited to, failure to timely file reports.
        b. A violation is considered "serious" if it involves intentional operational issues, including but not limited to, a failure to provide staffing as required by statute.
        c. An otherwise minor violation that is frequent or recurring may be considered by the Medical Control Authority to be "serious" for purposes of this section.
    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. A MCA may assess restrictions or limitations upon a licensed life support agency for non-compliance with protocols.

E. 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.

F. An EMS agency may appeal a decision of the Medical Control Authority. The EMS Agency must follow the **Disciplinary Action Appeal** policy.

VI. A licensee must notify the MCA of disciplinary action from the State of Michigan.

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]

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 the **Patient Care Record, Electronic Documentation and EMS Information System** procedure.
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] MCL 331.531 *et seq*.

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

Incident Classification

Purpose: To establish a process for the classification of Incidents reviewed by the MCA. Incidents will be divided into two categories, Level I and Level II.

Discretionary Powers
If the Medical Control Authority determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control privileges can be taken immediately and until the Medical Control Authority has had the opportunity to review the matter. A Professional Standards Review Organization (PSRO) hearing shall be held within three business days after the Medical Control Authority's determination to remove medical control. The Medical Director or his /her designee shall determine the personnel needed for the hearing.

Receipt and Investigation of Incidents
When the MCA becomes aware of a potential violation of the state approved policies, procedures, protocols, or statutes, the Medical Director, his/her designee, or the PSRO of the MCA will investigate the complaint per the state approved **Complaint Investigation Policy**.

Classification of Complaints
Complaints determined to be valid will be reviewed and will be classified using the criteria below. 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.

Level I Incidents
The following categories of incidents are defined as Level I incidents:

1. Willful neglect of a patient
2. Abandonment of a patient
3. Failure to obey a medical control physician's legitimate orders either by omission or commission in the presence of good communications.
4. Improper and inappropriate care which may result in compromise of wellbeing of the patient
5. Conviction of a felony or misdemeanor
6. Two or more Level II offenses in any six month period *
7. Breach of Confidentiality
8. Intentional falsification of EMS documentation, including patient care records.
9. Found to be under the influence of drugs or intoxicants while involved with patient care.
10. Violation of the EMS statute and its attendant rules and regulations, including care outside the scope of practice, as defined by protocol.
11. Practicing in the MCA without a current Michigan EMS provider license.
12. 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 Authorization for **Medical Control Privileges** Policy.

13. 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.
14. Failure to complete prescribed remediation from a previous incident. (Or see #14 of LEVEL II)
15. Arrest or criminal charges for criminal sexual conduct of any degree, violent crime, drug diversion or illegal possession or distribution of controlled substances.
16. Failure to notify the MCA of a criminal charge, arrest or conviction within 1 business day
17. 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.

Level II Incidents

The following categories of incidents are defined as Level II incidents:

1. 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.
2. 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.
3. Abuse and/or loss of system equipment due to neglect.
4. Significant documentation errors
5. Failure to accurately perform procedures as defined in protocols, policies and procedures.
6. 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.
7. Improper or unprofessional medical communications including, but not limited to, any violation of Federal Communications Regulations, and falsification of identification during medical communications.
8. 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.
9. 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.

10. Two or more orders of disciplinary action within a 6 month period **
11. 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.
12. Practicing in the MCA without current credentials required in order to maintain privileges, as identified in the Authorization for Medical Control Privileges Policy.
13. Medication error, which has a negative impact on patient care.
14. A determination by the designated PSRO Committee of failure to complete prescribed remediation 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.

Due Process and Disciplinary Actions
The application of disciplinary measures shall be defined by the state approved **Due Process and Disciplinary Action** Protocol.

Appeal Process
An appeal may be filed according to the **Disciplinary Action Appeal** Protocol.

Reapplication after Revocation
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.

Electronic Records & EMS Information System

I. **Responsibility for Records**
   A. Any PCR software utilized by an EMS agency must be National EMS Information System (NEMSIS) version 3.4 and Michigan EMS Information System (MIEMSIS) compliant.
   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 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.