	Section 8 - SYSTEM PROTOCOLS	**Released for Public Comment**	**Due Date**	
8.1	Cancellation/Downgrade of Call	11-Jul	9-Sep	Revised
8.2	**Use of Lights and Sirens/Patient Prioritization**	**TBD**		
8.3	Destination and Diversion Guidelines	11-Jul	9-Sep	Revised
8.4	High Risk Delivery Transport Guidelines	11-Jul	9-Sep	NO change
8.5	Intercept Policy	11-Jul	9-Sep	Revised
8.6	Dispatch	11-Jul	9-Sep	NO change
8.9	Helicopter Utilization	11-Jul	9-Sep	Revised
8.11	**Infection Control & Communicable Disease**	**TBD**		
8.11	Immunization and Testing	11-Jul	9-Sep	Revised
8.12	Communications Failure	11-Jul	9-Sep	Revised
8.13	Waiver of EMS Patient Side Communications Capabilities	11-Jul	9-Sep	NO change
8.14	Protected Health Information (Formerly HIPAA)	11-Jul	9-Sep	Revised
8.15	Inter-Facility Patient Transfers	11-Jul	9-Sep	Revised
8.15 A	Inter-Facility Enhance Paramedic & Critical Care (OTPIONAL)	11-Jul	9-Sep	NEW
8.16	Licensure Level Requirement of Attendant During Transport (Optional) -	11-Jul	9-Sep	Revised
8.17	Medical Control Privileges	11-Jul	9-Sep	Revised
8.18	Responsibilities of Participants in the MCA System	11-Jul	9-Sep	Revised
8.19	On-Scen Physician Interaction (Physician on Scene)	11-Jul	9-Sep	Complete Revision
8.20	Protocol Deviation	11-Jul	9-Sep	NO change
8.21	Violent/Chemical/Hazardous Scene	11-Jul	9-Sep	Revised
8.22	ME Notification and Body Disposition	11-Jul	9-Sep	Revised
8.23	Safe Delivery of Newborns	11-Jul	9-Sep	Revised
8.24	Complaint Investigation and Resolution	11-Jul	9-Sep	NEW - complete revision
8.25	Disciplinary Action Appeal	11-Jul	9-Sep	Revised
8.27	Quality Improvement Program	11-Jul	9-Sep	NO CHANGE
8.29	Electronic Records & EMS Information System	11-Jul	9-Sep	Revised
8.30	EMS Provider Criminal Charges and Convictions	11-Jul	9-Sep	NEW
8.31	ALS to BLS Transfer of Care (Optional)	11-Jul	9-Sep	NEW
8.32	Evidentiary Blood Draw (Optional)	11-Jul	9-Sep	NEW
8.33	Helicopter Personnel Scope of Practice	11-Jul	9-Sep	NEW

Cancellation/Downgrade of Call Policy

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

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

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

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

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

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

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

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

Cancellation/Downgrade of Call Policy

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

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

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

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

~~or~~

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

~~B.~~C. A 1st party caller (the potential patient[KK(C1)])~~(the potential patient)~~ states they no longer require a response from emergency medical services AND an EMS response is no longer requested AND there is not another indication that an emergency exists.

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

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

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.)

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 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 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 closest facility will only be 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 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. Documentation of the reason for the diversion shall be included in the EMS patient care record.

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

C. Contact with the initial receiving facility shall be made as quickly as possible to inform it of the diversion, 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. 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 regardless of the diversion status (open or closed) of the local facilities.

Destination and Diversion ~~Guidelines~~

Purpose: To define the decision-making process regarding EMS destination[BE(C1)].

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

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

~~1. The patient is a minor, or incompetent, the family or guardian may choose the destination facility.~~

~~2. Transportation to the chosen facility removes the EMS vehicle from the service area for an extended time. Consult medical control and an alternative may be considered.~~

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

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[BE(C2)] (STEMI)

1. .Transport to a facility capable of interventional cardiac care.

D. Return of Spontaneous Circulation (ROSC)

1. ~~Patients with ROSC, in most circumstances, will be~~ Ttransport~~ed~~ to a facility capable of interventional cardiac care[KK(C3]. Notify receiving facility, as soon as possible and give ETA.~~, of impending arrival of the patient and give~~ ETA~~.~~

E. Stroke[BE(C4]

1. Notify closest facility as soon as possible ~~i~~if Cincinnati Stroke Scale or other validated MCA approved stroke scale is abnormal with "Stroke Alert" and ETA

~~i. , notify receiving facility as soon as possible of impending arrival of "STROKE ALERT" patient, with the time the patient was last seen normal and give ETA. Transport to the closest facility.~~

F. Trauma Patients – follow Adult and Pediatric Trauma Triage Protocol

1. A patient may be transported to a Provider Based Emergency department if they are:
   i. ~~A~~ 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.

~~C.~~G. Documentation of destination will be the reason the facility was chosen (specialty care, trauma center) and closest facility will only be chosen when the facility is geographically the closest facility.[KK(C5]

~~II.~~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 requests diversion to another facility. ~~The facility may not deny the~~A receiving facility may not refuse a patient ~~individual access~~ 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 ~~may~~ should be ~~transported~~ diverted to the closest appropriate facility.

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

B. Immediate on-line medical direction shall be established with the receiving [KK(C6)]facility.

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.[KK(C7)]

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

~~D.~~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. 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 regardless of the diversion status (open or closed) of the local facilities.

High-Risk Delivery Transport Guidelines

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

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

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

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

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

Intercept Policy (Optional for all ALS Systems)

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

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

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

III. Contraindications
   a. Any intercept of low acuity patients for which advanced intervention would likely not be beneficial to the patient.
   b. Intercepts of patients with time sensitive emergencies where advanced intervention would likely not be beneficial to the patient

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

Intercept Policy (Optional for all ALS Systems)

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

~~I. Procedure~~

I. If a transport has begun by a Basic Life Support (BLS) unit, a rendezvous with an Advanced Life Support (ALS) (Limited Advanced Life Support[BE(C1)] if ALS unit not available) unit should be attempted at a mutually agreed upon location, if indicated and available.

II. Indications

a. Patients presenting with conditions for which ALS interventions would be potentially beneficial for patients, if the intercept can be completed approximately 10 minutes from the receiving facility, including, but not limited to:

i. Chest pain with suspected cardiac etiology
ii. Seizure patients
iii. Patients with uncontrolled pain
iv. Patients with hypoglycemia
v. Other patients, with medical control direction 
vi. Altered mental status
vii. Worsening respiratory distress
viii. Major trauma

~~NOTE, need more types of patients?~~

b. Patients presenting with conditions where ALS may be needed for life saving interventions may be intercepted at any distance from the hospital:

i. Those with an uncontrolled airway
ii. Patients in cardiac arrest without a mechanical CPR device in place
iii. Other patients, with medical control direction 

c. Per medical control direction 

~~Rendezvous is indicated if it will occur at a point which is greater than five (5) minutes from the receiving hospital. For patients in cardiac arrest being transported in BLS units, ALS intercept is indicated at any point during the transport.~~

~~I.~~ III. Contraindications

a. Any intercept of low acuity patients for which advanced intervention would likely not be beneficial to the patient.
b. Intercepts of patients with time sensitive emergencies where advanced intervention would likely not be beneficial to the patient

~~**A. Indications for ALS Intercept**~~

~~1. All priority 1 & 2 patients~~

~~B. Indications for LALS~~

~~1. All Priority 1 patients & some Priority 2 patients as indicated by Medical Control.~~

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

Dispatch

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

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

Protocol

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

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

Helicopter Utilization

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

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

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

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

II. Procedure

A. Request for helicopter service response will be approved by:

☐ **Online Medical Control**

OR

☐ **Medical Control Pre-Approved Guidelines**

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

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

D. Communications
   1. Communication with the helicopter dispatch should include information regarding location.
   2. Helicopter dispatch will request pertinent medical information to relay to the flight crew.
   3. Communications between the helicopter and ground ambulance shall be coordinated through dispatch and preferentially take place on air LZ2.

E. Landing Site
   1. Utilize trained personnel whenever possible.
   2. Locate a level, 100’ x 100’ area clear of obstacles (i.e. wires, trees)
   3. Mark landing zone with a marker at each corner and one upwind.
   4. Public safety vehicles should leave on flashers to assist in identifying site from the air.

5. Identify obstacles close to the landing zone and communicate all pertinent information about the landing zone to the flight crew.
6. Landing zone personnel will communicate by radio with the flight crew.

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

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

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

Helicopter Utilization

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

NOTE: These guidelines are offered as examples of patients who might benefit from helicopter transport. Additional considerations would include the physical exam, additional contributing factors such as age, mechanism of injury, ~~and~~ the level of care available in the area, and ground service availability. [KK(C1)]~~.~~

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

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

II. Procedure

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

☐ **Online Medical Control**

OR

☐ **Medical Control Pre-Approved Guidelines**

~~A.~~

~~III.~~

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

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

~~C.~~D. Communications
   1. Communication with the helicopter dispatch should include information regarding location~~, identifying marks or vehicles and landing sites.~~ [BE(C2)].
   2. Helicopter dispatch will request pertinent medical information to relay to the flight crew.
   3. Communications between the helicopter and ground ambulance shall be coordinated through dispatch and preferentially take place on air LZ2.~~.~~

E. Landing Site

~~D.~~1. Utilize ~~we~~ trained personnel whenever possible.

~~1.~~2. Locate a level, 100’ x 100’ area clear of obstacles (i.e. wires, trees)

~~2.~~3. Mark landing zone with a marker at each corner and one upwind.

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

~~E.~~F. Safety
1. Under NO~~no~~ circumstances should the helicopter be approached from the rear due to the extreme danger of the tail rotor. ~~unless signaled to do so by the pilot or flight crew.~~
~~1.~~2. The flight crew will direct all actions around a helicopter including personnel approach/departure of the helicopter, and loading/unloading of patients and/or equipment.
~~2.~~3. Personnel should be in a crouched position in the vicinity of the helicopter and NEVER near the tail rotor. ~~Always approach the helicopter from the front, **NEVER** from the rear and only when signaled to do so by the pilot or flight crew.. Under no circumstances should the helicopter be approached from the rear due to the extreme danger of the tail rotor.~~
~~3. Loading and unloading of the patient is done at the direction of the flight crew.~~
~~4. Crews should crouch down when in the vicinity of the main rotor blades.~~

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

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

Initial Date: NEW
Revised Date: Formerly 10.8
2022 REVISIONS-PUBLIC COMMENT READY

Immunization & Testing

Purpose:

To allow paramedics or other Medical Control Authority (MCA) approved personnel to provide testing and vaccinations for agency personnel and the community.

Community immunization and other public health applications are important duties that EMS personnel may perform as determined necessary in cooperation with the medical control authority, local hospitals, and the local public health department. Training will be approved by the EMS Medical Director and the MCA, and may be accomplished under the direction of the MCA and/or local public health department.

1. **Indications for immunization and/or testing:**
   A. Public or EMS agency personnel may be immunized or tested under guidelines developed by the public health department or MCA. Testing may include tests for infectious diseases or other diagnostic testing as needed.
   B. Age groups for immunization will be determined by the MCA or public health department as appropriate.
   C. Timing of immunizations or testing will be determined by the MCA, hospital, EMS agency and public health department to comply with public health needs or agency immunization requirements as determined by agency infection control guidance.
   D. Immunizations or testing may be performed in clinic, NEHC, mass immunization or agency setting as approved by the MCA and/or local public health department.

2. **Immunization or testing**
   A. Immunizations may be administered via intramuscular (IM), subcutaneous (subcut), or intranasal route in dosing determined by guidance provided by the MCA or local public health department as required for the agent administered.
   B. Screening will be performed as determined appropriate for the agent administered by the MCA or local health department.
   C. TB tests are intradermal and require additional training and certification in order to perform. Tests will be interpreted by paramedics performing the tests or personnel trained to review TB tests under MCA approved training programs.

3. **Training**
   A. Training for immunization will be provided by local public health department personnel or under an approved MCA program.

4. **Personnel requirements**
   A. Immunizations or testing may be performed by paramedics trained by local

public health department personnel or under approved MCA training programs.

5. Record keeping

A. A record of public or agency personnel receiving immunizations or TB testing will be maintained by the agency performing the immunizations or TB testing as determined by the local public health department/Medical Control Authority.

B. The Michigan Care Improvement Registry (MCIR) record keeping is required for immunizations.

Immunization & Testing

Purpose:

To allow paramedics or other Medical Control Authority (MCA) approved personnel to provide ~~agency~~ ~~TB~~[KK(C1] ~~testing~~ and vaccinations for ~~seasonal influenza and during public health emergencies~~ agency personnel and the community.

Community immunization and other public health applications are important duties that EMS personnel ~~paramedics~~ may perform as determined necessary in cooperation with the medical control authority, local hospitals, and the local public health department. Training will be approved by the EMS Medical Director and the M~~edical~~ C~~ontrol~~ A~~uthority~~, and may be accomplished under the direction of the MCA and/or local public health department.

1. **Indications for immunization and/or ~~TB~~ testing:**
   A. Public or EMS agency personnel may be immunized or tested ~~for TB~~ under guidelines developed by the public health department[LH(2] or MCA. Testing may include tests for infectious diseases or other diagnostic testing as needed.[KK(C3]
   B. Age groups for immunization will be determined by the MCA or public health department as appropriate. ~~for the immunization clinic setting or agency TB testing requirements as determined necessary by the local public health department or agency infection control guidance~~.
   C. Timing of immunizations or ~~TB~~[AT(4] testing will be determined by the MCA, hospital, EMS agency and public health department to comply with public health needs or agency immunization requirements as determined by agency infection control guidance.
   D. Immunizations or ~~TB~~ testing may be performed in clinic, NEHC, mass immunization or agency setting as approved by the MCA and/or local public health department.

2. **Immunization or ~~TB~~ testing**
   A. Immunizations ~~or TB testing~~ may be administered via intramuscular (IM), subcutaneous (subcut), ~~, SQ~~ [LH(5] or intranasal route in dosing determined by guidance provided by the MCA or local public health department as required for the agent administered.
   B. Screening will be performed as determined appropriate for the agent administered by the MCA or local health department.
   C. TB tests are intradermal and require additional training and certification in order to perform. Tests will be interpreted by paramedics performing the tests or personnel trained to review TB tests under MCA approved training programs.[KK(C6]

3. **Training**

A. Training for immunization will be provided by local public health department personnel or under an approved MCA program[AT(7)][LH(8)].

4. **Personnel requirements**
   A. Immunizations or ~~TB~~ testing may ~~only~~ be performed by paramedics trained by local [KK(C9)]public health department personnel or under approved MCA training programs.
5. **Record keeping**
   A. A record of public or agency personnel receiving immunizations or TB[LH(10)] testing will be maintained by the agency performing the immunizations or TB testing as determined by the local public health department/Medical Control Authority.
   ~~B.~~ The Michigan Care Improvement Registry (MCIR) record [KK(C11)]keeping ~~may be~~ is required for [KK(C12)][AT(13)]~~some~~ immunizations. ~~such as is required for H1N1.~~

Communications Failure

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

Procedure

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

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

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

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

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

Communications Failure

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

Procedure

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

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

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

~~3.~~4. The electronic patient care record will have a protocol deviation noted and the circumstances around the communication failure described in the narrative section.

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

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

Waiver of EMS Patient Side Communication Capabilities

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

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

Protected Health Information

Purpose:

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

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

Policy:

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

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

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

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

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

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

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

~~Health Insurance Portability Accountability Act (HIPAA~~Protected Health Information~~)~~

[BE(C1]

Purpose:

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

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

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

Inter-facility Patient Transfers

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

1. Responsibility:
   A. Patient transfer is a physician-to-physician referral. The transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility prior to the transportation. The name of the accepting physician must be included with the transfer orders.
   B. It is the responsibility of the transferring facility to:
      a. Perform a screening examination.
      b. Determine if transfer to another facility is in the patient's best interest.
      c. Initiate appropriate stabilization measures prior to transfer.

   C. During transport, the transferring physician is responsible for patient care until arrival of the patient at the receiving facility.
   D. It is the transferring physician's responsibility to know and understand the training and capabilities of the transporting EMS personnel.
   E. BLS may transport the following (per MCA selection)
      a. IV fluids without medications added on dial-a-flow or gravity run – peripheral site.

MCA Approval for BLS care during Interfacility transfer

☐ IV Pump

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

☐ IV Lipids/TPN

☐ PCA Pump

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

2. Transportation
   A. Pre-transport

a. Care initiated by the transferring facility that requires continuation during transport, along with additional treatment(s) will be determined by the transferring physician.
b. Orders for treatment shall be provided in writing to the EMS personnel prior to initiation of the transport by the transferring Physician.
    1. A mutually agreed upon mechanism of contact with the transferring physician for the duration of the transfer.
c. Ordered medications not contained within the EMS System Medication Box/Bag must be supplied by the transferring hospital.
d. EMS personnel must be trained in all the equipment, procedures, and medications being used in the patient's care during the transfer. see **ENHANCE PARAMEDIC INTERFACILITY CARE/CRITICAL CARE PROTOCOL**
e. Patient care, procedures, equipment, or medications that exceed EMS personnel training require additional/accompanying staff (see section 1.F. above).
f. EMS personnel has the right to decline transport without additional/accompanying staff if patient care is outside their scope of practice and/or training.
g. The following information should accompany the patient (but not delay the transfer in acute situations):
    1. Copies of pertinent hospital records
    2. Written orders during transport
    3. Any other pertinent information including appropriate transfer documents.

B. During Transport
a. Hospital supplied medications not used during transport must be appropriately tracked, wasted and documented.
    1. All controlled substances and Propofol must have a documented chain of custody.
b. The concentration and administration rates of all medications being administered will be documented on the patient care record.
c. Interventions performed en route, and who performed them, will be documented on the patient care record.
d. Intervention beyond the written orders provided by the transferring Physician, require contact with the transferring Physician.
e. Order of operation for care and communication when unable to contact the transferring physician.
    1. Follow Medical Control approved Protocols under which the EMS agency has Medical Control privileges and initiate contact with:
        a. Receiving physcian
        b. On-line Medical Control Physician from the sending facility.
        c. On-line Medical Control Physician from the receiving facility
        d. Closest appropriate on-line Medical Control facility.

3. Special Treatments

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

Interfacility High Flow Nasal Oxygen Included?
☐ Yes ☐ No

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

Medication Custody Form

Patient Name _____

EMS Staff Receiving Medication

Name	Signature

Hospital Staff Sending Medication

Name	Signature

Medication	Amount Received From Hospital	Administered	Wasted

EMS Staff Wasting Medication

Name	Signature

Hospital Staff Witnessing Waste

Name	Signature

Inter-facility Patient Transfers

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

1. Responsibility:
   A. Patient transfer is a physician-to-physician referral. The transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility prior to the transportation. The name of the accepting physician must be included with the transfer orders.
   B. It is the responsibility of the transferring facility to:
      a. Perform a screening examination.
      b. Determine if transfer to another facility is in the patient's best interest.
      c. Initiate appropriate stabilization measures prior to transfer.

   C. During transport, the transferring physician is responsible for patient care until arrival of the patient at the receiving facility.
   ~~D. If unanticipated events occur during patient transport, and contact with the transferring physician is not possible, then on-line Medical Control will serve as a safety net.~~
   D. It is the transferring physician's responsibility to know and understand the training and capabilities of the transporting EMS personnel.
   E. BLS may transport the following (per MCA selection)
      a. IV fluids without medications added on dial-a-flow or gravity run – peripheral site.

MCA Approval for BLS care during Interfacility transfer
☐ IV Pump
☐ IV Antibiotics that have been infusing for at least 15 minutes prior to departure
☐ IV Lipids/TPN
☐ PCA Pump

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

2. Transportation
   A. Pre-transport
      a. Care initiated by the transferring facility that requires continuation during transport, along with additional treatment(s) ~~may need to be continued during transport. The transferring physician~~ will be determined by the transferring physician. ~~the method and level of transport and any additional treatment(s), if any, that will be provided during the course of transport.~~
      b. Orders for treatment~~, including medications for ALS transfers, or other orders~~ shall be provided in writing to the EMS personnel prior to initiation of the transport by the transferring Physician.
         ~~b.~~1. A mutually agreed upon mechanism of contact with the transferring physician for the duration of the transfer.
      c. ~~For ALS transfers, o~~Ordered medications not contained within the EMS System Medication Box/Bag must be supplied by the transferring hospital.
      d. EMS personnel must be trained in all the equipment, procedures, and medications being used in the patient's care during the transfer. ~~or~~ see **ENHANCE PARAMEDIC INTERFACILITY CARE/CRITICAL CARE PROTOCOL**~~appropriately trained staff must accompany the patient.~~
      e. ~~Should the p~~Patient ~~require~~ care, procedures, equipment, or medications that exceed ~~and/or equipment above and beyond the normal scope of practice and training of the~~ EMS personnel training require additional/accompanying staff (see section 1.F. above). ~~, the transferring facility shall provide appropriate staff or consider other appropriate means of medical transportation.~~
      f. EMS personnel ~~The paramedic~~ has the right to decline transport without additional/accompanying staff if ~~he/she is convinced~~ patient care is outside their scope of practice and/or training. ~~or, alternatively, to insist a hospital staff member accompany them on the transfer or consider other appropriate means of medical transportation.~~
      ~~g. If additional staff accompanies the patient, the transferring physician is responsible for ensuring their qualifications. This staff will render care to the patient under the orders of the transferring physician. It will be the responsibility of the transferring facility to provide arrangements for the return of staff, equipment, and medications.~~
      ~~h.~~g. The following information should accompany the patient (but not delay the transfer in acute situations):
         1. Copies of pertinent hospital records
         2. Written orders during transport
         3. Any other pertinent information including appropriate transfer documents.

   B. During Transport
      a. Hospital supplied medications not used during transport must be appropriately tracked, wasted and documented.
         ~~a.~~1. All controlled substances and Propofol must have a documented chain of custody.
      b. The concentration and administration rates of all medications being administered will be documented on the patient care record.

c. Interventions performed en route, and who performed them, will be documented on the patient care record.
d. ~~In the event that a patient's condition warrants i~~Intervention beyond the written ~~Physician~~ orders provided by the transferring Physician, require ~~the EMS personnel will~~ contact with the transferring Physician.

e. Order of operation for care and communication when unable to contact the transferring physician.
   1. ~~If that is not possible, the EMS personnel will follow local~~ Follow Medical Control approved Protocols under which the EMS agency has Medical Control privileges and initiate contact with:
      a. Receiving physcian
      b. ~~the o~~On-line Medical Control Physician from ~~either~~ the sending ~~or receiving~~ facility.
      c. ~~-~~On-line Medical Control Physician from the receiving facility
   ~~d. or, if not able to contact those facilities, the c~~Closest appropriate on-line Medical Control facility.

3. Special Treatments

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

Interfacility High Flow Nasal Oxygen Included?
☐ Yes ☐ No

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

Medication Custody Form

Patient Name _____

EMS Staff Receiving Medication

Name	Signature

Hospital Staff Sending Medication

Name	Signature

Medication	Amount Received From Hospital	Administered	Wasted

EMS Staff Wasting Medication

Name	Signature

Hospital Staff Witnessing Waste

Name	Signature

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

Paramedic Use Only

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

☐ Medical Control Authorities choosing to adopt this protocol for **Enhanced Paramedic Inter-Facility Transfers** may do so by selecting this check box.

☐ Medical Control Authorities choosing to adopt this protocol for **Critical Care Inter-Facility Transfers** may do so by selecting this check box.

ENHANCED PARAMEDIC INTER-FACILITY PATIENT TRANSFERS

A. Training:

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

B. Medications:

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

☐ Amiodarone
☐ Antibiotics
☐ Antifungals
☐ Antihistamines
☐ Antivirals
☐ Beta Agonists
☐ Beta Blockers
☐ Blood – see **Blood Product** protocol
☐ Magnesium Sulfate
☐ Nexium (esomeprazole)
☐ Nitroglycerin
☐ Nitroprusside
☐ NSAIDs
☐ Oxytocin (Pitocin)
☐ PCA Pumps (closed systems)
☐ Pepcid (famotidine)

- ☐ Calcium Channel Blockers
- ☐ Calcium Gluconate
- ☐ Collids/Crystalloids/Lipids
- ☐ Electrolytes
- ☐ Glycoprotein IIa/IIIB Inhibitors
- ☐ Heparin
- ☐ Insulin Pumps (closed systems)
- ☐ Lidocaine
- ☐ Potassium (up to 20 mEq)
- ☐ Protonix (pantoprazole)
- ☐ Sodium Bicarbonate
- ☐ TPN (Total Parenteral Nutrition)
- ☐ Tranexamic Acid (TXA)
- ☐ Vitamins
- ☐ Zantac (ranitidine)

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

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

C. Skills:

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

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

☐ **Pressors: [P]**

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

☐ **tPA: [T]**

Paramedics in the participating medical control authority may transport patients receiving tPA, Tissue Plasminogen Activator (Alteplase, Activase), in the presence of acute ischemic stroke, myocardial infarction, pulmonary embolism, central venous catheter occlusion, arterial thrombus or embolism, or other medical indication. In long transports where tPA dosing changes, transition between hospital premixed bags may be performed in transit with

written orders, and medication cross check prior to departure from the facility. Agencies and sending facilities should collaborate with regard to equipment necessary for continuation of tPA therapy.

☐ **Paralytics/Sedatives: [S]**

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

☐ **Ventilators: [V]**

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

☐ **Insulin: [I]**

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

Critical Care Patient Inter-Facility Transport Requirements

Purpose: To provide hospital facilities, physicians, and medical transport personnel with guidelines to facilitate inter-facility transportation of critically sick and injured patients within Advanced Life Support vehicles.

1. Vehicle and Staffing Policy
    A. MDHHS Vehicle License. All vehicles conducting Critical Care Inter-Facility Patient Transports must be licensed as transporting Advanced Life Support (ALS) vehicles.
    B. Equipment. The following is the minimum equipment that will be carried by an ALS vehicle while it is providing Critical Care Inter-Facility Patient Transport, in addition to the equipment required by Part 209, P.A. 368 of 1978, as amended, and local medical control authority protocols:
        a. Waveform Capnography
        b. Portable Ventilator or staff capable of providing ventilatory support
        c. Portable Infusion Pump(s)
        d. Pressure infusion bag(s)

    C. Staffing
        e. All ALS vehicles that conduct Critical Care Inter-Facility Patient Transports will be staffed in accordance with local medical control requirements with at least one (1) paramedic trained in the Critical Care Inter-Facility Patient Transport curriculum. The trained paramedic must be in the patient compartment while transporting the patient.

f. The above requirement for staffing does not apply to the transportation of a patient by an ambulance if the patient is accompanied in the patient compartment of the ambulance by an appropriately licensed health professional designated by a physician and after a physician-patient relationship has been established as prescribed. (PA 368, Section 20921(5)).

2. Critical Care Inter-Facility Patient Transport Physician Director/Quality Improvement
   A. Ambulance services that utilize this protocol must designate a Critical Care Inter-Facility Patient Transport Physician Director.
   B. The Critical Care Inter-Facility Patient Transport Physician Director will be responsible for:
      a. Oversight of a quality improvement program for Critical Care Inter-Facility Patient Transports
      b. Oversight of the training curriculum for EMS personnel trained under this protocol.
3. Critical Care Inter-Facility Patient Transport Curriculum

CRITICAL CARE PATIENT INTER-FACILITY TRANSPORT CURRICULUM

COURSE OUTLINE

1. Ventilator patient concerns (4 hours total)
   A. Types of ventilators
   B. IPPB, SIMV, PEEP, CPAP
   C. Use of transport ventilators
   D. Complications
   E. Use of Pulse Oximeter/Capnography
2. Chest Tubes and Pleurovac (1 hour)
   A. Principles of pleural cavity evacuation
   B. Maintaining chest tubes
   C. Review various systems
   D. Pleurovac Practical Lab
3. Maintenance of invasive lines (2 hours)
   A. Types of hemodynamic monitoring
      a. Various equipment
      b. Insertion sites
      c. Maintaining infusions
      d. Complications
4. Equipment Training Videos (1 hour)
   A. IV Pumps
   B. Ventilator
   C. 12 Lead Monitoring
5. Thrombolytics (1 hour)
   A. Indications, contraindications, adverse effects, and administration

a. Streptokinase
b. tPA
c. Retavase
d. TNKase
e. Heparin
f. Lovenox

6. Interpreting blood gases (1 hour)
   A. The use of ABGs in ventilator managements
7. Blood products (1 hour)
   A. Whole blood/Packed RBCs/Plasma
8. Cardiac Enzymes (1 hour)
   A. Cardiac physiology and the meaning of enzyme abnormalities
9. Vasoactive drugs (2 hours)
   A. Indications, contraindications, adverse effects, and administration
      a. Dopamine
      b. Epinephrine
      c. Dobutamine
      d. Levophed
      e. Amrinone/Milrinone
      f. Nitroglycerin
      g. Nitroprusside
      h. Esmolol
      i. Labetalol
10. Critical Care Patient Transport Protocol Review (1 hour)
   A. Protocol review and miscellaneous drugs
      a. Indications, contraindications, adverse effects, and administration
         1. Aminophylline
         2. Mannitol
         3. Phenytoin
         4. Insulin
         5. Propofol
         6. Oxytocin and related drugs
11. Paralytics (1 hour)
   A. Indications, contraindications, adverse effects, and administration
      a. Non-depolarizing neuromuscular blockers
      b. Sedatives during paralytic maintenance
      c. RSI indications during critical care patient transport
   B. Administer with Medical Control
12. Practical Lab (1 hour)
   A. IV Pumps
      a. Various tubing
      b. Maintaining a drip while changing to the pump
   B. Ventilator
   C. 12 Lead
   D. CO2 detector
13. Cardiac Physiology/12-Lead ECG (4 hours)
   A. Cardiac physiology and cardiac drug review
      a. Indications, contraindications, adverse effects, and administration

1. Lidocaine/Procainamide
2. Potassium
3. Morphine
4. Cardizem
5. Amiodarone

14. 12-Lead AMI Recognition (2 hours)
15. High Risk Pregnancy (1 hour)
    A. Indications, contraindications, adverse effects, and administration
        a. Magnesium Sulfate
        b. Pitocin
16. Antibiotics (1 hour)
17. Pediatrics (4 hours)
    A. Pediatric Airway and Ventilation management including Ventilator Dynamics and Chest Tube Monitoring and pneumothorax recognition and treatment (1 hour)
    B. Pediatric fluid requirements including maintenance and bolus therapies (1 hour)
    C. Pain management (1 hour)
    D. Case studies, trauma specific (1 hour)
18. Critical Care Patient Transport Charting (1 hour)
19. Critical Care Patient Transport Call: Start to Finish (1 hour)
    A. General considerations
    B. Staffing and quality management considerations
    C. When to refuse a call
20. Critical Care Patient Transport Case Presentations (1 hour)
21. Daily Quizzes
    A. Ventilators, chest tubes, invasive lines
    B. Thrombolytics, ABGs, blood, enzymes, pressers, paralytics
22. Written and Practical Exam (4 hours)

Licensure Level Requirement of Attendant during Transport (Optional)

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

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

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

I. Patient care transport level is to be determined by the individual(s) whose license is at least equal to the level of the vehicle license. This individual will perform a patient assessment to determine the level of patient care transport. The electronic patient care record must reflect this assessment both as a procedure and in components of the assessment.

   A. EMT-Basic may attend in the patient compartment during transport on a patient deemed to be within the scope of practice for an EMT-Basic as defined by the State of Michigan.
   B. EMT-Specialist may attend in the patient compartment during transport on a patient deemed to be within the scope of practice for an EMT-Specialist as defined by the State of Michigan.
   C. EMT-Paramedic may transport a patient at any level.

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

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

Licensure Level Requirement of Attendant during Transport (Optional)

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

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

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   (3b) If designated as providing limited advanced life support, with at least 1 emergency medical technician specialist and 1 emergency medical technician.
   (3c) If designated as providing advanced[BE(C1]] life support, with at least 1 paramedic and 1 emergency medical technician.

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

Medical Control Privileges

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

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

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

III. Optional Training Standards: mark and specify as applicable

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

☐ Practical Competency (Specialist Skills)

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

IV. Specialty Care Privileges (MCA Optional)
- A. ☐Community Integrated Paramedicine
  - V. Trained according to CIP Program Policy Protocol
  - VI. Access to necessary equipment for MCA approved CIP protocols
- B. ☐Critical Care Interfacility Transport
  - V. Trained according to MCA approved standards
  - VI. Access to necessary equipment at time of transport

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

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

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

III. Optional Training Standards: mark and specify as applicable

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

☐ Practical Competency (Specialist Skills)

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

☐

☒~~☐~~

IV. Specialty Care Privileges (MCA Optional)

A. ☐Community Integrated Paramedicine

V. Trained according to CIP Program Policy Protocol

VI. Access to necessary equipment for MCA approved CIP protocols

B. ☐Critical Care Interfacility Transport

V. Trained according to MCA approved standards ~~protocol XXX~~

VI. Access to necessary equipment at time of transport

~~IV.~~V. Scope of Privileges

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

Initial Date: 09/2004
Revised Date: 10/25/2017
2022 REVISIONS-PUBLIC COMMENT READY Section: 8-18

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.
      c.
   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. Will immediately notify the Medical Control Authority and the Department if the EMS agency is unable to provide staffing at the level required by its State license.
E. Licensed EMS vehicles will be equipped with all Medical Control Authority required equipment, if applicable, in addition to that equipment required by the State of Michigan.
F. EMS agencies will promptly inform their EMS personnel of Medical Control Authority policy and protocol changes.
G. EMS agencies will provide an annual listing of EMS personnel. This listing shall note the license and Medical Control Authority authorization status of each individual.
H. If an employee of an EMS agency is found to be in violation of a Medical Control Authority protocol, the EMS agency will cooperate with the Medical Control Authority in addressing the violation and taking corrective measures.
I. Assure training and competency of personnel in the case of new or expanding department approved protocols.

IV. Accountability

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

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.

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   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 ~~are up-to-date,~~ reflect current medical practice~~,~~ and address issues as necessary to assure quality pre-hospital patient care.
   C. In cooperation with the EMS agencies, the Medical Control Authority will coordinate training to implement protocols ~~if~~ not included in ~~routine~~ initial EMS education.
   ~~C.~~D. Ensure that all significantly affected parties in the MCA will have sixty-days' notice for protocol changes (aside from emergency protocols).
   ~~D.~~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.

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   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: ~~is:~~
      a. ~~is properly t~~ Has access to the current MCA approved protocols
      b. Provides medical direction consistent with MCA approved protocols.
      ~~Trained in current MCA protocols~~
      ~~and qQualified as a XXX[BE(C1]~~
      ~~A.~~c. ~~and a~~Abides ~~by Medical Control Authority 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 ~~Division~~ Department[KK(C2]] approved protocols.

B. Assure ~~O~~only persons currently authorized to do so by the Medical Control Authority will provide pre-hospital patient care.

~~B.~~C. Each EMS agency will assure that their personnel have current training and certifications as required by **Medical Control Privileges ~~p~~Protocol**.

~~C.~~D. ~~The Medical Control Authority w~~Will ~~be~~ immediately ~~notified~~ notify the Medical Control Authority and the Department if ~~an~~ the EMS agency is unable to provide staffing at the level required by its State license.

~~D.~~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.

~~E.~~F. EMS agencies will promptly inform their EMS personnel of Medical Control Authority policy and protocol changes.

~~F.~~G. EMS agencies will provide an annual listing of EMS personnel ~~upon request of the Medical Control Authority~~. This listing shall note the license and Medical Control Authority authorization status of each individual.

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.

~~G.~~I. Assure training and competency of personnel in the case of new or expanding department approved protocols.

IV. Accountability

A. The ~~State of Michigan, Department of Health and Human Services, Division of EMS and Trauma~~Department, designate~~sd~~ the Medical Control Authority for a specific geographic area~~region~~. As such, the Medical Control Authority is accountable to th~~at agency~~e Department in the performance of its duties.

B. The hospitals and possibly the FSEDs [KK(C3]within the Medical Control Authority system collectively administer this Medical Control Authority. Each individual hospital[BE(C4]] and FSED that receives emergency patients by ambulance is accountable to the Medical Control Authority to meet the responsibilities listed above. Failure to meet those responsibilities may result in a termination of the ability of a hospital or FSED to provide on-line medical direction or receive emergency patients (by ambulance).

C. EMS agencies within the Medical Control Authority system are accountable to the Medical Control Authority, as detailed and defined in protocol. Failure to comply with approved protocols may result in sanctions against that EMS agency.

On-Scene Physician Interaction

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

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

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

Procedure:

A. Physician's Office, Clinic or Ambulatory Patient Care Facility

1. Physician Office, Clinic or Ambulatory Patient Care Facility to hospital transfers are considered scene calls unless a physician-to-physician transfer is designated bythe Physician Office, Clinic or Ambulatory Patient Care Facility. EMS personnel will take responsibility for the patient as if the patient were coming from aprehospital scene.

2. EMS personnel should obtain pertinent history, from the patient and physician (or designee). Destination should be determined based on the priorities in the **Transport Protocol**. If physician to physician destination determination is inconsistent with the **Transport** Protocol or not appropriate for patient condition, appropriate destination should be communicated to the patient, family and physician. If the physician wishes to communicate with Medical Control to facilitate continuing patient care, EMS personnel will assist with communications.The physician may consult with the medical control physician regarding thepatient's further care and subsequent transport.

3. Transport of unstable patients should not be delayed to contact medical control. It is recommended that the senior paramedic inform the transferring physician that medical control will be contacted in route to determine the destination and/or orders

for care to be given in route.

4. If the private physician in attendance wishes to continue to give orders to be used during transport, he must have online medical control approval. The patient's physician may treat and accompany the patient during transport with the assistance of the EMS system.

5. Upon departure from the scene, contact Medical Control as would be done for any EMS scene patient per the **Communications** protocol.

B. Free Standing Emergency Department (FSED) to Hospital Transfers

1. FSED is defined in the **Transport Protocol**.

2. A FSED to hospital transfer is considered a physician-to-physician interfacility transfer.

3. EMS personnel responding to a FSED should receive a patient report from the treating physician (or designee). This report should include the physician's assessment, the requested destination, name of the person who accepted the transfer, care to be given during transport, and any potential problems felt likelyto occur in route.

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

5. The scope of practice for EMS when performing a FSED to Hospital transfer is determined by the **Interfacility Patient Transfer** protocol.

6. At the discretion of the FSED physician, the FSED physician or designated facility staff may treat and accompany the patient during transport with the assistance of the EMS system.

7. Upon departure from the scene, contact Medical Control as would be done for any EMS scene patient per the **Communications** protocol.

C. Physician On-scene

1. As time and patient condition permit, EMS personnel should make a reasonable effort to establish the identity or credentials of anyone at the scene of a medical emergency (not a covered by previous sections of this protocol) who professes to be a Michigan licensed physician who expresses an interest in participating in patient care activities.

2. An on-scene physician must identify himself and verify to Medical Control either the fact of an established physician-patient relationship with the patient, or willingness to assume responsibility for the patient and to accompany the patient to the hospital. The Medical Control physician may allow the on-scene physician to provide on-scene Medical Direction and then not accompany the patient to the hospital. Should this occur the Medical Control physician re-assumes responsibility for the patient during transport.

3. The Medical Control physician will verify over the radio his delegation of responsibility to the physician on-scene and the nature of that delegation.

4. A physician on-scene may participate with paramedic(s) in the resuscitation of a patient with permission of Medical Control without assuming full responsibility for the patient. This responsibility will, in this case, remain with the Medical Control physician and the ALS system.

5. It should be noted that responsibility for the patient at the scene rests with the on-line medical control physician. Decisions releasing medical care responsibility to another physician should be considered carefully.

6. If an on-scene health care professional has identified himself/herself, and obstructs efforts of the paramedic(s) to aid a patient for whom they are called, or who insists on rendering patient care inconsistent with the system standards and resists all invitation to function appropriately to the point where his continued intervention will result in obstruction to rendering good and reasonable patient care, EMS personnel should:

    a. Request Public Safety Officers become involved, if necessary, so that the team members can continue to provide patient care according to system protocol.
    b. Communicate the situation promptly to On-Line Medical Control.
    c. Document the behavior of the on-scene health care professional on the patient care record.

D. On-Scene Interaction with Emergency Medicine Residents, Fellows, Medical Control Physicians, and the EMS Medical Director:

1. Emergency medicine residents and fellows as part of their training will be participating in pre-hospital care. In each of their residency years they may be third-riding and can be a valuable addition to the pre-hospital care team.

2. First year residents will participate primarily as observers. They may assist pre-hospital personnel upon request. The senior paramedic is in charge of patient care at the scene.

3. Second year residents should begin to participate as part of the pre-hospital care team taking direction from the senior paramedic. They should be encouraged to participate with procedures (IVs, spinal precautions, intubation, and others as possible). The senior paramedic is in charge of patient care at the scene.

4. Third and Fourth year residents should participate fully as part of the pre-hospital care team. In addition, they may provide on-scene medical direction at the request of the senior paramedic. If on-scene direction is requested/used, the same communications procedures should be used as if on-scene direction was not available. Inform the hospital of the care given and the name of the resident at the scene in addition to the usual report. If on-scene medical direction by the Third/Fourth year resident is not desired by the senior paramedic, medical direction may be obtained in conventional ways by contacting the appropriate medical control hospital. The senior paramedic is ultimately in charge of patient care at the scene; therefore, any conflicts that arise will be resolved in favor of thesenior paramedic or through conventional ways by contacting the appropriate medical control hospital. Conflicts will be reported promptly to the EMS Medical Director.

5. Medical Control Physicians and the MCA EMS Medical Director may provide on-scene medical direction at their discretion. In this environment it will be expected that this physician will assume medical control and will give medical direction as needed. The physician must either accompany the patient to the hospital or remain available for direct two-way communication until the patient arrives at the hospital. If at any point communication cannot be maintained, medical control reverts to the Online Medical Control at the receiving facility. “Medical Control Physicians” refers to active licensed physicians with expertise in Emergency Medical Services and formally recognized by the MCA as a part of the administrative and oversight team.

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Procedure:

A. Physician's Office, Clinic or Ambulatory Patient Care Facility

1. Physician Office, Clinic or Ambulatory Patient Care Facility to hospital transfers are considered scene calls unless a physician-to-physician transfer is designated bythe Physician Office, Clinic or Ambulatory Patient Care Facility. EMS personnel will take responsibility for the patient as if the patient were coming from aprehospital scene.

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4. If EMS personnel do not agree with the destination or proposed ~~orders~~orders, they should discuss this with the transferring physician. If an agreement is not reached, medical control should be contacted to determine the destination and care to be given by EMS personnel in route to the hospital.

5. The scope of practice for EMS when performing a FSED to Hospital transfer is determined by the **Interfacility Patient Transfer** protocol.

6. At the discretion of the FSED physician, the FSED physician or designated facility staff may treat and accompany the patient during transport with the assistance of the EMS system.

7. Upon departure from the scene, contact Medical Control as would be done for any EMS scene patient per the **Communications** protocol.

C. Physician On-scene

1. As time and patient condition permit, EMS personnel should make a reasonable effort to establish the identity or credentials of anyone at the scene of a medical emergency (not a covered by previous sections of this protocol) who professes to be a Michigan licensed physician who expresses an interest in participating in patient care activities.

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3. The Medical Control physician will verify over the radio his delegation of responsibility to the physician on-scene and the nature of that delegation.

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5. It should be noted that responsibility for the patient at the scene rests with the on-line medical control physician. Decisions releasing medical care responsibility to another physician should be considered carefully.

6. If an on-scene health care professional has identified himself/herself, and obstructs efforts of the paramedic(s) to aid a patient for whom they are called, or who insists on rendering patient care inconsistent with the system standards and resists all invitation to function appropriately to the point where his continued intervention will result in obstruction to rendering good and reasonable patient care, EMS personnel should:

    a. Request Public Safety Officers become involved, if necessary, so that the team members can continue to provide patient care according to system protocol.
    b. Communicate the situation promptly to On-Line Medical Control.
    c. Document the behavior of the on-scene health care professional on the patient care record.

D. On-Scene Interaction with Emergency Medicine Residents, Fellows, Medical Control ~~Physicians~~Physicians, and the EMS Medical Director:

1. Emergency medicine residents and fellows as part of their training will be participating in pre-hospital care. In each of their residency years they may be third-riding and can be a valuable addition to the pre-hospital care team.

2. First year residents will participate primarily as observers. They may assist pre-hospital personnel upon request. The senior paramedic is in charge of patient care at the scene.

3. Second year residents should begin to participate as part of the pre-hospital care team taking direction from the senior paramedic. They should be encouraged to participate with procedures (IVs, spinal precautions, intubation, and others as possible). The senior paramedic is in charge of patient care at the scene.

4. Third and Fourth year residents should participate fully as part of the pre-hospital care team. In addition, they may provide on-scene medical direction at the request of the senior paramedic. If on-scene direction is requested/used, the same communications procedures should be used as if on-scene direction was not available. Inform the hospital of the care given and the name of the resident at the scene in addition to the usual report. If on-scene medical direction by the Third/Fourth year resident is not desired by the senior paramedic, medical direction may be obtained in conventional ways by contacting the appropriate medical control hospital. The senior paramedic is ultimately in charge of patient care at the scene; therefore, any conflicts that arise will be resolved in favor of thesenior paramedic or through conventional ways by contacting the appropriate medical control hospital. Conflicts will be reported promptly to the EMS Medical Director.

5. Medical Control Physicians and the ~~W/L~~ MCA EMS Medical Director may provide on-scene medical direction at their discretion. In this environment it will be expected that this physician will assume medical control and will give medical direction as needed. The physician must either accompany the patient to the hospital or remain available for direct ~~two way~~two-way communication until the patient arrives at the hospital. If at any point communication cannot be maintained, medical control reverts to the Online Medical Control at the receiving facility. "Medical Control Physicians" refers to active licensed physicians with expertise in Emergency Medical Services and formally recognized by the ~~W/L~~ MCA as a part of the administrative and oversight team~~, such as the Deputy Medical Director and the W/L Fellow in Emergency Medical Services~~.

E. On-Scene Interaction with Emergency Medicine Residents, Fellows, Medical Control ~~Physicians~~Physicians, and the EMS Medical Director:

1. Emergency medicine residents and fellows as part of their training will be participating in pre-hospital care. In each of their residency years they may be third-riding and can be a valuable addition to the pre-hospital care team.

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~~F. Physician on scene of a Tactical Emergency Medical Service (TEMS) situation:~~

~~1. In the event of a tactical emergency medical service situation, from here on referred to as TEMS, the responsibility of medical direction will rest upon the W/L MCA designated TEMS medical director or the on-line medical control physician in the absence of a TEMS medical director.~~

~~2. The TEMS medical director is a Washtenaw/Livingston MCA designated physician with special training in the tactical environment may elect to respond to a TEMS situation. In this environment it will be expected that this physician will assume medical control and will give medical direction for the care of any at the scene, treated and transported by the TEMS team.~~

~~3. At the time when the on-scene physician is no longer directly involved with patient care, the responsibility of medical direction will revert to the on-linemedical control physician.~~

PREVIOUS PROTOCOL:

~~***Physician on Scene***~~ ~~[BN(1]~~

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

~~I. Responsibility of Medical Control~~

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

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

~~II. Patient Management in the Presence of an On Scene Physician~~

~~A. The EMS provider may accept assistance and/or advice of the on-scene physician provided they are consistent with medical control protocols.~~

~~B. The assistance of an on-scene physician may be provided without accepting full responsibility for patient care, as long as there is ongoing communications and approval by the medical control physician.~~

~~C. The medical control physician may relinquish control of the patient to the on-scene physician provided the on-scene physician agrees to accept full responsibility for the patient. Full responsibility includes accompanying the patient to the hospital and completing a patient care record.~~

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

~~a.~~

~~E. If the~~

Protocol Deviation

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

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

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

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

III. All deviations must be reported to medical control.

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

Initial Date: 09/2004
Revised Date: 2/25/2022
2022 REVISIONS-PUBLIC COMMENT READY Section: 8-21

Violent/Chemical/Hazardous Scene

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

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

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

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

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

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

Special Considerations: For those patients, who have been contaminated in a hazardous material incident, refer to **Contaminated Patient Procedure**

Violent/Chemical/Hazardous Scene

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

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

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

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

II. If the scene is not secured: ~~n any situation in which the scene is not secured, EMS personnel are not to enter the scene until coordinated by law enforcement command. ARE NOT TO ENTER THE SCENE until it has been secured by the appropriate agency.~~
   A. ~~When responding to an unsecured scene,~~ EMS personnel will stage an appropriate distance away from the scene to protect themselves from danger.
   B. In hazardous material situations stage upwind and upstream.
   ~~A.~~ In violent situations
   C. EMS personnel who enter a potentially unsecure scene will NOT enter until coordinated by law enforcement command and WILL maintain law enforcement protection.

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

Special Considerations: For those patients, who have been contaminated in a hazardous material incident, refer to **Contaminated Patient Procedure**

Body Disposition and Medical Examiner Notification

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

- See **Dead on Scene & Termination of Resuscitation Protocol**

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

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

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

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

A. A body shall not be moved from the location of death if any mandatory Medical Examiner reporting criteria are present, **unless the ME's office provides official notification that an autopsy or external examination will not be performed and that the body will be released to the funeral home.**

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

C. **A situation which does not require notification of the ME's office does allow for movement of the body pending retrieval by the funeral home.**
D. Bodies must remain attended in the case of an unexpected death. Police should take custody of the body in the instance of an ME case. If there is a significant delay of the funeral home, the body may be left with the family.
E. Medical devices utilized during care by EMS may be removed from the patient if the body is released by the ME's office to the funeral home (IV's, advanced airways, defibrillation pads, etc.)
F. Medical devices utilized during care by EMS must remain in place if the ME's office advises that an autopsy of examination will be performed.
G. If there is evidence of suspicious, violent or unusual cause of death, caution should be taken to avoid contamination of the scene.
    1. In the instance of a scene resuscitation and termination, the identification may be removed from the body. No other personal items may be removed.
    2. Bodies may be covered with a sheet when the body is visible to the public or bystanders.
H.
I. If a body is moved, as permitted in the prior criteria, the location should be to a private, secure and nearby location pending retrieval by the funeral home or the ME's staff.
J. Bodies must be handled with care and respect for the deceased, the family and the public.

III. Death in an Ambulance – termination of care

A. Patients with valid DNR orders being transported for any reason, whether due to an emergency condition or during an interfacility transfer, who experience cardiac or respiratory arrest shall have the DNR honored unless, before arresting, the patient expressly withdraws their DNR.
B. Patients for whom transport was initiated but who, during transport, meet the criteria for either Dead on Scene or Termination of Resuscitation protocols, and for whom On-line Medical Control (OLMC) has approved a termination of resuscitation (as required by those protocols respectively), may have care terminated while still en route to the hospital.

IV. Death in an Ambulance – transportation of body

A. In the event of a patient death in an ambulance, the body shall be transported to the original destination hospital if the call was originally from a scene to a hospital or from a facility to a hospital (transfer).
    1. The patient's body shall be brought to the Emergency Department
    2. The patient will be registered to accommodate both the transfer of custody and for preservation of evidence, if indicated
    3. The Medical Examiner shall be contacted by the hospital and the disposition of the body shall be according to the direction of the ME.
B. If a patient is being transferred to a nursing home or to their home, immediately following discharge from a hospital, and death is determined, the body should be brought back to the hospital from which they were discharged, unless the patient is a hospice patient.
    1. If the patient is a hospice patient and hospice will be meeting you at the destination, or the destination is a hospice facility, you may continue on to the

destination and relinquish the body to hospice personnel. This is permitted, without notification of the Medical Examiner, since the patient was both a hospice patient and received medical attendance within the 48 hours immediately preceding the time of death. However, if the death was unexpected, the Medical Examiner must be notified.

2. If the patient is a hospice patient and hospice personnel will not be meeting you at the destination, continue on toward the destination, contact a supervisor from your agency and evaluate the situation. Where you ultimately go is dependent on how far you are from the destination, if family was intending to meet you at the destination, if the death was unexpected and any confounding factors. The body may not be left without there being a custodial transfer from EMS to an appropriate healthcare provider.
    a) Consider contacting the hospice care provider
    b) Consider consultation with online medical control
    c) If the death was unexpected, contact the Medical Examiner

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

Determination of Death, Death in an Ambulance and Transport of a Body Body Disposition and Medical Examiner Notification

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

- See **Dead on Scene & Termination of Resuscitation Protocol**

I. **Pronouncement/Determination of Death**

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

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

B. Contact with on-line medical control for the purpose of determination of death or pronouncement is not necessary unless expressly stated in the enabling protocolMedical control contact is dictated by either the **Dead on Scene Protocol** or the **Termination of Resuscitation Protocol**.

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

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

A. The Medical Examiner's office shall be notified for any out-of-hospital death under the following circumstances:
   1. The individual dies by violence
   2. The individual's death is unexpected
   3. The individual dies without medical attendance by a physician, or the individual dies while under home hospice care without medical attendance by a physician or registered nurse, during the 48 hours immediately preceding the time of death, unless the attending physician, if any, is able to determine accurately the time of death.

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

4. If the individual dies as a result of an abortion, whether self-induced or otherwise.
5. Death of a prisoner in a county or city jail.

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

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

A. A body shall not be moved from the location of death if any mandatory Medical Examiner reporting criteria are present, **unless the ME's office provides official notification that an autopsy or external examination will not be performed and that the body will be released to the funeral home.**

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

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

D. Bodies must remain in the physical custody of the police or EMS until custody is transferred to the funeral home or the ME's office staffattended in the case of an unexpected death. Police should take custody of the body in the instance of an ME case. If there is a significant delay of the funeral home, the body may be left with the family.

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

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

G. If there is evidence of suspicious, violent or unusual cause of death, caution should be taken to avoid contamination of the scene.
   1. In the instance of a scene resuscitation and termination, the identification may be removed from the body. No other personal items may be removed.

G.2. Bodies may be covered with a sheet when the body is visible to the public or bystanders.

1. Police may choose to photograph or document the placement of medical devices, medical equipment, etc. in suspicious situations, prior to their movement or removal.

H. No personal items should be removed from the body with the exception of identification.

I.H. Bodies may be covered with a burn sheet or other sheet which does not shed fibers.

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

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

IV.III. Death in an Ambulance – termination of care

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

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

V.IV. Death in an Ambulance – transportation of ~~patient's~~ body

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

B. If a patient is being transferred to a nursing home or to their home, immediately following discharge from a hospital, and death is determined, the body should be brought back to the hospital from which they were discharged, unless the patient is a hospice patient.
   1. If the patient is a hospice patient and hospice will be meeting you at the destination, or the destination is a hospice facility, you may continue on to the destination and relinquish the body to hospice personnel. This is permitted, without notification of the Medical Examiner, since the patient was both a hospice patient and received medical attendance within the 48 hours immediately preceding the time of death. However, if the death was unexpected, the Medical Examiner must be notified.
   2. If the patient is a hospice patient and hospice personnel will not be meeting you at the destination, continue on toward the destination, contact a

supervisor from your agency and evaluate the situation. Where you ultimately go is dependent on how far you are from the destination, if family was intending to meet you at the destination, if the death was unexpected and any confounding factors. The body may not be left without there being a custodial transfer from EMS to an appropriate healthcare provider.

a) Consider contacting the hospice care provider
b) Consider consultation with online medical control
c) If the death was unexpected, contact the Medical Examiner

C. If a patient is being transferred from a facility to an appointment, or vice versa, where neither the starting or ending destination was a hospital:

a) If no DNR exists, treat and transport the patient to a hospital
b) If a DNR exists but the patient is not a hospice patient, determine death, honor the DNR, and transport the body to a hospital
c) If a DNR exists and the patient is a hospice patient, determine death; honor the DNR, refer to V.B (1 and 2) above.

Safe Delivery of Newborns

Purpose

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

Definitions

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

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

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

Procedures

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

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

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

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

Michigan's
Safe Delivery of Newborns Law
FACT Sheet

SAFE. LEGAL. ANONYMOUS.

Background:

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

What the law provides?

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

What are the rights of the surrendering parent?

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

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

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

SURRENDERING PARENT BACKGROUND (Optional)

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

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

Surgical History

OTHER PARENT BACKGROUND (Optional)

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

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

Surgical History

INFORMATION ABOUT THE PREGNANCY

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

EMERGENCY SERVICE PROVIDER OBSERVATIONS

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

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

VOLUNTARY RELEASE FOR ADOPTION OF A SURRENDERED NEWBORN BY PARENT

Michigan Department of Human Services

In the matter of _____, a newborn child.

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

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

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

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

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

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

Date ___/___/_____ Parent Signature _____

Address _____

City _____ State _____ Zip _____

Witnessed by _____
Name (type or print)

on _____, at _____
Date Agency and Address

_____
Signature

IF A NOTARY IS AVAILABLE: Notary Public

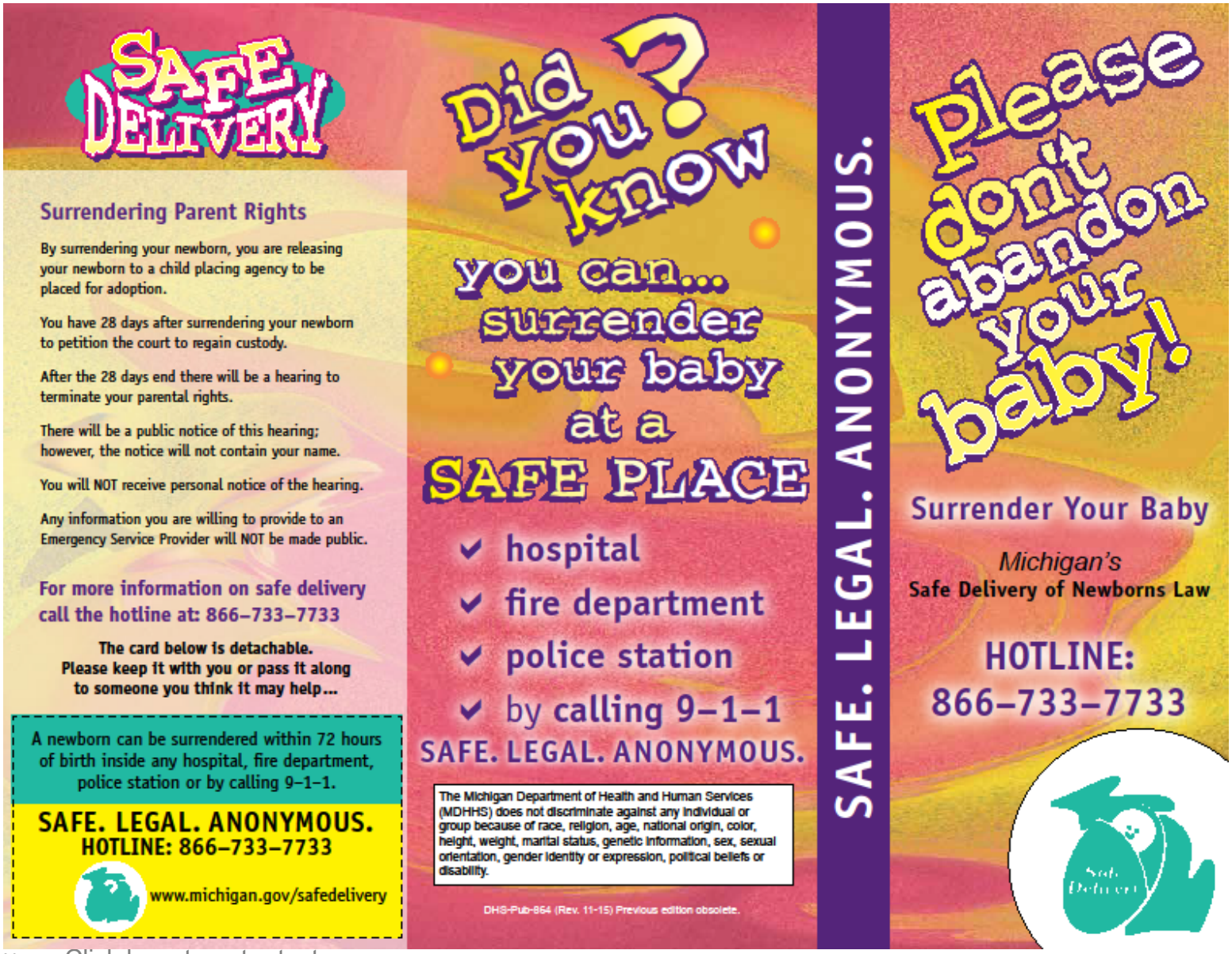
Subscribed and sworn to before me on _____, _____
Date County and State

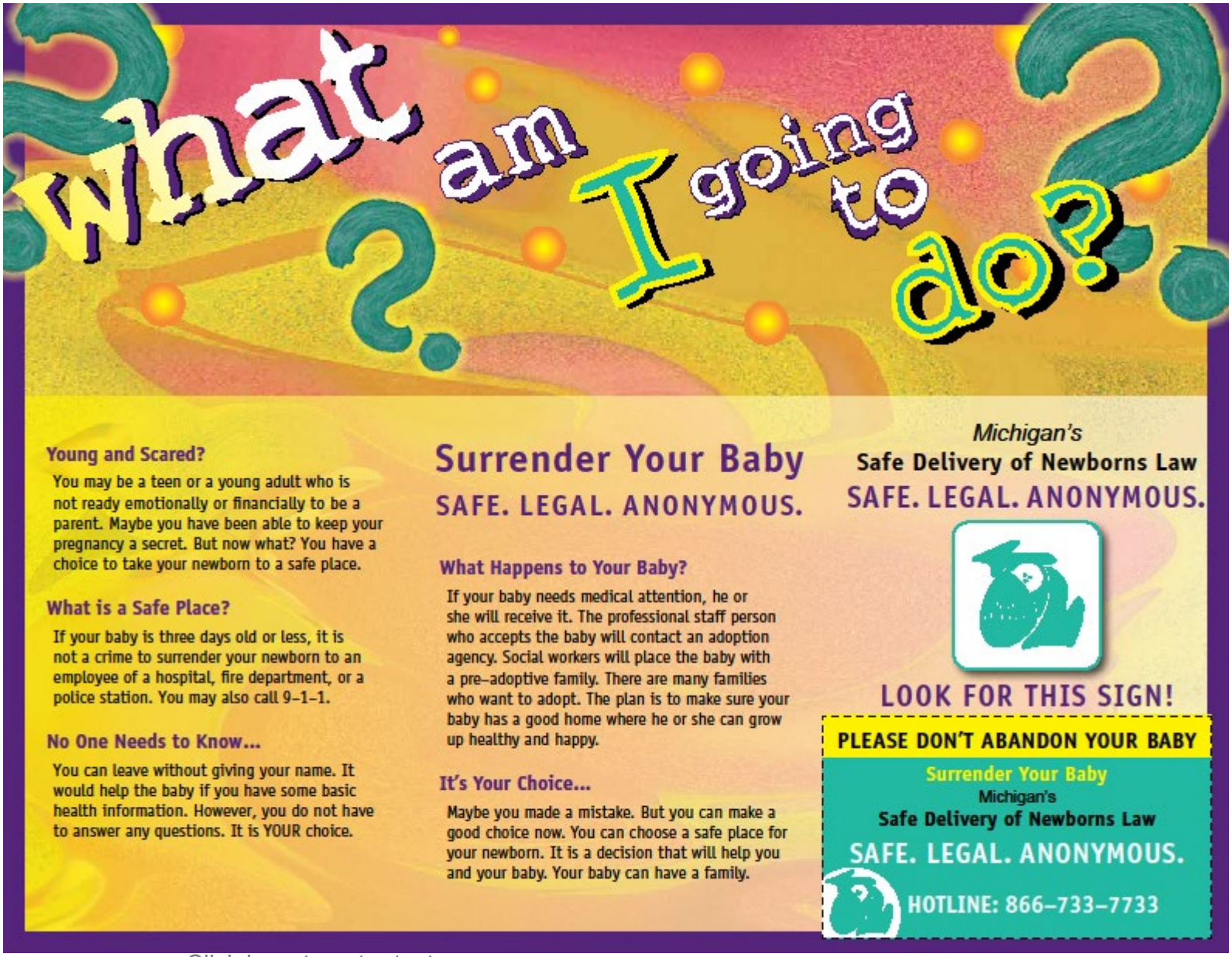
My commission expires: _____ Signature: _____
Date

_____
Name (type or print)

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

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


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


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

Safe Delivery of Newborns

Purpose

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

Definitions

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

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

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

Procedures

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

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

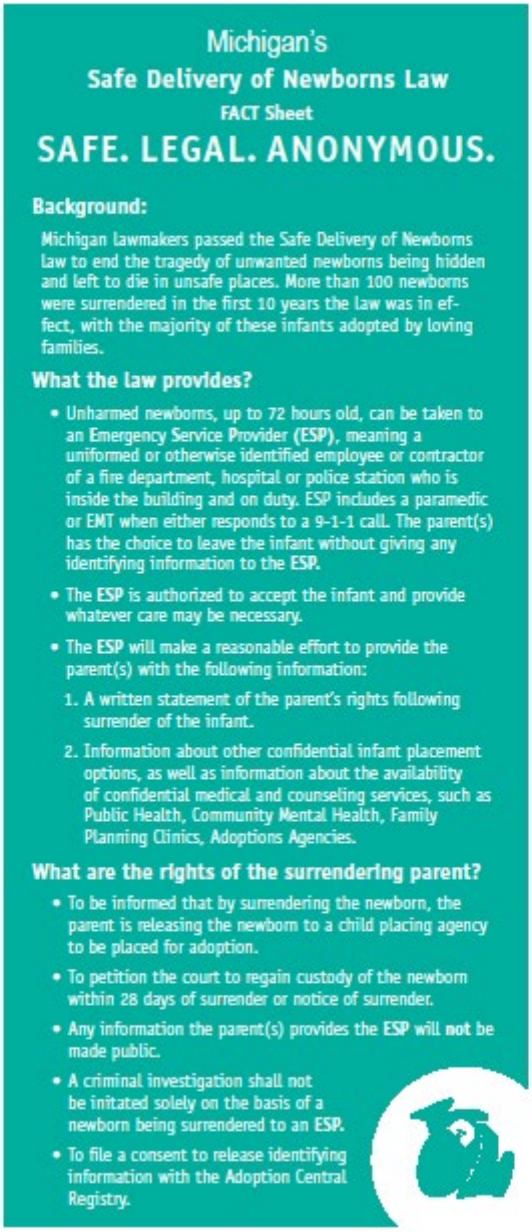
~~5.~~6. Provide the parent(s) with written material from the Department of Health and Human Services that includes:
   a. Safe Delivery Program FACT Sheet (DHHS Pub 867)
   b. What Am I Going To Do? (DHHS Pub 864) Optional

~~6.~~7. Make a reasonable attempt to:
   a. Reassure parent(s) that shared information will be kept confidential.
   b. Encourage parent(s) to identify him/herself.
   c. Encourage the parent(s) to share any relevant family/medical background, Voluntary Medical Background Form for a Surrendered Newborn (DHHS Form 4819).
   d. Inform the parent(s) of the newborn he or she can receive counseling or medical attention.
   e. Inform parent that in order to place the child for adoption the state is required to make a reasonable attempt to identify both parents. Ask for the non-surrendering parent's name. Do not press if the name is refused.
   f. Inform the parent(s) that he or she can sign a release for the child that could be used at the parental rights termination hearing, Voluntary Release for Adoption of a Surrendered Newborn (DHHS Form 4820).

~~7.~~8. Fire and Police ~~will~~ may contact emergency medical services (EMS) to transport newborn to hospital. ESP will accompany newborn to the hospital to provide hospital with any forms completed by the parent(s) and to transfer temporary protective custody.
   a. Note: Temporary protective custody cannot be transferred to EMS. A representative of the fire department or police station must go to the hospital to transfer temporary protective custody to the hospital.

~~8.~~9. ~~Paramedics and EMT responding to a 9-1-1 emergency call~~The ambulance will transport the newborn to ~~hospital~~closest appropriate facility, according to the, provide any forms completed by parent(s) and transfer temporary protective custody to hospital staff.

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



Michigan's

Safe Delivery of Newborns Law

FACT Sheet

SAFE. LEGAL. ANONYMOUS.

Background:

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

What the law provides?

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

What are the rights of the surrendering parent?

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

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

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

SURRENDERING PARENT BACKGROUND (Optional)

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

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

Surgical History

OTHER PARENT BACKGROUND (Optional)

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

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

Surgical History

INFORMATION ABOUT THE PREGNANCY

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

EMERGENCY SERVICE PROVIDER OBSERVATIONS

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

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

VOLUNTARY RELEASE FOR ADOPTION OF A SURRENDERED NEWBORN BY PARENT

Michigan Department of Human Services

In the matter of _____, a newborn child.

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

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

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

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

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

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

Date ___/___/_____ Parent Signature _____

Address _____

City _____ State _____ Zip _____

Witnessed by _____
Name (type or print)

on _____, at _____
Date Agency and Address

_____
Signature

IF A NOTARY IS AVAILABLE: Notary Public

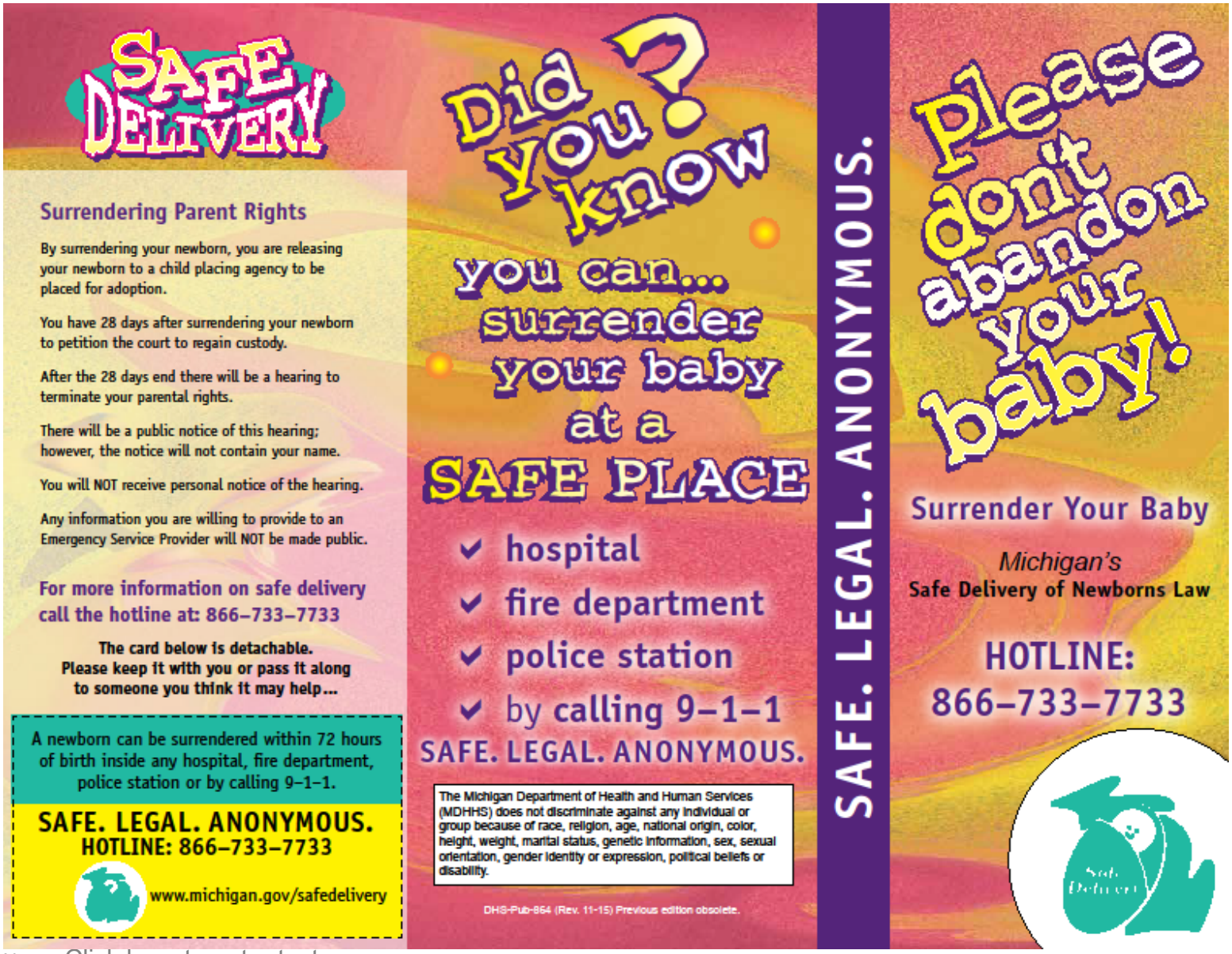
Subscribed and sworn to before me on _____, _____
Date County and State

My commission expires: _____ Signature: _____
Date

_____
Name (type or print)

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

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


SAFE DELIVERY
Surrendering Parent Rights
By surrendering your newborn, you are releasing your newborn to a child placing agency to be placed for adoption.
You have 28 days after surrendering your newborn to petition the court to regain custody.
After the 28 days end there will be a hearing to terminate your parental rights.
There will be a public notice of this hearing; however, the notice will not contain your name.
You will NOT receive personal notice of the hearing.
Any information you are willing to provide to an Emergency Service Provider will NOT be made public.
For more information on safe delivery call the hotline at: 866-733-7733
The card below is detachable.
Please keep it with you or pass it along to someone you think it may help...
A newborn can be surrendered within 72 hours of birth inside any hospital, fire department, police station or by calling 9-1-1.
SAFE. LEGAL. ANONYMOUS.
HOTLINE: 866-733-7733
www.michigan.gov/safedelivery
Did you know
you can... surrender your baby at a
SAFE PLACE
hospital
fire department
police station
by calling 9-1-1
SAFE. LEGAL. ANONYMOUS.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
DHS-Pub-864 (Rev. 11-15) Previous edition obsolete.
SAFE. LEGAL. ANONYMOUS.
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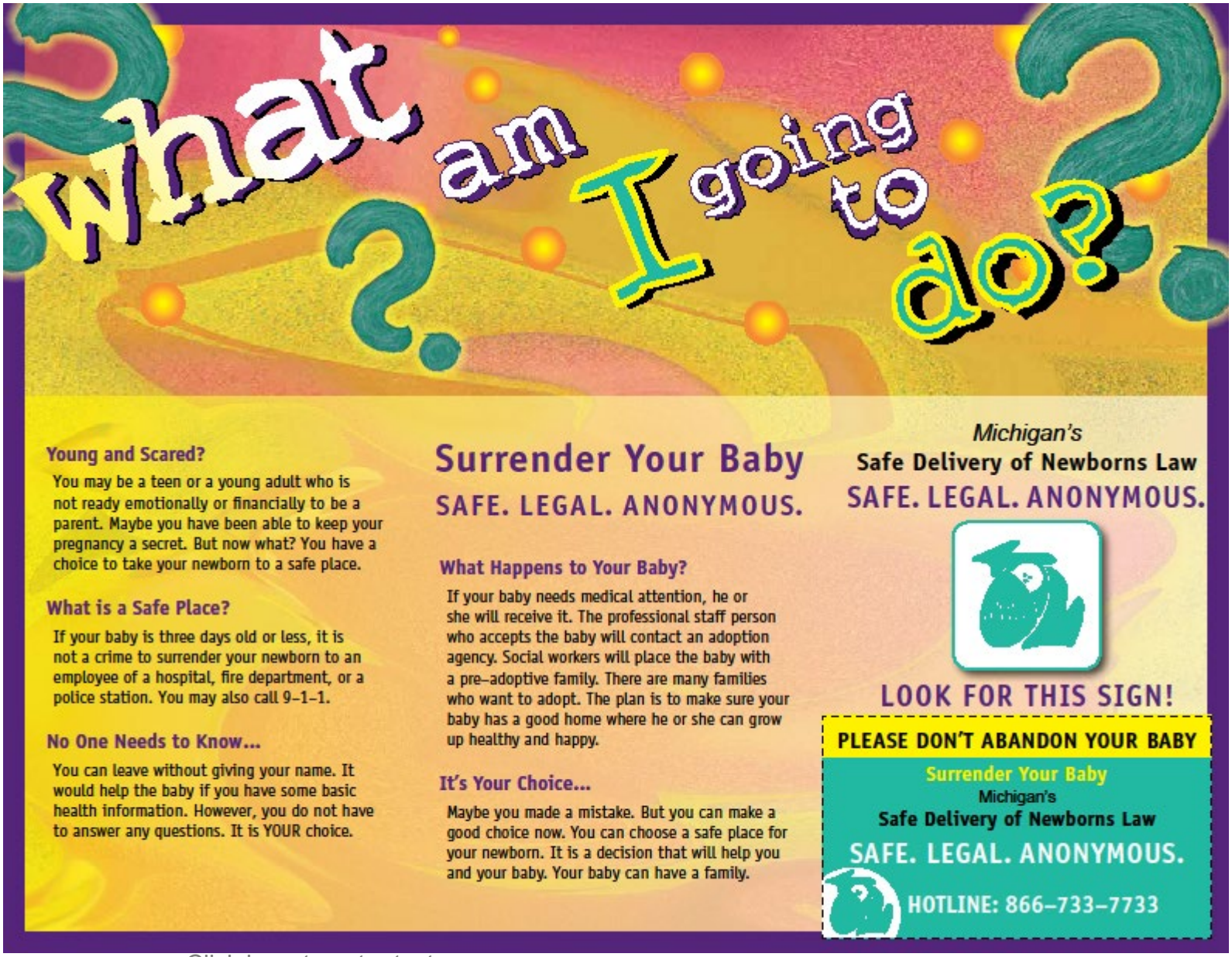
what am I going to do?
Young and Scared?
You may be a teen or a young adult who is not ready emotionally or financially to be a parent. Maybe you have been able to keep your pregnancy a secret. But now what? You have a choice to take your newborn to a safe place.
What is a Safe Place?
If your baby is three days old or less, it is not a crime to surrender your newborn to an employee of a hospital, fire department, or a police station. You may also call 9-1-1.
No One Needs to Know...
You can leave without giving your name. It would help the baby if you have some basic health information. However, you do not have to answer any questions. It is YOUR choice.
Surrender Your Baby
SAFE. LEGAL. ANONYMOUS.
What Happens to Your Baby?
If your baby needs medical attention, he or she will receive it. The professional staff person who accepts the baby will contact an adoption agency. Social workers will place the baby with a pre-adoptive family. There are many families who want to adopt. The plan is to make sure your baby has a good home where he or she can grow up healthy and happy.
It's Your Choice...
Maybe you made a mistake. But you can make a good choice now. You can choose a safe place for your newborn. It is a decision that will help you and your baby. Your baby can have a family.
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Complaint Investigation & Resolution

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

I. Definitions:

A. Allegation/Complaint Invalid

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

B. Allegation Valid Minor

This can be viewed two ways.

1. The licensee's role in the administrative rule or protocol violation was small.
2. The result of the administrative rule or protocol violation had a minor effect.

C. Allegation Valid Serious

This can be viewed two ways.

1. The licensee's role in the administrative rule or protocol violation was great.
2. The result of the administrative rule or protocol violation had a major effect.

D. Appeal Hearing

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

E. Order of Disciplinary Action (ODA)

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

F. Complaint

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

G. Due Process

A course of formal proceedings carried out regularly and in accordance with established rules and principles

H. Formal Inquiry

Formal inquiry means that a complaint has been found to either be valid, or that more detailed inquiry is necessary to determine the validity of the complaint; either of which will require that the subject licensee (individual/agency) be notified of the specific complaint. A formal inquiry may involve the gathering of incident reports which provide explanations for care rendered or justification for actions, as well as subject/witness interviews.

Some information gathering may not necessitate a formal inquiry.

I. Just Culture Guidelines

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

J. Licensee

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

K. Privileged Documents

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

L. Quality Improvement Action

An action taken to remediate a valid complaint to the MCA.

M. Sentinel Event

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

N. Subject Licensee

a. The individual provider that is the subject of the complaint received by the MCA

II. Complaints Received

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

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

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

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

b. The complainant must provide the MCA with his/her name, address, and telephone number. A request for anonymity by a complainant shall be honored by the MCA to the extent possible.
c. The complaint must be directed toward a licensee (individual or agency) within the MCA.
d. The complaint must include a potential violation of Michigan or Federal laws, EMS rules, or MCA protocol
    i. All complaint reviews will be based on MCA approved protocols that were approved and active on the date of the EMS call for service.

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

III. Complaint Delegation
A. Complaints directed toward an individual acting while employed by an agency outside of the jurisdiction of the MCA shall not be accepted or investigated but will be forwarded, or the complainant directed to, the MCA/agency under whose jurisdiction it does fall.
B. MCAs may cooperate on investigations which overlap jurisdictional boundaries. For the purposes of Quality Improvement Actions, the MCA granting Medical Control to the provider or agency where the primary action or actions being investigated took place shall be considered the jurisdictional MCA.
C. Complaints more appropriately investigated at the agency or operational level may be turned over to the life support agency or hospital involved. Investigation results should be reported to the MCA.

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

incidents:

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

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

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

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

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

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

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

B. Documentation

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

a. The name, address, and telephone number of the complainant (if known)
b. A copy of the stated complaint
c. The date and time of the receipt of the complaint
d. A copy of the complaint acknowledgement, if appropriate.
e. A copy of the notice to the subject licensee, if appropriate.
f. A copy of the pertinent protocol(s) and/or policy/policies.

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

V. Due Process

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

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

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

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

[1] MCL 331.533
[2] MCL 331.533

b. Valid – Minor
c. Valid – Serious

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

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

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

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

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

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

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

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

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

c. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
d. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.
e. Within one (1) business day of the removal of medical control privileges, the Medical Control Authority must notify all other Medical Control Authorities which it knows, or has reason to believe, have granted the licensee or agency Medical Control privileges.

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

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

individual financial penalties must purposely develop an addendum to this policy.

J. PSRO Communications

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

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

[3] MCL 331.532

Disciplinary Action Appeal

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

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

II. Appeal Hearing
   A. Upon receipt of a Request to Appeal an ODA, the MCA shall schedule a special meeting for the purpose of hearing an appeal. This meeting shall be scheduled as soon as practicable following receipt of a Request to Appeal.
   B. The receipt of a Request to Appeal does not stay the ODA or the imposition of the discipline on the appellant licensee.
   C. The MCA shall honor a request to postpone an appeal hearing, no later than thirty (30) days past the originally scheduled hearing date, to allow the appellant licensee opportunity to assemble information bearing upon his/her/their appeal.
   D. The MCA shall hold an appeal hearing to review the appellant licensee's new information and exercise one of the following options:
      1. Uphold the original decision and subsequent ODA.
      2. Diminish the ODA to a lesser Disciplinary Action (i.e., suspension of privileges diminished to written reprimand).
      3. Revoke the ODA (revocation of an ODA shall not expunge the appellant's record of the complaint process records for a period to twelve (12) months from date of original incident).
   E. Following exhaustion of the procedure stated herein, an appellant may appeal the decision of the MCA to the State of Michigan Emergency Medical Services Coordination Committee as defined in Part 209 of P.A. 368 of 1978, as amended Section 20919(4). An appeal must be filed with the Department of Health and Human Services, in writing, no more than 30 calendar days following notification of the final determination by the MCA.
      1. If a decision of the MCA is appealed to the Emergency Medical Services Coordination Committee, the MCA shall make available, in writing, the information it considered in makings its decision.

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      1. If a decision of the MCA is appealed to the Emergency Medical Services Coordination Committee, the MCA shall make available, in writing, the information it considered in makings its decision.

~~III. Appeal Hearing for an Immediate Threat~~
~~If the MCA determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control privileges can be taken immediately until the MCA has had the opportunity to review the matter at a MCA~~

~~hearing. The hearing shall be held within 3 business days after the MCA's (or Medical Director's) determination to remove medical control.~~

Quality Improvement Policy

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

I. Confidentiality Assurance

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

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

II. Professional Standards Review Organization

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

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

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

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

E. All Quality Improvement activities shall be performed by the PSRO, and all documents collected for Quality Improvement activities shall be held

by the PSRO subject to Michigan's peer review privilege.[1]

III. Data Collection

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

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

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

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

E. Incident Report Collection

[1] MCL 331.531 *et seq*.

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

IV. Data Review

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

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

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

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

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

VI. Quality Review Criteria

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

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

VII. Quality Improvement Actions

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

include:

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

Electronic Records & EMS Information System

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

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

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

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

E. **CARES Data**
    a. The LSA will submit cardiac arrest data for the cardiac arrest patients to the CARES registry.
    b. If multiple agencies are on scene the transporting agency is responsible for submittance of this data.
    c. The agency filling out the report should contact the PSAP to obtain the PSAP information.

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

Electronic Records & EMS Information System

I. **Responsibility for Records**
   A. Any PCR software utilized by an EMS agency must be compliant with the National EMS Information System (NEMSIS) system ~~version 3.4~~ and the Michigan EMS Information System (MIEMSIS) as determined by the department ~~compliant~~.
   B. All PCR are considered confidential medical records and must be treated in accordance with state and federal law.
   C. Signed electronic or paper PCR shall be maintained by the EMS agency as the official medical record for each patient treated and/or transported.
   D. All original PCR reports will be made available to the receiving facility, the MCA and the Bureau of EMS, Trauma and Preparedness, in electronic format, upon request.

II. **Submission to MIEMSIS Data Repository**
   A. All agencies must transfer data at least monthly. Reporting period begins at 00:00:01 hours on the 1st day of the calendar month, ending at midnight on the last day of the calendar month. Data must be uploaded by the 15th of the month following the close of the reporting period. MCAs may require data to be transferred more frequently.
   B. Agencies performing invasive skills (including supraglottic airways) must transfer data at least daily. PCR that include invasive skills will be available in MIEMSIS within 24 hours of incident completion.
   C. If technology permits, transfer should occur at the time of incident completion.
   D. Agencies are responsible to work with their MCA(s) and the department to ensure that the quality of the data submitted to the MIEMSIS repository is an accurate reflection of the information entered into their EMS information system. Agencies are responsible for ensuring accuracy in data element mapping, accuracy in data value coding, list compliance, and accuracy in data transfer between the vendor and the MI-EMSIS system. Agencies may access MIEMSIS to verify the submission of their records at any time.
   E. Agencies entering data from paper PCR after-the-fact are responsible for entering those PCR in accordance with the above time frames.
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   A. The MCA professional standards review organization (PSRO) will utilize data submitted by the life support agencies for the purpose of providing professional oversight and for improving the quality of medical care within the MCA region.
   B. MCAs may utilize aggregate data that does not identify the patient or agency to support EMS system and public health activities.

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

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    a. The LSA will submit cardiac arrest data for the cardiac arrest patients to the CARES registry.
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    c. The agency filling out the report should contact the PSAP to obtain the PSAP information.

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

EMS Provider Criminal Charges and Convictions (OPTIONAL)

Purpose:

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

Definitions:

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

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

Policy:

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

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

Procedure:

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

References:

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

ALS to BLS Transfer of Care (OPTIONAL)

☐ Medical Control Authorities choosing to adopt this protocol may do so by selecting this check box. In conjunction the MCA must also select the option for Interfacility High Flow Nasal Oxygen on the **Interfacility Facility Patient Transfers Protocol**.

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. 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.

Evidentiary Blood Draw Protocol (OPTIONAL)

This protocol is for specialist/AEMT and paramedic use only

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

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).

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.

Helicopter Personnel Scope of Practice (OPTIONAL)

The purpose of this protocol is to provide guidance for providers who are treating patients as part of an aeromedical service response.

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

Scope:
Helicopter programs may provide care over and above that specified in the local MCA protocols, including (but not limited to): administration of blood products, placement of central venous access devices, placement of thoracostomy tubes, establishment of a surgical airway, and administration of medications not included in the local MCA protocols. Policies and procedures regarding the use of equipment and medications not included in the local MCA Protocols will be made available by the flight service's medical director to the local MCA EMS Medical Director. Responsibility for training and quality assurance regarding these additional protocols will be the responsibility of the flight program.