QUALITY ASSURANCE TASK FORCE
AGENDA
January 27, 2023
10:00 a.m.
VIRTUAL ONLY
Click here to join the meeting
+1 248-509-0316 Conference ID: 875 086 495#

Attendance:
Member Roll Call:
Dr. Edwards-chair, Dr. Domeier, Dr. Fales, Dr. Noel, Dr. Wise, Dr. Paul, Deb Wagner, Lynn Weber, Lisa Martin, Betsy McDavid.
Guests:
BETP Staff:

Agenda and Minutes:

MCA Protocols/Bylaws:

1. **DETROIT EAST MCA**
   a. 14.02-Staffing-During-COVID-Pandemic-11.12.22-EMERGENCY PROTOCOL
   b. COVID-19-Treat-in-Place EMERGENCY PROTOCOL
   c. Air Q3® 7-9b
2. **MARQUETTE-ALGER MCA**
   a. Emergency Staffing 8-33
3. **OAKLAND COUNTY MCA**
   a. 8.1 Agency and EMS Personnel Criteria for Participation
   b. 8.2 ALS to BLS Transfer of Care
   c. 8.4 Alternative EMS Response Team
   d. 8.21 Medical Control and Participating Hospital Policy
   e. 8.21.1 Hospital Letter of Compliance
   f. 8.22 Mutual Aid Policy
   g. 8.23 New or Upgraded EMS Agency Policy
   h. 8.23.1 Appendix A New and Upgraded EMS Agency Application
   i. 8.24 Patient Prioritization
   j. 8.29 Rerouting Policy
   k. 8.31 Scene Patient Management
   l. 8.37 Tactical EMS Protocol
   m. 8.51 Transfer of Patient Care to Receiving Facility
4. **Region 6 – WMRMCC**
   a. Pediatric Interfacility High Flow Nasal Oxygen (HFNO) 8.59
   b. BLS Transport Utilization 8.XX
   c. Use of Basic Life Support Ambulances for 911 Responses 8.XX

State Protocols/Bylaws:

1. COVID-19
2. State Protocol Revisions-All protocols have gone out for public comment. This is FINAL REVIEW/APPROVAL so they may be released to MCAs to begin their committee review and adoption.
    a. Section 2 and 3 questions – Dr. Fill, JCMCA
        i. Spinal Assessment 2-8: Strike significant in line 2b?
        ii. Excited Delirium 3-6: Why was midazolam dose reduced to 5 mg IM?
    b. State Protocols packet for review and vote
        i. Pediatric Medication Emergency Dosing and Intervention Cards 4-1
        ii. Pediatric Respiratory Distress, Failure, or Arrest 4-5
        iii. Pediatric Fever
        iv. Pediatric Cardiac Arrest – General 6-1
        v. Pediatric Tachycardia – 6-3
        vi. Refusal of Care; Adult and Minor 7-19
        vii. Transport of Adult Ventilator-Dependent Patient 7-27
        viii. Transport Destination and Diversion 8-3
        ix. Responsibilities of the Participants in the MCA System
        x. Evidentiary Blood Draw (MCA Optional) 8-28

Detroit East Medical Control Authority

10200 Erwin Ave Detroit MI 48234

Contact: info@demca.org Website: www.demca.org

January 10, 2023

Kristy Kuhl
MCA Coordinator
Bureau of EMS, Trauma & Preparedness
Michigan Department of Health and Human Services
P.O. Box 30207
Lansing, Michigan 48909-0207

Dear Kristy,

Attached are two Detroit East Medical Control Authority Emergency Protocols;

1. Treat in Place
2. Alternate Staffing

These protocols have been reviewed and approved by our medical control board.

Also attached is a new protocol; AIR-Q3. This protocol has also been approved by the medical control board. Please contact our office if you have any questions or need further information.

Sincerely,

Robert Dunee, M.D.
EMS Medical Director
Detroit East Medical Control Authority

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: Detroit East

Medical Director: Dr. Robert Dunne

Protocol: Alternate Staffing

Submitted by: Damon Gorelick

Identify where you are requesting to make change/changes:

- ☐ Medication
- ☐ Pre-Medical Control
- ☐ Post-Medical Control
- ☐ Procedural
- ☒ Other (specify) Emergency Protocol
- ☐ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):

In ordered maintain the integrity of the EMS system and assist patients with receiving the most appropriate treatment

Rationale: Why is this addendum necessary for your MCA?

In ordered maintain the integrity of the EMS system and assist patients with receiving the most appropriate treatment

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

Medical Director's Signature: *Date:* 1/10/2023

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: MDHHS-MCAProtocols@michigan.gov

Staffing During the COVID-19

Pandemic Purpose: To provide direction for staffing alterations and vehicle usage during the COVID-19 Pandemic.

I. Ambulance Staffing
   A. Advanced life support (ALS) vehicles operate with the minimum staffing of a paramedic and a medical first responder (MFR), or higher.
   B. Limited ALS (LALS) vehicles operate with the minimum staffing of an advanced emergency medical technician specialist (AEMT-S) and an MFR, or higher.
   C. Basic Life Support (BLS) vehicles operate with the minimum staffing of an emergency medical technician and an MFR, or higher.

II. Vehicle Status
   A. Life support agencies (LSA), when staffing is not available for vehicles as they are currently licensed may staff them at a lower level to respond to requests for service.
   B. A vehicle that is licensed as an ALS vehicle may respond without a paramedic, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible.
   C. A vehicle that is licensed as an LALS vehicle may respond without an AEMT-S, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible.
   D. A vehicle that is licensed as a BLS vehicle may respond without an EMT, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible. A BLS ambulance must have an EMT in order to transport.

III. Equipment and Medications
   A. Equipment and medications that are accessible at any time, must be within the scope of practice of the personnel currently staffing the vehicle.
   B. It is acceptable to utilize ALS equipment in their BLS functionality (e.g. monitors set to AED mode)

IV. Scope of practice
   A. Personnel continue to be limited to their licensed scope of practice.
   B. This protocol does not preclude Healthcare providers who maintain current Michigan health professional licenses outside of EMS (e.g. RN, MD, PA) and that continuously work in emergency services, from practicing at their scope of practice in an ambulance with MCA approval. This scope is not covered by the level of license of an LSA vehicle.

V. Reporting

If an agency finds that they need to alter their staff in accordance with this protocol and the executive order, they should report the status to the MCA in which the altered staffing occurred.

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: Detroit East
Medical Director: Dr. Robert Dunne
Protocol: Treat In Place
Submitted by: Damon Gorelick

Identify where you are requesting to make change/changes:

- ☐ Medication
- ☐ Pre-Medical Control
- ☐ Post-Medical Control
- ☐ Procedural
- ☒ Other (specify) Emergency Protocol
- ☐ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):

In ordered maintain the integrity of the EMS system and assist patients with receiving the most appropriate treatment

Rationale: Why is this addendum necessary for your MCA?

In ordered maintain the integrity of the EMS system and assist patients with receiving the most appropriate treatment

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

Medical Director's Signature: *Date:* 1/10/2023

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: MDHHS-MCAProtocols@michigan.gov

***Stationary* Treatment *of Low Acuity and Asymptomatic Patients* During Covid-19 Outbreak**

Purpose: To reduce unnecessary EMS transport to hospital emergency departments during the COVID-19 outbreak while assuring delivery of appropriate healthcare services.

I. Description:

This Emergency System Protocol describes the process to be followed by EMS Personnel when, following an appropriate clinical assessment including a medical control consultation with an authorized physician, it is determined that the patient is not experiencing a medical emergency and will not likely benefit from transport by EMS to the hospital emergency department.

II. Definitions:

A. Emergency Patient: means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in one (1) 1 or all of the following:
   1. Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.
   2. Serious impairment of bodily function.
   3. Serious dysfunction of a body organ or part.

B. Non-Emergency Patient: For the purposes of this protocol, a non-emergency patient means an individual who has been jointly assessed by both EMS and an authorized medical control physician and has been determined, based on reasonable professional judgement and the information available at the time of the assessment, to not meet the definition of an emergency patient as defined above.

C. Asymptomatic COVID-19 individual means a person that has tested positive for the virus causing COVID-19 but does not have any observable signs or symptoms.

D. EMS Telemedicine Application: means a telecommunication application that is HIPPA-compliant and provides for remote medical control between the treating paramedic and the supervising authorized medical control physician and has been approved by the local medical control authority.

E. Medical Control Physician: means a physician authorized by the local medical control authority Medical Director to provide medical control and who serves as a representative of the local medical control authority.

F. Alternate Destination: means a healthcare facility other than a hospital emergency department approved by the local medical control authority Medical Director or by the Medical Control Physician to which a non-emergency patient may be transported. This

may include physician offices, clinics, urgent care centers, and other approved alternate healthcare facilities. Including designated alternate care centers.

G. Alternate Transport: means a vehicle, other than a licensed ambulance, used to safely transport a non-emergency patient to a hospital emergency department or approved alternate destination. This may include wheelchair van, private vehicle, ride share vehicle, licensed non-transporting EMS vehicle, non-licensed public safety vehicle, or other type of vehicle type approved by the local medical control authority Medical Director or Medical Control Physician.
H. Alternate Treatment Plan: This means a treatment plan for the non-emergency patient that involves care in the home or facility, transport to an alternate destination, or transport using and alternate vehicle.

III. Qualifying Patients:

This protocol is intended for patients who, following patient assessment and medical control consultation, are determined to not be an emergency patient AND not be in need of EMS transport to a hospital emergency department. Examples include, but are not limited to:

A. Mild respiratory infection symptoms including sore throat, cough, muscle pain
B. Mild respiratory illness with bronchospasm without signs of infection
C. Vomiting and diarrhea without signs of significant dehydration or circulatory shock
D. Mild exacerbations of chronic medical conditions
E. Mild soft tissue injuries such as superficial abrasions, lacerations, and minor burns
F. Minor orthopedic injuries such as sprains, strains, and contusions
G. Minor medical complaints such as urinary tract infection or minor skin infection without fevers or other comorbid factors
H. Other clinical conditions appearing to be of low acuity associated with stable vital signs
I. Asymptomatic COVID-19 individuals

IV. Excluded Patients:

This protocol does not apply to patients who, following patient assessment, are felt to reasonably have a clinical condition consistent with an emergency patient as defined above. Examples include, but are not limited to:

A. Significantly abnormal vital signs (excluding fever and mild tachycardia) that fail to resolve with initial treatment
B. Hypoxia, defined as a room air SPO2 less than 92% that does not promptly improve with EMS treatment (For patients who are usually on intermittent or continuous prescribed oxygen, SPO2 less than 90% while on baseline prescribed usual oxygen flow)
C. Chest pain suggestive of an acute cardiopulmonary condition, regardless of EKG finding
D. Labored breathing following EMS treatment
E. Acutely altered level of consciousness

MCA Name: DEMCA
MCA Board Approval Date: 1/11/2022
MCA Implementation Date: 11/12/2022
Protocol Source/References: PA 368 of 1978

F. Significant acute pain of known or unknown etiology
G. Other conditions that may otherwise be consistent with an emergency patient

V. Process:

A. EMS personnel dons appropriate PPE
B. EMS Personnel completes assessment in accordance with appropriate protocols, including complete vital signs (BP, HR, RR), temperature, and SPO2
C. EMS Personnel initiates treatment per appropriate protocol(s)
D. If patient clinically appears to be an emergency patient continue with treatment and transport per appropriate protocol(s)
E. If patient clinically appears to be a non-emergency patient or is asymptomatic, contact Medical Control Physician for consultation. Use MCA-approved EMS telemedicine application, if available
F. EMS Personnel provides appropriate clinical presentation to Medical Control Physician
G. If Medical Control Physician determines the patient continues to represent an emergency patient, EMS personnel continues treatment and transports to hospital emergency department per appropriate protocol(s)
H. If Medical Control Physician determines the patient's condition is consistent with a non-emergency patient (or asymptomatic COVID-19 individual), the patient (and family and/or staff) is advised of the clinical justification and rationale for the determination
I. An alternate treatment plan (if necessary) will be collaboratively developed with the patient, patient's family (or facility staff), EMS personnel, and Medical Control Physician, as described below.
J. When alternate transportation is indicated, EMS personnel may clear the scene prior to arrival of the alternate transport vehicle.
K. Initiate alternate treatment plan and document the encounter electronically utilizing an MCA approved documentation system.

VI. Alternate Treatment Plan Options:

A. At home treatment and follow-up with outpatient medical provider. Treatment may include:
    a. Common over-the-counter supportive self/family care and/or
    b. Medical Control Physician provided prescription (optional), as appropriate
    c. Community Paramedicine follow up, as available
B. Transport to an alternate destination using alternate transport (or licensed ambulance, as resources permit)

VIII. If Medical Control Physician determines an emergency does not exist and the patient or staff insists on Transport by Licensed Ambulance to Hospital Emergency Department:

A. Advise Medical Control Physician.
B. Medical Control Physician consults with patient, patient's legally authorized

MCA Name: DEMCA
MCA Board Approval Date: 1/11/2022
MCA Implementation Date: 11/12/2022
Protocol Source/References: PA 368 of 1978

decision-maker, staff, patient's physician, or advanced practice provider, and/or family, as appropriate.

C. If patient or staff continues to insist on EMS transport, transport patient to closest appropriate destination, as directed by Medical Control Physician.

IX. Notification and Review:

The use of this protocol when patient and/or staff is initially reluctant to non-EMS transport requires notification of the MCA by the EMS agency within 24 hours for review by the Medical Director (or designee).

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: Detroit East
Medical Director: Dr. Robert Dunne
Protocol: Air-Q SP
Submitted by: Damon Gorelick

Identify where you are requesting to make change/changes:

- ☐ Medication
- ☐ Pre-Medical Control
- ☐ Post-Medical Control
- ☐ Procedural
- ☑ Other (specify)
- ☐ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):
Adding a superglotic airway to give providers more options

Rationale: Why is this addendum necessary for your MCA?
We want to add another airway device to give providers to most current options avaible to them

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

Medical Director's Signature: *Date:* 12/7/2022

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: **MDHHS-MCAProtocols@michigan.gov**

Detroit East Medical Control Authority
PROCEDURES EMERGENCY AIRWAY (Supplement)
AIR Q3®

Initial Date:
Revised Date: Section 7-9b

Size of air-Q SP 3/3G used	Time of attempt(s)
Number of attempts	Suctioning required before placement
Ventilation compliance	Chest rise with ventilation
Capnography Used	ET CO2/Capnography reading (serial)
Equality of lung sounds	Absence of epigastric sounds
Method for securing airway	Any complications with procedure
Gastric decompression performed (excluding MFRs)	

Indications:

1. Cardiac arrest. Appropriate as first-line advanced airway.
2. Respiratory arrest (including agonal breathing), without gag reflex, not responsive to initial treatment including bag-valve-mask ventilation and naloxone (when indicated)
3. Rescue airway for failed endotracheal intubation (Paramedics only).

Contraindications:

1. Responsive patients with a gag reflex.
2. Trismus (limited mouth opening), suspected pharyngo/peri-laryngeal abscess, major facial trauma or oral-pharyngeal mass.
3. Patients in whom caustic substance ingestion is suspected.
4. Patients at high risk for regurgitation and/or aspiration.
5.

Equipment:

1. Air Q3® airway
2. O2
3. Support strap
4. Water-soluble lubricant
5. Supplies: bag-valve-mask, capnography, suction
6. Use appropriate size for patient based on table below.

air-Q SP 3/3G Pre-Insertion:

Initial Date:
Revised Date: Section 7-9b

1. Provide bag-valve mask ventilation using 2 person technique with an oropharyngeal airway, avoiding hyperventilation, and performing pharyngeal suctioning as needed.
2. Inspect the packaging and ensure it is not damaged prior to opening.
3. Inspect the device carefully, check that the airway is patent and confirm that there are no foreign bodies or a bolus of lubricant obstructing the distal opening of the airway or gastric channel.

air-Q SP 3/3G Placement Procedure

1. Lubricate the external surface including the mask cavity ridges.
2. Open the patient's mouth and elevate the tongue. Elevating the tongue lifts the epiglottis off the posterior pharyngeal wall and allows the air-Q SP 3/3G easy passage into the pharynx. A mandibular lift is especially recommended. A tongue blade placed at the base of the tongue also works well for this purpose.
3. Place the front portion of the air-Q SP 3/3G mask between the base of the tongue and the soft palate at a slight forward angle, if possible.
4. Pass the air-Q SP 3/3G into position within the pharynx by gently applying inward and downward pressure, using the curvature of the air-Q SP 3/3G mask and airway tube as a guide. Simply rotate the air-Q SP 3/3G forward and inward. Minimal manipulation may be necessary to turn the corner into the upper pharynx. Continue to advance until fixed resistance to forward movement is felt. Correct placement is determined by this resistance to further advancement. Some users place the back of the left index finger behind the mask, flexing the finger forward to help guide the mask around the corner into the pharynx. Once the mask has negotiated the turn, the left hand is then used to do a mandibular lift while exerting downward and inward pressure on the air-Q SP 3/3G with the right hand during final advancement into the pharynx.
5. Tape the air-Q SP 3/3G in place.
6. Check the air-Q SP 3/3G connector to ensure it is fully engaged within the airway tube, and attach the connector to the appropriate breathing device. Check for adequate ventilation.
7. If needed place a bite block between the patient's teeth. Keep the bite block in place until the air-Q SP 3/3G is removed.
8. Attach bag-valve device and verify placement by ALL of the following criteria:
    a. Positive end-tidal CO2 levels by waveform capnography (preferred) or by use of colorimetric qualitative end-tidal CO2
    b. Rise and fall of the chest
    c. Bilateral breath sounds and absent epigastric sounds
9. If there is any question about the proper placement of the air-Q SP 3/3G airway, remove the airway, ventilate the patient with BVM and OPA for at least 30 seconds and repeat insertion procedure (maximum of 3 attempts), considering different size.
10. If unsuccessful, return to BVM ventilation and consider alternative advanced airway as authorized by MCA.
11. If successful, continue positive pressure ventilation, avoiding hyperventilation.

Initial Date:
Revised Date: Section 7-9b

12. Continue to monitor the patient for proper airway placement throughout prehospital treatment and transport using waveform capnography.

Size Chart:

Size	IBW
5	>80- kg
4	60-80 kg
3	30-60 kg
2	17-30 kg
1.5	7-17 kg
1.0	4-7 kg
0.5	2-4 kg
0	< 2 kg

Annual Registration Successful

Facility: COOKGAS LLC, Saint Louis, Missouri, UNITED STATES

You have successfully updated your registration and listing information for 2023.

Your registration will be valid through Dec 31, 2023.

Be sure to print this page for your records.

The next registration renewal period is October 1 - December 31, 2023.

Registering your facility and listing devices does not, in any way, constitute FDA approval of your facility or devices.

You may contact the FDA with any questions at reglist@cdrh.fda.gov.

The Owner/Operator Number for this Registration is: 9056355.

Facility Information

Registration Number:	**3004594307**
Initial Importer:	**N**
Facility Name:	**COOKGAS LLC**
Legal Name:	
Address:	**1101 Lucas Ave Ste 200, Saint Louis, Missouri, 63101, UNITED STATES**
DUNS Number:	
Foreign Trade Zone:	**N**
Facility URL:	
Other Business Trade Name(s):	
Establishment located on a campus:	

Owner/Operator Information

Owner/Operator Number:	**9056355**
Contact Name:	**DANIEL J COOK**
Company:	**COOKGAS LLC**
Address:	**1101 Lucas Ave, Ste 200 Saint Louis, MISSOURI, 63101, UNITED STATES**

Telephone:	**314 - 7815700**
Fax:	**-**
E-mail:	**dcook@cookgas.com**
DUNS Number:	

Official Correspondent Information

Contact Name:	**DANIEL J COOK**
Company:	**COOKGAS LLC**
Address:	**1101 Lucas Ave, Ste 200** **Saint Louis, MISSOURI, 63101, UNITED STATES**
Telephone:	**314 - 7815700**
Fax:	**-**
E-mail:	**dcook@cookgas.com**
DUNS Number:	

Device Listings

Listing Number	Premarket Submission Number	Premarket Submission Type	Product Code(s)	Device Name(s)	Activities
B211168		510(k) exempt	CAE	AIRWAY, OROPHARYNGEAL, ANESTHESIOLOGY	Specification Developer Manufacturer
B237361		510(k) exempt	BSR	STYLET, TRACHEAL TUBE	Manufacturer Specification Developer
D151555		510(k) exempt	BSY	CATHETERS, SUCTION, TRACHEOBRONCHIAL	Manufacturer Specification Developer
D254683		510(k) exempt	CCW	LARYNGOSCOPE, RIGID	Specification Developer Manufacturer
D254684		510(k) exempt	CBH	DEVICE, FIXATION, TRACHEAL TUBE	Specification Developer Manufacturer

Date of Initial Registration: 2003-05-11 11:53:21.0

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

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Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: Marquette Alger
Medical Director: Michael Mlsna, MD
Protocol: Emergency Staffing
Submitted by: Katrina Rushford

Identify where you are requesting to make change/changes:

- ☐ Medication
- ☐ Pre-Medical Control
- ☐ Post-Medical Control
- ☐ Procedural
- ☐ Other (specify)
- ☑ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):

We continue to struggle with extreme shortages of personnel within our district. This is leading to lack of EMS coverage within the district causing an increased burden under our Supplemental/Mutual Aid agreements to cover those service areas. The change of staffing requirements under the emergency protocol led to overall greater ability of our agencies to provide

Rationale: Why is this addendum necessary for your MCA?

Due to lack of personnel, some of our agencies are unable to provide service at their level of licensure. Addition of this protocol would allow those struggling agencies to continue to provide services preventing that stress on the mutual aid agencies.

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

System Protocol

Medical Director's Signature: Michael Mlsna Digitally signed by Michael Mlsna Date: 2023.01.11 12:12:51 -05'00' *Date:* 1/11/23

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: **MDHHS-MCAProtocols@michigan.gov**

Marquette-Alger County Medical Control Authority

SYSTEM

EMERGENCY STAFFING

Initial Date: 11/2022 Section 8-33

Revised Date: 1/11/23

Staffing During Extreme Personnel Shortages

Purpose: To establish direction for staffing alterations and vehicle usage during periods of extreme shortages in personnel.

I. Ambulance Staffing

A. Advanced Life Support (ALS) vehicles operate with the minimum staffing of a paramedic and a medical first responder (MFR) or higher.

B. Limited ALS (LALS) vehicles operate with the minimum staffing of an advanced emergency medical technician specialist (AEMT-S) and an MFR, or higher.

C. Basic Life Support (BLS) vehicles operate with the minimum staffing of an emergency medical technician and an MFR, or higher.

II. Vehicle Status

A. Life support agencies, when staffing is not available for vehicles as they are currently licensed, may staff them at a lower level to respond for requests for service.

B. A vehicle that is licensed as an ALS vehicle may respond without a paramedic, if equipment outside the currently staffed personnel's scope of practice is secured in a way that is not accessible.

C. A vehicle that is licensed as an LALS vehicle may respond without an AEMT-S, if equipment outside the currently staffed personnel's scope of practice is secured in a way that is not accessible.

D. A vehicle that is licensed as a BLS vehicle may respond without an EMT, if equipment outside the currently staffed personnel's scope of practice is secured in a way that is not accessible.

III. Equipment and Medications

A. Equipment and medications that are accessible at any time, must be within the scope of practice of the personnel currently staffing the vehicle.

MCA Name: Marquette Alger Medical Control Authority
MCA Board Approval Date:
MCA Implementation Date:
Protocol Source/References: Staffing During the COVID-19 Pandemic (Protocol Section 14-02)

B. It is acceptable to utilize ALS equipment in their BLS functionality (e.g. monitors set to AED mode).

IV. Scope of Practice

A. Personnel continue to be limited to their licensed scope of practice.

B. This protocol does not preclude Healthcare providers who maintain current Michigan health professional licenses outside of EMS (e.g. RN, MD, PA) and that continuously work in emergency services, from practicing at their scope of practice in an ambulance with MCA approval. This scope of not covered by the level of license of an LSA vehicle.

V. Reporting

A. If an agency finds that they need to alter their staff in accordance with this protocol, they are required to report the status to the MCA.

OAKLAND COUNTY
MEDICAL CONTROL AUTHORITY

1200 N. Telegraph Road. Bldg. 36E, Pontiac, Michigan 48341
Telephone: 248 975-9704 Website: www.ocmca.org

December 21, 2022

Emily Bergquist
Bureau of EMS Trauma & Preparedness
Michigan Department of Health & Human Services
1001 Terminal Road
Lansing, Michigan 48906

Dear Ms. Bergquist:

Please allow this letter to serve as notice that the Oakland County Medical Control Authority (OCMCA) requests that part of our Section 8 protocols be reviewed and approved to implement. Many protocols in Section 8 were already approved when the QATF began our 3-year protocol review. After we pulled our 3-year review, we recognized the time-sensitive necessity to implement part of Section 8. The following protocols that we would like to have reviewed and approved include:

8.1 Agency and EMS Personnel Criteria for Participation
8.2 ALS to BLS Transfer of Care
8.4 Alternative EMS Response Team
8.21 Medical Control and Participating Hospital Policy
8.21.1 Hospital Letter of Compliance
8.22 Mutual Aid Policy
8.23 New or Upgraded EMS Agency Policy
8.23.1 Appendix A New and Upgraded EMS Agency Application
8.24 Patient Prioritization
8.29 Rerouting Policy
8.31 Scene Patient Management
8.37 Tactical EMS Protocol
8.51 Transfer of Patient Care to Receiving Facility

If you have any questions, please feel free to contact me at (248) 975-9798. Please let me know when our protocols will be reviewed by the QATF. Thank you for your time in this matter.

Sincerely,

Steve McGraw

Steve McGraw, DO
EMS Medical Director
Oakland County Medical Control Authority

June 3, 2022 Section 8.1

Agency and EMS Personnel Criteria for Participation

The Oakland County Medical Control Authority serves as the designee of the Michigan Department of Health and Human Services (MDHHS) pursuant to Act 368 of 1978, as amended in 2000, to serve as medical control authority for the Oakland County emergency medical services system. Pursuant to Sec. 20919(a) the medical control authority shall develop protocols and policies for the acts, tasks, and function that may be performed by EMS personnel and life support agencies.

NEW AND UPGRADING AGENCIES

(see New or Upgrading EMS Agency Policy)

RENEWING AGENCIES (ANNUALLY)

Renewing EMS Agencies will be eligible to be designated as a life support agency in Oakland County and receive Medical Control upon annual submission to the Professional Standards Review Organization (PSRO) of:

1. Evidence of licensure with the State EMS Division;
2. Designate an EMS Coordinator for the LSA. The EMS Coordinator must be a licensed provider, at or above the LSA's licensure level (e.g., paramedic working for an ALS agency), and employed by the LSA. The EMS Coordinator will serve as the liaison between the medical control hospital, the OCMCA and the life support agency. The responsibilities of the EMS Coordinator include, but are not limited to meeting all the criterion listed in the OCMCA LSA Letter of Compliance.
3. Designate a State Licensed Instructor Coordinator (IC). State Licensed IC must be commensurate with the LSA's licensure level. The Oakland County Instructor Coordinator will be responsible for maintaining ongoing education according to the OCMCA and MDHHS licensing requirements.
4. Evidence of compliance with OCMCA criteria for practice by completion of the Letter of Compliance;
5. List of current personnel including level of licensure, expiration dates, and current ACLS certification; and
6. Approval of the PSRO, MCC and Board of Directors.

AGENCY CRITERIA TO PARTICIPATE IN THE OCMCA

The Oakland County Medical Control Authority has an approval process in place to designate a life support agency in Oakland County to be eligible for Medical Control. This approval will be based on the PSRO review and approval; and MCC and Board of Directors approval. The criteria to operate as an OCMCA agency includes:

1. Licensed by the Michigan Department of Health and Human Services (MDHHS), or license pending.
2. Maintain a physical station with a minimum of one life support vehicle with 24/7 staffing (of a type commensurate with what is written on the agency's license) that is available for response to requests for emergency assistance, and is staffed on a 24/7 basis within Oakland County.
3. The ability to comply with the Oakland County 8.13 EMS Response Time Standards ~~(6-18).~~
4. Medical supplies, communications, equipment, procedures and protocols utilized meet criteria as established by MDHHS and Oakland County Medical Control Authority.
5. It is the agency's responsibility to educate and update all EMS personnel on the OCMCA protocols.
6. The agency designates the OCMCA (including its PSRO) to perform professional practice review functions on behalf of the agency, including review of pre-hospital care provided in Oakland County and recommendations for improvement of such care.
7. The agency agrees to participate in PSRO studies, EMS QI Program (EQIP), and abide by all PSRO Protocols and Policies.
8. Agency has designated a medical control hospital and medical control hospital physician.
9. Units are identified through standard terminology and uniform numbering system, issued
by the Oakland County Medical Control Authority. The OCMCA unit number will be documented on each run form and/or e-PCR and used in all radio communications.
10. The agency has designated an EMS Coordinator, EMS QI Coordinator, and a State Licensed Instructor Coordinator.
11. The agency has Emergency Medical Dispatch (EMD) protocols to ensure the appropriate dispatching of a life support agency based upon medical need and capability of the emergency medical services system. All calls have access to pre-arrival instructions through an approved MCA EMD program.
12. The agency has a policy to ensure that use of lights and sirens is based on EMD protocols and patient condition.
13. The agency is responsible for completing and forwarding the necessary quality improvement data, approved by the OCMCA Board of Directors, and to MI-EMSIS.
15. ~~All Life Support Agencies that provide emergency response in Oakland County agree to respond to emergency requests for aid across municipal boundaries, if available to~~

~~respond. This response will occur regardless of what type of primary agency (private or public) provides primary response to that municipality.~~

This agency understands that all LSAs that provide emergency response in Oakland County agrees to respond to emergency requests for EMS Aid across municipal boundaries, if available to respond, regardless of what type of primary agency (private or public) provides EMS to that municipality. Response availability is to be solely determined by the requested agency. This policy for EMS Aid is not a replacement for mutual aid agreements. No agency shall use this agreement to supplement the day-to-day operations for their agency. EMS Aid may only be utilized if Mutual Aid is not available.

ALS Agencies Only

LICENSED NON-TRANSPORTING ALS UNITS

1. Provide a minimum of one paramedic staffing each licensed Non-Transporting ALS unit at all times.
2. Contract for staffing services shall only be rendered with OCMCA approved Life Support Agencies.

LICENSED TRANSPORTING ALS UNITS

1. Provide a minimum of one paramedic and one EMT staffing each licensed Transporting ALS unit at all times.
2. Contract for staffing services shall only be rendered with OCMCA approved Life Support Agencies.

BLS Agencies Only

LICENSED NON-TRANSPORTING BLS AGENCY

Must provide a minimum of one (1) EMT to staff a licensed Non-Transporting BLS unit at all times.

LICENSED TRANSPORTING BLS AGENCY

A transporting BLS agency must provide a minimum of one EMT and one MFR to staff a licensed Transporting BLS unit for transport.

Agency Communications

In order to participate in the Oakland County Emergency Medical Services Communications system, it is required that all basic and advanced life support units are capable of communicating on the following channels:

-- 155.340 Michigan HERN Channel (Primary Vehicle to Hospital Channel)
-- 155.355 “VMEDTAC” (Scene Coordination Channel)
-- 155.7525 “VCALL10” (National Interoperable Channel)
-- 151.1375 “VTAC11” (National Interoperable Channel)

-- 154.4525 “VTAC12” (National Interoperable Channel)
-- 158.7375 “VTAC13” (National Interoperable Channel)
-- 159.4725 “VTAC14” (National Interoperable Channel)

All licensed EMS operations (transporting and non-transporting vehicles) will be assigned a specific MEDCOM mobile unit radio identification number, in accordance with the Oakland County Unit Identification Number System. To designate the capability of the unit, a prefix will be added to the unit ID number (numbers obtained through OCMCA), in accordance with the EMS capability and assignment codes. These identifiers will be used in all EMS radio and telephone traffic. All ALS units are required to be equipped with an Oakland County 800 MHz Radio system EMS portable radio.

EMS PERSONNEL TO PARTICIPATE IN THE OCMCA
All EMS personnel shall participate in peer reviewed quality improvement (PSRO).

Paramedic Qualifications
All Paramedics must:
1. Be licensed with the State of Michigan as a paramedic.
2. Personnel be trained and licensed in accordance with appropriate statutes, rules criteria and maintain current BCLS and ACLS, as approved by MDHHS.
3. Adhere to the State of Michigan’s EMS/Trauma Systems Section continuing education requirements.
4. Recommendation for a nationally recognized pediatric program.

AEMT Qualifications
All AEMT’s must:
1. Be licensed in the State of Michigan as an AEMT.
2. Be trained and licensed in accordance with appropriate statutes, rules criteria and maintain current BCLS, as approved by MDHHS.
3. Adhere to State of Michigan EMS Division’s continuing education requirements.
4. The AEMT is able to work up to their scope of practice on an ALS unit only.

EMT Qualifications
All EMT’s must:
1. Be licensed in the State of Michigan as an EMT.
2. Be trained and licensed in accordance with appropriate statutes, rules criteria and maintain current BCLS, as approved by MDHHS.
3. Adhere to State of Michigan EMS Division’s continuing education requirements.

MFR Qualifications
All MFR’s must:

1. Be licensed in the State of Michigan as an MFR.
2. Be trained and licensed in accordance with appropriate statutes, rules criteria and maintain current BCLS, as approved by MDHHS.
3. Adhere to State of Michigan EMS Division's continuing education requirements.

EMS RESPONSE

When responding to a non-emergency facility (e.g. nursing home, Urgent Care, physician's office, private residence, etc.) to a patient with a potentially life threatening condition, EMS personnel/life support agency must activate, upon identification of a potentially life threatening condition, the primary life support agency for that geographic service area of the call.

ALS to BLS Transfer of Care

Purpose

Patient needs or desires transport to a hospital and does not meet criteria for ALS interventions, may be transferred by a BLS unit.

1. Criteria for transfer of care from ALS to BLS must include:
   a. Patent airway, maintained without assistance or adjuncts.
   b. Patient appears hemodynamically stable with medical complaints or injuries that would be cared for at the BLS level.
   c. No imminent changes are anticipated in the patient's present condition.
   d. ~~GCS ≥ 14.~~ Patient presents at baseline mentation and GCS or if unknown, GCS ≥ 14.
   e. The EMT in attendance must be willing to accept the transfer of care in regards to the patient's condition.
   f. No patient may be transferred to BLS once an ALS intervention has been initiated. If the ALS unit provides ALS care as directed by protocol the patient will remain ALS.
   g. Notify Medical Control of ALS to BLS transfer of care prior to transport.

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

Documentation

1. If care is transferred to BLS the following should be completed:
   a. The ALS Provider will complete a Patient Care Record (PCR) and submit the data electronically.
   b. The ALS Provider will furnish the BLS transport unit with a record detailing the ALS assessment, a copy of which will be provided to the receiving hospital.
   c. ALS transferring unit is identified on the BLS PCR.

June 3, 2022 Section 8.4

Alternative EMS Response Team

Purpose:
The purpose of the policy is to provide a protocol for the use of alternative EMS response, which includes but is not limited to bicycles, golf carts, and other non-traditional response modes in the Oakland County Medical Control Authority (OCMCA) during events where their use would be advantageous.

Procedure:
Any agency that wants to utilize an alternative EMS response team (Team) will carry at least all the equipment listed in this protocol. Staffing of the alternative EMS response team will not exceed the agency's Oakland County licensing level.

When responding to an emergency, the Team will ~~respond along with a transport~~ ensure they are able to request a transport capable unit, to assure appropriate transport of the patient(s). If needed/requested, and upon arrival of a transport unit, the Team will give a complete report of patient condition(s) and treatments to the transporting unit(s), and will follow the OCMCA protocols. Mandatory communication capabilities include, allowing the Team to reach their agency's dispatch and to reach an OCMCA approved hospital for medical control.

Equipment List:
MFR/BLS/Paramedic
- AED
- Jump Kit
- Oxygen/Oxygen supplies
- Airway management supplies
- Suction
- Communication device

Paramedic
- ECG Monitor/Defibrillator
- IV Kit
- Drug Box
- A-pack

Drug Box (ALS only)
Any ALS agency wanting to obtain a drug box and A-pack for use on an Alternative EMS Response Team vehicle will ~~take~~ use a standard Oakland County drug box, A-pack, or use a device that can be sealed and is capable of carrying all of the medications ~~up to~~ consistent with what is carried in the Oakland County drug box (see **9.6 SE Michigan Medication Exchange and Replacement Procedure**) ~~to the agency's Medical Control Hospital to be filled~~.

Replenishment will be done at the agency Medical Control Hospital inpatient pharmacy only. Medication carriers other than standard drug boxes will not be exchanged in the Emergency Department. The agency must ensure that all medication boxes, A-packs, or carriers are secured via locking device, mechanism, or compartment, at all times when not in use. ~~The agency must also provide a device that can carry all controlled substances that can be attached to a paramedic.~~ Only one set of ~~boxes~~ (two) medication carriers may be filled for each paramedic Team an ALS agency deploys. Both ~~boxes~~ medication carriers will be inventoried and sealed with an expiration date labeled on them ~~box~~. The ~~boxes~~ medication carriers will be kept in a secured area when not in use.

Drug Box Exchange:

1. During an event, all medications used by the team will be replaced from the drug box of the transporting ALS unit.
2. The transporting ALS unit will use their opened drug box for any additional treatment the patient may need during the transport. The ALS unit will be responsible for documentation of drug use. Upon arrival at the hospital, the ALS unit will follow the usual drug box exchange procedure.
3. The paramedic Team will keep a daily log of all patients treated, drugs used and replaced from an ALS drug box.
4. At the end of the paramedic Team's event, the ~~drug box~~ medication carrier must be returned to the hospital pharmacy for update of its contents, seal, and expiration date.

Medical Control and Participating Hospital Policy

Definitions

1. Emergency Facility – a licensed hospital, freestanding surgical outpatient facility, or hospital provider-based emergency department.
2. Receiving Emergency Facility – an Emergency Facility approved by the OCMCA to give medical direction and receive EMS patients.
3. Medical Control Hospital – approved by the OCMCA and fulfills the criteria set by the OCMCA defining medical control hospital.
4. Online Medical Direction – pre-hospital direction given by an emergency physician over the radio or telephone to an EMS provider.

Annual Review Process

The Hospital Letter of Compliance will be completed annually in accordance with the published schedule, forwarded to PSRO for review and recommendation to the Medical Control Committee (MCC) and approved by the Board of Directors.

Emergency Facility Criteria and Compliance

1. Criteria –
   a. A qualified Emergency Physician will be available at all times to provide online medical direction at each Receiving Emergency Facility.
   b. A qualified Emergency Physician is defined as:
      i. Board Certified in Emergency Medicine, by either the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.
      ii. Residency trained in Emergency Medicine.
      iii. A physician practicing full-time in an Oakland County approved facility prior to July 1, 1993 and practicing full-time in emergency Medicine since that time. A one-time request for approval for this category for each physician shall be made through PSRO with a recommendation to the Medical Control Committee, and approval of the Board of Directors.
   c. Any variation in the above shall require special consideration by the Board of Directors.

2. Non-Compliance –
   Upon adequately establishing a Receiving Emergency Facility's inability to comply with the OCMCA Hospital Letter of Compliance, PSRO will:
   a. Advise the facility of its noncompliance status.
   b. Request a plan within two weeks from the hospital containing a timeline for achieving compliance.
      i. If the timeline to comply is less than one month, PSRO will monitor and assure completion.

ii. If the time allotted is more than one month, or, if the facility cannot complete the plan, its 800 MHz radio shall be relinquished until compliance with criteria for participating is met.

c. Any appeals of the decision or actions shall be according to the Incident Investigation Procedure.

Receiving Emergency Facility Responsibilities:

1. Receive EMS patients and provide medical direction.
2. Provide case-by-case quality assurance and performance reviews and communicate with the OCMCA office regarding deviations from protocol.
3. Participate in LSA QI programs, including a review of online medical control at their institution, and provide documentation to PSRO, when requested.
4. Adhere to Oakland County Medical Control Authority approved protocols and policies.
5. Ensure that hospital staff answering the communication device and/or giving medical direction have access and knowledge of the OCMCA Protocols.

Medical Control Hospital Participation

To provide the service of a Medical Control Hospital to a Life Support Agency, the Medical Control Hospital shall participate in the following educational activities:

a. Provide lecture activities for Life Support Agencies.
b. Additional activities as agreed by both the Life Support Agency and the Medical Control Hospital/Medical Control Physician.
c. Additional activities, as directed by OCMCA PSRO.
d. Activities/Programs may include EMS run reviews.

Medical Control Hospital Physician Responsibilities

1. Assign a Physician that is Board Certified in Emergency Medicine to serve on the Medical Control Committee and other OCMCA committees, as deemed necessary.
2. Provide a Medical Control Physician for EMS personnel of the Life Support Agency assigned to the Medical Control Hospital, whose responsibilities include:
   a. Physician advisor to EMS personnel.
   b. Educate and communicate with hospital medical staff on issues concerning the EMS community including all protocols and protocol updates. May include auditing the medical direction given by the Medical Control Hospital.
   c. Assist in developing EMS educational programs.
   d. EMS personnel/Life Support Agency incidents or concerns shall be reported to the OCMCA office.

Oakland County Medical Control Authority
Medical Control Hospital
2022 Letter of Compliance

Hospital/Facility Name:_____
(Print Name)

		YES	NO
1.	Licensed by the Michigan Department of Health and Human Services (MDHHS) as: (check one) A. Hospital _____ B. Free Standing Facility _____ C. Hospital Provider-based ED _____	____	___
2.	If a hospital/facility makes a permanent change in their categorization, the facility shall notify the Oakland County Medical Control Authority (OCMCA) 30 days in advance of the change.	____	____
3.	Hospital has 24/7 interventional cardiac catheterization capabilities.	____	____
4.	Trauma Levels: A. Verified by the American College of Surgeons as a Level 1, 2, or 3 Trauma Center.	____	____
	B. Verified by the State of Michigan as a Level 3 or 4 Trauma Center	____	____
	C. Designated by MDHHS as a Level 1 through 4 Trauma Center. Please indicate level and date of last inspection/designation. ADULT LEVEL: _____ DATE: _____ PEDIATRIC TRAUMA LEVEL: _____ DATE: _____	____	____
5.	Stroke Levels: Certified as a Stroke Center.	____	____
	A. Indicate the facility's certifying body: _____		
	B. Level I Comprehensive Stroke Center	____	____
	Level II Thrombectomy Stroke Center	____	____
	Level III Primary Stroke Center	____	____
	Level IV Acute Stroke Ready	____	____
	C. Please indicate date of last inspection/verification. DATE: _____		
6.	Assure that the emergency facility has a full-time emergency medicine Board Certified/Eligible emergency physician director whose primary clinical responsibility is emergency medicine.	____	____
7.	Assure that an emergency medicine Board Certified/Eligible emergency physician be available 24/7 to provide online medical direction and handle ALS runs at all times.	____	____
8.	Accept the responsibility for replenishing medication and medical supplies, expended by ALS personnel during treatment of a patient, as per the Regional Drug Box Policy and IV Auxiliary Supply Policy.	____	____

9. This facility designates the OCMCA (including its PSRO) to perform professional practice review functions on behalf of the facility, including review of pre-hospital medical direction furnished in Oakland County and recommendations for improvement of such care. ____ ____

10. Facility will participate in the EMS system quality assurance program, and will supply data on outcome of patients as agreed to by the OCMCA. ____ ____

11. MEDICAL CONTROL HOSPITALS WITH LSA OVERSIGHT

A. Facility will provide education activities for LSAs, additional activities agreed upon by the LSA and the facility, activities as directed by the OCMCA PSRO, and activities that may include EMS run report review. ____ ____

B. Facility agrees to allow and encourage the Medical Control Physician the ability to be an advisor to EMS personnel. Educate and communicate with hospital medical staff on issues concerning the EMS community, including all protocols and protocol updates. This may include: auditing the medical direction given by the Medical Control Hospital; and assist in developing EMS educational programs. The Hospital shall report all EMS agency and personnel incidents or concerns to the OCMCA office. ____ ____

12. Facility follows the OCMCA Medical Control and Participating Hospital Policy, and the Epi-Auto Injectors Exchange Policy. ____ ____

13. Hospital/facility will enter CARES data, as necessary. ____ ____

14. Completion of Addendum Facility Survey (see addendum). ____ ____

OAKLAND COUNTY
MEDICAL CONTROL AUTHORITY

Addendum to Letter of Compliance
Facility Survey

1. Helicopter Pad
   On-site _____ Off-site _____

Indicate Number

2. Estimated number of hospital personnel, including full/part time and volunteers. _____

3. Patient bed capacity. _____

4. EMS entrance code. _____

5. Please indicate the specialties that are available at your facility:

   ☐Cardiac – Cooling
   ☐Cardiac – Open heart
   ☐Cardiac - 24/7 interventional cardiac catheterization capabilities
   ☐Neonatal
   ☐NICU Level III II I
   ☐OB/Labor
   ☐Pediatrics
   ☐PICU Level I II
   ☐Adult Burn (severe)
   ☐Pediatric Burn (severe)

6. Select which Special Studies/Programs that your Hospital participates:
   Community Paramedicine Study
   Stroke Systems of Care Study
   Emergency Triage, Treat, and Transport (ET3) Special Study
   eComs/eBridge Study

OCMCA Hospital
Emergency Contact Information

In the event that the Oakland County Emergency Operations Center (EOC) is activated due to disasters/emergencies, additional county resources may be required. Please provide the following information:

Hospital:_____ **Address:**_____

ED 24/7 #: _____ ***ePCR Fax #:*** _____

ePCR E-mail Address_____ **EMS Recorded Line:**_____

CEO:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

Hospital EMS Coordinator/Liaison:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

ED Director:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

MCC Physician:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

MCC Physician Alternate:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

Pharmacy Director:_____ ***E-mail address*** _____

Work # _____ ***Cell #*** _____

Trauma Program Coordinator:_____ ***E-mail address*** _____
(if applicable)
Work # _____ ***Cell #*** _____

Please let the staff at the OCMCA know of any changes throughout the year.

Electronic Signature needed

ED Director (Signature)

ED Director (PRINT)

Date

Note: MCC Physician Member and Member Alternate Physician serve as the Medical Control Physician on behalf of Life Support Agencies represented by your facility, in accordance with the OCMCA Medical Control and Participating Hospital Policy.

Mutual/EMS Aid Policy

The Oakland County Medical Control Authority (OCMCA) requires all life support agencies, operating within the OCMCA area, have written mutual aid agreements with agencies that are geographically within and adjacent to the OCMCA.

Definitions

Automatic Aid: assistance provided by one agency to another that the dispatch center, without a command officer's input, can send or request equipment based on the information from the call to the public safety answering center. The intent of automatic aid is for day-to-day, pre-arranged, protocol driven, pre-hospital care deployment.

Mutual Aid: assistance provided by one agency to another and in return the other agency can expect help when needed; requires an agency's command officers to make a specific request for assistance from a neighboring jurisdiction.

EMS Aid: Agreement by all OCMCA agencies to provide response to **emergency requests (lights and sirens responses only)** across municipal boundaries, if available. Availability will be determined by the requested agency. EMS Aid **IS NOT** a replacement for the required mutual aid agreements and shall not be used to supplement day to day operations of any Life Support Agency~~agency or municipality~~. EMS Aid may only be utilized if Mutual Aid is not available.

Procedure

1. Mutual and Automatic aid agreements entered into by life support agencies within the OCMCA, shall be retained by the agency and a copy given to the OCMCA office upon request.
2. Automatic aid is restricted to congruent staffing and level of licensure. Mutual aid is not restricted to congruent staffing and level of licensure.
~~2.~~3. EMS aid shall only be requested by an OCMCA LSA, or their dispatch center as directed by the LSA having jurisdiction, and responses shall be based on the requested agencies availability.

Request for mutual/EMS aid (as defined above) should not exceed more than 5% of the requesting LSA's normal call volume.

New or Upgraded EMS Agency Policy

Requirements for new life support agencies (LSA's) and agencies that propose to change their level of services.
This protocol applies to:

1. Agencies that are applying as a new service in the Oakland County MCA area.
2. Existing agencies that are upgrading/changing the level of service they provide (e.g. MFR service that wants to now become a BLS service).
3. Any change in service not requiring a license change (e.g. addition of inter-facility transports) must include notification to the OCMCA.

The agency must electronically submit all of the required documentation (listed below) to the Oakland County Medical Control Authority. All paperwork must be submitted at least two weeks prior to the next Professional Standards Review Organization (PSRO) meeting. It is highly recommended that the agency has OCMCA staff review completed application prior to submission.

List of Required Paperwork:

1. A copy of the completed proposed application to be submitted to the State, with all signatures present. This will include:
   a. A list of all vehicles licensed/proposed to be licensed by the service with the State, the year, make, VIN, and license plate number for each vehicle.
   b. A list of all licensed EMS personnel, their names, license number, level, expiration date, and, if they are paramedics, ACLS certification expiration date; and
   c. Proof of State of Michigan required insurance.
2. A copy of the completed OCMCA Letters of Compliance, with all signatures present.
3. Copies of all mutual aid agreements with other Oakland County approved LSA's who are licensed at or above the level proposed by the applying agency. One mutual aid agreement is required with an OCMCA approved LSA at or above the level proposed by the applying agency.
4. A complete "New/Upgraded EMS Agency Form" signed by the Chief of the department, or the President of the agency.
5. Provide written documentation from each approving geographic service area (GSA), explaining how your agency will operate in the GSA and respond to emergencies in that area. Documentation must be signed by the GSA, or designee and agency. The documentation shall include the following:
   a. Provide at least 1 vehicle available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.
   b. Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its geographic service area, within the requirements set forth in the **8.13 Response Time Protocol**.

c. Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.
d. Proposed start of operations date.
e. Understands this documentation must be completed annually if the agency does not have primary geographical service area in Oakland County.

6. Provide the OCMCA with at least two references from other Medical Control Authorities where you have operated. The OCMCA will send a letter and form to each MCA requesting a report of Good Standing.
7. Maintain a physical station with a minimum of one life support vehicle with 24/7 staffing (of a type commensurate with what is written on the agency's license) that is available for response to requests for emergency assistance, and is staffed on a 24/7 basis within Oakland County.

The agency (chief, president or designee), along with their Medical Control physician, will be required to attend the PSRO meeting, in which the application will be reviewed and considered, and to answer questions regarding the application.

Once reviewed and endorsed by the PSRO, the application will be forwarded to the Medical Control Committee and Board of Directors for review and approval or denial.

Once approved, an agency will be placed on a 12-month evaluation period. During that period, the PSRO will closely oversee the agency and ensure compliance with Oakland County Protocols, Policies and Procedures. At the end of the evaluation period, the PSRO will make a recommendation to the Medical Control Committee to end the evaluation period, extend the period or deny the request to run in Oakland County. Final approval will be recommended to the OCMCA Board of Directors.

NEW / UPGRADE LIFE SUPPORT AGENCY APPLICATION

Date: _____ Agency: _____

Complete the following:

AGENCY:		**YES**	**NO**
1.	Agrees to operate under all Oakland County Medical Control Authority protocols, policies and procedures.	☐	☐
2.	Has a medical control hospital and medical control hospital physician. Medical Control Hospital: _____ Physician (MCC member/alt):	☐	☐
3.	If proposed coverage is less than current coverage in quantity of vehicles, level of licensure, or average response time, justification is attached explaining the reason for the proposed coverage.	☐	☐
4.	Have the owners/officers of the agency have ever been convicted of a felony?	☐	☐
STAFFING:		**YES**	**NO**
5.	Meets Oakland County staffing requirements and the personnel meet Oakland County qualifications.	☐	☐

NOTE: If "No" is checked for any statement (except for number 4), you must provide sufficient documentation to explain the variance. If "Yes" is checked for number 4, provide an explanation.

Agency will provide the following:

1. Attach a detailed communication plan that meets OCMCA Communication Policy requirements, based on level of licensure. Requests must meet current MDHHS MEDCOM plan requirements, as well.
2. Attach a 2-month schedule for the units and personnel proposed in this application.
3. List all types of service to be provided, as well as service area (list current as well as proposed).
4. Attach a written plan to meet and comply with the Oakland County EMS Response Time Standards (8.13).
5. Attach a map showing the response area for each Oakland County based vehicle (this can be drawn on the map). Response area must be small enough to ensure that Oakland County Medical Control Authority response time criteria are met. List each vehicle:

Level of Licensure:	Number of Vehicles:	Average Response Time:

6. Provide written documentation from each approving geographic service area (GSA), explaining how your agency will operate in the GSA and respond to emergencies in that area. Documentation must be signed by the GSA or designee and agency. The documentation shall include the following:
   a. Provide at least 1 vehicle available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.
   b. Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its geography service area, within the requirements set forth in the **8.13 Response Time Protocol**.
   c. Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.
   d. Proposed start of operations date.
   e. Understands this documentation must be completed annually if the agency does not have primary geographical service area in Oakland County.
7. If the application involves upgrading the level of service, a plan must be attached that explains how the agency will deal with newly licensed personnel working together.
8. Provide mutual aid agreement(s) with an OCMCA approved LSA at or above the level proposed by the applying agency.
9. If the service is a corporation, articles of incorporation are included.

_____
Signature – Chief of Department or Agency President

Patient Prioritization

The purpose of this protocol is to guide EMS to accurately assign patient priority based on condition.

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

Priority 1 *Unstable*	**Unstable** patients are critically ill or injured patient with an *immediate* life-threatening condition.	A patient that has an acutely life-threatening illness or injury and is unstable.
		• Unstable or deteriorating vital signs
		• Compromised airway that cannot be secured by EMS.
		• Severe respiratory distress/failure
		• Cardiac arrest or post cardiac arrest
		• Stroke ≤24 hours of last known well
		• STEMI
		• Significant blunt or penetrating trauma including but not limited to:
		  ○ Airway compromised
		  ○ Respiratory distress
		  ○ Signs of inadequate perfusion

Priority 2 *Potentially unstable*	**Potentially unstable** patients are seriously ill or injured patient *without immediate* life-threatening condition.	A patient that is currently stable but is felt to have a condition that may become unstable or life-threatening if not evaluated and treated rapidly. • Hemodynamically stable chest pain without signs of STEMI • Stroke >24 hours of last known well • Altered mental status – not acutely deteriorating • Seizure - Post-ictal not actively seizing • Hemodynamically stable abdominal pain • Hemodynamically stable >65 y/o fall with confirmed or suspicion of head injury and currently taking blood thinner medications
Priority 3 *Stable*	**Stable** patients are Ill or injured patients not fitting the above two categories who require medical attention but do not have a life-threatening problem.	A patient that does need to receive medical evaluation but does NOT have a potentially life-threatening illness or injury at the time of assessment or transport by EMS.

Priority 4 *Dead*	**Dead** patients are absent of all vital signs and do not require further medical attention, per protocol.	**See 7.6 Patient Death, Termination of Resuscitation and Pronouncement**

Rerouting Policy

Purpose

Michigan Public Act 368 of 1978, as amended, authorizes local medical control authorities to "…establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region". To ensure the availability of patient care, the following will be adhered to by OCMCA life support agencies and emergency facilities:

A. ED status limitation (rerouting of EMS patients) will only be considered in extreme circumstances. These are defined as: Facility-specific loss of CT scanner capability, loss of x-ray capability or lack of Operating Room capabilities.

~~B.~~ Facility specific in-house disaster such as an extensive fire, flooding or loss of electrical power, or other catastrophic event. The facility cannot change to Status C unless the facility has declared an in-house disaster, as defined in policy, by each facility.

C. ED status limitation (rerouting) is not to be initiated because of:
- Lack of staffing
- Lack of in-patient beds
- Overcrowding of the emergency department
- Actual community disaster (Unless system directed)

D. Critical patients will be accepted by the closest appropriate emergency facility when transportation to a more distant facility could pose further significant risk to the patient, regardless of the facility's rerouting status. Serious, but stable patients may be rerouted by an on-line medical control physician.

E. The "Status B and C" must be re-evaluated frequently by an authorized person to ensure immediate communication of the change in status. At a minimum, the "ED STATUS" will be re-evaluated no less than at the end of each shift. Any change will be communicated immediately to all concerned.

F. **If the three closest facilities to the incident are all Status C, or all on similar status, the unit should contact the closest facility for transport to that facility. The on-scene EMS crew will determine the three closest facilities.**

G. EMSystem, through EMResource is to be utilized by all participating emergency facilities. EMResource shall be updated two (2) times per day, and as status changes, with the current status of the facility. If a facility is rerouting (Status B or Status C) and has not updated EMResource with this status change, the facility shall accept incoming patients from the EMS system.

H. It is the responsibility of the emergency facility to use the following categories to indicate rerouting status:

STATUS A: Accepting patients appropriate for that emergency facility.
STATUS B: Emergency facility's capabilities are limited. Services or resources not available should be specified, and that facility's use avoided for patients requiring them.
STATUS C: The emergency facility meets the criteria to reroute EMS patients (see A.).

I. Facility
   1. Each facility shall have and follow their internal rerouting policy.
   2. Patients will not be rerouted on the basis of ability to pay.
   3. On-line medical control, via participating Medical Control hospitals, will remain available at all times.
   4. Ambulances already on hospital property will not be rerouted.

Scene Patient Management

Public Act
Authority for the management of a patient in an emergency is vested in the licensed health professional or licensed emergency medical services personnel at the scene of the emergency who has the most training specific to the provision of emergency medical care. If a licensed health professional or licensed emergency medical services personnel is not available, the authority is vested in the most appropriately trained representative of a public safety agency at the scene of the emergency.

Note: No other individuals (police, fire, other physician) shall be allowed to determine patient destination or disposition without prior approval from the on-line medical control physician providing medical control.

Transfer to Another Life Support Unit
A Basic Life or Advanced Life Support unit may transfer patient management to another life support unit of equal or greater qualification by mutual agreement, unless it falls under the ALS to BLS Transfer of Care Protocol (see protocol).

Multiple Unit Response
Second responding Advanced Life Support and Basic Life Support units are responsible to assist in patient care until released by the managing Advanced Life Support Unit.

"Call Jumping" is defined as responding to another agencies geographic service area for an emergency response, without the knowledge of the agency having jurisdiction. If an agency is responding into another agencies geographic service area, every effort shall be made to advise that agency to allow the agency having jurisdiction the ability to respond. This will be dealt with accordingly and reported to the appropriate agency.

Extended Care Facilities (ECF)
Once an EMS unit is on the scene, management of the patient shall be according to Oakland County policy with respect to patient care, communication and transportation.

Tactical Emergency Medical Services (TEMS) Team

Purpose:
The purpose of this protocol is to allow for the use of tactical EMS paramedics, within the Oakland County Medical Control Authority, during police related activities and training. This protocol does not provide liability coverage as prescribed under the EMS law, for tactical teams that originate and/or operate out of non-life support agencies (i.e. police departments, sheriff offices SWAT teams).

Procedure:
Any ALS agency that seeks to utilize a TEMS team will provide personnel with paramedic level licensure within the State of Michigan, and training in tactical scenarios.

When responding to a tactical scene, within their geographical service area (GSA), the TEMS team shall respond along with an ALS unit from their Agency. If responding outside of their GSA an EMS transport unit, preferably ALS, should be requested from the local jurisdiction. This will only be done if tactically feasible or prudent.

If responding to a tactical scene outside of their GSA, an ambulance from the local jurisdiction should be dispatched, or placed on standby, as well. In the event a patient(s) arises out of the tactical situation, the TEMS paramedic(s) will provide a comprehensive verbal report upon transferring care to the transporting unit. If the transporting unit is not ALS, or when it is deemed necessary, the TEMS paramedic(s) will accompany the patient to the hospital as to maintain or optimize patient care.

The TEMS paramedic(s) will follow the OCMCA protocols and will have radio capabilities to contact OCMCA hospitals for the purpose of accessing on-line medical control.

TEMS Equipment List
The following is a list of equipment that should be deployed with a TEMS team. In the interest of maintaining tactical mobility, items may be provided by the ALS unit providing standby.

- AED/Monitor (may be provided by standby unit)
- Jump kit/TEMS kit
- Oxygen and supplies (may be provided by the standby unit)
- Airway management supplies
- Suction (may be provided by the standby unit)
- IV kit
- Drug package/kit (modified)

TEMS Drug Package

Any ALS agency wishing to obtain a modified drug package may do so by working with their Medical Control Physician in developing a plan on how and which medications will be carried by the TEMS team. Once this plan is developed, it must be approved by the Medical Director of the OCMCA, or his/her designee.

Once approval is obtained, the agency must provide a device to the Medical Control Hospital Pharmacy, which is capable of being sealed. The drug package must remain with the TEMS team while deployed. This drug package must be inventoried and sealed with an expiration date listed on the label. The drug package must be kept in a secured area when not in use.

June 3, 2022 Section 8.51

Transfer of Patient Care to Receiving Facility

Purpose**:** To create a professional standardized approach to optimize communication between pre-hospital providers (EMS) and emergency department personnel when providing care for ill or injured patients. In addition, to decrease medical errors related to miscommunication between EMS and emergency department personnel.

Procedure:

1. Patient is brought into the designated room. EMS will give handoff report ONE time, at the patient side, to appropriate hospital personnel.

2. When patient requires emergent attention to airway, breathing, or circulation, transfer of patient care may occur prior to the formal handoff report.

3. Once an expeditious initial patient assessment is complete, a formal "**EMS Timeout**" handoff report will occur.

4. **EMS Timeout** is called by the hospital team leader. Each facility is to identify who has this task (Attending, Senior Resident, Charge Nurse, etc.)
   ALL participants in the room are expected to stop and listen to the EMS handoff report.
   ALL lifesaving interventions such as CPR, bag mask ventilation, etc., continues.

5. EMS delivers uninterrupted patient report, which should be no more than 30-45 seconds, when appropriate.

6. When EMS completes the handoff report, the EMS personnel will:
   - Answer questions.
   - A patient transfer of care signature is recommended*. If a signature is obtained, it will be from the hospital team lead, or appropriate designee. They will sign EMS patient care record (PCR) with legal signature, including full name and credentials.

7. Verbal EMS transfer of care report shall be treated as part of the health care record and must be professional, accurate, and consistent with information included in the final submitted EMS electronic, or written patient care report.

From: MDHHS-MCAProtocols
To: Babb, Nicole (DHHS)
Subject: FW: Revised Pediatric HFNC Protocol
Date: Wednesday, January 11, 2023 8:56:31 AM
Attachments: 8-59 Pediatric Interfacility High Flow Nasal Oxygen 12-14-22 MARKUP.docx

For January QATF agenda

From: Lance Corey <lcorey@kcems.org>
Sent: Tuesday, January 10, 2023 11:18 PM
To: MDHHS-MCAProtocols <MDHHS-MCAProtocols@michigan.gov>
Cc: Benjamin Long <Benjamin.Long@Ecs-wmi.com>; Bobbi Kelsch <BKelsch@wmrmc.org>; Bradley Huizenga <bradley.huizenga@spectrumhealth.org>; Brett Reich <reichbre@hotmail.com>; Carrie Clark, DO <Carrie.Clark@ecs-wmi.com>; Chad Lawton <clawton@wmrmc.org>; Courtney Greene <cploeg@wmrmc.org>; DO Loren Reed <reeddol@mercyhealth.com>; Dana Yarger <Dana.Yarger@spectrumhealth.org>; Deb Cholka <cholkad@mercyhealth.com>; Eric Smith <esmith@montcalm.us>; Jayme Madden <jayme.maddern@spectrumhealth.org>; Jen Mervau <Jennifer.Mervau@Ecs-wmi.com>; Jennifer Bach, DO, FACEP <Jennifer.Bach@Ecs-wmi.com>; Jeremy Baldrica <jbaldrica@kcems.org>; Jerry Evans <medicaldir@wmrmc.org>; Jim Walters <drj8892@gmail.com>; Joel Robinson <Joel.Robinson@ecs-wmi.com>; Kerri A. Wiseman <kerri.wiseman@spectrumhealth.org>; Kevin Franklin <kevin.franklin@spectrumhealth.org>; Lindsey Rauch <lrauch@kcems.org>; Matt Scarff <mattzilla714@hotmail.com>; Mitchell Van Overloop, RN, BSN, CEN <MVanOverloop@ecs-wmi.com>; Nicholas Chapin <Nicholas.Chapin@Ecs-wmi.com>; Nicholas McManus <nMcManus@wmrmc.org>; Rich Szczepanek <richs@omcba.org>; Ryan Munsell <Ryan.Munsell@Ecs-wmi.com>; Scott Wilkinson <swilkinson@wmrmc.org>; Susan Gatrell <susan.gatrell@spectrumhealth.org>; Tara Lanz <tara.lanz@sparrow.org>; Todd Chassee <tchassee@kcems.org>; Andrew Schrotenboer <Andrewschrotenboer@gmail.com>
Subject: Revised Pediatric HFNC Protocol

Good evening,

Attached is the final version of our Pediatric HFNC IFT protocol.

We are still awaiting a few MCA's that are still completing the final approval process which should be completed prior to the January QATF meeting.

Please let me know if there is anything that you are in need of.

Lance Corey
MCA Systems Administrator
Kent County EMS, Inc.
678 Front Ave. NW, Suite 410

Grand Rapids, MI 49504

C: (231) 742-1131
P: (616) 451-8438
F: (888) 505-6813
lcorey@kcems.org

Pediatric Interfacility High Flow Nasal Oxygen (HFNO)

Adopting MCAs will identify which level this protocol has been approved for ~~have an "X"~~ under their MCA name. If no provider level ~~"X"~~ is present, the MCA has not approved or adopted the protocol.

Allegan	Barry	Clare	Ionia	Isabella	Kent	Mason
	Paramedic		Paramedic		*Enhanced Paramedic*	Paramedic
Montcalm	**Muskegon**	**N. Central**	**Newaygo**	**Oceana**	**Ottawa**	
Enhanced Paramedic	*Paramedic*	*Paramedic*	*Enhanced Paramedic*	Paramedic	Paramedic	

If ***Paramedic*** is identified, only a Paramedic who has received additional MCA approved training, or an Enhanced or Critical Care Paramedic, is authorized to utilize this protocol.

If ***Enhanced Paramedic*** is identified, only an Enhanced or Critical Care Paramedic is authorized to utilize this protocol.

Purpose: This protocol is issued to outline the process for the identified EMS provider to transport a patient on a high flow nasal cannula while completing an interfacility transfer.

I. Indications
   A. Order from sending facility/physician as part of an interfacility transfer with an Paramedic Practitioner in attendance with the patient,
   B. Hypoxic respiratory distress or respiratory distress,
   C. Availability of an MCA approved high flow nasal cannula device and necessary supplies required to facilitate transport of the patient.

II. Contraindications
   A. Inability to provide continuous, humidification using an approved delivery device,
   B. Inability to provide therapy through appropriately sized nasal prongs,
   C. Insufficient supply of oxygen to complete the transport.

III. Procedure
   A. Ensure that an adequate supply of oxygen is available for the transport.
      i. Calculate the amount of oxygen needed prior to departure.
      ii. Ensure that you have at least two times the amount of oxygen anticipated.
   B. Perform appropriate patient assessment, including obtaining vital signs, pulse oximeter reading, cardiac rhythm, and current device settings
   C. Utilize facility settings to ensure FiO2 is set to maintain SpO2 at or above 94% (or to patient's baseline oxygen saturation).
   D. Utilize facility settings to set flow rate in liters per minute (L/min) to decrease work of breathing.

E. Reassess vitals, work of breathing, mental status, and breath sounds. Reassessment should be continuous, but documentation of vitals must occur at least every five minutes throughout patient contact.
F. Consider the need for escalation of respiratory support if patient remains in respiratory failure on more than 2 L/kg/min of flow or maximum settings for the delivery device.
G. If patient deterioration occurs, terminate HFNO and begin positive pressure respiratory support via BVM, CPAP, or BIPAP if necessary.

IV. Notes

A. The sending facility will provide Just In Time refresher training at the request of the EMS provider assigned to the interfacility transfer.
~~A.~~B. For suspected or confirmed COVID-19 patients, personnel must don respirators, eye protection, gowns, and gloves for transport.
~~B.~~C. If ground transport is not available, consider aeromedical transportation.
~~C.~~D. Informational videos for the Airvo II device are able to be accessed for review at: https://www.fphcare.com/us/hospital/adult-respiratory/optiflow/airvo-2-system/#airvo2videos
    i. Or by utilizing this QR Code:

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: KCEMS/WMRMCC

Medical Director: Dr. Todd Chassee

Protocol: BLS Transport Util

Submitted by: Lance Corey

Identify where you are requesting to make change/changes:

☐ Medication ☐ Pre-Medical Control ☐ Post-Medical Control ☐ Procedural

☐ Other (specify)

■ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):

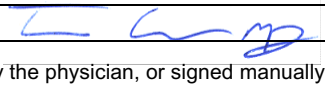
Currently there is not a consistent message throughout our local and regional medical control systems. Through review of current state approved protocols, national model protocols, and input from our local providers the attached protocol was developed.

Rationale: Why is this addendum necessary for your MCA?

Kent County EMS & the West Michigan Regional Medical Control Consortium feel that by developing this protocol we are providing clear direction and expectation setting for our systems and providers as it relates to the utilization of BLS transport units.

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

This protocol is a new system protocol for both Kent County EMS and West Michigan Regional Medical Control Consortium.

Medical Director's Signature:  *Date: 01/10/2023*

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: MDHHS-MCAProtocols@michigan.gov

West Michigan Regional MCC

SYSTEM

BASIC LIFE SUPPORT TRANSPORT UTILIZATION

Date: January 10, 2023 Section: 8.XX

Adopting MCAs will have an "X" under their MCA name. If no "X" is present, the MCA has not approved or adopted the protocol.

Allegan	Barry	Clare	Ionia	Isabella	Kent	Mason
Montcalm	**Muskegon**	**N. Central**	**Newaygo**	**Oceana**	**Ottawa**	

Purpose: This protocol is issued to outline the process for a Basic Life Support (BLS) ambulance to transport a patient and/or for an Advanced Life Support (ALS) unit to turnover care to a BLS unit when patients need or desire transport to a hospital.

BLS Transportation Determination Procedure:

1. A BLS ambulance shall transport a patient, and disregard an ALS response, if the patient meets the following criteria:
    a. The patient with vital signs within these normal ranges:
        i. Pulse Rate: between 50 – 110, and regular,
        ii. Respiratory Rate: greater than 10 and less than 26, without signs of respiratory distress,
        iii. Systolic Blood Pressure: greater than 90,
        iv. SpO2: greater than 94% on room air or maintained with the use of a nasal cannula.
    b. The patient is alert and oriented, or is alert to normal presentation, as determined by caregiver(s).
    c. The patient is not expected to require ALS care while being transported to the receiving facility.
    d. The patient does not require cardiac monitoring (e.g. chest pain, dyspnea, syncope).
2. A BLS ambulance may also transport a patient outside of these parameters if transport by a BLS ambulance to an appropriate receiving facility can be accomplished before an intercept with an ALS ambulance can be made. In this situation, the BLS ambulance should transport as soon as possible.
3. A BLS ambulance should not delay patient care and transport while waiting for an ALS ambulance. If ALS arrival at scene is not anticipated within 5 minutes of initiation of transport, arrangements should be made to intercept with the ALS ambulance enroute to the appropriate receiving facility.
4. A BLS unit can transport a patient not meeting the clinical criteria above without an ALS intercept, if the destination hospital can be reached under normal traffic conditions within 10 minutes.

Examples of patients appropriate for BLS transport:

1. Minor trauma without concerning mechanism of injury or special trauma considerations (e.g., pregnant, blood thinners), and not needing ALS medications (e.g., analgesia).
2. Opioid overdose with successful reversal with naloxone and with stable vital signs and normal level of consciousness.
3. Suspected alcohol intoxication with stable vital signs, alert, normal blood glucose, no recent seizure, no evidence of trauma, no concern for co-toxins.

4. Behavioral health condition with patient with stable vital signs, alert, and fully cooperative who have not required (or anticipated to need) physical or pharmacologic restraint.
5. Patient was found hypoglycemic, has received ALS care resulting in normal level of consciousness, and not taking oral or long-acting anti-hyperglycemic medications.
6. Patients who have received analgesia (e.g., fentanyl IV/IN) and otherwise meet criteria.
7. Note: Patients who meet above criteria who have a saline lock in place (no IV fluid infusion) who otherwise meet the above criteria may be transported by BLS.

ALS Consultation Procedure:

1. A BLS provider should request an ALS assessment to be conducted after their initial assessment is completed and there is a specific reason that the patient's needs exceed their capabilities.
2. Conditions that should have an ALS Consultation, but are not limited to, this request include:
    a. Altered Level of Consciousness
    b. Allergic Reaction resulting in difficulty breathing or swallowing, an altered level of consciousness, or hives within 5 minutes of exposure.
    c. Cardiac related symptoms.
    d. Impeding cardiac or respiratory arrest.
    e. Moderate to severe pain.

Criteria for patient care to be transferred from an ALS unit to a BLS transport unit

1. Patients must have:
    a. Patent airway, maintained without assistance or adjuncts.
    b. Patient appears hemodynamically stable with medical complaints or injuries appropriately cared for at the BLS level.
    c. No imminent changes are anticipated in the patient's present condition.
    d. Patient presents at baseline mentation and GCS, or if unknown baseline GCS greater than or equal to $\leq$14.
    e. The EMT in attendance must be willing to accept the transfer of care as it relates to the patient's condition.
    f. No patient may be transferred to BLS once an ALS intervention has been initiated with the following exceptions:
        i. IV placement with saline lock,
        ii. Dextrose administration with return to baseline mental status,
        iii. Naloxone administration with return to baseline mental status.

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

ALS to BLS HANDOFF PROCEDURE:

1. ALS personnel are required to provide BLS personnel with a complete hand-off including complete medical history, pertinent physical exam findings, vital signs, and treatment provided and response.
2. ALS personnel provide BLS personnel with an MCA approved EMS Field Note form with above information.
3. ALS Responsibilities:
   a. Provide assessment and care consistent with current MCA approved protocols
   b. Assure patient meets clinical criteria above
   c. Provide verbal and written hand-off to BLS personnel
   d. Remain with patient until transfer of care to BLS personnel
4. In the situation where the first responder unit is an ALS non-transporting unit the hand off will follow the following process:
   a. If the patient does not meet the BLS transport criteria, the ALS non-transport provider(s) must accompany the patient to the appropriate receiving facility and continue ALS care throughout.
   b. If the ALS non-transport provider(s) believe the patient can be managed by the BLS ambulance providers, but fall outside the clinical criteria, then a call to the appropriate Medical Control facility must be made to request approval. If approval is received, then the handoff will proceed as outlined.
      i. The approval must be documented on both ALS and BLS patient care reports.
5. BLS Responsibilities:
   a. Assure that patient meets clinical criteria above
   b. Receive verbal and written handoff from ALS personnel and obtain any additional information prior to transport.
   c. Provide continued BLS care consistent with current MCA protocols.
   d. In the event of an unanticipated medical emergency requiring ALS care, request an ALS intercept or continue to destination hospital alerting them as to change in condition (whichever provides most timely access to ALS care).
   e. Provide verbal and written EMS Field Notes hand-off to hospital personnel.
   f. Document EMS encounter (including ALS component) per protocol.
6. In the event an ALS ambulance is needed to respond to another emergency and, after determining a patient is appropriate for BLS transport as described above, it is permissible for the ALS unit to temporarily transfer care of the patient to the first responders on scene pending the arrival of the BLS ambulance provided the first responder personnel, on scene, are comfortable with handoff.
   a. Examples of appropriate use for this provision include:
      i. A critical 9-1-1 patient request with no other resources closer to respond including an ECHO response, a cardiac arrest, or a respiratory arrest.
      ii. A high priority patient on scene requiring immediate transport with additional low priority patients on scene.

Quality Improvement and Reporting Events:

1. All BLS transport responses occurring under this protocol will be reviewed by the EMS agency and reported weekly to the local MCA in a format acceptable to the MCA.
2. Any of the following conditions will be considered to be a mandatory reporting event and must be submitted to the local MCA by the transporting agency within 96 hours of the incident.
   a. Any BLS response under this protocol that responded to and transports a patient as an "ECHO", "DELTA" or "CHARLIE" patient without an ALS intercept.
   b. A Priority 3 response resulting in a need for ALS care, and/or any emergency transport to the hospital.
   c. Any approved requests from ALS providers for BLS units to transport patients outside of the stated clinical criteria.

Michigan Department of Health and Human Services
Bureau of EMS, Trauma and Preparedness
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207
517-335-8150 (Phone)

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA: KCEMS/WMRMCC

Medical Director: Dr. Todd Chassee

Protocol: BLS 911 Use

Submitted by: Lance Corey

Identify where you are requesting to make change/changes:

- ☐ Medication
- ☐ Pre-Medical Control
- ☐ Post-Medical Control
- ☐ Procedural
- ☐ Other (specify)
- ■ Additional Protocol

Failure to complete this form without appropriate documentation and/or justification will result in automatic denial and will be returned for resubmission.

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):

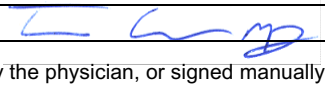
Currently there is not a consistent message throughout our local and regional medical control systems. Through review of current state approved protocols, national model protocols, and input from our local providers the attached protocol was developed.

Rationale: Why is this addendum necessary for your MCA?

Kent County EMS & the West Michigan Regional Medical Control Consortium feel that by developing this protocol we are providing clear direction and expectation setting for our systems and providers as it relates to the utilization of BLS transport units within the 911 system.

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)

This protocol is a new system protocol for both Kent County EMS and West Michigan Regional Medical Control Consortium.

Medical Director's Signature:  *Date: 01/10/2023*

This form may be electronically signed by the physician, or signed manually then scanned and emailed along with the appropriate attachments to: MDHHS-MCAProtocols@michigan.gov

West Michigan Regional Medical Control Consortium

SYSTEM PROTOCOL

Use of Basic Life Support Ambulances for 911 Responses

Date: January 5, 2023 Section: 8.XX

Adopting MCAs will have an "X" under their MCA name. If no "X" is present, the MCA has not approved or adopted the protocol.

Allegan	Barry	Clare	Ionia	Isabella	Kent	Mason
Montcalm	**Muskegon**	**N. Central**	**Newaygo**	**Oceana**	**Ottawa**	

Purpose: This protocol is issued to authorize the use of licensed Basic Life Support (BLS) ambulances for the use in 9-1-1 and other EMS Incidents.

Dispatching Procedure:

1. A BLS ambulance may be dispatched as part of a dual transport unit response for "ECHO" level responses.
    a. A BLS ambulance should be dual dispatched with ALS to "ECHO" Level incidents when the BLS ambulance is closer than ALS ambulance, regardless of response times.
    b. The BLS ambulance should return to service (including while on scene) whenever services no longer needed.
2. A BLS ambulance may be dispatched when an ALS ambulance is not readily available.
    a. In the event that no ALS unit is available to respond (including in- and out- of-county mutual aid) or if the anticipated response time of an ALS unit exceeds the projected time interval for BLS response to hospital arrival, a BLS ambulance may be used to respond to the incident.
3. A BLS ambulance may be the primary responding unit to all predetermined Emergency Medical Dispatch (EMD) codes approved by the local Medical Control Authority.
    a. A BLS ambulance may replace an ALS ambulance on Priority 2 and 3 incidents when an on-scene life support unit has determined the patient is not in need of ALS care.

Quality Improvement and Reporting Events:

1. All BLS responses occurring under this protocol will be reviewed by the EMS agency and reported weekly to the local MCA in a format acceptable to the MCA.
2. Any of the following conditions will be considered to be a mandatory reporting event and must be submitted to the local MCA by the transporting agency within 96 hours of the incident.
    a. Any BLS response under this protocol that response to and transports a patient as an "ECHO", "DELTA" or "CHARLIE" patient without an ALS intercept.
    b. A Priority 3 response resulting in a need for ALS care, and/or any emergency transport to the hospital.

MCA Name:
MCA Board Approval Date:
MCA Implementation Date:

Michigan
OBSTETRICS AND PEDIATRICS
PEDIATRIC MEDICATION EMERGENCY
DOSING AND INTERVENTION CARDS

Initial Date: 9/25/2014
Revised Date: ~~10/25/2017~~ Section 4-1

Pediatric Medication Emergency Dosing and Intervention Cards

Purpose: Instructions for using the Michigan Medication Emergency Dosing and Intervention Cards (MI-MEDIC). ~~Protocols are dynamic and may change based on current science. EMS personnel must be familiar with the most current set of approved protocols which take precedence over the information included in the MI-MEDIC.~~ Pediatric patients (< 14 years) utilize MI MEDIC cards for appropriate medication dosage. When unavailable utilize pediatric dosing listed within protocol

1. Obtain correct weight of the child
    a. If patient's actual weight is known, use MI MEDIC card for that weight. (DO NOT CONFUSE POUNDS and KILOGRAMS)
    b. If patient's weight is not known, use length-based resuscitation tape to determine the proper color zone.
    c. If a length-based resuscitation tape not available, use patient's age to determine color of card to use. DO NOT GUESS THE WEIGHT OF THE CHILD.
2. Select appropriate weight-based medication for intervention.
3. Select the corresponding colored card
4. Select desired medication from Cardiac Resuscitation or Medical Conditions
5. ASSURE medication CONCENTRATION on hand is as specified on card
6. Some medications should be diluted as instructed on card
7. If dilution is required, follow steps to dilute entire vial of medication prior to drawing up final ml volume to administer.
8. Confirm medication dose and volume to be delivered.
9. Administer volume of medication as desired.
10. Contact Medical Control for questions or concerns.

NOTE: Some medication doses have been rounded for safety and ease of use for the prevention of medication errors. These doses may not exactly correspond with the mg/kg dose in the pediatric treatment protocols. The use of these rounded doses has been approved for use and administration will be acceptable as long as the dose was referenced from the MI MEDIC cards.

Protocol Source/References:

Pediatric Respiratory Distress, Failure or Arrest

1. Follow **General Pre-hospital Care-Treatment Protocol.**
2. Pediatric patients (≤ 14 years) utilize MI MEDIC cards for appropriate medication dosage. When unavailable utilize pediatric dosing listed within protocol
3. Assess the patient's airway
   A. If unable to ventilate patient after airway repositioning refer to **Foreign Body Airway Obstruction-Treatment Protocol** and/or **Emergency Airway-Procedure Protocol**
   B. Consider anaphylaxis refer to **Allergic Reaction/Anaphylaxis- Treatment Protocol**
4. Allow the patient a position of comfort that also maintains an open airway
5. Titrate SpO2 to 94%
   A. Have a parent assist with **oxygen** via blow by or mask support
6. Airway should be managed by least invasive method possible.
7. Suction secretions if needed.
8. Consider CPAP (Per MCA selection, may be a BLS procedure) follow **CPAP-Procedure Protocol**
9. Do not delay transport for interventions.
10. Attempt vascular access only if necessary for patient treatment.

Suspected Bronchospasm (Wheezing):

1. Assist the patient in using their own **albuterol** Inhaler, if available
2. Administer **albuterol 2.5 mg/3ml** NS nebulized (EMT if approved by MCA) per **Nebulized Bronchodilators-Medication Protocol**

Per MCA Selection ☐ EMT

3. Consider CPAP (Per MCA selection, may be a BLS procedure) follow **CPAP-Procedure Protocol**
4. In cases of respiratory failure administer **epinephrine auto-injector** (MFR if approved by MCA). BLS not carrying auto-injectors must participate in draw up epinephrine.

Per MCA Selection ☐ MFR (Provide participating agency list to BETP)

   A. If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to epinephrine if possible.
   B. If child weighs between 10-30 kg (approx. 20-60 lbs.); administer **pediatric epinephrine auto-injector**.
   C. Child weighing greater than 30 kg (approx. 60 lbs.); administer **epinephrine auto-injector**.
5. In cases or respiratory failure administer **epinephrine** 1 mg/ml IM (BLS and MFR if selected by MCA)

MCA Approval of draw up **epinephrine**
☐ MFR
☐ BLS
(Provide participating agency list to BETP)

A. If child appears to weigh less than 10 kg (approx. 20 lbs.), contact medical control prior to epinephrine if possible.
B. If child weighs between 10-30 kg (approx. 60 lbs.) administer **epinephrine** (concentration of 1mg/1mL) 0.15 mg (0.15mL) IM
C. Child weighing 30 kg or greater; administer **epinephrine** (concentration of 1mg/1mL) 0.3 mg (0.3 mL) IM

6. Per MCA selection, if a second nebulized treatment is needed also administer **prednisone** OR **methylprednisolone**.

Medication Options:
Prednisone
50 mg tablet PO
Do not cut tablet
(Children 10 and above, if tolerated)
☐ YES ☐ NO

Methylprednisolone
2 mg/kg IV/IO/IM
(Maximum dose 125 mg)
☐ YES ☐ NO

A. For MCA with both selected, **prednisone** PO is the preferred medication. **Methylprednisolone** is secondary and reserved for when a patient can't take a PO medication.

Stridor/Suspected Croup:
1. Croup is most common in children 6 months to 6 years of age
2. Commonly associated with recent upper airway infection or fever
3. If foreign body is suspected, contact Medical Control prior to administration of nebulized **racepinephrine/epinephrine**
4. Consider humidified **oxygen**
5. If patient presents with stridor at rest without suspected airway obstruction administer nebulized **epinephrine** per MCA selection (Medical Control contact not required):

Commented [KK(C1]: Yes, if FB suspected, perhaps on-line direction may be indicated but what is on-line direction going to add? If there is stridor from any cause, racepinephrine may be helpful and is probably harmless.

MCA Selection

☐ **Racepinephrine** 2.25% inhalation solution via nebulizer

Administer by placing 0.5 mL of **Racepinephrine** 2.25% inhalation solution in nebulizer and dilute with 3 mL of normal saline.

☐ **Epinephrine** 5 mg (1mg/1ml) nebulized

6. Do not delay transport.

Respiratory Failure or Arrest:

1. Ventilate the patient using an appropriately sized BVM with supplemental oxygen.
   A. Chest rise is the best indicator of successful ventilation
   B. Ventilate at a rate appropriate for the patient:
      i. Infant: 30 breaths per minute
      ii. Child: 20 breaths per minute
   C. Utilized capnography per **End Tidal Carbon Dioxide Monitoring-Procedure Protocol** when available, to maintain end tidal CO2 35-45 mm Hg.
2. Bag Valve Mask is the preferred method of ventilation for kids under 8 years old.
   A. When unable to ventilate with BVM and basic airway adjuncts, consider advanced airway see **Emergency Airway-Procedure Protocol**
3. If opioid overdose is suspected, administer Naloxone according to MI-MEDIC cards. If MI-MEDIC is unavailable, administer **naloxone** per **Opioid Overdose Treatment and Prevention-Treatment Protocol**.
4. Monitor EKG Monitor and refer to Pediatric Crashing Patient/Impending Arrest or appropriate cardiac protocol as required?

Commented [KK(C2]: I think the Emergency Airway Protocol says use basic maneuvers when possible for patients under 15. Make sure this protocol agrees with EAP as far as age for basic maneuver preference

Commented [KK(C3R2]: Have NOT revised 7.9 yet

Medication Protocols
Albuterol
Epinephrine
Prednisone
Methylprednisolone
Racepinephrine

Protocol Source/References:

Pediatric Fever

This protocol is intended to assist EMS providers in reducing fever in the pediatric patients prior to arrival to the emergency department**. Fever is defined as a temperature of 100.4 degrees Fahrenheit (38 degrees Celsius) or greater.** Emergency management of the febrile child involves an assessment to determine if any associated problems are present which may require emergency treatment.

1. Follow **General Pre-hospital Care-Treatment Protocol**.
2. Pediatric patients (≤ 14 years) utilize MI MEDIC cards for appropriate medication dosage. When unavailable utilize pediatric dosing listed within protocol.
3. Obtain baseline temperature and document method used.
4. For patients less than 60 days, do not administer antipyretics.
5. For those who are 60 days or greater with a fever, administer antipyretic according to MCA selection

MCA Antipyretic Selection (Must select at least one) ☐ **Ibuprofen** ☐ **Acetaminophen**

6. Administer i**buprofen** if child is over 6 months old, has not been given **ibuprofen** (Motrin/Advil) in the last 6 hours and is alert.
   i. If patient's weight is known, utilize that weight and MI-MEDIC for dosing.
   ii. If patient's weight is not available, utilize length-based tape and MI-MEDIC for dosing.
   iii. If MI-MEDIC is not available, give **ibuprofen** 10 mg/kg PO or see chart below.

   OR

7. Administer **acetaminophen** if the child is over 60 days (2 months) old, has not been given acetaminophen in last four (4) hours and is alert, and:
   i. If patient's weight is known, utilize that weight and MI-MEDIC for dosing.
   ii. If patient's weight is not available, utilize length-based tape and MI-MEDIC for dosing.
   iii. If MI-Medic is not available, give **acetaminophen** 15 mg/kg PO or see chart.
8. If any question concerning alertness or ability to swallow, **DO NOT ADMINISTER.**
9. Dosing questions should be directed to online medical control.

Commented [KK(C1]: It is good that the actual dosing is listed in the protocol but these two sections conflict with the 4-1 purpose. Perhaps a reference to the dosing table included in the protocol would be appropriate

Commented [KK(C2R1]: KK - changed the clause in 4.1 should be good

Dosing Table

Child's Weight (AGE)	Children's Acetaminophen Elixir (160 mg/5ml)	Children's Ibuprofen Elixir (100 mg/5 ml)
6-12 lbs. (0-2 mos.)	DO NOT GIVE	DO NOT GIVE
13-16 lbs. (3-6 mos.)	3 mL (96 mg)	DO NOT GIVE
17-20 lbs. (7-10 mos.)	4 mL (128 mg)	4 mL (80 mg)
21-25 lbs. (11-18 mos.)	5 mL (160 mg)	5 mL (100 mg)
26-31 lbs. (19 mos-3yrs)	6 mL (192 mg)	6 mL (120 mg)
32-35 lbs. (3-4 yrs.)	7 mL (224 mg)	7.5 mL (150 mg)
36-40 lbs. (4-5 yrs.)	8 mL (256 mg)	8.5 mL (170 mg)
41-45 lbs. (5-6 yrs.)	9 mL (288 mg)	9.5 mL (190 mg)
41-51 lbs. (5-6 yrs.)	10 mL (320 mg)	11 mL (220 mg)
52-64 lbs. (7-9 yrs.)	12 mL (384 mg)	13 mL (260 mg)
65-79+ lbs. (10-14 yrs.)	15 mL (480 mg)	15 mL (300 mg)

Medication Protocols
Acetaminophen
Ibuprofen

Protocol Source/References: http://assets.babycenter.com/ims/Content/first-year-health-guide_acetaminophen_chart_pdf.pdf

Pediatric Cardiac Arrest – General

This protocol should be followed for all pediatric cardiac arrests.

- If an arrest is of a known traumatic origin refer to the **Traumatic Arrest-Treatment Protocol**.
- If it is unknown whether the arrest is traumatic or medical, and the patient does not meet dead on scene criteria per **Dead on Scene Termination of Resuscitation-Procedure Protocol**, start CPR and continue with this protocol.
- If patient is hypothermic (temperature less than 86° F (30° C):
  - Protect against heat loss
  - Remove wet clothing and consider external rewarming methods
  - If available administer warmed humidified **oxygen** and warmed **NS or LR** .
- Once arrest is confirmed, emphasis should be on avoiding interruptions in CPR.
- CPR should be done in accordance with current guidelines established by the American Heart Association.

Note: Primary cardiac arrest in the pediatric patient is rare. Most arrests are secondary to respiratory failure. Maintaining basic airway management techniques unless unable or ineffective. Advanced airway insertion attempts should be performed only if BLS airway management is ineffective. Keep CPR interruptions to a minimum. Medications given during cardiac arrest are given IV or IO.

1. Confirm Arrest
   a. Assess for signs of normal breathing.
   b. Check a carotid or brachial pulse as age appropriate for no more than 10 seconds.
2. Initiate CPR or continue CPR if already in progress and apply and use AED per **Electrical Therapy-Procedure Protocol** as soon as possible.
3. Ensure CPR quality
   a. Compressions at least 1.5” in depth for infants, 2” in depth for children (at least one third the anteroposterior diameter of the chest).
   b. Compression rate of at least 100-120 per minute
      i. Manual chest compressions remain the standard of care. Mechanical chest compression devices may be a reasonable alternative to conventional CPR in specific settings where the delivery of high quality manual compession may be challenging or dangers for the provider (e.g., limited rescuers, prolonged CPR, CPR during hypothermic cardiac arres, CPR in a moving ambulance). An FDA approved, MCA authorized mechanical CPR device operating at the manufacturers pre-set rate may be utilized. See **Mechanical Chest Compression Device-Procedure Protocol** for age/weight requirements and limitations. (MCA Optional)
   c. An impedance threshold device is not to be used on patients 14 years of age or younger.
   d. Allow full chest recoil with each compression for maximum perfusion.

e. Avoid excessive ventilation (volume and rate).

4. Continue CPR with minimal interruptions, changing the rescuer doing compressions
5. Initiate ALS response if available.
6. Establish a patent airway, maintaining C-Spine precautions if indicated, beginning with BLS airway adjuncts and a BVM with high flow **oxygen**. Ventilations with BVM and airway adjuncts are at least as effective as endotracheal intubation in children.
7. If Return of Spontaneous Circulation (ROSC) has **not** been achieved after three, two-minute cycles of CPR AND ALS is not available or delayed, contact medical control, initiate transport.
8. If unable to ventilate or unable to maintain a patent airway, establish an airway per the **Emergency Airway-Procedure Protocol**. (Supraglottic airways are first choice advanced airway for pediatrics when age approved sizes are available)
    a. Minimize interruptions in compressions during airway placement to less than 10 seconds.
    b. After insertion provide continuous CPR, without pauses for ventilation and ventilate at 20 breaths per minute or 1 breath every 3 seconds.
    c. All airway adjuncts should be utilized with high flow oxygen.
    d. Utilize waveform capnography
        i. All advanced airways (includes supraglottic) require end tidal carbon dioxide monitoring.
9. Verify CPR quality frequently and any time rescuer providing compressions or ventilations change.
10. Start an IV/IO **NS** or **LR** KVO. IO may be the first choice. See **Vascular Access & IV Fluid Therapy-Procedure Protocol.**
11. Check rhythm, defibrillate if indicated (2 J/kg) and continue CPR.
12. Administer **epinephrine** according to MI MEDIC cards.
    a. Initial dose should be administered within 5 minutes of compressions or ALS/LALS contact, whichever is first
    b. If MI MEDIC cards are not available administer:
        i. 1 mg/10 ml, 0.01 mg/kg (0.1 ml/kg)
        ii. Max dose 1mg (10 ml)
        iii. Repeat every 3-5 minutes
13. If airway has not been established, and unable to ventilate, establish airway per **Emergency Airway-Procedure Protocol.** (Supraglottic airways are first choice advanced airway for pediatrics when age approved sizes are available)
    a. Minimize interruptions in compressions during airway placement to less than 10 seconds.
    b. Supraglottic airways are preferable to endotracheal intubation.
    c. After advanced airway placement, ventilation rate is 20 breaths per minute
14. Utilize waveform capnography; if ETCO2 is < 10 mm Hg attempt to improve CPR quality.
15. Recheck rhythm and pulse every 2 minutes. Change resucer performing compressions. Interruption in compressions must be less than 10 seconds
16. If shockable rhythm persists:

a. Defibrillate at 4 J/kg every 2 minutes with immediate resumption of compressions. Subsequent defibrillations must be at least 4 J/kg, but may escalate to 10J/kg or adult dosage.
b. Administer antiarrhythmic per MCA selection and according to MI MEDIC cards. When MI MEDIC cards are unavailable administer antiarrhythmic as follows:

Per MCA Selection
☐ **Amiodarone** 5 mg/kg (max single dose 300 mg) IV/IO (May repeat twice) Do not exceed 450 mg total IV/IO
or
☐ **Lidocaine** 1 mg/kg IV/IO (May repeat 0.5 mg/kg twice at 5-10 minute intervals. Maximum 3 doses total

17. Consider causes of arrest (non-shockable)
   a. Hypovolemia (including vomiting/diarrhea)– Administer 20 ml/kg **NS** or **LR** IV/IO bolus
   b. Hypoglycemia – check blood glucose (may be MFR skill, see **Blood Glucose Testing-Procedure Protocol**)
      i. If blood glucose is less than 60 mg/dL administer dextrose according to MI MEDIC cards.
      ii. If MI-MEDIC unavailable, administer **dextrose** 0.5 g/kg per Pediatric Altered Mental Status.
   c. Tension pneumothorax – see **Pleural Decompression-Procedure Protocol**
   d. Hyperkalemia (renal failure) – Contact Medical Control
      i. Administer **calcium chloride 10%** per MI MEDIC cards
         1. If MI MEDIC cards are unavailable administer 20 mg/kg (0.2 ml/kg), max single dose 1 gm
      ii. Administer **sodium bicarbonate** per MI MEDIC cards
         1. If MI MEDIC cards are unavailable administer 1 mEq/kg IV/IO with 20 ml **NS** flush between medications
18. Additional basic and/or advanced life support care as appropriate.
19. Consider termination of resuscitation per **Dead on Scene/Termination of Resuscitation Protocol.**
20. Identify and treat reversible causes.
   A. Hyper/hypokalemia, other metabolic disorders
   B. Hypothermia
   C. Hypovolemia (including vomiting/diarrhea)
   D. Hypoxia
   E. Hydrogen ion excess (acidosis)
   F. Toxins/ overdose (e.g., beta-blocker or calcium channel-blocker)
   G. Tamponade
   H. Tension pneumothorax
   I. Thrombosis (pulmonary or coronary)

Commented [KK(C1]: In 17 the reversable causes that can be reversed are listed and the treatments listed. In 20 there is just a list of reversible caused, some of which are not reversible. These seem redundant. Perhaps delete 20 and change the beginning of 17 to Consider reversible causes of arrest.

Commented [KK(C2R1]: Concerned about 'consider' vs. you are expected to treat

21. Routine use of **sodium bicarbonate** and **calcium chloride** in cardiac arrest is not indicated.
22. If ROSC is achieved refer to **Return of Spontaneous Circulation (Pediatric)-Treatment Protocol**

Medication Protocols
Epinephrine
Amiodarone
Lidocaine
Dextrose
Calcium Chloride
Sodium Bicarbonate

Pediatric Tachycardia

This protocol is for paramedic use only

Aliases: Supraventricular tachycardia (SVT), atrial fibrillation (a-fib), atrial flutter, ventricular tachycardia (V-tach)

This protocol is intended for symptomatic pediatric patients with elevated heart rate, relative to their age. Refer to MI-MEDIC for appropriate vital signs and medication doses.

I. General Treatment
- A. Pediatric patients (≤ 14 years) utilize MI MEDIC cards for appropriate medication dosage. When unavailable utilize pediatric dosing listed within protocol.
- B. Follow General Pre-Hospital Care-Treatment Protocol
- C. Determine if patient is stable or unstable
- D. Manage airway as necessary
- E. Provide supplemental **O2** as needed to maintain O2 saturation > 94%
- F. Initiate monitoring
- G. Perform 12-lead EKG but do not delay care for 2-lead EKG on unstable patients
- H. Establish vascular access
- I. Identify and treat underlying causes of tachycardia such as dehydration, fever, vomiting, sepsis and pain.
- J. Administer **NS** or **LR** bolus 20ml/kg with possible hypovolemia.
- K. Consider the following additional therapies if specific dysrhythmias are recognized:

II. **UNSTABLE**
- A. Regular Narrow Complex Tachycardia – Unstable
  - i. Prepare for immediate cardioversion. In conscious patients consider sedation prior to electrical cardioversion. Refer to **Patient Procedural Sedation-Procedure Protocol.**
  - ii. Deliver a synchronized shock; 1 J/kg for the first dose
  - iii. Repeat doses should be 2 J/kg
  - iv. DO NOT EXCEED ADULT DOSING.
- B. Regular, Wide Complex Tachycardia – Unstable
  - i. Prepare for immediate cardioversion. In conscious patients consider sedation prior to electrical cardioversion. Refer to **Patient Procedural Sedation-Procedure Protocol.**
  - ii. Synchronized cardioversion 1 J/kg

Commented [KK(C1]: For unstable wide complex tachycardia with recurrent or refractory wide complex tachycardia, I think repeated shocks is indicated. PALS does not list going to medications. I think this section should be not be in this protocol per PALS.

iii. For recurrent or refractory wide complex – unstable tachycardia, Give antiarrhythmic medication per MCA Selection

Per MCA Selection
☐ Amiodarone 5 mg/kg (max single dose 300 mg) IV/IO (May repeat twice). Do not exceed 450 mg total IV/IO
or
☐ Lidocaine 1 mg/kg IV/IO (May repeat 0.5 mg/kg twice at 5-10 minute intervals). Maximum 3 doses total

C. Irregular, Wide Complex Tachycardia – Unstable
   i. Defibrillate according to **Electrical Therapy Procedure**
   ii. Refer to **Pediatric General Cardiac Arrest Protocol**

D. If able to convert tachycardia, maintain full cardiac monitoring including pulse oximetry and supportive care until transfer of care at the receiving facility.

III. **STABLE**

A. Regular Narrow Complex Tachycardia – Stable (SVT)
   i. Perform vagal maneuvers
      1. Ensure the patient is on **oxygen** and on a cardiac monitor.
      2. Run ECG strip during the procedure.
      3. If child is able to follow instructions:
         a. Blow into a into a 10 mL syringe for 15 seconds
         b. Squat and bear down
      4. If child is not able to follow instructions:
         a. While supine elevate the patient's legs to the knee chest position for 60 seconds.
         b. If available consider quickly placing a bag of ice on the eyes and forehead. Do NOT occlude the nose or place below the bridge of the nose.
            i. Results are generally seen within 15 seconds.
            ii. This is not an ongoing intervention, it is an abrubt maneuver not be maintained for more than 15 seconds.
      5. DO NOT USE CAROTID MASSAGE.

   ii. Contact Medical Control prior to administration. Administer **adenosine according to MI MEDIC cards** if vagal maneuvers are ineffective**.**
      1. If MI MEDIC cards are not available administer **adenosine**
         a. 0.1 mg/kg (max of 6 mg) rapid IV push through the most proximal injection site, immediately followed by a 10 mL flush.
         b. May repeat once with 0.2 mg/kg (max of 12 mg) administered as above.

B. Regular, Wide Complex Monomorphic QRS Tachycardia – Stable
   i. Contact Medical Control
   ii. Consider **adenosine** per MI MEDIC cards.
      1. If MI MEDIC cards are not available administer **adenosine**
         a. 0.1 mg/kg (max of 6 mg) rapid IV push through the most proximal injection site, immediately followed by a 10 mL flush.
         b. May repeat once with 0.2 mg/kg (max of 12 mg) administered as above.

Medication Protocols
Adensoine
Amiodarone
Lidocain

Refusal of Care; Adult & Minor

EMS personnel have an affirmative duty to provide care to any patient presenting to them after a report of an emergency situation.

Individuals who have the capacity ~~are competent~~ may object to treatment or transportation by EMS personnel. MCL 333.20969 "If emergency medical services personnel, exercising professional judgment, determine that the individual's condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical services may provide treatment or transportation despite the individual's objection unless the objection is expressly based on the individual's religious beliefs."

1. **Definition**
   - A. An individual who has capacity to make medical decisions is:
     - a. One who is awake, oriented, and has the capacity ~~is capable~~ of understanding the circumstances of the current situation. This includes risks, treatments, transport, and alternatives.
     - b. Does not appear to be under the influence of alcohol, drugs or other mind-altering substances or circumstances that may interfere with mental functioning.
     - c. Is not a clear danger to self or others.
     - d. Is 18 years of age or older, or an emancipated minor.
   - B. "Emancipated Minor" is one who is married, is on active duty with the Armed Forces of the United States, or has been granted emancipation by the court.

2. **Procedure for an individual who has capacity to Refuse Care or Transport**
   - A. All patients with signs or symptoms of illness or injury shall be offered assessment, medical treatment and transport by EMS.
   - B. Clearly explain the nature of the illness/injury and the need for emergency care or transportation.
   - C. Explain possible complications that may develop without proper care or transportation.
   -  D. For individuals with signs or symptoms of serious or potentially fatal illness or injury, contact medical control.
   - E. Request that the individual sign an EMS Refusal Form. If the individual refuses to sign the EMS Refusal Form, attempt to obtain signatures of witnesses (family, bystanders, public safety personnel).
   - F. Document assessment and complete approved EMS Refusal Form, including risks of refusal
   - G. Inform the individual that if they change their mind and desire evaluation, treatment, and/or transport to a hospital, to re-contact the emergency medical services system or seek medical attention.
   - H. Inability to obtain a signature does not preclude completion of documentation of a refusal.

3. **Procedure for the Individual who does not have the capacity to object to Treatment or Transportation**
   - A. Contact medical control as soon as practical and follow applicable treatment protocol.
   - B. Any patient with an urgent/life-threatening illness or injury who does not have the capacity ~~is incapable of~~ to competently objecting to treatment or transportation shall be transported by EMS for further evaluation and treatment.
   - C. Police assistance may be sought if needed.
   - D. A patient with non-urgent/non-life-threatening illness or injury who does not have the capacity ~~is incapable~~ of competently objecting to treatment or transportation should be transported for further evaluation and treatment after consultation with on-line medical control.

4. **Procedure for the Individual who gains capacity to make decisions after Treatment has been Initiated and Refuses Transport**
   - A. Contact medical control in all cases when a patient (now refusing transport) has been given medications or other advanced treatment by EMS personnel (e.g., glucose, albuterol, naloxone, IV, etc.).
   - B. Such patients should be strongly encouraged to seek further evaluation and treatment.
   - C. Comply with Section 2 above and document treatment on a patient care record.

5. **Procedure for the Minor Patient Refusing Care or Transport**
   - A. A minor is any individual under the age of 18 and who is not emancipated.
   - B. In general, minor patients are unable to consent or refuse consent for medical care. Such permission can only be provided by the minor's parent or legal guardian.
   - C. Treatment and transport of real or potential life-threatening emergencies will not be delayed by attempts to contact the parent or guardian.
   - D. For all emergency and non-emergency patients, contact medical control.

6. **Procedure for Parent/Guardian Refusing Care or Transport of the Minor Patient**
   - A. All patients with signs or symptoms of illness or injury shall be offered assessment, medical treatment and transport by EMS.
   - B. Clearly explain the nature of the illness/injury and the need for emergency care or transportation.
   - C. Explain possible complications that may develop without proper care or transportation.
   - D. For individuals with signs or symptoms of illness or injury, contact medical control.
   - E. Request that the parent/guardian sign an approved EMS Refusal Form. If the parent/guardian refuses to sign the EMS Refusal Form, attempt to obtain signatures of witnesses (family, bystanders, public safety personnel).
   - F. Document assessment and complete an approved EMS Refusal Form.

Commented [KK(C1]: Scan document for capable/incapable and change all

G. Inform the parent/guardian that if they change their mind and desire evaluation, treatment, and/or transport to a hospital, to re-contact the emergency medical services system or seek medical attention.

Note: A sample EMS Refusal Form has been included on a separate page.

SAMPLE EMS REFUSAL FORM

REFUSAL OF TREATMENT, TRANSPORT AND/OR EVALUATION

PLEASE READ COMPLETELY BEFORE SIGNING BELOW!

Because it is sometimes impossible to recognize actual or potential medical problems outside the hospital, we strongly encourage you to be evaluated, treated if necessary, and transported to a hospital by EMS personnel for more complete examination by a physician.

You have the right to choose to not be evaluated, treated or transported if you wish; however, there is the possibility that you could suffer serious complications or even death from conditions that are not apparent at this time.

By signing below, you are acknowledging that EMS personnel have advised you, and that you understand, the potential harm to your health that may result from your refusal of the recommended care; and, you release EMS and supporting personnel from liability resulting from refusal.

PLEASE CIRCLE THE FOLLOWING THAT APPLY:

I refuse:

EVALUATION **TREATMENT** **TRANSPORT**

☐ **IF YOU CHANGE YOUR MIND AND DESIRE EVALUATION, TREATMENT, AND/OR TRANSPORT TO A HOSPITAL, YOU MAY RE-CONTACT THE EMS SYSTEM AT ANY TIME.**

Patient's Printed Name _____Age____DOB_____Phone #_____
Patient's Address_____City_____State____Zip_____

Signature_____ Relationship, if applicable_____

Witness Signature_____ Witness Printed Name_____
Date and Time_____

BP_____Pulse_____Resp._____Skin_____Pupils_____LOC_____

1. Oriented to person, place, and time? ☐ Yes ☐ No
2. Coherent speech? ☐ Yes ☐ No
3. Auditory and/or visual hallucinations? ☐ Yes ☐ No
4. Suicidal or homicidal? ☐ Yes ☐ No
5. Able to repeat understanding of their condition and consequences of treatment refusal? ☐ Yes ☐ No
6. Narrative: describe reasonable alternatives to treatment that were offered; the circumstances of the call; specific consequences of refusal; and, names of family or witnesses present:

_____
_____
_____
_____

_____	_____	_____	_____
EMS Agency Name	Printed Crew Names		Signature of EMS Provider

Initial Date:
Revised Date: Section 7.27

Transport of Adult Ventilator-Dependent Patient

The purpose of this protocol is to establish a uniform procedure for using mechanical ventilation for the transport of patients who are otherwise stable and do not meet criteria for MICU or Air Medical transport.

Criteria

A. BLS may transport patients on their own ventilator if:
   a. Patient caregiver trained on the ventilator accompanies patient
   b. Waveform capnography is available
   c. Scheduled transport (interfacility, facility to home, home to appointment, etc.) OR
   d. Low acuity 9-1-1 that requires BLS level care.
B. ALS (non-Critical Care, non-Enhance Paramedic) in which all agency paramedic personnel are trained on and carry ventilators.

Procedure

A. Always keep a bag valve mask resuscitator close by in case of ventilator failure.

B. Patients who are ventilator dependent may be transported on their own ventilator (home ventilator) if desired. Assure the BVM is available for back up use if transporting with a home ventilator. Patient caregiver trained in the use of ventilator should attend during transport if possible. (BLS)

   1. Verify tube placement with waveform capnography prior to placing the patient on the transport ventilator.

   2. Patient lung sounds should be checked and documented. Tube placement must be rechecked via lung sounds and continuous waveform capnography every time the patient is moved, i.e., stretcher to stretcher or in or out of a vehicle. Continuous monitoring with the pulse oximeter will be used on all patients.

C. Patients on agency supplied ventilator:
   1. Newly vented - Ventilatory status should be established via Venous Blood Gas (VBG) in the newly intubated patient and documented when available. Continuous monitoring with the pulse oximeter and capnography will be used on all patients. If pulse oximetry is not attainable due to poor circulation, an ABG may be used to ensure adequate oxygenation. If unavailable, consider MICU or air medical transport.

   2. Ventilator and circuit must be set up according to manufacturer's recommendations.

   3. Patient should be placed on the ventilator approximately 5 minutes prior to departure to ensure the patient tolerates the ventilator. Appropriate adjustments should be made prior to departure.

4. Assist Control (AC) and Synchronized Intermittent Mandatory Ventilations (SIMV) are acceptable modes of operation. Set Positive End Expiratory Pressure (PEEP) and Sigh as established by sending facility. PEEP greater than 5 cmH2O should be referred to MICU or Air Medical Services for transport or appropriate hospital staff must accompany the patient.

    a. Verify tube placement with waveform capnography prior to placing the patient on the transport ventilator.

    b. Patient lung sounds should be checked and documented. Tube placement must be rechecked via lung sounds and continuous waveform capnography every time the patient is moved, i.e., stretcher to stretcher or in or out of a vehicle. Continuous monitoring with the pulse oximeter will be used on all patients.

Transport Destination and Diversion

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

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

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

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

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

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

III. Patient Diversions

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

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

~~3.~~i. Documentation of the reason for the diversion shall be included in the EMS patient care record.

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

C. If EMS personnel determine diversion is necessary, ~~C~~contact ~~with~~ the initial receiving facility ~~shall be made~~ as quickly as possible to inform it of the diversion., ~~if the diversion has been requested by a different facility~~.

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

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

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

patient thus overriding ~~regardless of~~ the diversion status. ~~(open or closed) of the local facilities.~~

Responsibilities of the Participants in the Medical Control Authority System

Purpose:

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

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

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

III. Responsibilities of EMS Agencies

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

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IV. Accountability

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

Evidentiary Blood Draw Protocol (MCA OPTIONAL)

This protocol is for specialist/AEMT and paramedic use only

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

Purpose

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

Definitions

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

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

Medical Environment: Any peripatetic area, which is not a freestanding medical facility, that a paramedic obtains a blood sample or specimen (EG: booking area, jail, or other scene where the paramedics may provide medical care).

Commented [KK(C1]: Definition: traveling from place to place, in particular working or based in various places for relatively short periods.

Commented [KK(C2R1]: KK- I think this indicating not IN the hospital (HFA foyer so not a pt in the ED)

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

Procedure

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

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

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

Pre-Radio
PARAMEDIC

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