

Medical Control Authority Handbook



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Introduction

The MCA Handbook is developed as a guide to hospital administrators, medical directors, and support staff. Throughout the handbook, tips, key terms, and hyperlinks will be supplied to supplement the information provided in the document. Frequently Asked Questions and Answers will be supplied at the end of each section.

We at the Bureau of EMS Trauma and Preparedness would like to thank you for all of the important work that you do in support of the Michigan EMS and Trauma System. Please feel free to contact the office with any questions or concerns. Our contact information is listed below.



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Section I

The Basics of a Medical Control Authority



Key Terms

MEDICAL CONTROL: Means supervising and coordinating emergency medical services through an MCA, as prescribed, adopted, and enforced through department-approved protocols, within an emergency medical services system.

MCA: Means an organization designated by the department under [section 20910\(1\)\(g\)](#) to provide medical control.

EMS MEDICAL DIRECTOR: Means a physician who is appointed to that position by an MCA under [section 20918](#).

What is a Medical Control Authority?

Authority

Medical Control Authorities are designated by the state to provide supervision and coordination of emergency medical services within a specified geographic region. The authority for MCAs is provided through the Public Act 368 of 1978 as amended, commonly referred to as the Public Health Code, in particular Parts 201 and 209. The Public Health Code is an extremely valuable resource for every MCA. At first it may appear daunting, however, it is relatively easy to navigate this online resource with a couple of key strokes. The Public Health Code in its entirety can be found at http://www.mcecc.org/documents/Public_Health_Code.pdf. To navigate through the Public Health Code, pull up the PDF found in the link and navigate as instructed below.



To Navigate the Public Health Code:

1. Hold down Ctrl + F, then type in the search term

The screenshot shows a PDF document viewer interface. At the top, there are navigation controls including a search bar with the text 'Find form...', a dropdown menu showing 'emergency medical services', and 'Previous' and 'Next' buttons. A red arrow points to the search bar. The main content of the PDF is visible below, including a paragraph defining disaster, a history note, and a section titled '333.20904 Definitions; E.' with a list of levels for training.

property resulting from a natural or man-made cause, including but not limited to, fire, flood, snow, ice, wind, wave action, oil spill, water contamination requiring emergency action to avert danger or damage, utility hazardous peacetime radiological incident, major transportation accident, hazardous materials accident, epidemic, air contamination, drought, infestation, or explosion. Disaster does not include a riot or other civil disorder unless it directly results from and is an aggravating element of the disaster.

History: Add. 1990, Act 179, Imd. Eff. July 2, 1990;—Am. 2000, Act 375, Imd. Eff. Jan. 2, 2001.

Popular name: Act 368

333.20904 Definitions; E.

Sec. 20904. (1) “Education program sponsor” means a person, other than an individual, that meets the standards of the department to conduct training at the following levels:

- (a) Medical first responder.
- (b) Emergency medical technician.
- (c) Emergency medical technician specialist.
- (d) Paramedic.

2. The next instance of that term will be highlighted.

PUBLIC HEALTH CODE

patient transportation between health facilities and that is capable of providing patient care according to orders issued by the patient's physician.

(4) "Ambulance" means a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

(5) "Ambulance operation" means a person licensed under this part to provide **emergency medical services** and patient transport, for profit or otherwise.

MCA Membership

Medical Control Authorities are administered by the participating hospitals of the designated MCA region. The participating hospitals shall appoint an advisory body for the MCA that shall include, at a minimum, a representative of each type of life support agency and each type of emergency medical services personnel functioning within the MCA's boundaries. Any licensed hospital within the geographic area served by the MCA that operates an Emergency Department (ED) 24/7/365 may participate and serve on the MCA board. This includes freestanding emergency rooms (ER). In addition, each freestanding surgical outpatient facility licensed under Part 208 of the code that operates a service for treating emergency patients 24/7/365 and meets standards established by the MCA may participate. If a freestanding surgical outpatient facility participates in the MCA, the facility shall meet all applicable standards established by the MCA. All hospitals, freestanding ERs, and freestanding surgical outpatient facilities must comply with established MCA protocols. ([PA 368 of 1978 as amended § 20918 \(1\) and Rule 201\(7\)](#)).

Structure

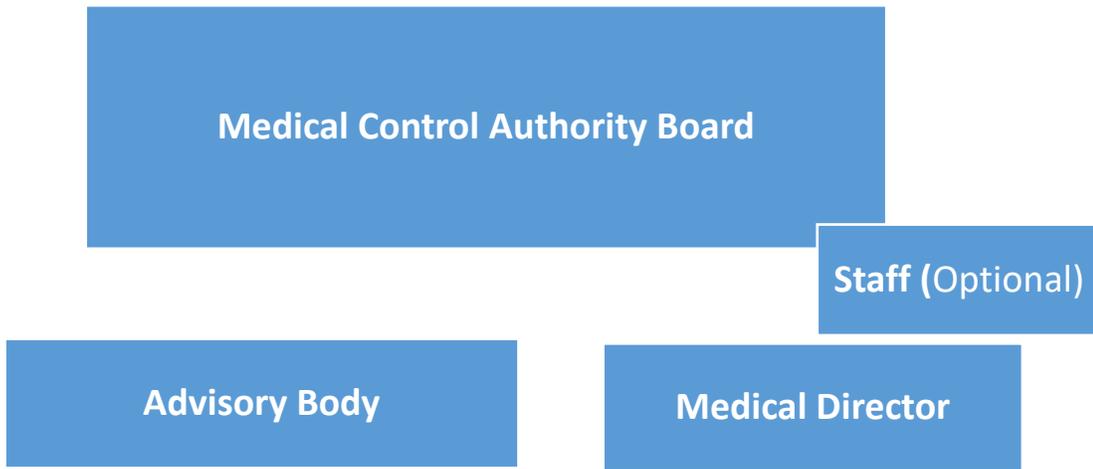
The organizational structure of an MCA is determined by the participating hospitals. It is an entity unto itself and must always act in the interest of the EMS system, not necessarily any one of its contributing members.

Examples include establishing an MCA as:

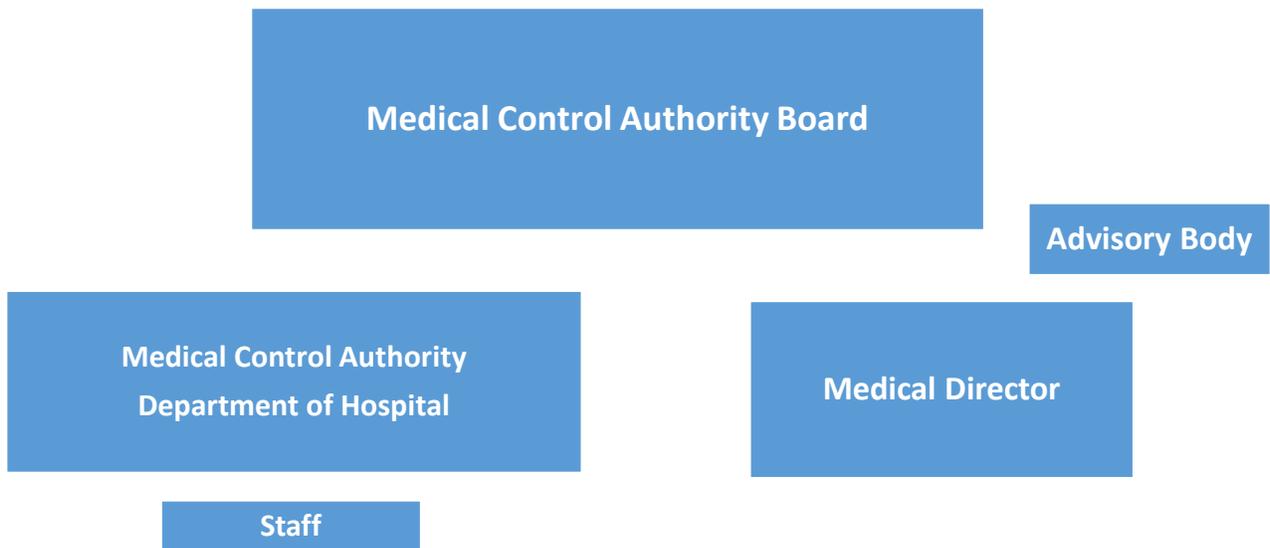
- * An independent corporation
- * Within a county agency
- * Within an educational organization
- * As a specific department of a hospital
- * As any other organizational structure as designated by the hospital(s) for example a contract
- * Designation, by the hospital(s), in no way mitigates the responsibility of the participating hospitals.

MCA Structure Examples

Example 1



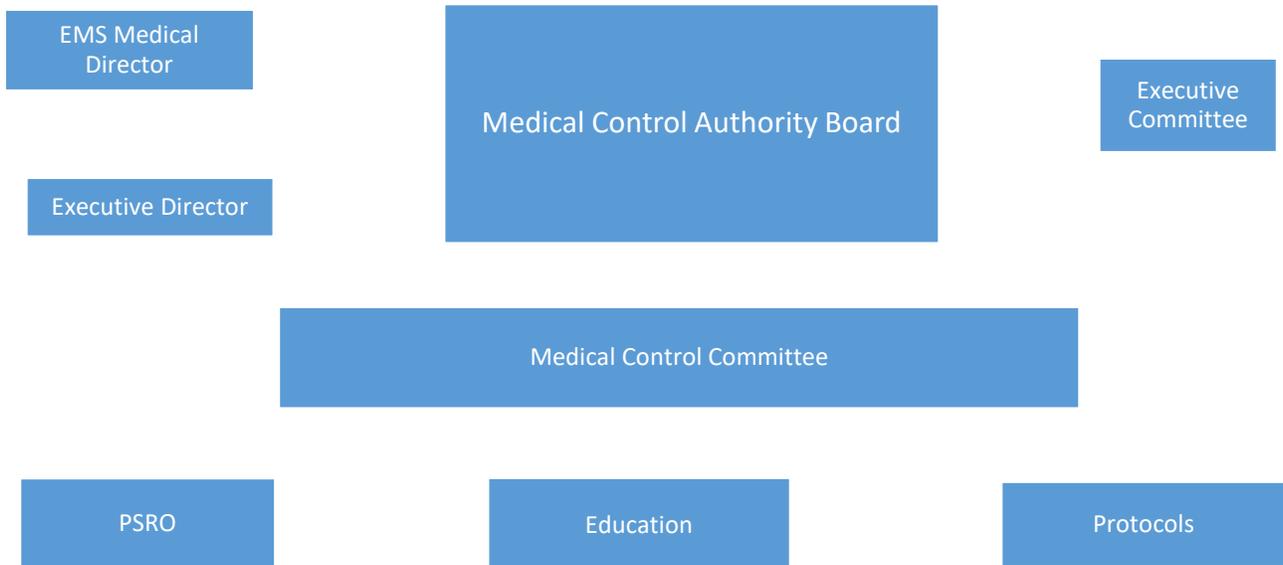
Example 2



Example 3



Example 4



Rules to the Design

According to PA 368 of 1978 as amended the MCA shall do all of the following:

- * Develop bylaws that define the MCA organizational structure
- * Appoint an MCA board to administer the MCA. The majority of the board shall be comprised, at a minimum, of members of the hospitals, and, when applicable, freestanding surgical outpatient facilities. The board may include representation of life support agencies.
- * If the board also functions as the advisory body to the MCA, then the board shall include a representative of each type of life support agency and emergency medical services personnel functioning within the MCA region.
- * Appoint an Advisory Body as defined in [Section 20918 \(2\) and \(4\)](#). The advisory body shall meet at least quarterly.
- * Appoint a medical director, with the advice of the advisory body, in accordance with [Section 20918 \(3\)](#) of the code.
- * Appoint a professional standards review organization for the purpose of improving the quality of medical care.

Board

The participating hospitals and freestanding surgical outpatient facilities, where appropriate, within an MCA region shall appoint an MCA board. The majority of the board shall be comprised, at a minimum, of members of the hospitals, and, when applicable, freestanding surgical outpatient facilities. The board may include representation of life support agencies.

If the board also functions as the advisory body to the MCA, then the board shall include a representative of each type of life support agency and emergency medical services personnel functioning within the MCA region.

Advisory Body

The MCA must appoint an advisory body. The advisory body is mandated by law to advise the MCA on the appointment of a medical director. The advisory body shall be comprised, at a minimum, of a representative of each type of life support agency and each type of emergency medical services personnel functioning within the MCA's boundaries ([Section 20918\(2\)](#)). No more than 10% of the membership of the advisory body shall be employees of the medical director or of an entity substantially owned or controlled by the medical director ([Section 20918\(4\)](#)).

The advisory body shall, at a minimum, do the following:

- * Advise the MCA on the appointment of a medical director
- * Advise the MCA on the development of protocols.
- * Meet at least quarterly.

An MCA may combine the Board and Advisory Body. This combined body must meet the requirements as identified above.

Medical Director

The **MCA with the advice of the advisory body appoints the medical director**. They may appoint more than one physician to serve as the medical director as long as the defined criteria are met. The medical director shall be a physician who is board certified in emergency medicine by a national organization approved by the Division of EMS and Trauma, or who practices emergency medicine and has successfully completed and is current in both Advanced Cardiac Life Support and Advanced Trauma Life Support. The medical director is an agent of the MCA and is responsible for medical control for the emergency medical services system.

The medical director shall ensure the provision of medical control. The medical director's signature on a life support agency's application for licensure or re-licensure affirms that the MCA intends to provide medical control to the life support agency.

Medical Director Duties:

- * Participate every 2 years in at least one division-approved educational program relating to medical control issues.
- * Responsible for the supervision, coordination, implementation, and compliance with protocols of the MCA.
- * Receive input from, and be responsive to, the advisory body.
- * Complete, within one year of initial appointment, a medical director's educational program provided by the Division.

MCA Staff

Some MCAs utilize staff to support the functions of the MCA. This may range from clerical to professional administrative staff. Responsibilities may include: training, provider testing, medication management, grants management, emergency management, provider and agency accountability, coordination or provision of continuing education, quality improvement, data entry, etc. Staff may be shared between agencies, hospitals, or employed solely by the medical control authority. It is important to remember that staff of the MCA, shared or otherwise, when acting on behalf of the MCA, must remember that the best interest of the EMS system is paramount.

Funding of a Medical Control Authorities

The EMS statute does not address the funding of medical control authorities, but there are several options to be considered. Many medical control authorities have used incorporation and obtaining non-profit status in order to open funding opportunities.

Hospital Funding

Participating hospitals/freestanding surgical outpatient facilities and ERs often support all or part of the medical control authority budget. This support may be in the form of direct cash contribution to the medical control authority or to individual medical control authority staff (i.e., a stipend to the medical director). Alternatively, hospitals/free standing surgical outpatient facilities may provide in-kind support through existing hospital human and physical resources. For example, a hospital may provide administrative offices and secretarial support. The responsibilities of the medical director may be included in the general job description of a hospital emergency department medical director, emergency physician, or in the responsibilities of a contracting emergency physician group.

Grant

Grants may be available for special projects and also may be available for operating income. Grants may be obtained from foundations, directly from businesses, or from State or Federal Government agencies.

Pre-hospital Providers

Federal court has ruled that while medical control authorities perform governmental service, they do not have taxing authority and therefore can't mandate involuntary financial contributions. When developing voluntary funding programs, make sure you comply with anti-kickback laws ([42USC1320a/7b\(b\)](#)).

Local Businesses

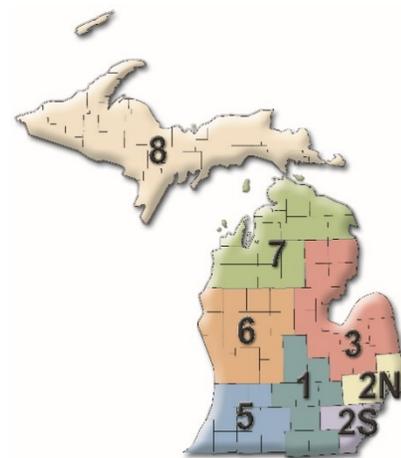
Many local businesses make charitable contributions to non-profit organizations, and may be interested in providing on-going support for certain activities. While support for day-to-day medical control authority operating costs may be possible, it is likely that this source of funding may be more readily available for special system projects (i.e., expanded early defibrillation project).

Municipal Funding

The State Attorney General has indicated that funding from counties for medical control authorities is permissible. While this is often accomplished in conjunction with a county run EMS system, counties have the ability and authority to provide separate funding for medical control authority activities. This can occur through funding from local government (e.g., general fund or dedicated millage). Some counties provide in-kind contributions to support medical control authority activities through existing county agencies. For example, the emergency management agency or health department may provide staff support to the medical control authority.

RMCANS

Regional Medical Control Authority Networks (RMCANs) are regional groups with jurisdictional areas identical to the HCCs and EM districts. The RMCANs are regional planning groups which are tasked with the management of state provided grant funds intended to assist the regions in developing cooperative plans for the accomplishment of all responsibilities related to the individual MCAs. The funds were initially slated to assist the regional in the formation of regional MCAs. When this effort morphed into a regional collaborative, rather than a regional MCA, the funding was dedicated to supporting projects which would help the regions through economies of scale and comprehensive planning.



Regional Trauma Networks and Regional Trauma Advisory Committees

Regional Trauma Networks (RTNs) and Regional Trauma Advisory Committees (RTACs) are committees established per the state Trauma Rules. Per the Trauma Rules, the RTN is comprised of the Medical Control Authorities with the region. The RTACs are formed of all stakeholders involved in the trauma system. The trauma rules define the responsibilities of these groups including membership, the development of a regional trauma plan, PSRO functionality, etc. The authority for the groups falls under the statutory authority granted to the MCA's.

The goal of these committees and groups is to develop protocols, plans and policies which establish the components of the regional trauma system. And to operationalize those plans to effectuate a working trauma system. The trauma rules may be found at: [TRAUMA RULES](#)

Frequently Asked Questions

1. It has been mentioned that medical control authorities are governmental entities and are subject to the freedom of information act (FOIA). Can you provide clarification regarding this issue?

A. If an MCA encounters a FOIA request, they should consult with their legal counsel.

2. Are MCAs subject to the Open Meetings Act?

A. The Open Meetings Act applies to public bodies. MCA are public bodies, because they are empowered by the State and perform an essential public purpose. They are subject to the Open Meetings Act.

3. Based on our current law, is it implied, suggested or directed that EMS personnel function under the medical license of the medical director?

A. It is the Department's position that emergency medical services personnel do not operate under the physician's license. EMS personnel must maintain their own State issued license. The focus for pre-hospital emergency care is developed in protocols, which are established by the medical control authority. The function of the Medical Director, under each authority, is to carry out those activities established by the medical control authority based upon its protocols.

4. Can we base our voluntary funding on call volumes per agency so each agency contributes according to their use?

A. Formulas in which the contributions from pre-hospital agencies are tied to call volume have been challenged by some as potentially in violation of the Medicare anti-kickback statute and should be very carefully evaluated before implementation. Whatever method is used to allocate volunteer contributions, there must be collaboration with agencies to find a method that is fair and acceptable.

Section II

Processes of a Medical Control Authority



Key Terms

ADVANCED LIFE SUPPORT: means patient care that may include any care a paramedic is qualified to provide by paramedic education that meets the educational requirements established by the Division under section 20912 or is authorized to provide by the protocols established by the local medical control authority under [section 20919 for a paramedic](#), [§20902](#) or [Section 20919](#)

AMBULANCE: means a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

BASIC LIFE SUPPORT: means patient care that may include any care an emergency medical technician is qualified to provide by emergency medical technician education that meets the educational requirements established by the Division under [section 20912](#) or is authorized to provide by the protocols established by the local medical control authority under [section 20919](#) for an emergency medical technician.

DISCIPLINARY ACTION: is an action taken by the Division against an MCA, LSA, or individual; or an action taken by an MCA against a LSA or individual for failure to comply with the code, rules, or protocols approved by the Division.

EMERGENCY MEDICAL SERVICES: means the emergency medical services personnel, ambulances, non-transport pre-hospital life support vehicles, aircraft transport vehicles, medical first response vehicles, and equipment required for transport or treatment of an individual requiring medical first response life support, basic life support, limited advanced life support, or advanced life support.

EMS COORDINATION COMMITTEE (EMSCC): was created under statute and is comprised of members representing many groups within the EMS community. The EMSCC provides an advisory role to the Division and Legislature.

“FAIR” OR DUE PROCESS: is an EMS Section approved protocol that clearly delineates the process to be followed in situation where a member of the EMS system has allegedly breached a division-approved protocol.

NON-COMPLIANCE: is the failure to comply with a division approved protocol.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO): means a committee established by a life support agency or a medical control authority for the purpose of improving the quality of medical care.

PROTOCOL: means a patient care standard, standing orders, policy, or procedure for providing emergency medical services that is established by a medical control authority and approved by the Division under section 20919.

QUALITY ASSURANCE TASK FORCE: (QATF) is a standing subcommittee of the EMSCC that reviews all protocols within MCA. The QATF advises the EMSCC on protocol compliance.

QUALITY REVIEW COMMITTEE: is a formal committee (PSRO) established within the MCA whose purpose is to review ensure quality standards are maintained.

What Does an MCA Do?

Activities

While each medical control authority is different, there are certain things that all MCA must do.

- * MCAs are required to comply with the Michigan statute and promulgated administrative rules. The National Association of State Emergency Medical Services Officials (NASEMSO) provides a very organized link to both at <http://www.nasemso.org/legislation/Michigan/michigan.html>.
- * Ensures the accountability of each licensed life support agency and individual in the provision of emergency medical services, as defined in Division-approved protocols.
- * Establish written protocols for the practice of life support agencies and EMS personnel.
- * Collect data as necessary to assess the quality and needs of emergency medical services throughout its MCA region.
- * Each participating and non-participating hospital within an MCA region shall follow all standards, policies, procedures, and protocols established by the MCA and approved by the Division.
- * Each MCA shall submit to the Division current protocols for review and approval. Division approval shall be on a 3-year cycle as defined by the Division.
- * Medical control authorities that adopt the state protocols as written need only submit a letter.
- * Medical control authorities that adopt the state protocols with changes need to submit the revised protocols. The protocols should be submitted in both redline and clean versions. This [form](#) should be filled out with justification for changes.
- * Medical control authorities desiring additions to the state protocols may continue to submit updated protocols as needed.
- * The QATF reviews all proposed protocol changes and advises the Division on whether the protocols should be approved, altered, or denied.
- * The MCA shall notify the Division if a life support agency fails to provide at least one life support vehicle 24-hours-a-day, 7-days-a-week.

Protocols

[P.A. 368 of 1978 as amended](#), and the promulgated administrative rules, define the responsibilities of the medical control authority in the development, review and implementation of written protocols. The protocols that an MCA implements provide the standard by which all participants in the MCA are measured. Thus, protocols are the foundational means through which the MCA exercises authority and holds participants accountable.

The protocols must be developed and adopted in accordance with procedures established by the Division and include all of the following:

- * The acts, tasks, or functions that may be performed by each type of licensed emergency medical services personnel or agency.
- * Medical protocols to ensure appropriate dispatching of a life support agency based upon medical need and the capability of the EMS system.
- * Protocols for complying with the Michigan do-not-resuscitate procedure act, [1996 PA 193, MCL 333.1051 to 333.1067.](#)
- * Protocols defining the process, actions, and sanctions a medical control authority may use in holding a life support agency or personnel accountable.
- * Protocols to ensure that if the MCA determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control can immediately be taken until the MCA has had the opportunity to review the matter at an MCA hearing. The protocols shall require that the hearing is held within three business days after the MCAs determination.
- * Protocols to ensure that if medical control has been removed from a participant in an EMS system, the participant does not provide pre-hospital care until medical control is reinstated, and that the MCA that removed the medical control notifies the Division within one business day of the removal.
- * Protocols that ensure a quality improvement program is in place within an MCA and provides data protection as provided in [1967 PA 270, MCL 331.531 to 331.533.](#)
- * Protocols to ensure that an appropriate appeals process is in place.
- * A protocol to ensure that each LSA that provides BLS, LALS, or ALS is equipped with epinephrine or epinephrine auto-injectors and that each EMS provider is authorized to provide those services, and is properly trained to recognize an anaphylactic reaction, to administer the epinephrine, and to dispose of the epinephrine auto-injector or vial.
- * Protocols to ensure that each life support vehicle that is dispatched and responding to provide MFR life support, BLS, or LALS is equipped with an automated external defibrillator (AED) and that each EMS provider is properly trained to utilize the AED.
- * Procedures to assure that LSAs are providing clinical competency assessments to EMS personnel before the individuals provide patient care within



IF THERE IS A THREAT TO THE PUBLIC HEALTH,
SAFETY, OR WELFARE, APPROPRIATE ACTION
SHOULD IMMEDIATELY BE TAKEN BY THE

the MCA region.

- * Protocols that delineate that if LSAs routinely transport pre-hospital patients to hospitals outside of their originating MCA region, they will comply with their originating MCA protocols.
- * Written procedures for the security, control, dispensing, and exchange of pharmaceuticals, intravenous solutions, tubing, and related apparatus. LSA medication exchange shall only take place with a participating hospital or freestanding surgical outpatient facility or ER.
- * Develop standards for the withdrawal of a hospital or freestanding surgical outpatient facility from an MCA or the restoration of a hospital or freestanding surgical outpatient facility to an MCA.
- * Develop specific protocols applicable to the acquisition, storage, and use of drugs, intravenous fluids and medical devices. All drug and intravenous fluids shall be under the control of a pharmacist licensed in this state affiliated with a participating MCA hospital or freestanding surgical outpatient facility or ER.
- * Protocols to ensure that each life support vehicle that is dispatched and responding to provide medical first response life support, basic life support, or limited advanced life support is equipped with an automated external defibrillator and that each emergency services personnel is properly trained to utilize the automated external defibrillator.)
- * A protocol established under this section shall not conflict with the Michigan do-not-resuscitate procedure act, [1996 PA 193, MCL 333.1051 to 333.1067](#).

The standard state protocols, provide for all requirements and are considered the minimum standard for adoption.

Standards for Protocol Establishment

Protocols serve as the standard of performance of the Emergency Medical Services (EMS) system. They define the roles and responsibilities of the EMS providers and serve as a standard against which field performance can be measured. Protocols are a valuable tool for ensuring consistency in, and accountability for, patient care among the many agencies and providers within the medical control authority. Lastly, a protocol guides the accountability of EMS providers in the system and may provide a foundation for actions taken to support or refute the performance of EMS agencies. Formally, case law, as well as the Michigan Attorney General's office informally, has stated that "protocols carry the force of law." For these reasons, protocol development and review is considered one of the most important functions of the medical control authority.



**A FULLY IMPLEMENTED PROTOCOL
CARRIES THE WEIGHT OF LAW.**

Accountability for Adherence to Protocols

By statute, EMS agencies (ambulance operations, medical first responder operations, etc.) and EMS personnel are required to “operate in accordance with this part, rules promulgated under this part, and approved local medical control authority protocols” ([PA 368, of 1978 as amended §20920\(5\); §20926\(3\); §20931\(3\); §20941\(3\); §20956\(1\)](#)). This is an important consideration when developing a new protocol and when an existing protocol is under revision. Protocols need to be clear, realistic, and enforceable. MCAs have an obligation to seek uniform compliance with local protocols from all of its providers. More on compliance and providers will be covered in other sections of this handbook.

The procedures established by the Division for development and adoption of written protocols under this section shall comply with at least all of the following requirements:

- * At least 60 days prior to **adoption** of a protocol, the MCA shall circulate a written draft of the proposed protocol to all significantly affected persons within the emergency medical services EMS system served by the MCA and submit the written draft to the Division for approval.
- * An MCA must submit a written draft of proposed protocols to the Division for review by the quality assurance task force (QATF) not later than the 10th day of any given month. A protocol received not later than the 10th day of a given month will be reviewed that month. A protocol received after the 10th day of a given month will be reviewed the next month following the date of receipt by the Division.
- * The Division shall review a **proposed** protocol for consistency with other protocols concerning similar subject matter that have already been established in this state and shall consider any written comments received from interested persons in its review.
- * The division shall provide written recommendations to the MCA within 60 days of receipt of a protocol in compliance with this rule, and comments, suggested changes, deletions, denial, or approval on the proposed protocol. Protocols resubmitted with changes or modifications by the MCA fall under the 60-day response deadline as prescribed in rule.



EACH PARTICIPATING AND NON-PARTICIPATING HOSPITAL WITHIN A MEDICAL CONTROL AUTHORITY REGION SHALL FOLLOW ALL STANDARDS, POLICIES, PROCEDURES, AND PROTOCOLS ESTABLISHED BY THE MEDICAL CONTROL AUTHORITY AS APPROVED BY THE DEPARTMENT.

- * After Division approval of a proposed protocol, the MCA may formally adopt and implement the protocol.
- * A medical control authority may establish an emergency protocol necessary to preserve the health and safety of individuals within its jurisdiction in response to a present medical emergency or disaster in accordance with [section 20919\(3\)\(e\)](#) of the code.
- * Emergency protocols developed in accordance with [section 20919\(3\)\(e\)](#) of the code shall be submitted to the Division, within five business days, for review and shall remain in effect for not more than 60 days unless approved by the Division.



IF NEGATIVE MEDICAL OR ECONOMIC
IMPACTS OUTWEIGH BENEFITS,
ADDITIONAL STANDARDS SHALL NOT BE
ADOPTED.

If adopted in protocols approved by the Division, an MCA may require life support agencies, other than MFRs, within its region to meet reasonable additional standards for equipment and personnel that may be more stringent than are otherwise required under the code. If an MCA establishes additional standards for equipment and personnel, the MCA and the Division shall consider the medical and economic impact on the local community, the need for communities to do long-term planning, and the availability of personnel. If either the MCA or the Division determines that negative medical or economic impacts outweigh the benefits of those additional standards as they affect public health, safety, and welfare, protocols containing those additional standards shall not be adopted.

If adopted in protocols approved by the Division, a local MCA may require licensed agencies and personnel within its region to meet additional standards for equipment and personnel. Such as: requiring that each MFR service is equipped with an epinephrine auto-injector, and that each licensed MFR is properly trained to recognize an anaphylactic reaction and to administer and dispose of the epinephrine auto-injector, if a life support agency that provides BLS, LALS, or advanced life support is not readily available in that location. If a decision of the MCA to implement further requirements is appealed by an affected person or agency on financial grounds, the MCA shall make available, in writing, the medical and economic information it considered in making its decision. On appeal, the QATF shall review and make recommendations to the statewide EMSCC. The EMSCC shall review this information and shall issue its findings in writing to the Division before Division approval.

Legislation was passed, effective October 2015, that all levels of EMS (including MFR) must carry and be trained to administer the opioid antagonist naloxone for potential opioid overdoses.

Minimum Protocols

EMS PROVIDERS MUST BE ALLOWED AN OPPORTUNITY TO REVIEW THE PROTOCOL BEFORE ADOPTION. THIS CAN HAPPEN BEFORE OR AFTER DEPARTMENT APPROVAL.

The department has developed a minimum set of State Protocols that must be adopted by each MCA. However, these protocols can be modified to adapt to individual jurisdictional needs following a prescribed approval process by the department.

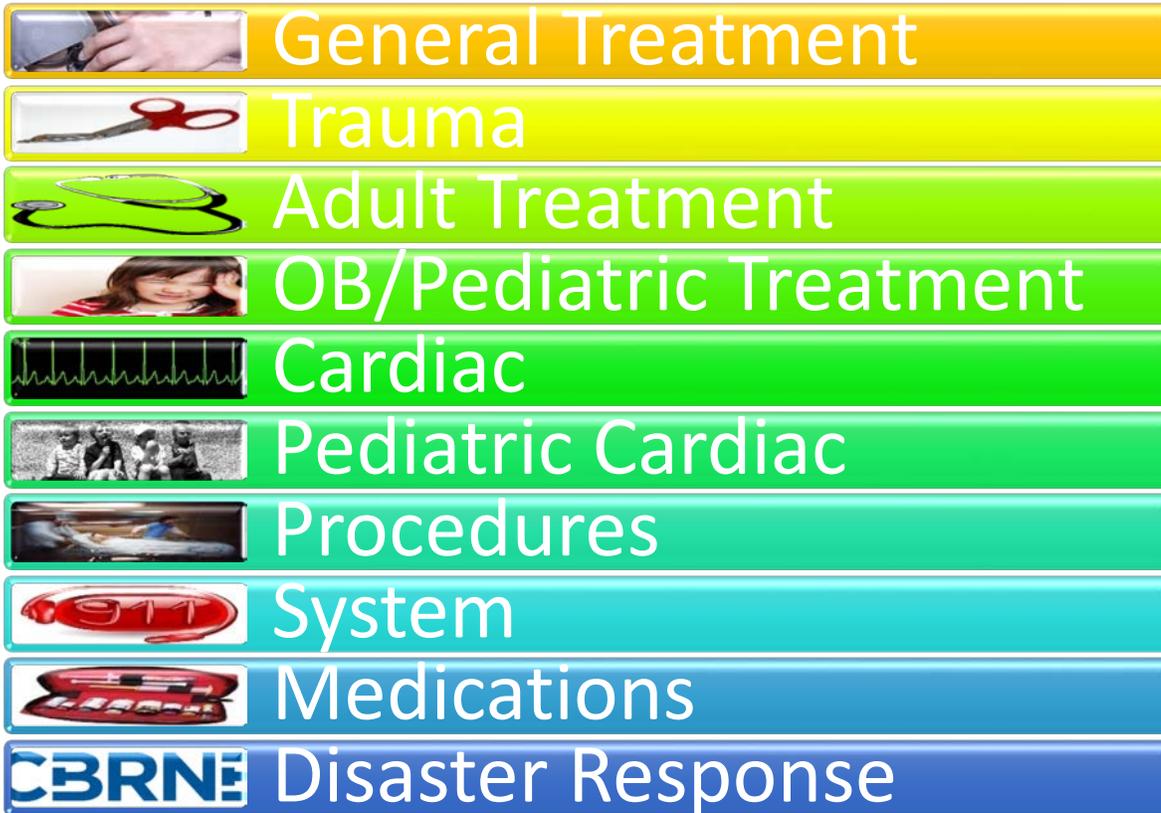


FIGURE 1 CATEGORIES OF STATE EMS PROTOCOLS



The State protocols can be found online at: [PROTOCOLS](#).

Protocol Approval Process

As stated previously, an MCA may alter a State protocol or develop a protocol specific to that MCAs jurisdictional region.

Prior to submitting a protocol to the State for approval, it should be formally reviewed by the medical director and by the medical control authority. EMS providers must be allowed an opportunity to review the protocol and make comments. The statute states that this review period must be 60 days duration and must occur before adoption of the protocol. Since only Division (EMS Section Office)-approved protocols may be adopted and implemented, this allows flexibility for the sixty-day provider review process to occur either prior to, or

after submission to the Division for approval. If there are significant provider comments that may change the protocol, resubmission to the Division for approval of the changes might need to concur. It is recommended that the provider review process occur prior to submission to the State to avoid the need for multiple submissions to the Division.

Addendums to protocols must be submitted for review, and have the accompanying training literature. The medical control authority should submit the form contained here

http://www.michigan.gov/documents/mdhhs/MCA_request_for_addendum_318149_7_distributed_558406_7.pdf, to MDHHS-MCAprotocols@michigan.gov, with the protocols and training curriculum, for review before the 10th of the month for review in the same month. Addendum forms received after the 10th of the month will be placed on the agenda for review the following month.

Occasionally a situation arises where there is a need for immediate action to address an urgent situation. There are provisions in the EMS law for the enactment of an emergency protocol that the medical control authority feels is necessary “to preserve the health or safety of individuals within its jurisdiction...” This emergency protocol is only in effect for 60 days and may not take permanent effect without engaging in the formal approval process.

Once a protocol has been drafted and supported at the local level, it is submitted to the Division of EMS and Trauma for review and approval. The QATF initially reviews the protocol. There are three possible recommendations that can be made by the QATF to the Division as it relates to protocols submitted for approval. They are:

- * Recommended approval, which will allow the protocol to be formally adopted and implemented.
- * Recommend conditional approval, with recommendation for specific minor revisions provided. Once corrections are made and a copy submitted to the EMS Section Office, the protocol is considered approved.
- * Not recommended for approval. The protocol is returned to the submitting organization with recommended changes, or with comments seeking clarification or additional information. This protocol must be resubmitted for review in the future and go through the entire local process again.

Representation of the medical director of the MCA is recommended at the session of the QATF that is reviewing protocols. The protocols are standing physician orders for providers. If there are questions about the protocol, often the medical director is the best suited to answer those questions.

Protocols may not be formally adopted until approved by the Division. MCAs are strongly cautioned against circumventing any of the steps for protocol approval as outlined by Divisional policy. To do so may result in

the MCA having to reverse its position, resulting in embarrassment and potentially, future ineffectiveness. Such a practice may also expose the medical control authority to a significant legal risk.

The Division may approve protocols that have been generated through cooperative efforts, such as the Regional Medical Control Authority Network and allow their adoption by whomever chooses to use them. The same process for protocol development (specifically the opportunity for provider review and approval by the local medical control authority) must be followed. Changes that are made must be submitted and reviewed by the QATF as described above.

Requesting Changes to State Protocols

A process is in place for modification of a State protocol. The MCA Medical Director, must complete and sign the approved form DCH1454 which can be downloaded from

http://www.michigan.gov/documents/mdhhs/MCA_request_for_addendum_318149_7_distributed_558406_7.pdf



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

CLEAR ALL FIELDS

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information	
MCA:	Medical Director:
Protocol:	Submitted by:

Identify where you are requesting to make change/changes:

Medication Pre-Medical Control Post-Medical Control Procedural

Other (specify)

Additional Protocol

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

In addition to this form, a copy of the State protocol that is being modified with track changes enabled and a clean copy of the protocol with the individual MCA replacing Michigan in the header must be attached. They can be emailed to MDHHS-MCAprotocols@michigan.gov.

Personnel and Agency Approval

In regards to personnel and agencies, the medical control authority works in conjunction with the Division. The Division licenses, inspects, and sets forth minimum rules for both personnel and agencies that make up the EMS system. The medical control authority provides the guidance, leadership, and medical direction in the EMS system. The medical control authority can act as a liaison between other members of the medical

community and the EMS community where necessary.

Agencies

LSAs and vehicles must operate under an MCA ([PA 368 of 1978 as amended § 20921 \(c\)](#)). All LSAs must provide the Division with documentation that it participates in an MCA and will remain in compliance with approved protocols as a condition of licensure.

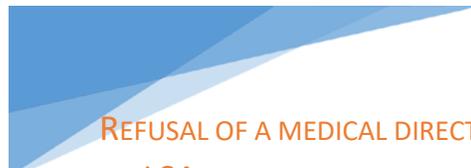
When the MCA medical director signs an application for licensure of an LSA (Part 1), the signature indicates that the medical director and/or authority has reviewed the application and provided comments, where deemed appropriate, and agreed to provide medical control to that life support agency.

If the medical director or the authority refuses to sign the application for licensure or re-licensure of a LSA, the medical director must notify the Division, in writing, within five business days, providing justification for the denial. Refusal of a medical director to sign a life support agency application will result in denial justification review by the Division. The Division will not issue a license until resolution of the issue(s).

An affected participant in an emergency medical services system shall be provided an opportunity to appeal a decision to the MCA. Following appeal, the MCA may affirm, suspend, or revoke its original decision. After appeals to the MCA have been exhausted, the affected participant may appeal the MCA's decision to the statewide Emergency Medical Services Coordination Committee (EMSCC). An appeal to the EMSCC shall be filed with the Division, in writing, not more than 30 calendar days following notification to the agency or individual of the final determination of the medical control authority. The EMSCC shall issue an opinion on whether the actions or decisions of the medical control authority are in accordance with the Division approved protocols of the MCA and the Code.

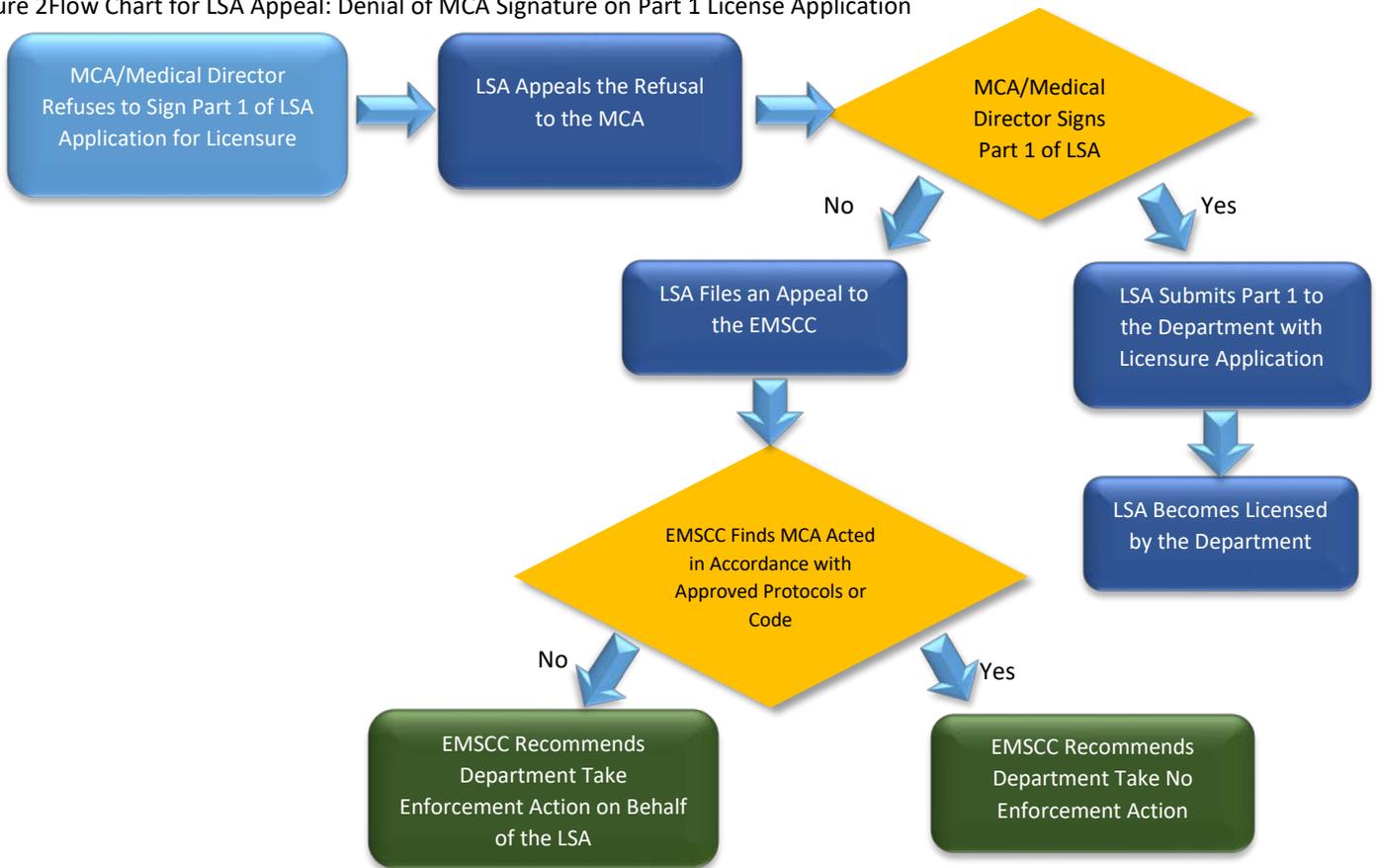
If the EMSCC determines, in its opinion, that the actions or decisions of MCA are not in accordance with the MCA's Division approved protocols or the code, then the EMSCC shall recommend to the Division that it intervene, and possibly take enforcement action, on behalf of the complainant, as authorized under the code.

If the EMSCC determines, in its opinion, that the actions or decisions of the MCA are in accordance with the MCA's Division approved protocols or the Code, then the EMSCC shall recommend to the Division that it not take enforcement action against the MCA, and possibly take action against the complainant, as authorized under the code.



REFUSAL OF A MEDICAL DIRECTOR TO SIGN
A LSA APPLICATION MUST BE FOLLOWED
WITH NOTIFICATION OF THE DEPARTMENT
WITHIN FIVE BUSINESS DAYS.

Figure 2 Flow Chart for LSA Appeal: Denial of MCA Signature on Part 1 License Application



Personnel

EMS personnel within a medical control authority are accountable to that medical control and the established protocols. Each MCA should have a process for credentialing and tracking personnel who operate within the MCA. This may include (but are not limited to) written examinations, practical competencies, background checks, as well other certifications. While the medical control authority does not have the ability to sanction a provider's license (only the Division can do that), the treatment and actions of a provider while operating under a medical control authority are actionable within the medical control authority.

Because the foundation for due process and complaint resolution is protocol driven, the MCA can have much of the details dictated in advance. While the amount of detail of the protocol and subsequent process is not dictated, there are minimums outlined in the code.

- * The process, actions, and sanctions the MCA may use for accountability.
- * The ability to immediately remove medical control from an agency or provider when there is a threat to the public health, safety, or welfare.
- * The assurance that if medical control has been removed from a participant that the participant does not practice within that MCA.
- * Notification guidelines for the Division (within 1 business day of medical control removal).
- * Opportunity for an affected participant to appeal MCA decisions.
- * Advisement of the process to appeal to the Division (EMSCC) after appeals to the MCA.

Along with those mandated items, there is great potential for more clarification for the process within the protocol. It is advisable to have things set up in advance in order to create a smooth process in the future.

Some ideas to include:

- * Specifics for the MCA to follow after the report of an incident
- * Types of occurrences that are considered incidents, divided into levels of severity
- * Types of actions that the MCA might take at conclusion of an investigation
- * Timelines for the processes to occur

Investigations and Discipline

Prior to making any decision to remove medical control oversight, the MCA must evaluate the incident and the impact that the removal would have on the EMS system. Fact-finding and information gathering may need to happen quickly, so having a process in place would be advantageous to the MCA. There are many things to evaluate when investigating an incident. Helpful things are:

Dispatch Tapes
Medical Control Communications
AED Recordings
Written Documentation
Interviews with Those Involved
Maps
Timelines

In the best situations the MCA and agency(ies) would work together to resolve issues and to deter further events. In any case, every step of due process must be thoroughly documented.

Outcomes

There are multiple options for outcomes from the investigation, and these actions need to be listed in protocol. Some options include:

- Remediation**
 - Provider continues to provide care
 - Provides specific education to correct inappropriate actions
- Probation/Restriction**
 - Provider continues to practice, under supervision
 - Provider continues to practice with 100% chart review
- Removal/Withdrawal**
 - May be considered in serious cases
 - Provider may not provide care
 - The MCA must notify the department within 1 business day
 - Used when above measures are not sufficient enough to assure patient safety, or if the above measures have failed

 Remember that the MCA can't take any action against the license of the provider. Only the EMS section can do that. Even if medical control is removed from an individual, they can apply for medical control in a different MCA.

Suspension, Removal or Restriction of Medical Control

Each LSA and individual licensed is accountable to the MCA in the provision of emergency medical services. An MCA establishes written procedures defining the process, actions, and sanctions that will be utilized to

hold a LSA or EMS provider accountable. Procedures must include disciplinary action that can be taken to assure compliance with standards of medical care, protocols, and operational procedures or to protect the public health, safety or welfare.

An MCA may exercise disciplinary action against a LSA and its EMS personnel that may result in the suspension, limitation, or removal of a LSA or EMS provider's ability to provide emergency medical services within the MCA.

If disciplinary action against an agency or individual results in the suspension, limitation, or removal of medical control, the MCA must advise the Division, in writing, of such action within one business day. If a suspension or removal of medical control to a LSA or individual occurs by the MCA, the LSA or individual shall not operate or practice in that MCA until medical control is restored by the MCA.

MCAs have the option to request the Division enforce protocols through licensure action, administrative order, suspension or revocation of license. If the Division takes action, it is required to provide an administrative appeal process and is subject to legal challenges through the judicial system.



ALL ACTIONS TAKEN AGAINST AN INDIVIDUAL PROVIDER'S OR LSA'S ABILITY TO PRACTICE BY AN MCA MUST BE REPORTED TO THE DEPARTMENT WITHIN ONE BUSINESS DAY.

Quality Improvement

Provision in Protocol

The Division has several reporting requirements and activity recommendations for MCAs with regard to Professional Standards Review Organization (PSRO)/quality improvement within the current EMS law. In addition to those required by the State of Michigan, each EMS system may develop system-based recommendations regarding quality improvement activities. There are nationally recognized recommendations from several professional organizations such as the National Association of EMS Physicians (NAEMSP), The Commission on Accreditation of Ambulance Services (CAAS) and the National Association of EMS Quality Professionals (NAEMSQP), from which an MCA is welcome to draw upon. The minimum requirements are as follows:

- * The quality improvement program shall include a requirement that each LSA collects and submits data to the MCA.
- * Each MCA shall appoint a Professional Standards Review Organization (PSRO).
- * Data collected by the MCA shall be reviewed by the PSRO.

- * All information and data collected for the purpose of quality improvement is not discoverable. It is confidential and not a part of the public record.
- * The purpose shall be improving the quality of medical care within the MCA.
- * All agencies using approved EMSIS software shall transfer data 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. MCA's may require data to be transferred more frequently.
- * Agencies using approved EMSIS software are responsible to ensure that the quality of the data submitted to the MI-EMIS repository is an accurate reflection of the information entered into their EMS information system.
- * Agencies entering data from paper PCRs after-the-fact are responsible for entering those PCRs in accordance with the above time frames.

There are many options for implementing a QI process, but it should begin with a profile of the system. Once the profile is known, benchmarks or indicators can be established for the system. Ideas for QI include:

- * Use protocol, peer, and physician driven issues as indicators.
- * Perspectives should be combined to examine prospective, concurrent, and retrospective mechanisms.
- * Training and education can be used as a part of QI system wide and can be implemented either through the MCA or the local providers.
- * Joint efforts will always be more successful than individual ones.

Quality Improvement Examples

1. The local medical control authority establishes a professional standards review organization/committee comprised of agency and EMS community representatives to review information and data that are collected and reported within each agency and then summarized for the system by this committee. This committee meets monthly and reviews cases from the previous month. This committee uses a structured audit form to evaluate the documentation of patient care performed by providers. This documentation audit is performed by each agency on randomly selected cases.
2. The medical control authority wishes to review the care and transport of priority one trauma patients. Each agency in the system agrees to provide the patient care records for these patients over a specified time frame. The receiving hospital records are matched with these cases to ascertain the role of pre-hospital care in the outcome and hospital care of the patient. Feedback is

provided to agencies and individual providers via their agencies to identify the role of pre-hospital care in patient outcomes. Teaching or remediation points, or system trends may be identified through this process.

3. An EMS agency in the medical control authority area collects significant information about all patient encounters. On a regular basis, this information is summarized and provided to the medical control authority to report on the care and activities of this agency. This provides the medical director an opportunity to review patient care aspects for that agency, without creating an additional audit process. The medical director will work with the agency to obtain the information needed to ensure quality patient care.

Online Medical Control

Online medical control, online medical direction, concurrent medical direction, online medical oversight, immediate medical control and direct medical direction are all terms that have been used to describe the direct voice communication between physicians or physician designees and field providers. There is a need to have a communication system where the provider can contact the hospital for medical direction. Protocols should address actions that providers can do pre-radio (prior to online medical control contact) and post-radio (after online medical control contact).

MEDCOM Requirements

The Bureau of EMS, Trauma & Preparedness publishes and maintains the medical communications system plan. MEDCOM requirements are contained here

http://www.michigan.gov/documents/mdhhs/MEDCOM_Plan_rev.2017_553981_7.pdf.

A reliable means of communication between field EMS units and medical control physicians is vital to an effective advanced life support system. Increasingly, non-ALS units are finding themselves in positions that require the ability to contact medical control (i.e., use of the Epi-Pen). The State must approve medical control communications systems.

A reliable means to record medical control communications must exist. Each medical control authority must designate a single facility or facilities responsible for maintaining telecommunication records. Such records may be in the form of detailed written logs or electronic recordings. These communications should be regularly review by the medical control authority. They provide a valuable means to assess protocol compliance, assist with incident investigations, and quality improvement.

The requirements for eligible emergency facilities and hospitals for communications are as follows:

- * All communications related to patient care between EMS agencies and hospitals or other Division-approved facilities receiving emergency patients shall be recorded electronically and maintained for

not less than 60 days. These electronically recorded communications are considered under the Quality Improvement program and will be reviewed under the Medical Control Authority Professional Standards Review Organization (PSRO).

- * Hospitals or other Division-approved facilities receiving emergency patients shall be equipped to communicate by voice with all basic, limited, and advanced life support agencies within the medical control authority and in accordance with the local communication requirements of that medical control authority.
- * If the communication plan allows for primary or secondary use of telephone line, all hospitals or other Division approved facilities receiving emergency patients shall have a dedicated phone line with recording capability as above.
- * Hospitals and other Division-approved facilities receiving emergency patients shall be equipped to communicate on the HEAR/HERN frequency of 155.340 MHz. CTCSS (continuous tone coded squelch system) tones will be assigned by the Division and are listed in the current MedCom Frequency and CTCSS Tone directory published by the bureau.
- * 155.340 MHz shall not be licensed or used for dispatch or “paging” purposes within the State of Michigan. Use of this frequency is reserved for communication regarding direct patient care between EMS personnel and an emergency receiving facility.
- * All radio speakers used to communicate shall have an audible output when the volume control is set to the minimum position.
- * If using telephones for EMS primary or secondary communication, ringers must have an audible output when set to the minimum position.
- * Changes to MCA system communications must be coordinated between hospitals, and life support agencies. Notice of any substantial MCA communication plan change must be given to the EMS and Trauma Systems Office. The communications consultant of the EMS Section Office must be involved in the planning or revisions of any proposed communication system plan.
- * Each hospital and Division approved facility receiving emergency patients shall provide training to their staff sufficient to assure proper operation of MedCom radio components at that facility.
- * All basic, limited and advanced life support vehicles, hospitals, and Division approved facilities receiving emergency patients shall be equipped with radio communication capability on 155.34 MHz.
- * All Limited Advanced and Advanced Life Support Agencies must provide reliable voice communications from patient side to hospitals and other Division-approved facilities receiving emergency patients

throughout 90% of the Agency’s primary geographic service area 90% of the time without harmful interference.

- Patient side (scene) communication may be exempted if a Medical Control Authority has adopted a protocol not requiring patient side communication and the Division has approved it. A state model protocol has been developed for this purpose.

- * Agencies within medical control authorities which have protocols requiring telemetry communication must have reliable telemetry communications throughout 90% of the Agency’s primary geographic service area 90% of the time without interference from other life support agencies.

Back-up Systems

- * All components of the Life Support Agency to Hospital communications system must have a back-up power supply.
- * All equipment shall be equipped with necessary lightning and surge protection devices for all components and circuitry susceptible to damage by lightning and power or telephone control line voltage surges.

Disaster Communications (Agency and MCA requirements)

- * Each medical control authority shall have a protocol for communications between Division-approved facilities receiving emergency patients and life support agencies during disasters.



WHOEVER PROVIDES ONLINE MEDICAL CONTROL SHOULD BE KNOWLEDGEABLE REGARDING EMERGENCY CARE AND THE LOCAL EMS SYSTEM.

Discretionary Medical Control Authority Activities

In addition to those activities that are required, medical control authorities may put additional protocols in place in their system.

Typically, the hospital receiving the patient provides the online medical control. There are other options open to medical control authorities, and the practice varies from region to region. Online medical control utilizes the concept that the pre-hospital provider is the “eyes and ears” of the medical control physician or designee. Medical communication gives the physician the opportunity to order or withhold additional interventions. The physician makes that determination based upon information relayed by the provider.

Whoever provides online medical control should be knowledgeable regarding emergency care and the local EMS system. The medical control authority may develop educational programs to train physicians and designees who will be providing online medical control.

As in other aspects of medical control, the medical director and/or medical control authority staff should have a working relationship between physicians providing online medical control, participating facilities, pre-hospital providers and agencies. Such a relationship enhances the system's capacity to resolve conflicts when they arise.

Special Studies

Choosing What to Propose

There are occasions when a new idea, practice, medication, or piece of equipment, not covered under the Division's standard protocols, may present the potential for positive outcomes within your medical control authority. Additions of this nature are considered special studies and must be orchestrated carefully between providers, agencies, hospitals, the medical control authority, and the Division.

Special studies should be submitted in the same fashion as any other protocol with the form contained [here](#). It should be submitted with the protocols and training curriculum, for review before the 10th of the month for review in the same month. Addendum forms received after the 10th of the month will be placed on the agenda for review the following month.

The Proposal Process

Before you submit your proposed special study to the Quality Assurance Task Force (QATF) for review, there are a few things to make certain are prepared.

- * Training – all personnel participating in the study must receive training. This training needs to be submitted with the proposed study. This means all presentations, lecture notes, objectives, evaluations, and references used. Minimal proficiency standards should be established. Initial and refresher requirements should be included.
- * Documentation that the study is supported by at least one hospital within the medical control authority. Ideally an institutional review board will approve it, but otherwise can be substituted with risk management, quality review, a clinical department associated with EMS, or an equivalent.
- * A time line clarifying duration of the study. This should include any goals for number of cases desired as well as an estimated date to reach the required number.
- * Life support agencies involved in the study, their licensure level, the number of personnel to be trained, and their licensure levels.
- * Any needed mutual aid contracts to allow the medical control authority to continue to use its own protocols.
- * Identification of the special study coordinator.
- * Data parameters to be collected and the quality review process that shall be implemented need to be

identified. The medical control authority will need to submit quarterly reports based on these parameters, and a final report at the completion of the study.

- * Protocols that will be included in the study.

Once all materials are assembled, they should be submitted, along with the form contained here

http://www.michigan.gov/documents/mdch/MCA_request_for_addendum_318149_7.doc, in electronic form, via email to mdhhs-mcaprotocols@michigan.gov. If the packet is submitted prior to the 10th of the month, the study will be placed on the agenda for review in the same month. Otherwise, it will be placed on the agenda for the following month. Please be prepared to have key people available to answer questions during the meeting in order to expedite approval. If no one is available for questions, the proposal may be tabled for a different month.

Study Termination

The Division, under the advice of the QATF may terminate any special study for any of the following reasons:

- * The study jeopardizes the health, safety, or welfare of the citizens of the state.
- * There is evidence of failure to follow study parameters.
- * There is evidence of failure to submit reports.
- * The medical control authority or medical director requests termination.
- * There is not sufficient data to support continuation.

Appropriate and timely documentation of your studies will help ensure that it continues for the designed amount of time.

Interfacing with Public Safety Agencies

Within the EMS system, and dependent on the type of the emergency, other agencies may augment the licensed EMS agencies that are part of the medical control authority. These include both fire and police agencies. The degree to which these agencies interact is dependent on the structure within your medical control authority. Police officers and fire fighters may, in addition to their primary duties, also serve as EMS providers. In addition to those that are license EMS providers, there may be agencies and personnel that provide other types of medical aid within the MCA such as AEDs and naloxone administration.

The EMS statute addresses interactions with public safety agencies both directly and indirectly.

- * Fire suppression agencies that are licensed as a medical first response service are subject to the medical control authority. Agencies that provide medical first response should be licensed to do so.
- * Law enforcement agencies are only included as medical first response if the agency is licensed as a medical first response service and the unit responding was dispatched to provide medical first response.

MCA staff and other leaders in the EMS system benefit from frequent interaction with local fire and police officials as a mechanism for holding lines of communication open to circumvent potential “power struggles” on emergency scenes. Authority for the management of a patient in an emergency is vested in the licensed professional at the scene who has the most training specific to the provision of emergency medical care. EMS systems are encouraged to participate in local incident management or incident command systems as a mechanism for scene control as well as for an understanding of how to manage emergency scenes.

Pharmacy

While the public health code does not directly address the partnership between a medical control authority and the pharmacy, the administrative rules that accompany it do. It is clear that medical control authority must have written protocols to define and regulate the provision, storage, and dispensing of drugs and IV supplies. These protocols must address:

- * The initial provision and stocking of drugs boxes or “kits.”
- * Requirements for drug storage and security in the EMS and hospital environment.
- * Procedures for replacement of drugs used in patient care.
- * Reporting requirements for EMS and hospital personnel after drugs or IV solutions have been dispensed.
- * Procedures for “wasting” unused or contaminated narcotics.
- * Procedures for regular, scheduled inventories of drugs and IV solutions.
- * Assignment of authority for implementation of the protocols.

The hospital pharmacist is ultimately responsible for the drugs and IV solutions carried on ambulances. Medical control authority “Pharmacy” protocols must be developed with the active input of pharmacists named by the hospitals which make up the medical control authority. This is usually accomplished when the medical control authority involves pharmacists and other practitioners to make recommendations to the medical control authority regarding the specific protocols.

Drug Boxes

There is no specific requirement in Statute or Administrative Rule addressing the labeling of EMS drug boxes. However, there is an MDHHS EMS Section Office policy, detailed in the annual “Ambulance Inspection” report form. That policy requires the following on each EMS drug box:



ACCORDING TO PHARMACY LAW, AN ALS AGENCY **CANNOT** OWN MEDICATIONS. THE HOSPITALS WITHIN THE MCA OWN THE MEDICATIONS.

- * Name of the authorizing medical control authority.
- * Name of the hospital which last filled the box.
- * Date of the last inspection of the box (by a pharmacist).
- * Initials of the inspecting pharmacist.
- * Expiration date of the “first to expire” drug in the box.

The only specific reference to EMS drug box security is found in Michigan Board of Pharmacy rules covering controlled Substances. Since most EMS drug boxes contained at least one “Schedule II” drug, the Board of Pharmacy rules require that they be packaged in “...**securely locked, substantially constructed**...” container.

Frequently Asked Questions

Role of MCAs

1. The law requires that each life support agency and individual licensed under this part is accountable to the medical control authority in the provision of emergency medical services. What does accountable mean and how do we achieve this? Does a medical control authority or medical director have the authority to develop a protocol to limit, suspend or withdraw medical control?

A. Medical control authorities are responsible for providing medical control. This means the medical control authority is responsible for supervising and coordinating the EMS system in their region as prescribed, adopted, and enforced through Division-approved protocols.

“Accountable” means ensuring compliance on the part of each life support agency or emergency medical services personnel in carrying out emergency medical services based upon protocols established by the medical control authority and approved by the Division.

A medical control authority may suspend or remove medical control of a licensed agency or its personnel. To achieve accountability can mean nothing less. Medical control authorities cannot effectively supervise or hold accountable those personnel or agencies without the authority to suspend or remove medical control. In order to achieve this accountability, the medical control authority must enact protocols, which specify the consequences and remedies with failure to comply with protocols.

2. Does a medical control authority or medical director have the authority to develop a protocol that allows emergency powers to immediately suspend medical control of an individual or agency when a clear and immediate public health threat exists?

A. Yes. The medical control authority must develop a protocol that specifies if an immediate threat to the public health, safety, or welfare is determined, appropriate action to remove or suspend medical control can be immediately taken. The action is in effect until the medical control authority has had the opportunity to review the matter at a medical control hearing. The protocols should specify that the hearing will be held within 3 business days after the determination has been made that an immediate threat existed.

3. Can a medical control authority establish standards that exceed the minimum state standards?

A. Yes. [Section 20919\(4\)](#) of the state law allows a medical control authority, if adopted in protocols approved by the Division, to establish standards that may require life support agencies to meet

reasonable additional standards for equipment and personnel, other than medical first responders, that may be more stringent than otherwise required.

4. As a provider, I know what the protocol says and every time I attempt to do it a physician in the emergency department tells me not to. What should I do?

A. This is an important opportunity for the medical control authority to be more involved in the liaison between EMS and other medical providers. The medical control authority is responsible for making sure that the physicians know the protocols and follow them, unless specific circumstances dictate otherwise.

Protocols

1. How can comprehensive in-services for new protocols be accomplished?

These can be accomplished through a number of means. If the medical control authority has the ability to hire educators, they may choose to offer educational sessions to the individual providers or agencies. In some cases, educators will volunteer their time to provide MCA-based education. Another mechanism may be to work with hospital or life support agency personnel. Records should be kept to track personnel who have been up-dated and whenever possible, ongoing education credits should be provided to the participants of the session(s). The medical control authority must work with the life support agencies to ensure that all personnel have been informed of new protocols or any changes to existing protocols. A videotape, Internet, teleconferencing, or other audio-visual materials may enhance or supply an appropriate in-service. Self-study guides, while time intensive to develop initially, may accomplish what is needed. On occasion the state may release an educational component along with a new protocol.

2. We have no staff and protocol development is a labor-intensive process. What are some of our options if we need a protocol that is not already a state protocol?

A. The best options for protocol development are to work collectively to share the workload. This may mean obtaining protocols from other areas, websites, or publications such as the National Association of State EMS Officials National Model EMS Guidelines that can be found at <http://www.nasemso.org/Projects/ModelEMSClinicalGuidelines/index.asp>. Editing and authoring the documents is the most labor-intensive portion of this task. Hospital staff, life support agency staff and the medical control authority, may share these activities. If local activity is prohibitive, consideration should be given to enter into regional MCA network protocol efforts.

3. Does the Medical Director have to sign authorization for the MCA to adopt a protocol?
 - A. *Yes the Medical Director must sign an acknowledgement of acceptance of State protocols as well as any MCA specific protocols. These protocols are in effect the same as a physician's order. They authorize treatments and medications and the circumstances in which they may be implemented or administered.*

Quality Improvement

1. Are EMS agencies required to participate in QI activities? Conversely, can an EMS agency establish internal standards that exceed MCA standards?
 - A. *Yes, on both counts. QI should be outlined in protocol; MCA are required to have a QI protocol in effect. However, if an employer or agency establishes higher standards for their providers, that is also allowable. If an MCA decides to adopt those higher standards, they need to be placed in protocol and submitted to the state.*
2. If a life support agency is delegated the function of medical control authority quality improvement review, are the data and actions resulting from the review discoverable? Is the summary information synthesized through the system quality improvement process discoverable?
 - A. *No. Both medical control authorities and life support agencies fall under the category of health care facility and are protected under the law. The QI program should be established consistent with PA 270 of 1967, Section 531-533.*
3. If our QI committee finds that we have a provider that is not following protocols, can he/she be sanctioned?
 - A. *Yes, as defined by protocol. The paramedic is accountable to medical control authority. The employer is accountable for the actions of an employee. Each medical control authority must have in place (also required) a due or fair process procedure that offers a mechanism for resolution of issues of this nature. Remediation mechanism and educational forums are common mechanisms for resolution. If the medical control authority feels that the individual represents a risk to the public health and safety of the greater community in his/her practice, then emergency measures may be taken in conjunction with the employer and the Division.*

Due Process/Complaint Resolution

1. A paramedic within our system performs a procedure not allowed in protocol. What can the medical control authority do?
 - A. *First and foremost the MCA should commence to find the facts. Once there is a clear idea of what has transpired, the MCA should follow the protocol to decide what actions should be taken. Remember, if the provider's privileges are suspended, you must notify the Division within one business day.*
2. What considerations should be made in regards to actions against a provider or agency?
 - A. *The Division recommends the MCA utilize the resources at its disposal to make determinations. The seriousness of the incident, if it is a repeat incident, the attitude about the incident, and whether it was self-reported can all be considered. Ultimately it is up to the MCA board to decide the best course of action.*

Pharmacy

1. Who is responsible for deciding drug box and pharmacy issues not covered by Rule or Statute?
 - A. *The pharmacist (or group of pharmacists, if a multiple hospital medical control authority) designated by the medical control authority to oversee pharmacy issues. Note that in each rule quoted above most details are left to the discretion of the pharmacist.*
2. How often must EMS drug boxes be inspected or inventoried?
 - A. *The pharmacist shall routinely inspect drug boxes when it is turned in for restocking.*
3. How does our medical control authority determine the drugs to be carried in our drug box?
 - A. *Drugs carried by the EMS system must be those drugs required for treatments authorized in the medical control authority's written protocols. There should be a specific protocol(s) for each drug carried.*
4. Is there a "standard" method for a medical control authority to provide drug boxes?
 - A. *No, each medical control authority working with their participating hospital pharmacies and EMS services, must define the details of their own drug box system. However, you must remember that the hospital owns the medications, not the agency. A hospital cannot sell medications to the agencies in the MCA. They may only charge an administrative fee for the restocking of medications.*
5. Can a service buy medications from a local pharmacy?
 - A. *No. Consistency in delivery of medications is important. In order for that to be accomplished, all medications must be ordered, provided, and exchanged through MCA member pharmacies.*

Section III

Other Issues



PSAP (PUBLIC SERVICE ANSWERING POINT): the term typically used to refer to 911 communications centers.

E-911 (ENHANCED 911): a special type of 911 technology in which the caller's telephone number and address are immediately displayed on the PSAP's computer screen.

EMD (EMERGENCY MEDICAL DISPATCHING): system designed to prioritize request for EMS, determine the appropriate resources to respond, determine the mode of EMS vehicle response (i.e., lights and siren), and provide pre-arrival (post-dispatch) basic patient care instructions to the caller.

CAD (COMPUTER ASSISTED DISPATCH): uses computer systems to monitor the location and status of emergency (and non-emergency) units, record dispatch information, assist in determining units to respond, and perform other activities intended to optimize dispatching. Increasingly, EMS CAD systems are incorporating vehicle locator systems using global positioning satellite (GPS) tracking systems.

SYSTEM STATUS MANAGEMENT: process of dynamic vehicle deployment in which EMS units are constantly repositioned to different geographic sites within the agency's service area to await an EMS dispatch. System status management takes into consideration the number of units available and the historical prediction of EMS activity locations.

What Other Issues Does a Medical Control Authority Encounter?

Dispatch and Communications

An effective emergency medical services (EMS) system requires a high quality communication system. Such a system allows for rapid system access via the universal 911 number, which should result in the dispatch of the appropriate EMS and public safety resources. EMS systems in which multiple EMS agencies co-exist should have Pre-determined means for interagency radio communications. Indeed, the EMS communication system must allow for operational interagency communications within the broader public safety system.

Legal Basis

Dispatch and communications are integral to the delivery of EMS and thus medical control authorities should be an active contributor to the EMS dispatching process and the overall EMS communication system. The role for medical control authorities in this area is further defined in [Section 20919\(1\)\(b\)](#), which charges medical control authorities with the responsibility for developing and adopting “medical protocols to ensure the appropriate dispatching of a life support agency based upon the medical need and the capability of the EMS system”. As with any protocol, the development process should include collaboration with the local EMS system and include participation from EMS agencies, dispatch centers and other appropriate organizations. Licensed EMS agencies themselves are required to comply with regulations and policies established the State. [Section 20923 \(7\)](#) requires that “an ambulance shall be equipped with a communications system utilizing frequencies and procedures consistent with the statewide EMS communications system”. This is further supported under [Section 20963\(2\)](#) that requires “a person participating in radio communications activities in support of EMS, on frequencies utilized in the statewide EMS communications system, shall comply with procedures and radio system requirements established by the Division”.

A final area under PA 368 addressing EMS communications is intended to prevent an unauthorized EMS response to an incident. [Section 20963\(2\)](#) specifies, “A person who receives any intercepted public safety radio communication shall not utilize the contents of the communication for the purpose of initiating an EMS response without the authorization of the sender”.



IN ORDER TO FACILITATE
COMMUNICATIONS, A MEMBER OF 911
DISPATCH SHOULD BE INCLUDED ON THE
MCA BOARD.

The Role of the Medical Control Authority in Dispatch

As noted, EMS communication involves two distinct phases: Dispatch and Online Medical Direction. The medical control authority, under current Michigan Law, has a very limited role in the actual dispatch of EMS units to a scene. Only in those few Michigan counties without an established county 911 plan does the medical control authority have a direct responsibility to design or supervise EMS dispatch.

The Division encourages medical control authorities to work with their county 911 in the development of dispatch protocols. Michigan's "911 law" (PA 29 of 1994) gives the County Board of Commissioners the responsibility for oversight of all public safety (police, fire and EMS) dispatch. The details of this oversight must be contained in the county's "911 Service Plan". If the details are not included, the medical control authority should work with their 911 committee to ensure inclusion. The act, at Section 303(2), says the plan must include "Operational considerations, including but not limited to, the designation of PSAP's and secondary PSAP's, the manner in which 911 calls will be processed, the dispatch functions to be performed, plans for documenting closest public safety service unit dispatching requirements...". The Medical control authority in these counties should be sure that any medical control authority "dispatch" protocols are in agreement with their county 911 plans.



THE STATE 911 COMMITTEE HAS A WEBSITE [HERE](#). THE POLICY ABOUT EMS, POLICY E, IS [HERE](#).

Emergency Medical Dispatch (EMD)

One component part of "dispatch" communication is the provision of various forms of formal "Emergency Medical Dispatch" (EMD). The decision to provide this level of dispatch service rests with the county 911 plan. However, since both call screening and pre-arrival instructions are medical in nature, the EMS medical control authority should be actively involved in these programs, if they are provided by the 911 plan. The next section outlines EMD with more precision.

Not all 911 PSAPs use EMD; however, EMD is rapidly becoming adopted nationally. The following is being provided for your information. Several nationally recognized, high quality emergency medical dispatch (EMD) programs exist. Dispatch centers should be encouraged to adopt one of these to address the components of the EMD process. These components include call prioritization, unit dispatch, pre-arrival instructions, and quality improvement. The adoption of a nationally recognized EMD program avoids the need to "reinvent the wheel", provides a means for bench-marking between systems, and affords some degree of legal protection through the use of a nationally established (versus a "home grown") program.

Clearly, every request for EMS does not warrant the same system response. Some serious incidents may warrant a rapid response of both basic and advanced life support units. Other more minor incidents may only need a BLS ambulance for transport to the hospital. An important goal of an EMD program is to assure the appropriate EMS unit(s) are dispatched in the right response mode (i.e., lights and siren). In order for call prioritization to safely and effectively occur, dispatchers should rigidly follow approved guidelines. “Free-lancing” should be discouraged as this tends to create errors in prioritization. It is not unusual for callers to be emotionally very upset in non-emergency situations. Conversely, true emergencies are occasionally reported by a caller who underestimates the gravity of the problem and is extremely calm. The dispatch protocols should serve as a template for interviewing the caller and identifying the presence of lack of certain priority



IN ORDER FOR CALL
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signs and symptoms. These include such things as level of consciousness, difficulty or absence of breathing, lack of a pulse, severe bleeding, etc. To some, this rigid approach may appear to cause significant dispatch delays. To the contrary, experienced and trained emergency medical dispatchers can prioritize a call routinely in less than 60 seconds with a very high degree of accuracy.

Once a call has been prioritized, the appropriate EMS system response is initiated based on pre-determined response configurations. These address not only what type of units are dispatched but also the manner in which the units should respond to the scene. This may vary from system to system. An important concept is the recognition that an emergency response using warning lights and siren typically saves only a few minutes in the overall response. For example, if the use of emergency lights and siren permits a vehicle to safely travel and average of 50 MPH instead of 40 MPH, on a five mile run only 1 ½ minutes would be saved. Except in the case of an agency responding to a sudden cardiac arrest, such timesaving is unlikely to impact patient outcome. On the other hand, the use of emergency lights and siren have been clearly associated with an increase in motor vehicle collisions. This includes direct emergency vehicle crashes as well as crashes in which the emergency vehicle is not directly involved; the so-called “wake effect”. Thus, the use of lights and siren response should be reserved for those high priority cases in which a



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real or potential life-threatening situation exists. Like any intervention, the potential risks must justify the potential benefits.

Pre-arrival instructions are another important area in EMD. Again, the particular pre-arrival instructions should conform to nationally recognized guidelines. Most EMS incidents require only basic supportive instructions (i.e., “keeping the patient lying still and call back if his condition worsens”). However, certain situations warrant more specific medical instructions. These include such things as CPR, management of an obstructed airway, control of bleeding, and assistance in childbirth. Some dispatch centers have been reluctant to provide medical instructions for fear of potential litigation. To the contrary, studies have found that the public indeed has come to expect such instructions when activating the EMS system. Medical control authorities should advocate for this important component of the EMD system.

Just as MCAs and EMS agencies should be committed to PSRO/QI in clinical activities, so too should QI be embraced for EMD activities. EMD centers should have a formal QI program in place. This should allow sampling of random calls and a structured review of the audiotape. As with any QI program, it is vital that regular feedback mechanisms exist to provide performance information back to the involved personnel. Areas of review should include timeliness and appropriateness of call prioritization and performance with pre-arrival instructions.

EMS Operational Communications

The responsibility for an EMS agency’s operational communication system is fundamentally the responsibility of the agency. Agencies operating under a consolidated, centralized dispatch system may use a common radio frequency while maintaining a private frequency for non-EMS communications. In multi-provider systems, it is important that provisions exist for inter-agency communications, primarily between field units. The responding ALS units should be able to communicate directly with BLS units on scene. In multiple casualty incidents (MCI’s), units from different agencies may need to be able to communicate with one another. Provisions should be made to support direct communications between agencies from adjacent EMS systems who may be providing mutual aid in larger incidents. The medical control authority should encourage collaboration among the EMS community to promote effective operational communication systems.

Emergency Preparedness

One of the foundational responsibilities of the MCA is to develop the protocols, plans and policies which result in the proper care and management of injured or ill individuals, regardless of cause, from the single person to the systems of care needed to effectively treat mass illness or injury.

The Emergency Management (EM) responsibilities of the MCA coalesce all of the individual parts of the EMS system design into a functional, operational framework. This preparedness at the local level involves communications infrastructure and plans for communications interoperability for larger scale events, defining roles and responsibilities of responders and agencies during events, dispatch responsibilities, logistics, patient tracking, event notification, resource management, accountability, security, required training, credentialing of medical volunteers, utilization of medical volunteer groups, and, in some MCA's, acquisition and management of physical resources, such as disaster trailers.

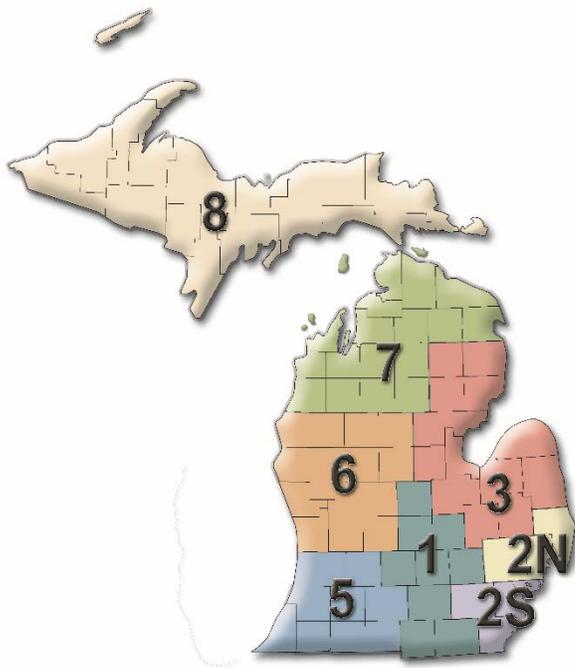
Each MCA in the state has its own unique design and responsibilities related to Emergency Management. Some MCA's rely almost completely on their local Emergency Management (EM) programs for the disaster response structure, and county-run dispatch entities for all communications and logistical support for their medical responders, and only operationalize disaster preparedness through the state MCI protocol and the MedCom plan. Other MCA's work as an extension of the local EM program and are responsible for the development of the pre-hospital annexes to the County plans. These annexes typically include all of the aspects related to the medical care, movement, tracking and management of patients as well as for the operational components of life support agencies at the non-transport and transport levels. Most MCA's have a strong working and collaborative relationship with their local EM programs and work symbiotically to plan and prepare for disasters utilizing both the public health code and the Emergency Management Act to augment a comprehensive and integrated response plans. Participation of the MCA in local EM planning efforts, exercises, hazard assessment, and mitigation strategies for an all-hazards response is of vital importance to developing a resilient and responsive plan.

Beyond the isolated local response to disasters is the understanding that, while events initially begin locally, disasters do not adhere to boundary lines. Because of the high probability of multi-jurisdictional disasters and Mass Casualty Incidents (MCIs) which may require mutual aid, MCAs are tasked with developing protocols which establish and require mutual aid. A component of mutual aid is interoperability and includes the use of similar plans and processes, Unified Incident Command Structure, regional patient tracking, regional trauma

protocols, regional burn and transfer protocols, regional protocols for the management of significant pathogens, CBRNE treatment protocols, and communications platforms which will operate cohesively when a disaster occurs and all become part of the planning and protocol process. Rather than develop and acquire resources at every individual local level, which will seldom be used and which are often costly to sustain and maintain, economies of scale are brought to bear through regional planning and the sharing of resources.

In order to meet the needs and challenges of disasters and MCI events which impact areas outside of just the local area, or which require resources from outside of the event jurisdiction, the state has formed Regional Healthcare Coalitions (initially these were called Regional Bioterrorism regions funded by HRSA and ASPR, among other grants), supported with federal guidance and funding. MCA's are crucial to this regional planning effort, not only for the management of the attached federal grant funds at some MCA's, but for the statutory authority granted to the MCA's in the development of protocols, for immunity in the planning processes, and for the PSRO status of evaluations of real world and exercise events.

Regional Healthcare Coalition districts match up with the Regional Medical Control Authority Networks (RMCANs) and the Michigan State Police Emergency Management districts.



The MCA in each region plays a critical role in coordinating regional activities to meet the federal priority planning areas and critical benchmarks. All MCAs are highly encouraged to participate in the regional Hospital Preparedness Program (HPP) Regional Healthcare Coalitions.

Each region selected an MCA to serve as the contract/fiduciary agency. This fiduciary MCA hires or contracts a Regional Healthcare Coalition Coordinator, Medical Director, and support staff. The HCC staff maintains the responsibility to ensure coordination and implementation of regional emergency preparedness and response activities. The most up to date

information about your region and its corresponding healthcare coalition is located at:

www.michigan.gov/healthcarecoalitions.

The state and, by delegation of the state, the HCCs and the MCA's are accountable to the National Response Framework and for integrating with national disaster management entities in the event of a declared disaster.

This ability for integration requires commonality in plans, terms used and the framework of the command and operational structures at all levels; local, regional, state and federal.

The State of Michigan's emergency management plan is located at [STATE EMERGENCY PLAN](#). The site also offers a workbook to help develop local emergency plans and protocols.

In order to facilitate timely notifications of potential public health threats that could impact your EMS agencies hospital or healthcare system, and other pertinent emergency preparedness and response information; key staff at your MCA, including your medical director should be registered for the Michigan Health Alert Network (MI HAN). Registration for the MI HAN is located at <https://www.michiganhan.org/>.



Other resources that your MCA should be familiar with can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54826_64377---,00.html, and include:

- * Michigan Emergency Drug Delivery Resource Utilization Network (MEDDRUN) provides mobile standardized caches of medication and supplies to treat approximately 50 patients. These caches are located at Michigan rotary air and select ground EMS agencies around the state. Supplies arrive to 90% of the state within one hour of a request. The contents are intended to be dynamic and evolve over time based on potential threat scenarios, recommendations, available funding, and changes to medical management strategies. As the MEDDRUN MedPack is an important Homeland Security asset, the contents of the MedPack are considered confidential and not for public release.



- http://www.michigan.gov/documents/chempack_130360_7.pdf
- Dispatch center **(877) 633-7786** or **(616) 391-5330**

- * CHEMPACK is a state managed federal resource of pre-positioned nerve agent/organophosphate antidotes, housed across the state. This resource is intended to treat between 400 and 1000 patients. The Centers for Disease Control and Prevention (CDC) established CHEMPACK, throughout the United States starting in 2005. CHEMPACK would be an augmenting resource to the above noted MEDDRUN, which is more quickly mobilized due to size and transportation mechanisms.

- Dispatch center **(877) 633-7786** or **(616) 391-5330**

- * EMTrack and EMResource are state provided EM programs which allow for healthcare notifications of MCI and disaster events and are used for bed polling. EMResource is required of all hospitals and EMS agencies in the state. EMTrack is used for the tracking of patients. Patient tracking is a federal requirement and EMTrack is the program utilized by the state to accomplish the goal. MCA's may opt for other means of tracking patients but are encouraged to use EMTrack.
- * WebEOC is another state funded program which is used as the foundational communications platform for state disaster notifications and mitigation at the EM level. Many MCA's are functional parts of the local EOC's and are WebEOC users responsible for coordination, documentation and update of EMS system needs and situational reports when disasters occur.
- * MI-Train is a learning management system for professionals who protect the public's health. There are many free trainings located here. <https://mi.train.org>
- * MI Volunteer Registry is used to register, notify, and inform medical individuals who are interested in volunteering in the event of a natural or public health emergency. <https://mivolunteerregistry.org/>
- * MI-MORT assists local medical examiners with disaster recovery and victim identification in mass fatality incidents with the ultimate goal of returning the deceased to loved ones. <https://mimort.org/>
- * There are many resources for members of your MCA and laypeople as well through the Michigan State Police. http://www.michigan.gov/msp/0,4643,7-123-72297_60152---,00.html
- * For more information about disasters and disaster planning for both your MCA and your personal life, go to www.michigan.gov/depr .

Liability

The fact that we live in a litigious society can pose a great deal of concern for any organization or individual. The Michigan State Legislature has recognized that the EMS community needs to be focused on patient care and not on potential lawsuits. In the law that governs EMS activities there is a section that provides for limited immunity from liability for those responsible for providing pre-hospital care in Michigan. That portion of the law is divided into two parts, one for clinical liability and one for administrative liability, and both include language covering medical control authorities (MCAs) and persons responsible for administering MCAs. While the law does provide this liability protection for MCAs, it is **limited** immunity from liability. MCAs and those individuals involved in the activities of MCAs have a responsibility to act professionally and within the law. If an MCA commits "an act or omission... of gross negligence or willful misconduct," they can be held accountable through legal action. Additionally, the law does not insulate an MCA from the threat of lawsuit. Many MCAs have and will find themselves in court even in cases not involving "gross negligence or willful

misconduct.” However, the law provides an MCA attorney with a legal basis with which to go into court and have a suit dismissed.

Although the MCA, its committees and employees may not actually provide pre-hospital clinical care, they may be sued for the actions of the field provider. The medical director is responsible for medical control for the emergency medical services system served by the MCA. This means the actions of the field provider may be linked to the medical director and therefore the MCA. Additionally, the MCA and its committees are responsible for establishing the protocols used in the field. In this way, the MCA may again be held liable for clinical actions taken in the field. In light of these facts, the law provides MCAs with limited immunity liability for the treatment of a patient.

The MCA is protected under [statute 333.20965](#)

Frequently Asked Questions

Liability

What is the definition of “gross negligence and willful misconduct?”

A. *Gross negligence and willful misconduct has been defined as “intent to do harm.”*