ENGLISH

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

MICHIGAN EMS COORDINATION COMMITTEE MEETING
Friday, May 17, 2024
9:30 a.m.
Bay de Noc Community College
2001 N. Lincoln Road
Joseph Heirman University Center
Big Bay De Noc Conference Room 952A
Escanaba, MI 49829
Join the meeting now
1 248-509-0316 Phone Conference ID: 247 805 362#

AGENDA

Call to Order:
Roll Call
Approval of Agenda:
Approval of Minutes:
Announcements:
Reminders of upcoming educational opportunities:
2024 Bay College EMS Conference - May 17-18 in Escanaba

Guest Speaker: None.

Public Comment on Agenda Items:

Old Business & Committee Reports:
EMS Systems/Strategic Planning Update – E. Bergquist
Emergency Preparedness Update – Dr. Edwards
Systems of Care Report – E. Worden
State 911 Administrator Report – J. Harvey
EMS Medical Director Report – Dr. Fales

Committee Reports:
- Quality Assurance – Dr. Edwards
- Ambulance Operations – M. Nye
- Medical Control Authority – D. Condino
  - MCA Assessment Final Report
- Patient Movement Ad Hoc – D. Condino
- Ethics and Compliance – K. Cummings
  - Removing disciplinary action from public portal discussion
- Education – K. Wilkinson
  - Dynamic Roster discussion
  - EMS-3XX Continuing Ed for Course Coordination
- Bylaws – B. Trevithick

- Data – D. Gorelick
    - NEMSIS 3.5 Transition discussion
- Legislative – B. Trevithick
    - HIB 5695 Ground Emergency Transport Reimbursement
    - SIB 0849 Health Professions Reciprocity
    - HIB 5636 Freestanding Birthing Centers
    - HR 6960 Reauthorization of Federal Funding for EMSC Programs
- Rural – G. Wadaga
- Pediatric Emergency Medicine – S. Mishra
- Air Medical – K. Wilkinson
    - Air Equipment Changes
    - Air Agency Inspection form
    - Rotary checklist
    - Fixed Wing checklist
- EMS Safety – K. Miller
- Critical Care Ad Hoc – E. Bergquist
- Communications – B. Forbush

Recruitment and Retention Work Group – K. Cummings/E. Bergquist

- Report on Recruitment Campaign – S. Bliss
- Agency Assessment

Community Integrated Paramedicine (CIP) – E. Bergquist

New Business:

- Meeting location for 2025 discussion
- July meeting discussion

Public Comment:
Membership Round Table Report:
Adjournment:

NEXT MEETING: *July 19, 2024*

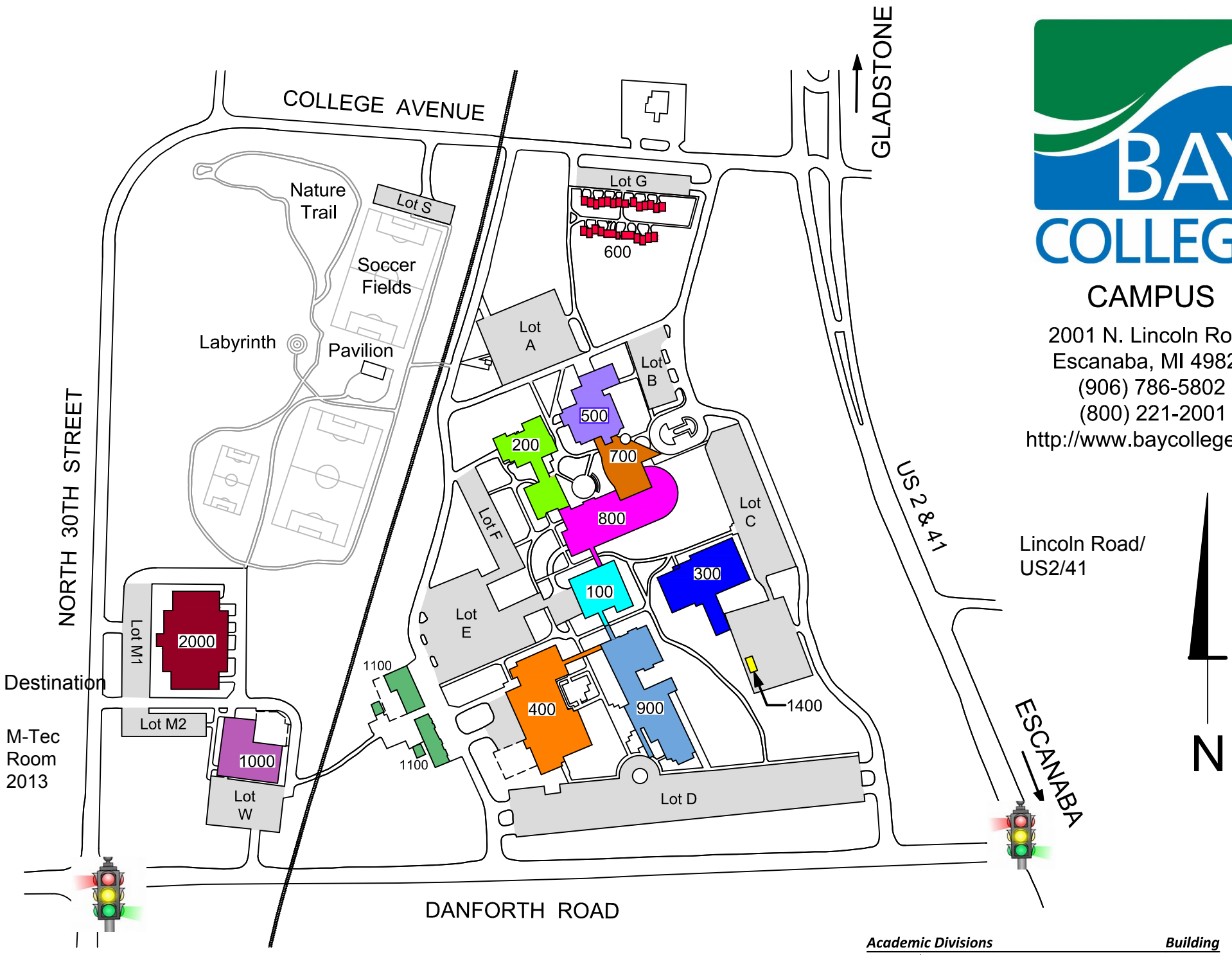
NOTE: The chair requests that all phones and pagers be turned off or placed in silent mode during meetings.
NOTE: Per the EMSCC Bylaws, public comment is limited to three minutes.

TELECONFERENCE INFORMATION:

Join the meeting now
1 248-509-0316 Phone Conference ID: **247 805 362#**
To reach out to a specific member with questions or concerns prior to the meeting, please email EMS@michigan.gov and your question will be relayed.

- Meetings will be recorded per the Open Meetings Act (PA 267 of 1976).

From Marquette MI



BAY COLLEGE

CAMPUS

2001 N. Lincoln Road
Escanaba, MI 49829
(906) 786-5802
(800) 221-2001
http://www.baycollege.edu

LEGEND

100	Math / Science Building (MS)
200	Catherine Bonifas / Administrative Services (CB)
300	YMCA / Gymnasium / Child Care
400	Besse Health and Technology (BHAT)
500	Student Center
600	Student Apartments
700	Besse Center
800	HUB
900	Joseph Heirman University Center (JHUC)
1000	Welding / Shipping and Receiving
1100	Maintenance Buildings
1400	Career Closet (CC)
2000	Michigan Technical Education Center (M-TEC)
	Parking Lots - A, B, C, D, E, F, G, M1, M2 ,S, W

Academic Divisions — ***Building***

Arts and Letters Division.....200
Business Division.....900
Math/Science Division.....100
Nursing/Allied Health and Wellness Division.....400
Social and Behavioral Science Division.....200
Technology Division.....400

Academic Support and Services

Accessibility.....800
Admissions.....500
Bookstore.....500
Cafeteria.....500
Cashier.....500
Student Success Center.....800
Event Coordinator.....900
Conference Rooms.....500, 800, 900, 2000
Financial Aid.....500
Information Technology Services.....900
Testing and Certification.....800
Tutoring.....800
Supplemental Instruction.....800
Library.....800
Online Learning and Instructional Technology.....800
Registrar/Student Records.....500
Safety and Security.....200
TRIO.....800
Veteran Support.....500

Offices

Business Office.....200
College Advancement Office.....200
Human Resources.....500
President's Office.....200
LSSU University Office.....900

Other

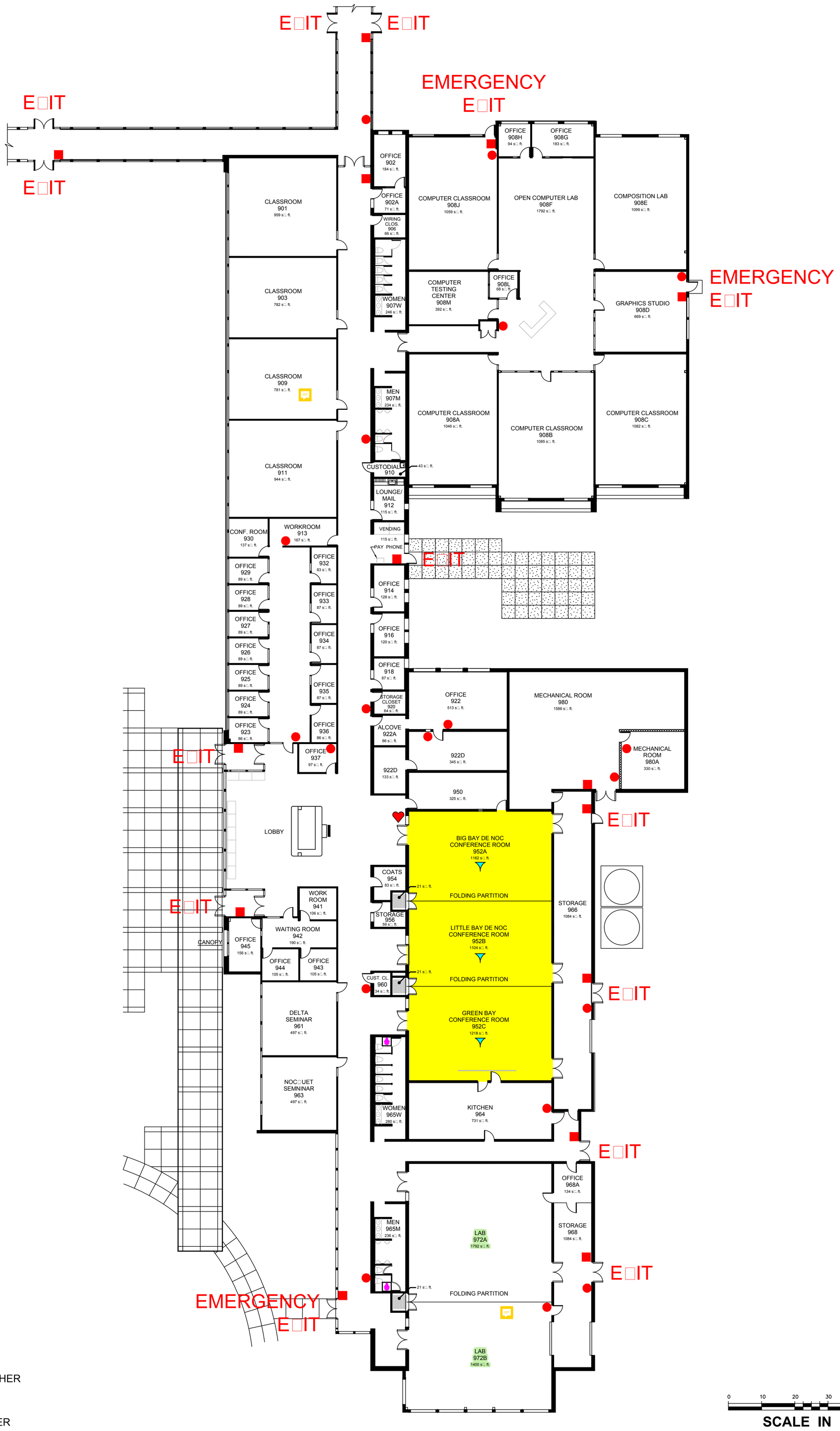
Art Galleries.....200, 700
Besse Theatre/Gallery.....700
Building and Grounds.....1100
Shipping and Receiving.....1000
Workforce Development.....2000

Contact: LaVerne Smith, EMT/Paramedic Program Director
Office: 906-217-4226; Cell: 906-367-1338

Joseph Heirman University Center(JHUC)

Building 900

40,600 SQ. FT.



LEGEND

- □ FIRE E□TINGUISHER
- □ PULL ALARM
- □ SEVERE WEATHER SHELTER
- □ AUTOMATED E□TERNAL DEFIBRILLATOR
- □ BABY CHANGING STATION

0 10 20 30 40 50

SCALE IN FEET

Medical Control Authorities in Michigan

Evaluation Report

Prepared by MPHI

May 2024

Executive Summary

Overview of Evaluation

Medical control authorities (MCAs) are designated by MDHHS Bureau of Emergency Preparedness, EMS, and Systems of Care (BEPESOC) to supervise and coordinate EMS systems within their regional jurisdictions. MCAs provide medical control to their region's life support agencies (LSAs), which provide prehospital care and transport before a patient is received at a hospital, free-standing emergency department (FSED), or free-standing outpatient facility (FSOF). MCAs are administered by participating hospitals, FSEDs, and FSOFs in each MCA region.

MCAs have a crucial role in the provision of safe, effective EMS to their communities. MPHI's evaluation approach was designed for MDHHS and other relevant stakeholders to learn more about the current capacity of MCAs in Michigan. The purpose of the evaluation was to understand the organizational strengths and effectiveness of MCAs so that gaps and challenges can be identified and addressed. The data generated by this evaluation is meant to be used by stakeholders to better support MCAs and implement policies that encourage best practices and address the current challenges that MCAs face.

Evaluation Approach

First, the evaluation team finalized the scope of data collection through document review and extensive input from MDHHS BEPESOC leaders. Subsequently, data collection tools, including two surveys, were developed collaboratively using an evaluation framework, and then programmed within the RedCAP survey environment. First, the Phase 1 survey, along with a data extraction template to collect basic organizational and functional information about the MCAs, was sent to one key contact at each MCA. Second, the Phase 2 survey was disseminated to MCA stakeholders to collect more comprehensive and role-specific data. Once the surveys were closed, data was analyzed to identify factors that contribute to the or ineffectiveness of MCAs.

Key Takeaways

Phase 1

Overall Structure of MCAs

Common Organization Structures

- **46%** are organized as a **specific department of a hospital.**
- **30%** are organized as an **independent corporation**.

Common Staffing Models

- **57%** use a staffing model in which **staff are employed by another entity and are shared** between that work and the work of the MCA.
- **26%** use a staffing model in which **staff are employed by and are fully dedicated to MCA work.**

Common Funding Sources

- **61%** received **monetary contributions** from hospitals.
- **48%** received **in-kind support** from hospitals.

Website and App Usage

- **68%** have an **official website.**
- **55%** have **websites containing their protocols.**
- **39%** use an **app.**

Medical Director Appointment and Training

- **51%** of MCAs have a medical director who was **appointed within the last five years**.
    - Among medical directors appointed within the last five years, **54% completed educational programs** specific to medical directors since 2020.
- Medical director educational training programs taken included:
    - **MCA Trauma Conferences (70%)**
    - **In-person MCA Training (26%)**
    - **Recorded MCA Training on MI-TRAIN (26%)**

Communications

- **96%** of MCAs **record communication** between field EMS units and hospitals **electronically**.
    - Over half (**56%**) maintain records for **more than 6 months**
- **78%** of MCAs have a communication records maintenance mechanism in which **the hospital receives and maintains transmission.**
- **10%** of MCAs maintain communication records by **an accessible cloud-based platform.**

Protocol Distribution and Awareness

- In **87%** of MCAs, EMS personnel are supplied with the current protocol **through their agency.**
- **54%** are supplied the current protocol through the **MCA website**.
- **37%** are supplied the current protocol via phone app update.
- In **89%** of MCAs, licensed EMS personnel are **made aware of their MCA's protocols** through **agency assurance**.

LSA Credentialing and Monitoring

- **56%** of MCAs have a **formal process for granting authority to LSAs**.
- **46%** of MCAs **do not monitor LSA availability.**

Phase 2

Years of Experience

- **44%** of respondents held their current position for **one to five years**.
- **44%** held their current position for **more than five years**.

Time Allocation

- **45%** of respondents spend **less than five hours a week** on MCA work.
- **24%** spend **more than 20 hours a week**.
- **Ideally,** a majority **(79%)** would spend **more than five hours a week** on MCA work, compared to the 55% who do so currently.

Training

- **41%** of respondents **attended an in-person MCA training**.
- **Most (83%)** respondents **rated the training as very useful** (seven or above), with an average rating of 8.1.

MCA Handbook

- About **1 in 3 (33%)** respondents had **thoroughly read or were familiar with the handbook.**
- About **1 in 4 (25%) did not know an MCA handbook existed**.

Understanding of MCA Structure and Functions

- Over **80%** of respondents said they had a **comprehensive understanding for each topic** (rating of seven or above):
    - **87%** for **processes and requirements for personnel credentialing.**
    - **85%** for **processes and requirements for agency licensure.**
    - **84%** for **statutory responsibilities of an MCA's functions.**
    - **83%** for **statutory responsibilities for an MCA's structure.**
    - **80%** for **protocol submission processes.**

MCA Bylaws

- **49%** of respondents said their **bylaws were updated in the last five years.**
- Notably, **almost half (46%)** reported that they were **not sure when bylaws were last updated.**

Perception of MCA Effectiveness

- **82%** of respondents said **their MCA was very effective** (rating of seven or higher).

Regional Activities

- **66%** of respondents agreed or strongly agreed that their MCA regularly participates in a **Regional Trauma Advisory Committee (RTAC).**
- **68%** agreed or strongly agreed that **their MCA regularly participates in a Regional Trauma Network (RTN).**
- **79%** agreed or strongly agreed that their MCA has been involved in the **development of regions for systems of care (SOC)**, such as stroke, STEMI, and trauma.

Quality Improvement

- **75%** of respondents agreed or strongly agreed that **their MCA has a defined quality improvement process.**
- Only **51%** reported they **receive reports of quality indicators.**

Knowledge Test

- Overall, **67%** of survey respondents **selected correct responses** for most knowledge test questions.
- **97%** was the highest rate of correct answers, for whether an **MCA can revoke or suspend an EMS license.**
- **47%** was the lowest rate of correct answers, for whether the **authority of an MCA comes from the bylaws**.
- When stratified by respondent primary role, the **lowest overall score** on the knowledge test was among **PSRO members (64%)**, followed by **MCA Board and Advisory Body members (66%)** and **key staff (69%).**
- **MDs and AMDs** had the **highest overall score** on the knowledge test, getting **75%** correct on average.

Key Recommendations and Action Steps

Updated manuals and handbooks and accessibility of materials.

- Creation and distribution of a "quick manual" for those who may not read the MCA Handbook in full – especially for Board, Advisory Body, and PSRO members.
- Development of a new MCA Handbook which is regularly updated based on need.
- Creation of easily accessible MCA manuals and handbooks that are published electronically and provided in hard copy as needed.

Improved data collection for regular oversight of MCAs.

- Regular collection of relevant data points regarding the structure and functions of all MCAs.
- Creation and regular maintenance of databases encompassing relevant data points.

Increased enforcement of MCA policies and procedures.

- Level-setting with all stakeholders to stress importance and legal weight of MCA protocols.
- Administration of regular knowledge tests regarding understanding of MCA policies and procedures.
- Implementation of other enforcement mechanisms, as needed.

Increased stakeholder engagement.

- Review of knowledge test results with stakeholders based on composite scores, especially MCA Board, Advisory Body, and PSRO.
- Increased engagement with stakeholders, including enhanced feedback and input mechanisms for Advisory Body and MCA Board.

Continued, consistent training and education.

- Provision of regular education and training opportunities regarding MCA policies and procedures, not just upon onboarding.
- Continued knowledge dissemination at conferences, workshops, and other educational forums.

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Introduction

Medical control authorities (MCAs) are designated by the state of Michigan to supervise and coordinate emergency medical services (EMS) in a specific geographic jurisdiction. MCAs are authorized by the Public Act 368 of 1978 (i.e., Public Health Code) to oversee EMS services in their regions. MCAs are overseen by the Michigan Department of Health and Human Services (MDHHS) Bureau of Emergency Preparedness, EMS, and Systems of Care (BEPESOC) and must adhere to its policies.

Background

MCAs are designated by MDHHS to supervise and coordinate their respective EMS systems as prescribed, adopted, and enforced through protocols approved by MDHHS. MCAs provide medical control to life support agencies (LSAs), which provide prehospital care and transport before a patient is received at a hospital or emergency department. They engage in a wide range of functions and can generally take many different types of structures. They do not receive any state or federal funding and are responsible for acting in the best interests of the EMS systems in their region.

MCAs are administered by participating hospitals in each region. Any hospital, free-standing emergency department (FSED), or free-standing outpatient facility (FSOF) that receives emergency patients can participate in the MCA. Participating members can have representatives on the MCA Board, which is required to comprise mostly of hospital and FSED/FSOF representatives. All members of the MCA must comply with MDHHS-approved MCA protocols.

Additionally, each MCA has a medical director, appointed with the advice of the Advisory Body, who is a board-certified emergency medicine physician tasked with providing medical control to the participating LSAs. The MCA's Advisory Body consists of representatives of participating LSAs, including different types and levels of EMS personnel. Many MCAs also have clerical or administrative staff who engage in other MCA responsibilities, including training and continuing education, personnel testing, medication management, quality improvement, and data entry. Finally, MCAs have professional standard review organizations (PSROs), which are focused on reviewing quality improvement data and improving quality of care.

Evaluation Purpose

MCAs have a crucial role in the provision of safe, effective EMS to communities in Michigan. Due to the essential nature of MCAs, the purpose of this evaluation was to understand the organizational strengths and effectiveness of MCAs so that gaps and challenges can be identified and addressed, and best practices can be documented and replicated. The data generated by this evaluation is meant to be used by relevant stakeholders to better support MCAs and implement policies that encourage best practices as well as address current challenges.

Evaluation Approach

MPHI developed an evaluation approach so that MDHHS and other relevant stakeholders could learn more about the current capacity of MCAs in Michigan. This included learning more about the current structure and functions of MCAs. MPHI started its evaluation process by finalizing the scope of data collection through document review and meeting with MDHHS BEPESOC leaders. Subsequently, using a comprehensive evaluation framework, the evaluation team developed data collection tools, including two surveys, which were disseminated to the MCAs. Once data was collected, MPHI analyzed the data to look at factors that contribute to the effectiveness and inefficiencies of MCAs.

Document Review

At the start of the evaluation, MPHI conducted a document review to gather existing information about the structure and functions of MCAs in Michigan. MPHI first reviewed the most recent (2017) edition of the MCA Handbook which was prepared by BEPESOC. The handbook is a guide for hospital administrators, clinical providers, LSA leaders, EMS personnel, medical directors, and staff involved in MCA administration and work. The MPHI evaluation team reviewed the 54-page document and took notes on key terms and areas of work.

The evaluation team also reviewed a prior evaluation of Michigan MCAs conducted in 2012, including the associated evaluation survey and results. This 2012 survey formed the basis of the surveys that were developed for the present evaluation. Further document review was facilitated through the development of the initial data collection tool, along with which individual MCAs were asked to send their department-approved protocols and bylaws.

Framework Development

MPHI developed an evaluation framework with guidance from the MCA Handbook, the 2012 MCA evaluation, and other areas of interest for the BEPESOC team which were determined through conversation with them. The evaluation framework was developed systematically, using information gathered from the document review. The three domains that were developed were: Descriptive Information, Structure and General Operations, and Processes for Providing Key Functions. Under each domain, evaluation concepts and data resources for potential metrics and questions were determined. This framework laid the foundation for survey development.

Initial Data Collection

The evaluation team created an Excel spreadsheet with multiple tabs to capture relevant information from each MCA. The first worksheet collected demographic and staffing data from each MCA. This included geographic and demographic data, the number of staff employed, full-time equivalents (FTEs) dedicated to MCA work, number of EMS providers stratified by certification level.

The second worksheet collected the names of participating hospitals, as well as their zip code and trauma level designation. The last two worksheets collected data about the rosters of the MCA Board and Advisory Body (when a separate entity from the MCA Board). These spreadsheets collected names, email contact information, which agency the person belonged to, hospital or non-hospital membership, designated statutory role they were filling, title at their place of employment, and board position, if they held one.

Surveys

MPHI programmed two surveys on the RedCAP platform, each designed to address different aspects of the MCA evaluation. Additionally, the Initial Data Collection spreadsheets were sent out along with the survey.

The first survey (Phase 1 Survey) was sent out to only one key contact at each MCA. Concurrently, the Initial Data Collection tool was also sent out to these key contacts. Once the Phase 1 Survey was closed, the second survey (Phase 2 Survey) was sent to various types of MCA staff and stakeholders to get their perspectives on their work with MCAs. For the Phase 2 Survey, many MCAs had multiple respondents, while Phase 1 produced only one response per responding MCA.

Phase 1 Survey

Using the framework developed for the evaluation, MPHI developed questions within all three domains of the evaluation. Questions that were not selected for Phase 1 were planned to be used in the Phase 2 Survey. The BEPESOC team reviewed a draft of the Phase 1 Survey and provided feedback before MPHI started programming the survey. Overall, 47 questions were selected for the final survey.

Questions were organized into general questions (e.g., MCA name), structure and operations (e.g., type of organization, staffing model, Board and Advisory Body, medical director and staff, funding, communications), and key function processes (e.g., protocol development, protocol adherence, EMS credentialing, quality improvement, participation in public safety answering points and dispatch, discretionary activities).

After the survey was programmed in RedCAP, it was sent by BEPESOC staff to one key contact at each of the MCAs, with MPHI developing recruitment language for the survey which contained clear communication that only MPHI staff would have access to the survey data.

Phase 2 Survey

The evaluation framework was also used to develop Phase 2 questions. The Phase 2 Survey was designed to ask specific questions about MCA functions, including those that are role-specific, as well as qualitative, open-ended questions about stakeholder perspectives on MCA work.

The survey included general questions for various types of MCA staff and stakeholders. Questions were about protocols, regional trauma collaboration, and quality improvement.

Role-specific questions were also included (i.e., specific questions for medical director or assistant medical director, key staff, voting members of MCA Board, participants of the Advisory Body, and PSRO members). Additionally, one section was dedicated to an 11-question "knowledge test" which was proposed by the BEPESOC team as a metric of how knowledgeable MCA staff and stakeholders were about MCA structure and functions.

After the survey was programmed in RedCAP, it was sent by key staff at each MCA to relevant staff and stakeholders, once again using recruitment language that MPHI developed.

Data Analysis

Initial analysis of Phase 1 and Phase 2 data was conducted using SPSS. Basic analysis consisted of generating descriptive statistics from quantitative data that was received from MCAs. Descriptive statistics included frequencies and other forms of univariate analysis. Phase 1 data was combined with the initial data collection tool data to facilitate inferential crosstab and chi-square analysis. Further data analysis examined differences across trauma region, type of organization, type of staffing structure, and primary role within the MCA. Additionally, qualitative analysis was conducted to extract themes from the responses to open-ended questions from Phase 1 and Phase 2.

Phase 1 and Initial Data Collection Results

Survey Response Overview

A total of 42 respondents provided complete responses to the Phase 1 survey, as well as 4 incomplete responses. The overall survey response rate was 71%.

Overall Structure

Trauma Region

Respondents reported which trauma region their MCA belonged to. As shown in Figure 1, of those who reported their region, 6% of MCAs were from Region 1, 9% from Region 2N, 9% from Region 2S, 16% from Region 3, 16% from Region 5, 11% from Region 6, 9% from Region 7, 16% from Region 8, and 3% from multiple regions.

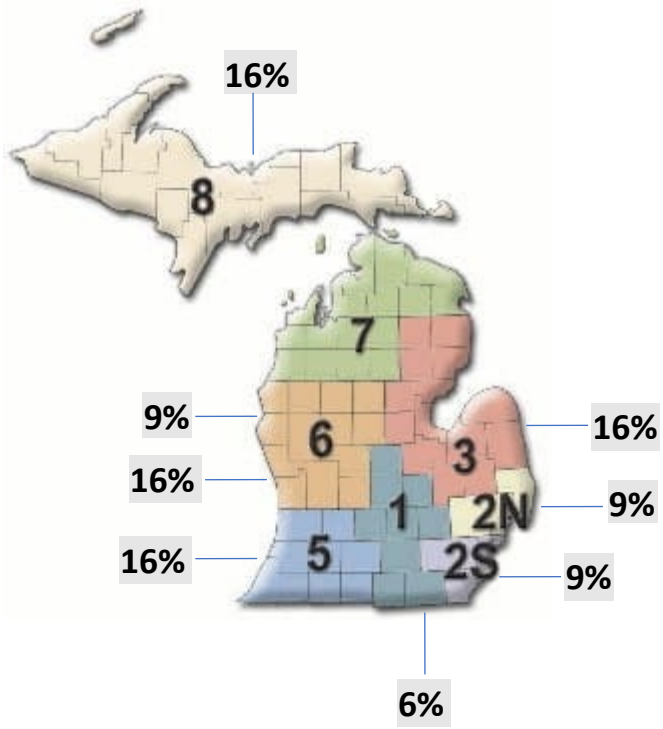

Figure 1. MCA Survey Participation by Michigan Trauma Region.

Organizational and Staffing Structure

MCAs vary greatly in the way they are structured. Some MCAs are independent organizations, while others are affiliated with member hospitals or are part of an educational or county organization. An MCA's staffing model, which is related to its organizational structure, can vary greatly as well; MCAs are often either employed or shared between another entity, employed by the MCA itself, or have a mix of both models.

Respondents were asked about the organizational structure of their MCA. Among the respondents, almost half (46%) the reporting MCAs are organized as a specific department of a hospital, 30% as an independent corporation such as a 501c3, 4% as an entity or unit within a county agency, and 4% as an entity or unit within an educational organization (Figure 2, left). Another 22% had some other type of organizational structure, including a hospital-led but independent entity, or a combination of multiple types of organizational structures.

Respondents were further asked about their MCA's staffing model. Among the respondents, 57% had a staffing model in which staff are employed by another entity and are shared between that work and the work of the MCA, 26% of MCAs had a staffing model in which staff are employed by and fully dedicated to MCA work, and 2% had a mix of both models (Figure 2, right). Another 15% had some other type of staffing model. Other reported staffing models included part-time or full-time employment by a hospital with added position tasks related to the MCA, part-time administrative or coordination roles, part-time medical director roles, or on an as-needed basis.

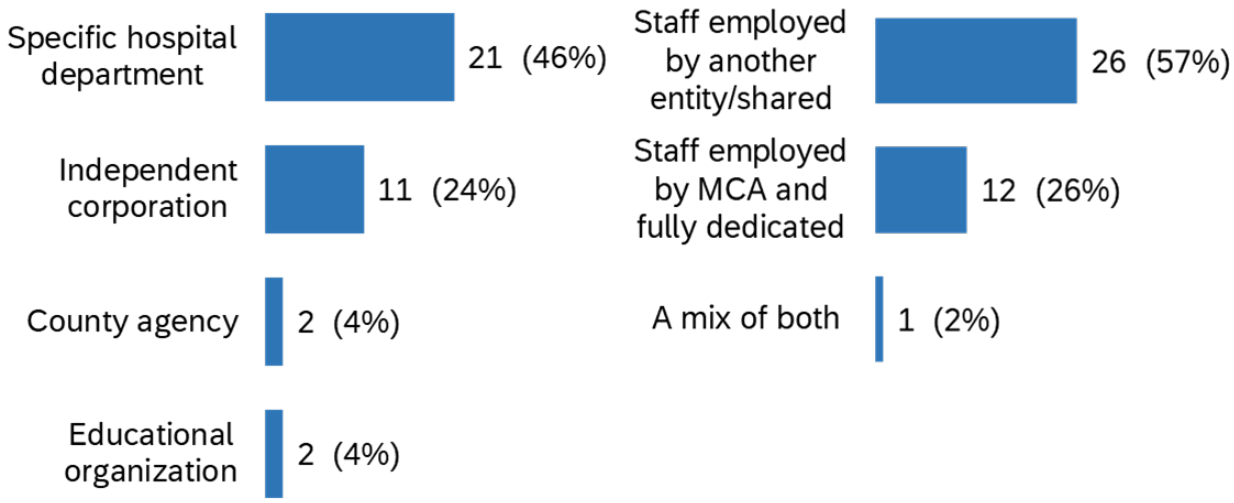

Figure 2. MCA Organizational Structure (left) and Staffing Model (right).

Funding Sources

Respondents were asked how their MCA is funded. They reported that MCAs derive their funding from various sources, including monetary contributions from hospitals (61%), in-kind support from hospitals (48%), grants such as those from a community foundation or United Way (22%), local government funding (17%), voluntary allocations from LSAs (15%), in-kind support from a non-hospital entity (11%). A few MCAs (7%) do not receive any funding at all. Another 4% of MCAs receive funding from another source not listed (Figure 3).

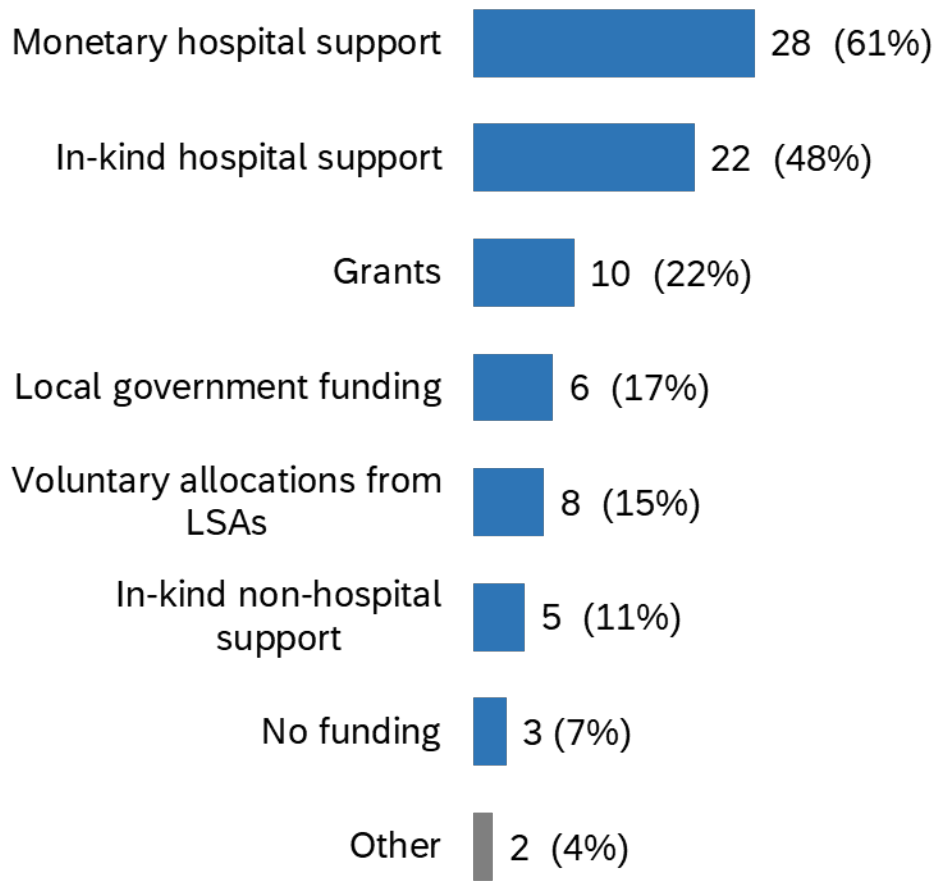

Figure 3. Funding Sources.

Use of Official Website and App

Respondents were asked if their MCA has an official website. Results showed that 68% of MCAs have an official website, and 55% have websites containing their protocols. Respondents were also asked if their MCA has an app. Results showed that 39% of MCAs use an app (Figure 4).

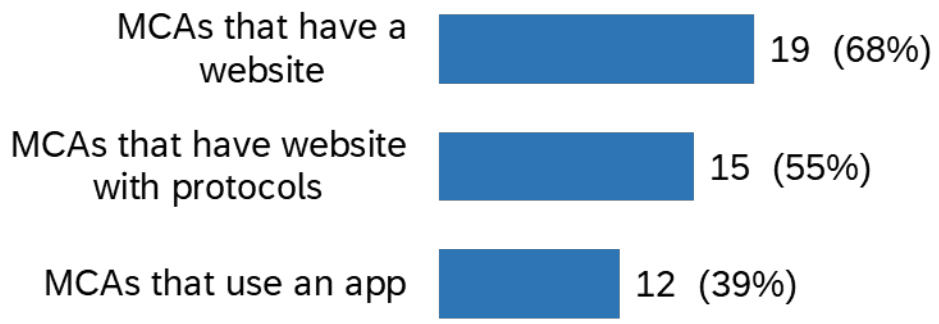

Figure 4. Use of Websites and Apps.

Medical Director Appointment, Training, Reporting and Responsibilities

Respondents were asked if the medical director at their MCA was appointed in the last five years. Slightly over half (51%) of the participating MCAs reported having a medical director who was appointed within the last five years. Those respondents with medical directors appointed in the last five years were asked further questions about their appointment and training.

Respondents were asked to describe the process of appointing a medical director at their MCAs. Content analysis results demonstrated that there were some common themes in appointment processes. These themes, listed from most common to least common, are presented in Table 1, along with selected quotes that fall under each theme.

Table 1. Common Medical Director Appointment Processes.

Theme	Quotes
Medical director is selected through an MCA Board and/or Advisory Body process (n=9)	*MCAB nominates, votes, and recommends appointment to Board of Trustees.* *The Medical Director candidate was suggested to the Advisory Body by the (then) current Medical Director. The Advisory Body voted to accept the recommendation and the candidate was appointed by the Board.* *Nominations were provided by the MCA Board, reviewed and voted on by the Advisory Board, then submitted to the Executive Committee for approval.*
Medical director is appointed by MCA-affiliated hospital(s) and/or by a candidate search at the hospital (n=7)	*The position is posted within local hospitals and candidates submit CV/resume to the board.* *The medical director was appointed by hospital staff and the employing agency. Candidates identified through ED staffing availability and willingness.* *Every three years the Medical Director is appointed by either [of two local hospitals].*
Medical director role is a part of existing hospital role tasks (n=6)	*The current medical director is also the current director of the ER as well, this position has been "attached" to that position and when ER directors change, so does the med control director.* *The medical director is an employee of the MCA sponsoring hospital. Part of their role includes MCA medical director.*

Among MCA medical directors appointed within the last 5 years, 54% had completed educational programs specific to medical directors since 2020. These educational programs

included MCA Trauma Conferences (70%), in-person MCA Training with the MCA Coordinator (26%), and recorded MCA Training on MI-TRAIN (26%) (Figure 5).

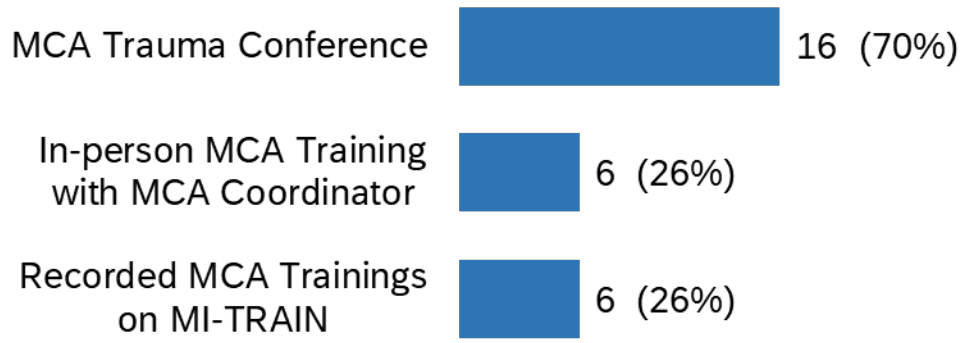

Figure 5. Education Programs Completed by Medical Directors Since 2020.

Another 35% of MCA medical directors took other types of trainings, including the National Association of EMS Physicians (NAEMSP) course for medical directors, remote education programs, Nationally Registered EMT (NREMT) Paramedic training, an EMS state director-provided course, board-provided education for EMS physicians, and various conferences (e.g., Regional Healthcare Coalition, National Healthcare Coalition, Homeland Security, State MCA, Local MCA, etc.).

Respondents were asked an open-ended question about how their MCA's medical director interacts with Board members. They shared that in most MCAs, the medical director is a part of Board and Advisory Body meetings and sometimes leads those meetings as well. In these cases, the medical director may either be a voting or non-voting member of the Board. In some MCAs, the medical director leads meetings with LSAs and hospital staff, including administration, and regularly interacts and provides updates through emails and in-person staff meetings.

Respondents were also asked how the medical director reports to the Board. They shared that in most MCAs, the medical director reports to the Board on issues related to the EMS system through regular Board meetings. Some medical directors also use quarterly Board meetings and executive board member meetings to provide their reports. Apart from meetings, medical directors often use email, phone, and the Teams application for reporting. In some MCAs, reporting is done by the medical director's liaison or in coordination with the MCA's key staff.

Respondents were further asked how medical directors receive input from the Advisory Body. They shared that, in most cases, medical directors receive input during Advisory Body meetings and through periodic formal meetings with members. In many cases, the medical

director is also a Board or Advisory Body member and directly receives feedback from other staff. Medical directors also receive input through email, phone, or via formal liaison.

Communications

Respondents were asked if their MCA records communications between field EMS units and hospitals electronically. Almost all (96%) of the responding MCAs record communication between field EMS units and hospitals electronically. Among these MCAs, over half (56%) maintain records for more than 6 months, 22% maintain communication records for less than 6 months, and the remaining 4% maintain records for some other length of time.

Respondents were asked how communication records are maintained by their MCAs. In over 78% of MCAs, the hospital receives and maintains transmission, while 10% of MCAs maintain communication records by using an accessible cloud-based platform. Additionally, 12% of MCAs maintain records by other methods, such as meetings, an online countywide bulletin board, apps, podcasts, and verbal communications.

Quality Improvement

Respondents were asked if their MCA has a currently functioning Quality Improvement (QI) program in place. Most MCAs (86%) said they have a currently functioning QI program in place, while 12% said they do not have one. The remaining 2% of MCAs shared that they are not aware if they have a currently functioning QI program in place.

Respondents were asked how often their MCA's QI activities are evaluated. More than half of the MCAs (54%) shared that their QI activities are evaluated monthly, 22% evaluate them quarterly, and 19% of MCAs evaluate them as needed. The remaining MCAs (5%) shared that their QI activities are evaluated at some other frequency.

Respondents were asked about the type of QI activities their MCA regularly participates in. Most MCAs (74%) regularly participate in providing feedback to LSAs, 70% regularly participate in data review work, 70% regularly participate in audit of patient care documentation, and 61% regularly participate in training and education.

Protocol Adherence

Respondents were asked how EMS personnel within each MCA are supplied with the current MCA protocol. In most MCAs (87%), EMS personnel are supplied with the current protocol through their agency, over half (54%) are updated through the MCA website, 37% via a phone app update, 4% via bulletins or newsletters, 4% via hard or digital copies sent to agencies, and 2% via social media (Figure 6).

Respondents were further asked how EMS personnel are made aware of protocols. Survey results showed that in most MCAs (89%), licensed EMS personnel are made aware of their MCA's protocols through agency assurance, 15% through annual testing of licensees, 4% through training and education, and 4% through reviews and audits. Another 15% of

respondents reported some other way of making personnel aware of protocols, such as through the licensee renewal process, updates and memos, and meetings.

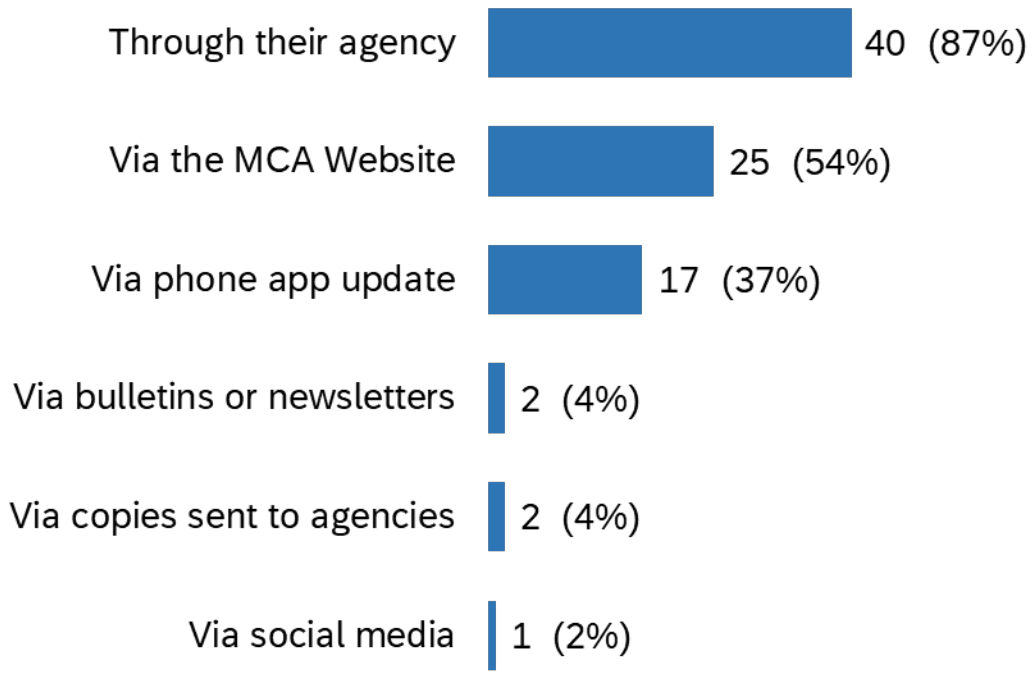

Figure 6. Methods of Protocol Distribution.

EMS and LSA Credentialing and Monitoring

Granting MCA Authority to LSAs

Respondents were asked if their MCA has a formal process in place to grant LSAs authority to function within its jurisdiction. A little over half (56%) of the responding MCAs have a formal process for granting authority to LSAs, while 21% said they do not have any formal process. The remaining 23% of respondents shared that they were not sure if their MCA had a formal process for granting LSAs authority. Following up, respondents were asked to describe their MCA's formal process to grant authority to LSAs to function. Most respondents stated that their MCA has an application process and that LSAs must meet the minimum requirement for credentialing within the MCA, along with application review by Advisory Body members. Some MCAs also require that the participating LSAs maintain records of required certifications and licensure and receive feedback through quality assurance.

Monitoring LSA Availability

Respondents were asked to share how MCAs monitor LSA availability. Results showed that 14% of MCAs monitor LSA availability through dispatch and 911 tracking logs, 12% through a vehicle tracking system, 9% through agency reliance, and 7% through report monitoring. However, 46% of the MCAs reported that they do not monitor the availability of LSAs (Figure

7). Another 12% of respondents said they had other ways of monitoring LSA availability, including on an as-needed basis, and through radio.

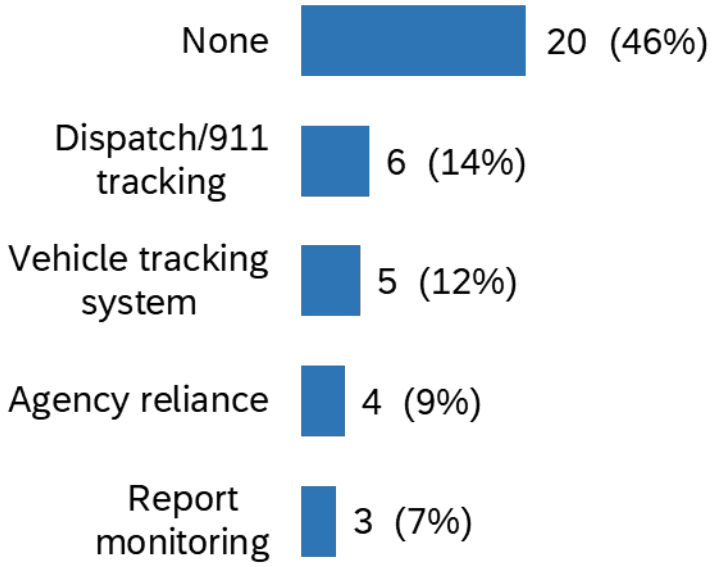

Figure 7. Mechanisms for Monitoring LSA Availability.

Phase 2 Results

Survey Results Overview

There were 262 complete responses to the Phase 2 survey, out of 286 total responses. Respondents included staff, medical directors, assistant or alternate medical directors, MCA Board members, Advisory Body participants, PSRO members, and other staff and stakeholders who are involved in MCA work throughout the state.

Respondent Role

Respondents were asked about their primary role within their MCA. Overall, the greatest proportion of respondents were Advisory Body members (18%) and PSRO members (18%), followed by key staff (17%) and MCA Board members (16%). Additionally, another 12% were members of a combined Advisory Body and MCA Board, and 11% were medical directors (MDs) or assistant medical directors (AMDs) (Figure 8). Another 8% had another role not listed above, including fire chiefs, those in leadership roles related to operations and administration, and first responders.

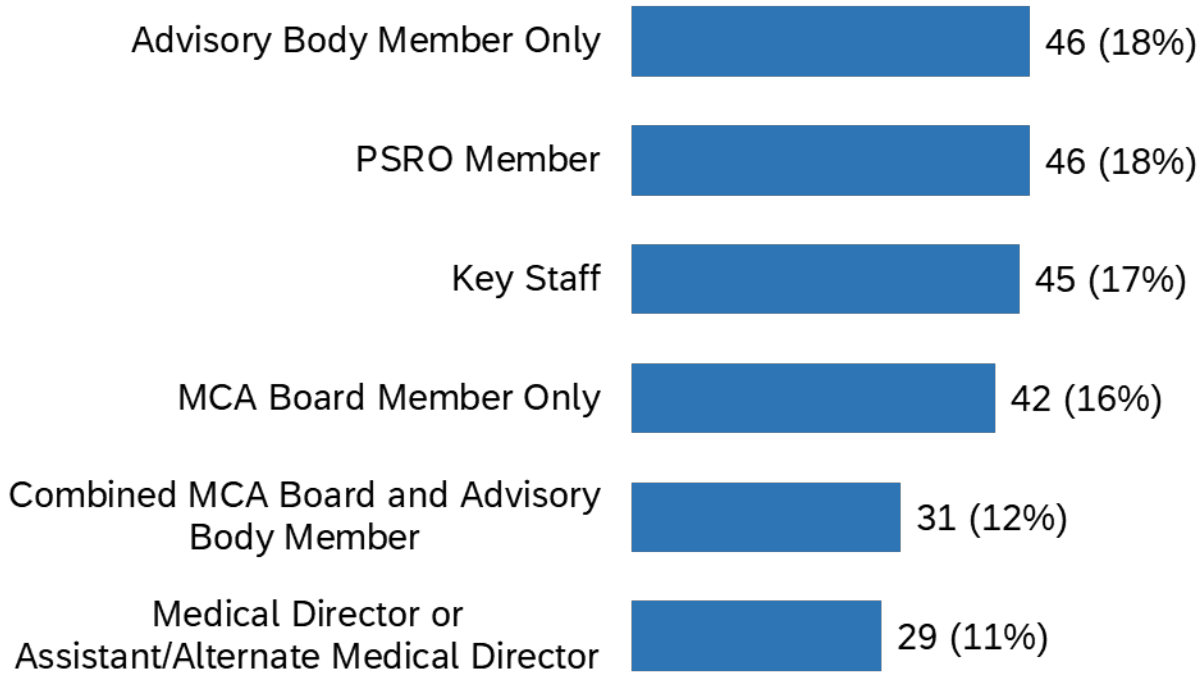

Figure 8. Primary MCA Role of Phase 2 Respondents.

Many respondents hold multiple roles simultaneously within their MCA. When all respondent roles were taken into consideration, 40% were PSRO members, 15% were key staff, 25% were MCA Board members, 15% were members of a combined Advisory Body and Board, 24% were Advisory Body participants, and 12% were MDs or AMDs. Another 6% had another role not listed. Almost one in three respondents (32%) held more than one role within their MCA, and almost 14% held more than two roles.

Years of Experience

Respondents were asked about the amount of MCA experience they had. When asked how long they have served with the MCA they are currently affiliated with, the largest portion (44%) responded that they had held this position for more than five years, while another 44% had held their position for one to five years. However, when asked about **overall** MCA experience, regardless of which MCA, a large portion of stakeholders said they had one to five years of experience (36%), while almost one in four (23%) had over 20 years of experience (Figure 9).

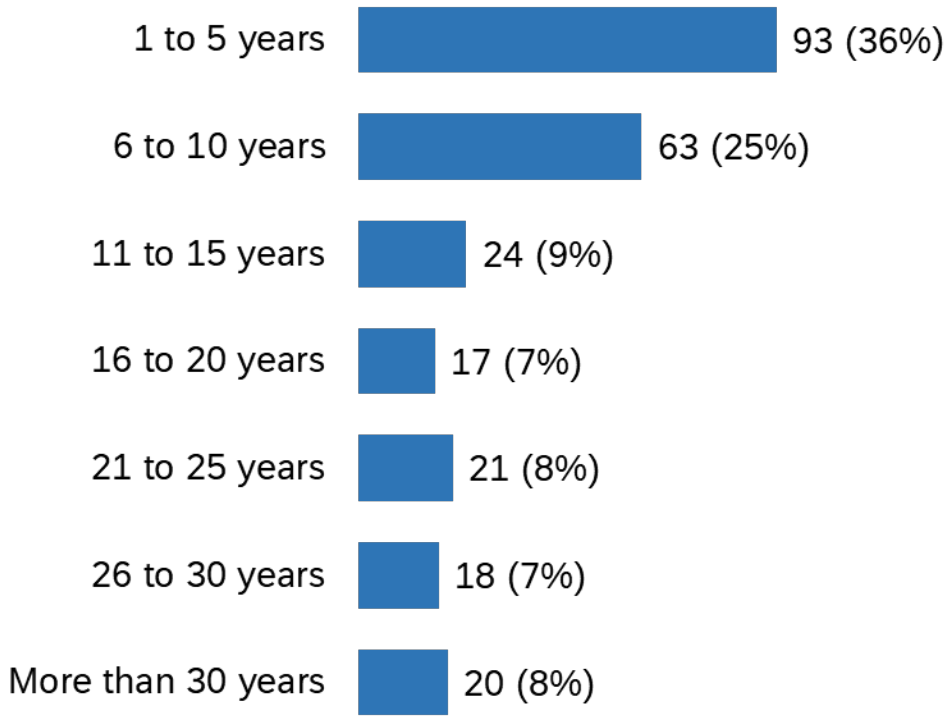

Figure 9. Number of Years of Experience Working with Any MCA.

Over half (55%) of the MDs and AMDs had worked with their MCA for over five years. A similar pattern was noted among key staff members, 58% of whom had worked with their current MCA for over five years, while 80% had been there over three years. Board members had mixed employment lengths at their current MCA, with about 46% of the members having worked with the MCA less than two years.

Interestingly, a significant portion of staff had between one and five years of experience with MCAs in general, including 43% of PSRO members, 38% of MCA Board members, 37% of Advisory Body members, 35% of MDs and AMDs, and 29% of key staff. Most staff had under 15 years of experience working with MCAs.

Time Allocation

Respondents were asked about their time commitment to MCA work. Specifically, they were asked how much time they dedicate to MCA work, as well as how much time they ideally would dedicate to MCA work, free of any other constraints. Overall, almost half (45%) of the respondents spent less than five hours a week on MCA work, while 16% spent five to ten hours, and 15% spent 11 to 20 hours. Almost a quarter (24%) spent more than 20 hours a week. Ideally, however, a majority (79%) would spend more than five hours a week on MCA work, compared to the 55% who do so currently (Figure 10).

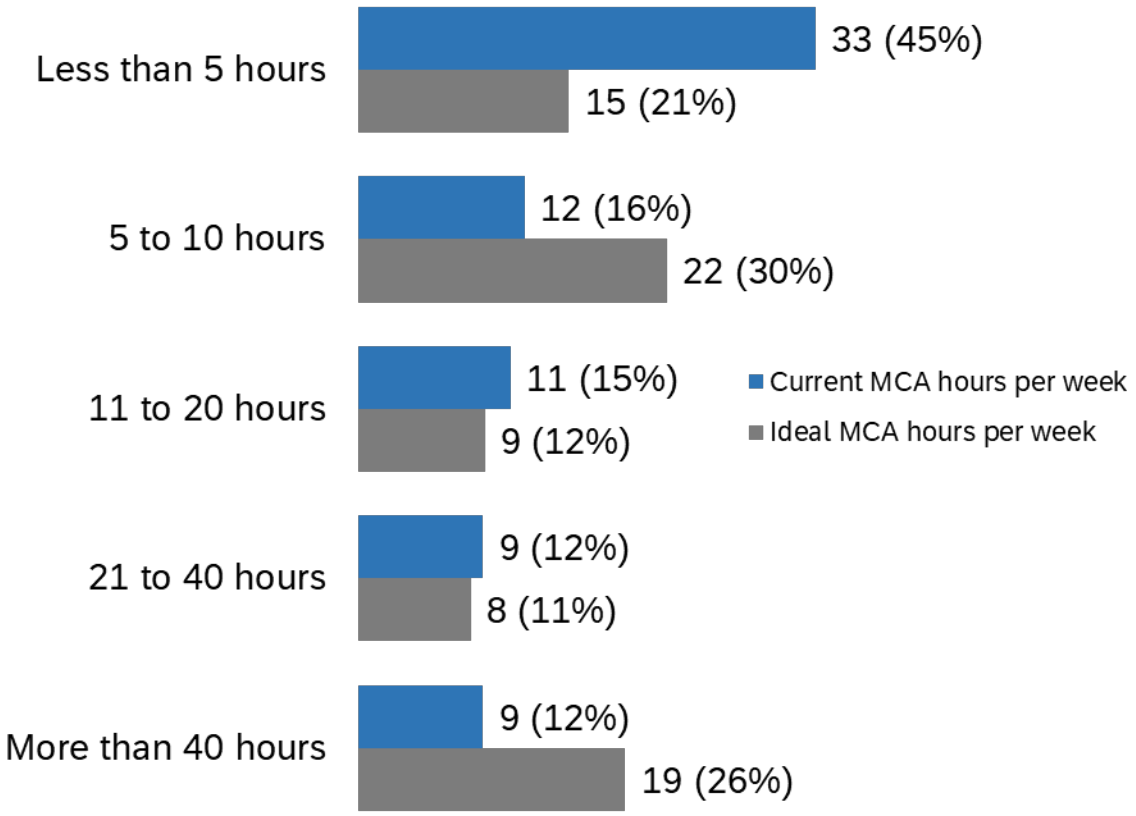

Figure 10. Current and Ideal Time Allocation for MCA Work.

Group differences among respondents representing different primary roles were also examined. Almost all (97%) MDs and AMDs spend under 20 hours a week on MCA-related work, with a little over half (52%) spending less than five hours. However, most (79%) would ideally schedule more than 5 hours of work a week, with 45% wanting to dedicate five to ten hours. Key staff are more spread out in terms of how many hours of work they spend on MCA tasks, but about one in five (20%) spend more than 40 hours a week on MCA tasks. However, among those who work less than 40 hours, the majority work less than 20 hours a week. Ideally, about half of the key staff respondents would spend between 21 and 40 hours a week on their work as opposed to only 18% who do so currently.

Training

Respondents were asked if they had taken an in-person MCA training. Overall, 41% attended an in-person MCA training provided to them by the MCA Coordinator. Further analysis to explore group differences showed that key staff had the highest rates of attendance (58%) for in-person training, followed by PSRO Members (46%) and MDs or AMDs (45%) (Figure 11). Among the stakeholders with the lowest attendance, MCA Board members, 29% had attended the training.

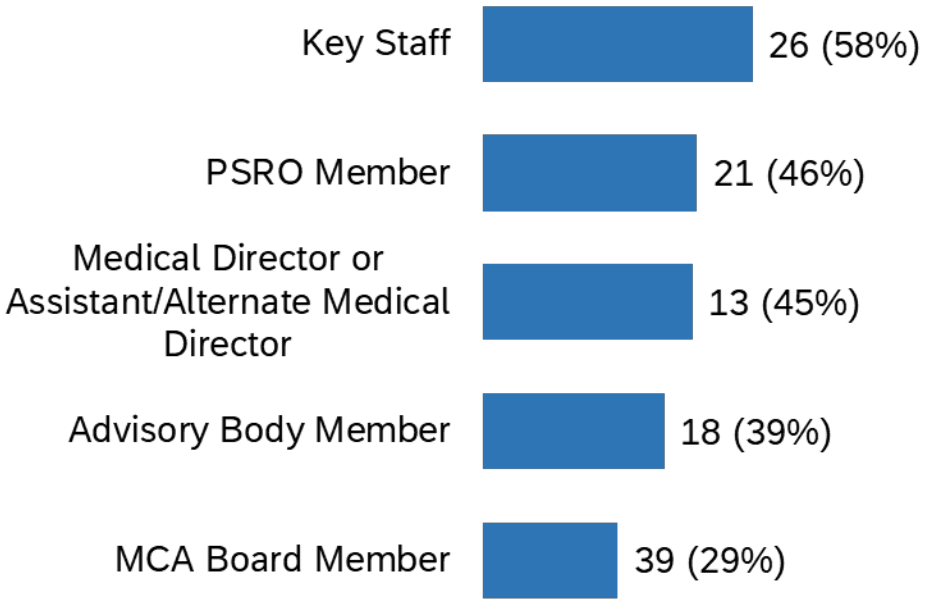

Figure 11. In-Person MCA Training Attendance by Primary Role.

Those respondents who completed an in-person MCA training were asked how long ago it was held. A little less than half (47%) of the survey respondents reported that their in-person MCA training was held more than three years ago.

Respondents were also asked to rate their opinion on the quality of the in-person MCA training on a Likert-type scale ranging from 1 (not at all useful) to 10 (extremely useful). Results showed that 83% of respondents rated the training as very useful (7 or above), with an average rating of 8.1 (Figure 12).

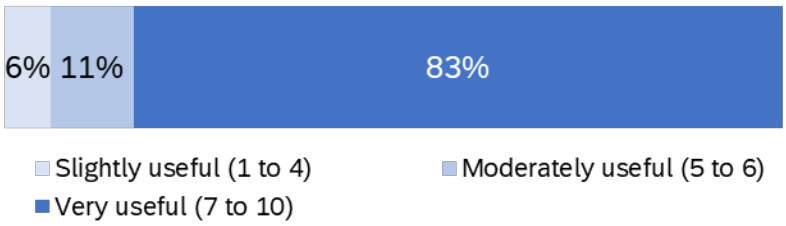

Figure 12. Perceived Usefulness of In-Person MCA Training.

As a follow-up, survey respondents were invited to provide additional information regarding the parts of the in-person training that they found most useful. Content analysis results

showed that the most frequently reported themes included education on MCA policy, structure, and role, face-to-face, hands-on aspects, and collaboration and networking. These results are summarized in Table 2.

Table 2. Useful Parts of In-Person MCA Training.

Theme	Quotes
Education on policy, structure, and role (n=32)	*Despite having lots of MCA experience, it is always good to get a refresh of different aspects of the MCA role and function as well as the state's perspective on that role.* *Legislative review, role and responsibilities of the MCA and participants* *just gaining familiarity with what a med control is and what it does, its structure and statutes, etc.* *learning about the MCA and their role in every day running of the MCA*
Face-to-face, hands-on (n=15)	*the face to face aspect is helpful* *Real time communication and education* *in person demonstrations, practice* *Hands-on AED reviews.*
Collaboration and networking (n=15)	*networking discussions* *Networking; Peer support* *We have had multiple trainings – collaboration*
New protocol review (n=7)	*Implementation of new protocol and training* *state update on protocols*

Respondents were also asked how the in-person training they attended could be improved. Common themes that emerged from content analysis included more trainings, more interactive, hands-on aspects, more participation from different staff, and the availability of virtual options. These results are summarized in Table 3.

Table 3. Ways MCA In-Person Training Could Be Improved.

Theme	Quotes
More trainings (n=14)	*Have more trainings on skills not used very often* *More of it and experienced persons providing the training.* *Have more of them, covering different topics.*

	Develop an introduction to MCA course, that MCA staff not as familiar could take, but then expand on that, and include best practicing from across the MCA's in the state.
More hands-on, interactive aspects (n=7)	*Provide real life, blinded examples of who a PSRO functions using cases as an evaluative tool. The PSRO role is a critical one and needs greater attention.*
	more hands on instead of power point
	Realistic simulations
More participation from different staff (n=4)	*Greater participation of Members*
	More participation from road providers
	more physician involvement, or experienced paramedics
Virtual options (n=3)	*Offering a virtual option, I think will increase availability to MCA members*

MCA Handbook

Respondents were asked about their familiarity with the most recent MCA handbook. Results showed that only 11% of survey respondents had thoroughly read the handbook, 22% were familiar with the handbook, and 21% sought only specific answers within the handbook. By contrast, 25% of respondents did not know an MCA handbook existed, while another 20% knew of its existence but never utilized it (Figure 13).

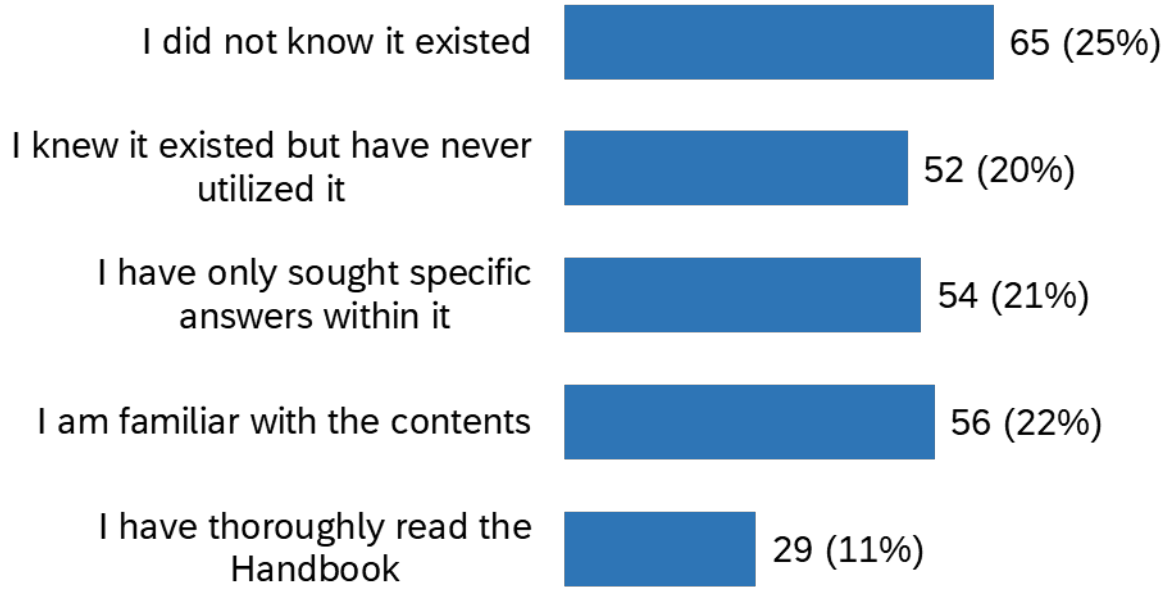

Figure 13. Level of Familiarity with MCA Handbook.

Group differences were examined based on the primary role of respondents. The lowest rates of familiarity with the MCA Handbook were among members of the MCA Board, Advisory Body, and PSRO. Among these groups, 41% of Advisory Body participants did not know it existed, followed by PSRO members (28%), combined Advisory Body and Board members (26%), and MCA Board members (21%).

Understanding of MCA Structure and Functions

Survey respondents were asked to rate their own understanding of various facets of MCA structure and functions. They rated their understanding of each topic based on a Likert-type scale ranging from 1 (no understanding) to 10 (full understanding).

Results showed that at least 80% of respondents provided a rating of seven or higher (i.e., comprehensive understanding) for each topic. Overall, 87% of respondents provided a rating of seven or higher for their understanding of processes and requirements for personnel credentialing, 85% for processes and requirements for agency licensure, 84% for statutory responsibilities of an MCA's functions, 83% for statutory responsibilities for an MCA's structure, and 80% for protocol submission processes (Figure 14).

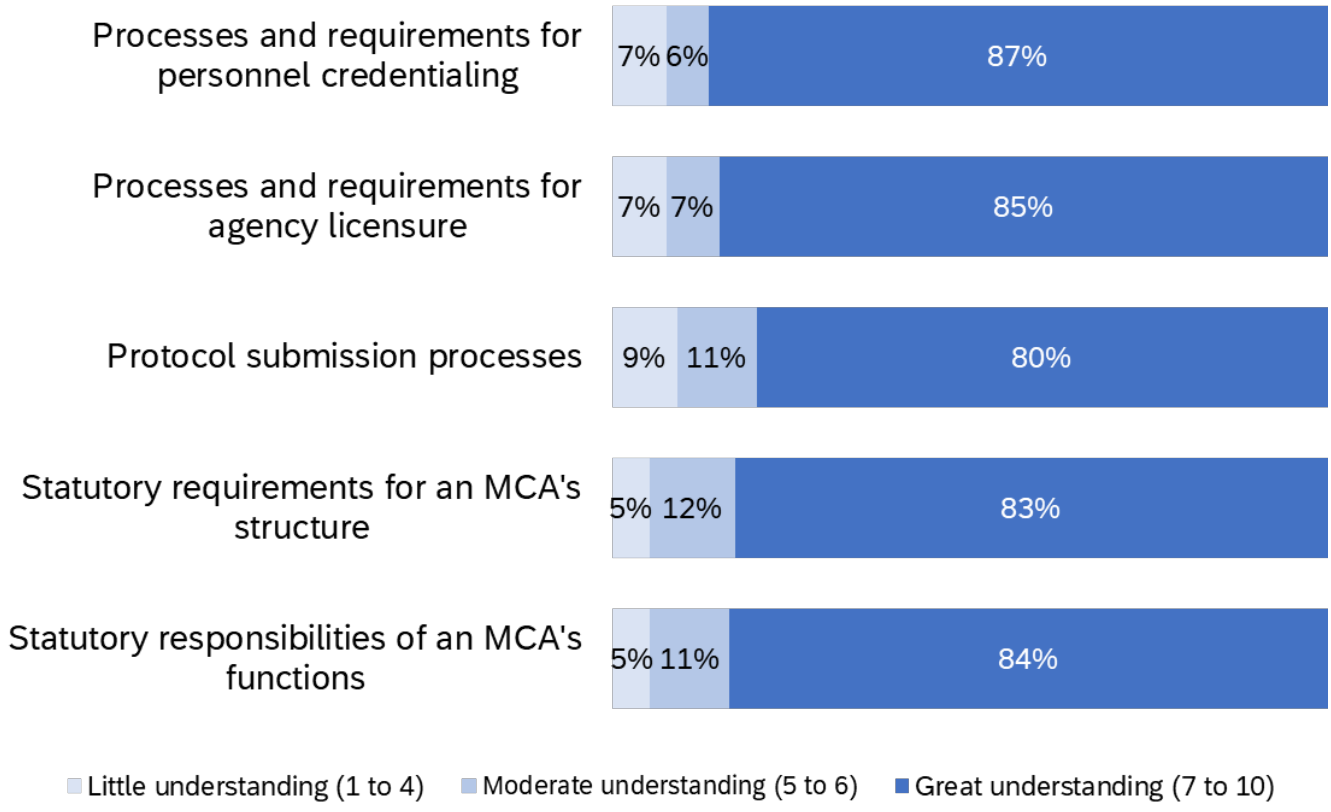

Figure 14. Self-Reported Level of Understanding of MCA Processes and Requirements.

MCA Bylaws

Survey respondents were asked when their MCA's bylaws were last updated. Almost half of the respondents (49%) said their bylaws were updated in the last five years and another 5% reported an updated occurring 6 or more years earlier (Figure 15). Notably, almost half (46%) reported that they were not sure when bylaws were last updated.

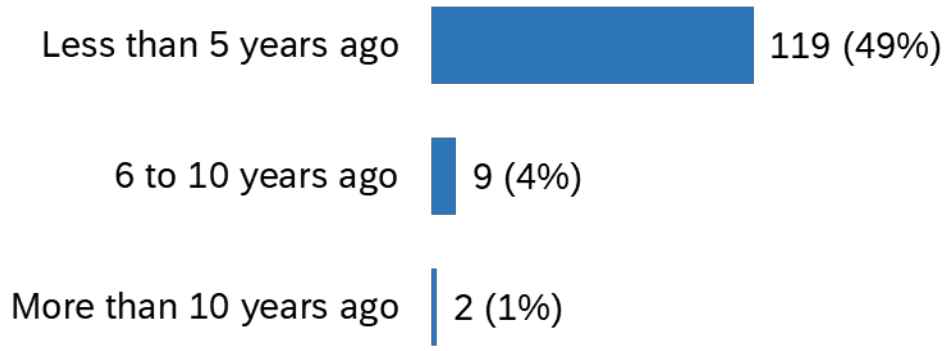

Figure 15. Last Time MCA Bylaws Were Updated.

Survey respondents were asked how well they had read the bylaws, on a Likert-type scale ranging from 1 (I haven't read the bylaws at all) to 10 (I have carefully read the bylaws). Only 46% provided a rating of seven or higher (i.e., read the bylaws comprehensively). The stakeholders who provided the highest proportion of ratings of seven of higher were medical directors (80%) and key staff (64%). Conversely, the stakeholders who reported the lowest proportion of ratings of seven of higher were MCA Board (40%), PSRO (32%), and Advisory Body (29%) members (Figure 16).

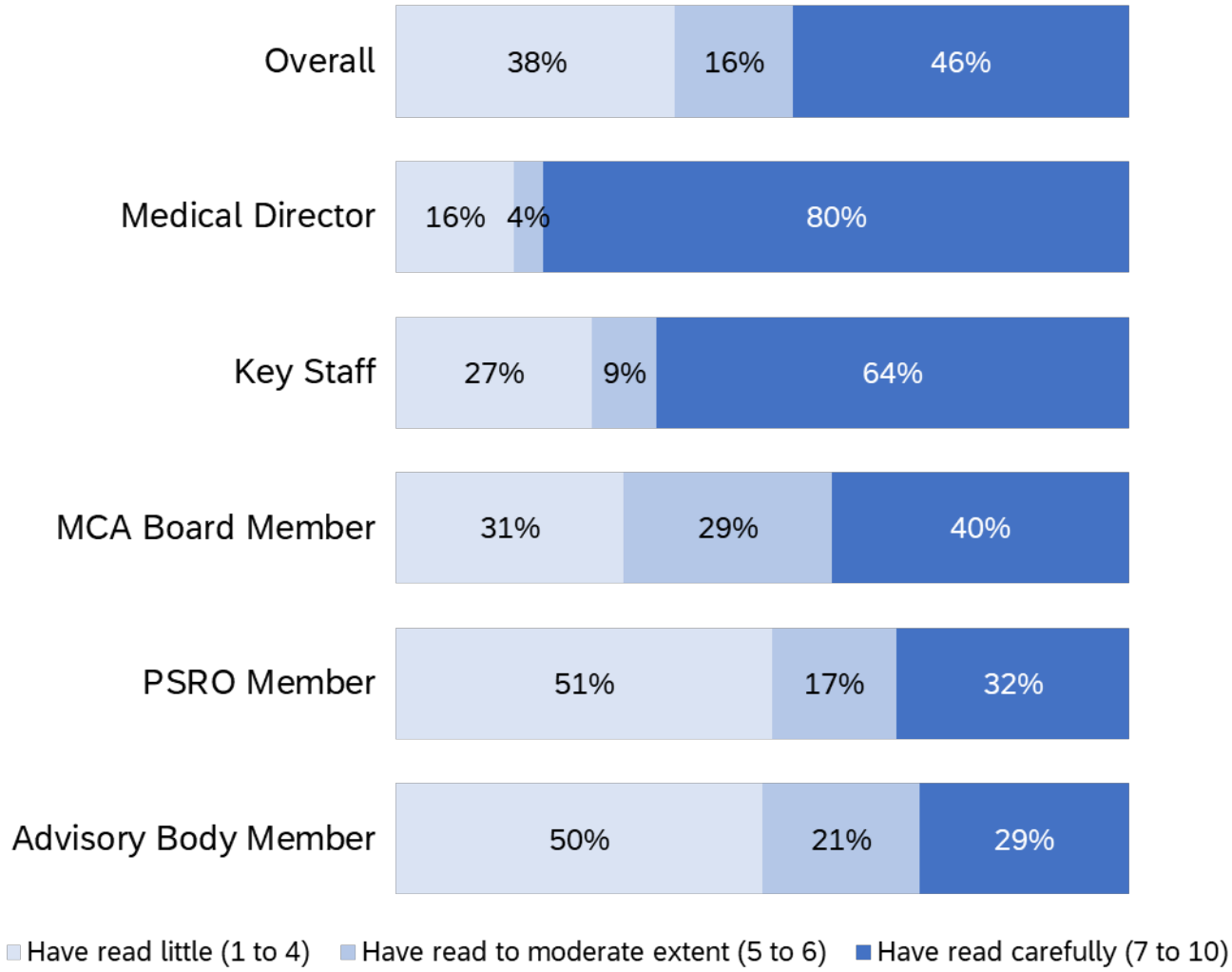

Figure 16. Self-Reported Comprehensiveness of Reading MCA Bylaws by Primary Role.

Perception of MCA Effectiveness

Respondents were asked, on a Likert-type scale ranging from 1 (not at all effective) to 10 (extremely effective), their perception of how effective their MCA is. Overall, 82% provided a rating of seven or higher (i.e., very effective).

Group differences in perceived MCA effectiveness based on the primary role of respondents were observed. The highest proportion of ratings of seven or higher came from medical directors and assistant medical directors (93%), followed by key staff (88%). The lowest proportion of ratings of seven or higher were from Advisory Body (76%), PSRO (84%), and MCA Board members (85%) (Figure 17).

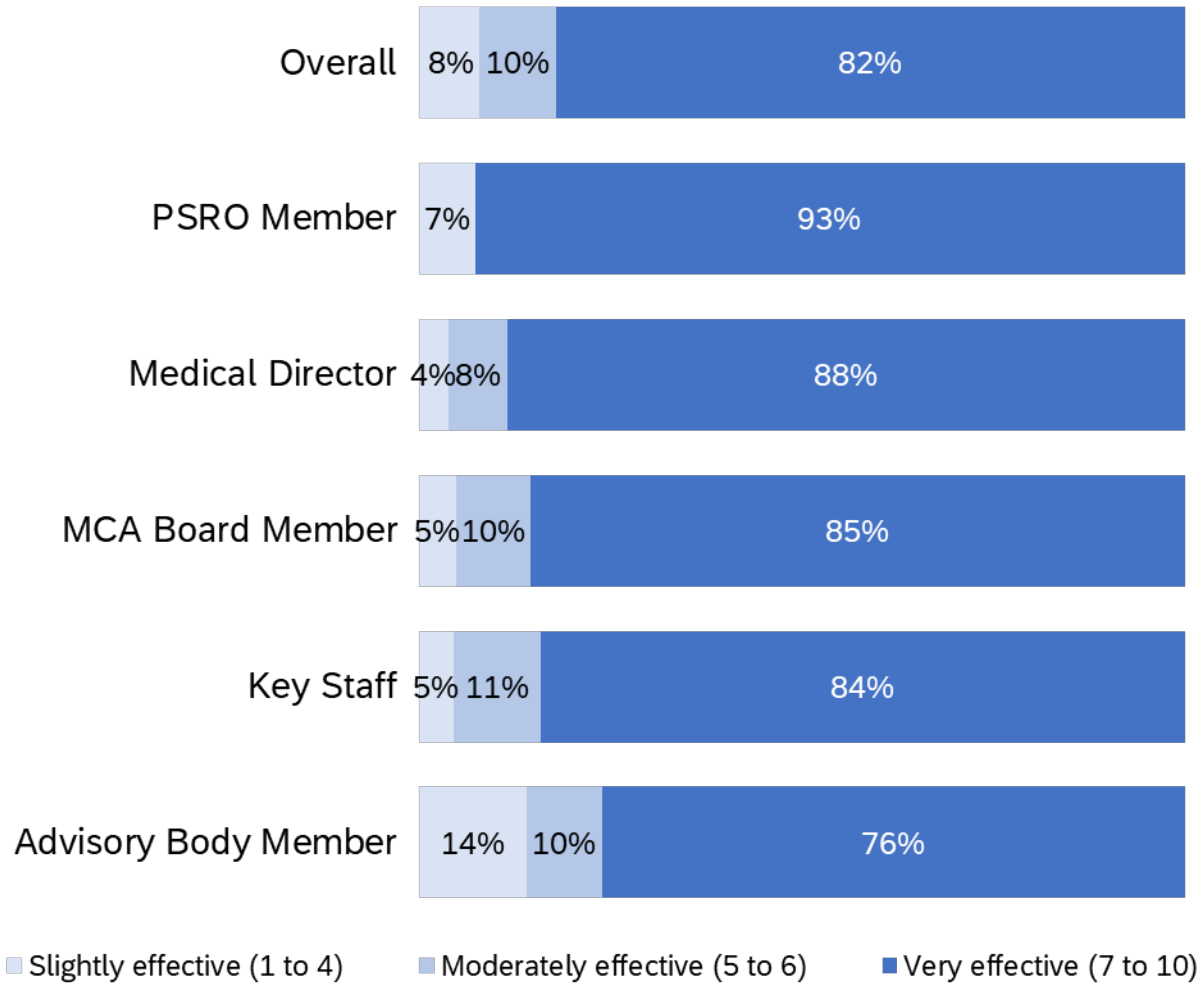

Figure 17. Perceived Overall Effectiveness of MCA by Primary Role.

An open-ended question was also asked about respondents' perspectives on how their MCA can become more effective. Content analysis results showed that respondents' most frequently reported themes were collaboration and engagement among all stakeholders, such as hospitals, LSAs, and the MCA Board, better communication, more staffing, more funding, and training and education (Table 4).

Table 4. Ways MCA Can Become More Effective.

Theme	Quotes
Collaboration and engagement between all stakeholders (n=34)	*Be involved in EMS, currently there is little to no involvement from our medical director.* *improved relationships between all agencies involved, increased collaboration and shared goals, dedicated focus to advancement and improvement*

	Continued engagement by Physician, Nursing and EMS leaders in our County.
Better communication (n=16)	*Better communication and orientation for new members* *Better communication to agencies and field personnel* *Better communication of upcoming changes*
More staffing (n=15)	*they can employ additional people to be able to improve the Data/QA/QI process, work on additional studies and research, and improve MCA provided education.* *Have full time staff* *I think one of the bigger problems is that they are understaffed.*
More funding (n=14)	*increased funding and cooperation from health systems.* *grant money to extent our community outreach* *Having legislation that fully funds MCA activities to get more parity with other states*
Training and education (n=12)	*Continued generation of EMS focused educational activities, and to create more mentoring opportunities for all levels of clinicians that participate in MCA functions.* *We need an active education committee and an annual assessment to touch base with each credentialed personnel annually* *More communication and training for field personnel*

Protocol Circulation, Feedback, and Enforcement

Respondents were asked to indicate, on a Likert-type scale, their level of agreement or disagreement that their MCA engages in protocol circulation and feedback processes. Of the respondents, 87% agreed or strongly agreed that their MCA circulates proposed protocols to provide affected entities ample opportunity to comment prior to adoption, and 74% agreed or strongly agreed that their Advisory Body has a standard process for providing feedback on proposed protocols (Figure 18).

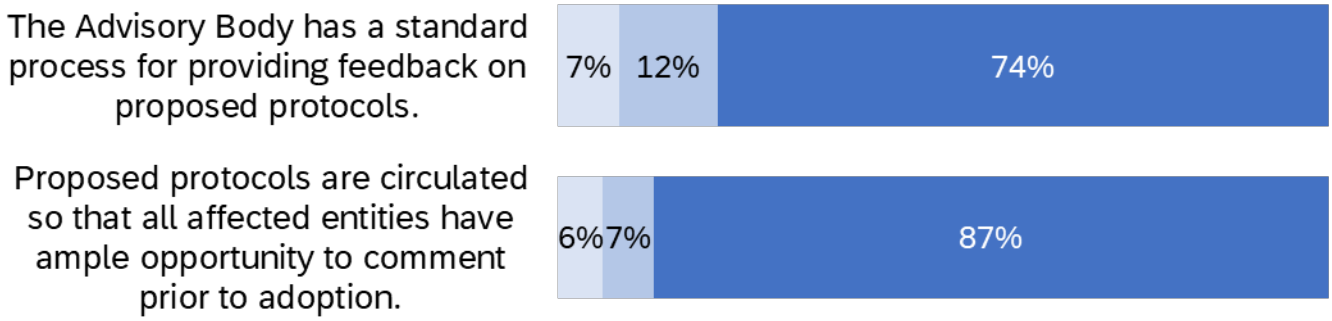

Figure 18. Self-Reported Participation in Protocol Feedback Processes (top) and Circulation (bottom).

Survey respondents were asked about their MCA's processes for ensuring protocols are circulated effectively and that end users have received them. The most common processes reported included protocols being sent to agency administrators (80%), protocols being posted on a public site (49%), and protocols being sent directly to personnel (45%). About 7% of respondents said they used other processes not listed above, including reviewing protocols at MCA Board and Advisory Body meetings, using a mobile phone application, and sending protocols out to MCA Board members, often prior to meetings. In addition, 13% of survey respondents reported that they were not sure which processes their MCA used for protocol circulation.

Finally, respondents were asked about awareness about MCA protocols among the leaders of member hospitals and FSEDs. Specifically, respondents were asked if their MCA make hospital and FSED leaders aware of protocols that may affect their operations, and if a formal procedure was in place to ensure that all hospitals and FSEDs adhere to the MCA protocols that apply to them. Overall, 71% of respondents said that hospital and FSED leaders and staff are made aware of MCA protocols that might impact their operations. However, only 55% of respondents said there is a formal procedure in place to ensure that all hospitals and FSEDs within their MCA adhere to relevant protocols.

Regional Activities

Respondents were asked their level of agreement that their MCA participates in various regional leadership activities. Specifically, they were asked about their participation in a Regional Trauma Advisory Committee (RTAC), Regional Trauma Network (RTN), and in the development of regional systems of care (SOC), such as stroke, STEMI, and trauma. Among the respondents, 66% said they agree or strongly agree that their MCA regularly participates in a RTAC, and 68% that their MCA regularly participates in a Regional Trauma Network (RTN). In addition, 79% agreed or strongly agreed that their MCA has been involved in the development of regions for systems of care (SOC), such as stroke, STEMI, and trauma.

Respondents were further asked about their participation in other activities and organizations at the regional level. These include pharmacy and medication box exchange (66%), education

(57%), protocol consistency and adoption (56%), regional MCA networks (50%), mass casualty incident (MCI) planning and operations (46%), health care coalitions (43%), patient destination (42%), other regional activities (41%), interoperable comms (31%), subcommittees (28%), and websites (27%) (Figure 19). Content analysis results showed that the most reported other types of regional activities were various emergency preparedness exercises and drills.

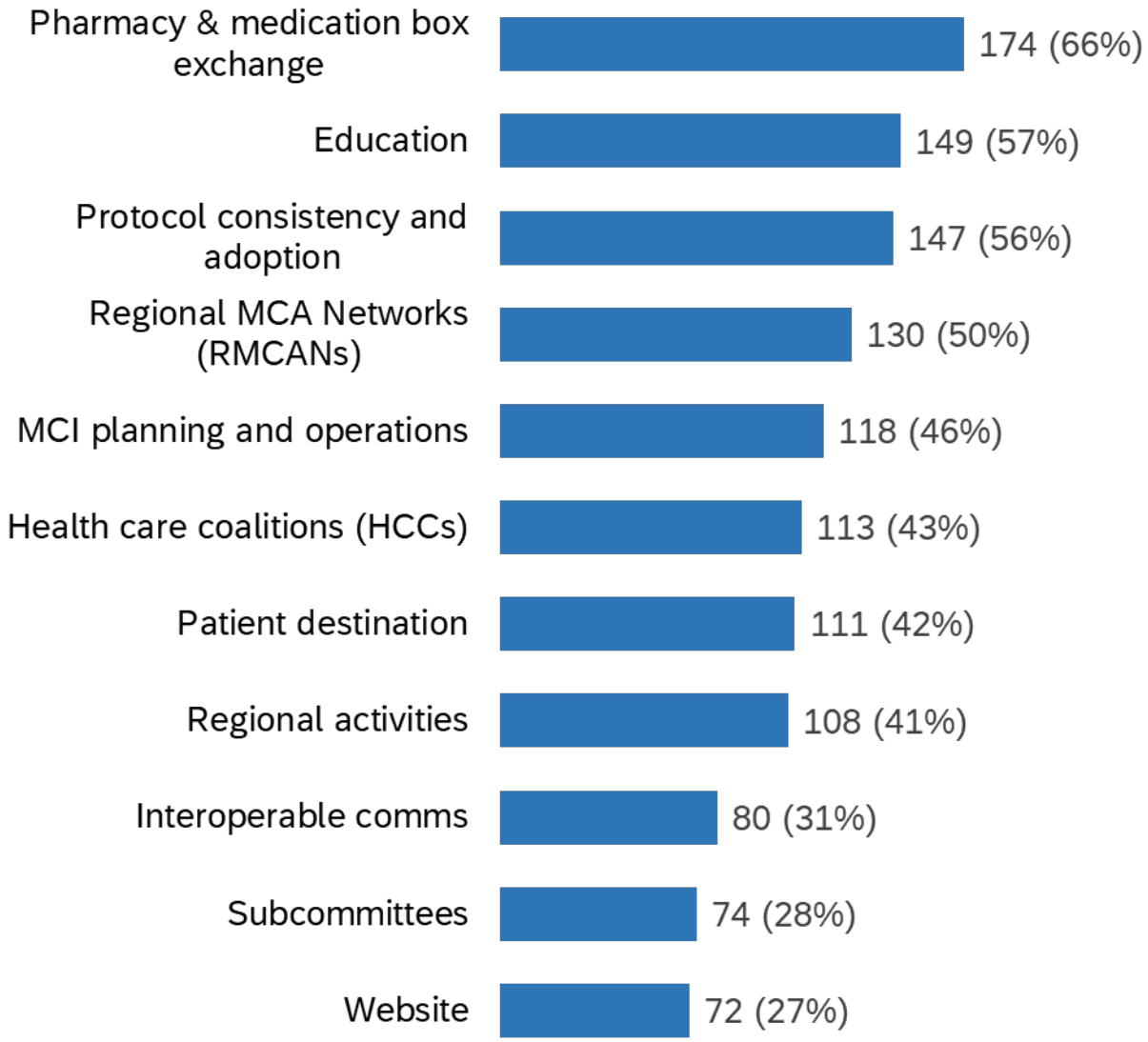

Figure 19. Participation in Regional Activities.

Survey respondents were asked if they knew who their MCA representative on the HCC. Almost half (46%) of the respondents said they knew who represented them on the HCC.

Quality Improvement

Respondents were asked to indicate their level of agreement or disagreement with a statement expressing the view that their MCA has a defined quality improvement (QI) process. Results showed that 75% of respondents agreed or strongly agreed that their MCA has a

defined quality improvement process. Respondents were also asked how often they receive regularly scheduled reports about MCA quality indicators. By contrast to the 75% of respondents who reported that their MCA has a defined QI process, only 51% reported they receive reports of quality indicators.

Respondents were asked about the involvement of their MCA's PSRO in regular review of QI data from LSAs. A majority (71%) of respondents said that their MCA's PSRO reviews QI data on a regular basis. When asked about the frequency of such reviews, a little over half (52%) of those who said their PSRO regularly reviews such data reported that their PSRO reviews QI data monthly, while 18% said such reviews occur quarterly. Smaller proportions of respondents reported semi-annual (4%), annual (4%), or other frequencies (6%) of QI data review (Figure 20).

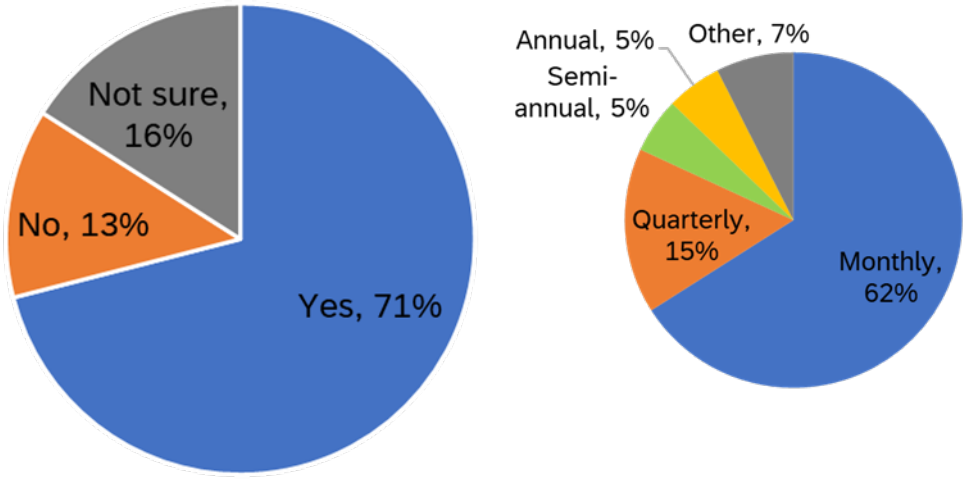

Figure 20. Whether PSRO Regularly Reviews QI Data (left) and Review Frequency (right).

Respondents were further asked about their level of agreement with a statement expressing the view that the Medical Director at their MCA uses QI data to improve upon aspects of patient care. Results showed that 75% of the respondents agreed or strongly agreed that the Medical Director at their MCA uses QI data to improve patient care.

Respondents were asked about the monitoring of QI benchmarks within their MCA. Overall, 51% of respondents said their MCA regularly monitors QI benchmarks. When asked about the frequency of such monitoring, 40% said they are monitored monthly, and 26% said they are monitored quarterly. Smaller proportions of respondents reported semi-annual, annual, or other frequencies of QI benchmark monitoring.

MCAs often use QI data tools, such as Biospatial and Image Trend, to keep track of data and benchmark monitoring. When respondents were asked about which tools or methods of QI data management their MCA uses, 39% said their MCA uses Image Trend, 25% use Biospatial, 11% use an Electronic Patient Care Record (ePCR) such as Eso or e-Bridge, 3% receive direct

reporting from LSAs and conduct a direct, manual review of data, and 1% does not use any QI data tool (Figure 21). Another 5% use some other tool or method of QI data management not listed above. Notably, almost half (45%) of the respondents said they were not sure which tools their MCA uses.

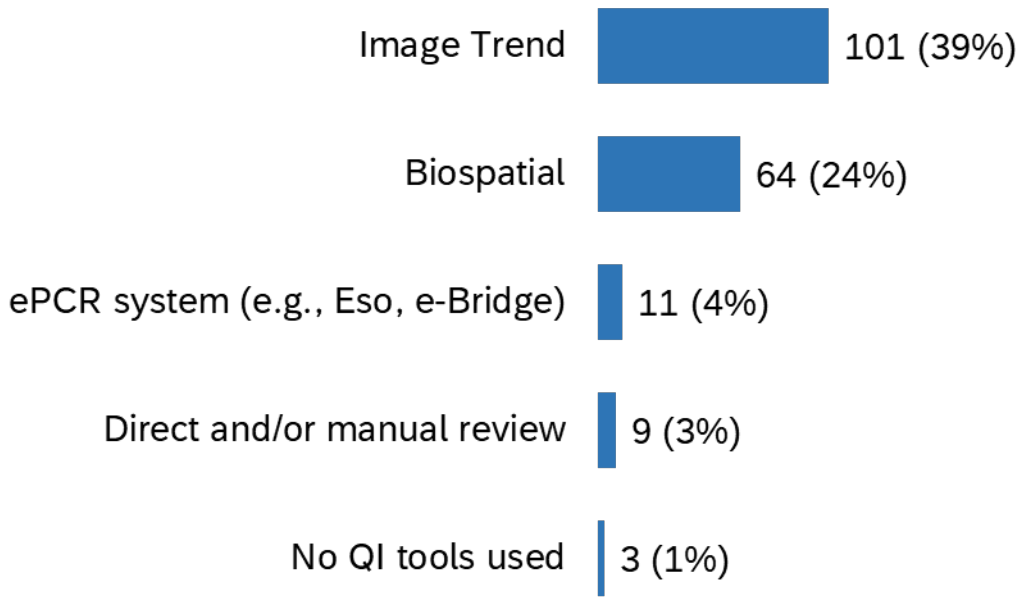

Figure 21. Quality Improvement Data Management Tools and Methods.

Knowledge Test

To gauge respondents' understanding of an MCA's structure and functions, an 11-question knowledge test with true or false answers was proposed by the BEPESOC team. Overall results, as well as results stratified by respondent primary role, are reported below (Table 5). Composite scores out of 100 were calculated for each respondent primary role category as well, with equal weight given to all 11 questions.

Across all questions, 67% of respondents selected the correct response. The highest portion of current answers was with regards to whether an MCA can revoke or suspend an EMS license, which 97% of all respondents answered correctly. By contrast, the lowest rate of correct answers was for whether the authority of an MCA comes from the bylaws created by the MCA, with less than half (47%) of respondents answering this question correctly.

When stratified by respondent primary role, the lowest overall score on the knowledge test was among PSRO members, at 64%. The next lowest score was among Board and Advisory Body members (66%) and key staff (69%). MDs had the highest score on the knowledge test, getting 75% correct on average.

Table 5. Knowledge Test Results.

Questions	Correct Answers (%)

	Overall	*MDs and AMDs*	*Key Staff*	*Board & Advisory Body*	*PSRO Members*
An MCA can revoke or suspend an EMS personnel license.	61%	58%	78%	59%	54%
An MCA can revoke or suspend an EMS personnel's MCA privilege.	97%	92%	100%	97%	97%
A protocol is a recommendation or guideline for clinical care.	62%	71%	44%	67%	63%
A protocol carries the weight of the law.	56%	46%	76%	53%	47%
An MCA is to be administered by participating hospitals.	84%	88%	93%	84%	77%
An MCA is to be administered by participating EMS agencies and personnel.	50%	63%	66%	42%	47%
An MCA Board must be a majority (50% plus one) of hospital representatives.	62%	65%	71%	60%	61%
An MCA Board must be a majority (50% plus one) of EMS agencies and personnel.	68%	75%	73%	68%	58%
The authority of an MCA comes from the bylaws created by the MCA.	47%	67%	61%	42%	35%
The authority of an MCA is a delegation from the Department that can be granted or removed.	83%	83%	88%	78%	87%
An emergency protocol requires approval from MDHHS.	72%	50%	73%	75%	77%
Overall Score	**67%**	**69%**	**75%**	**66%**	**64%**

Role-Specific Results

Medical Directors and Assistant Medical Directors

Medical Directors (MDs) and Assistant Medical Directors (AMDs) were asked if their role in the MCA is contingent on another position they hold, such as one within a hospital. Results showed that more than half (56%) of MDs and AMDs reported that their role in their MCA was not contingent on another position, but a significant portion (40%) reported having a contingent role.

MD and AMD respondents were asked how they work with other bodies within their MCA, specifically the Advisory Body, PSRO, and Board. When asked about how they receive input from the Advisory Body, most respondents (92%) said they receive input by attending Advisory Body meetings, 52% by being notified as needed, and 32% by receiving a regular report. When asked how they receive information from the PSRO, MDs and AMDs said they do so by attending their meetings (88%), being notified as needed (44%), and receiving a regular report (36%).

MDs and AMDs were also asked if and how they report to the Board of Directors. Overall, 74% --+--of respondents said they report to the Board. When asked about specific ways in which they +report to the Board, 70% of respondents reported that they attend Board meetings, 48% notify the Board as needed, and 26% provide a regular report.

+

+

of MDs provided a rating of 7 or higher (i.e., very important) When asked how involved the assistant medical directors is in daily medical activities, 68% reported a rating of 7 or higher (i.e., very involved) (Figure 22).

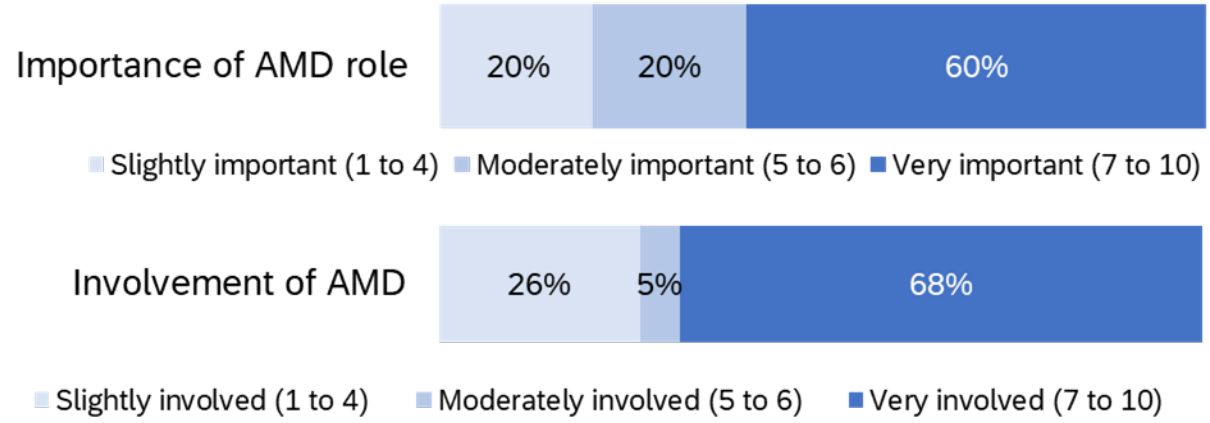

Figure 22. Subjective Rating of the Importance (top) and Involvement (bottom) of Assistant Medical Director.

Key Staff

Key staff respondents were asked about their title within their MCA. Most respondents (75%) said they have a title within their MCA, such as executive director, key staff, general manager, or operations manager. They were also asked about how their employment at their MCA is structured. Results showed that 28% of key staff respondents were employed by an MCA which is an independent organization full-time, and 3% part-time. Another 15% are employed full-time, while 35% were part-time, by a hospital, EMS agency, or education institution.

Key staff respondents were asked the duties their role encompassed. The most frequently reported duties include attending MCA Board meetings (83%), attending Advisory Body meetings (80%), attending PSRO meetings (75%), attending specialty group meetings (e.g. fire chiefs, education, dispatch, emergency management, etc.) (73%), quality improvement and quality assurance (73%), complaint resolution (65%), protocol development (65%), education development (63%), attending interdepartmental meetings (58%), education delivery (58%), protocol submission to MDHHS (58%), attending licensed agency meetings (38%), and attending MDHHS Quality Assurance Task Force meetings (35%) (Figure 23). Additionally, of the respondents, 8% said they had other job duties, which included involvement in regional

activities, business and financial oversight, involvement in pharmacy processes and compliance, website development, continuing education sponsorship, and other duties as assigned.

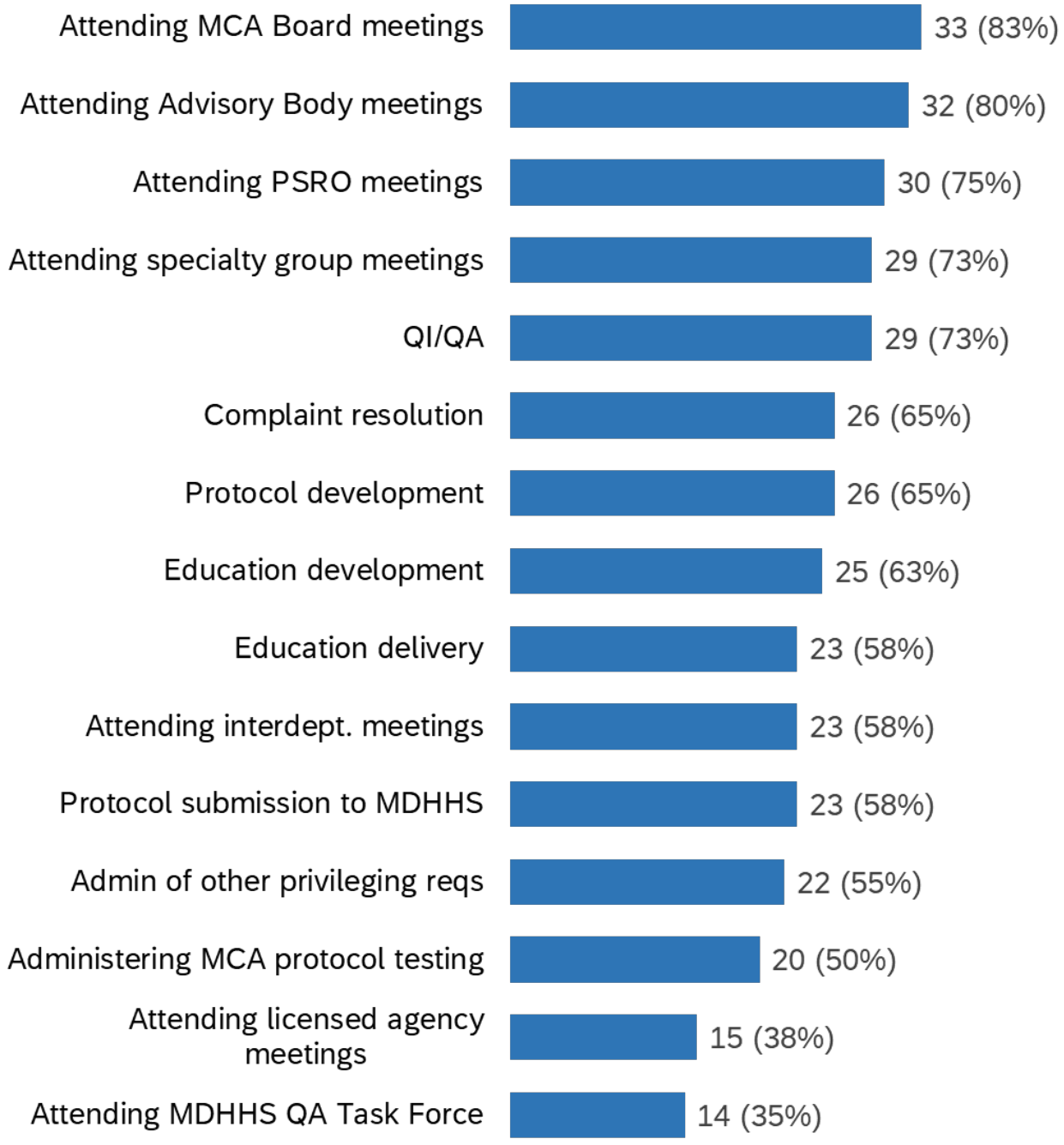

Figure 23. Key Staff Responsibilities.

MCA Board Members

MCA Board members were asked what type of entity they represented within the Board. The most common entity represented by MCA Board members who responded to the survey were

hospitals (51%), followed by LSAs (39%), and FSEDs (3%). Another 3% represented 911 Central Dispatch, 2% represented emergency management, and 2% belonged to some other type of entity (Figure 24).

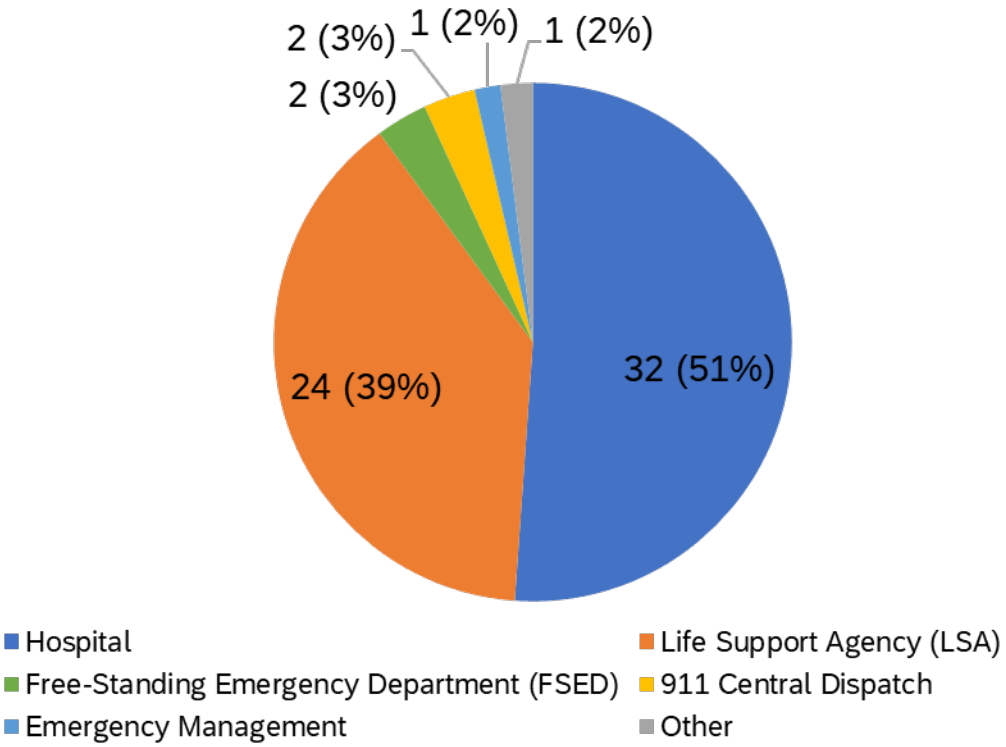

Figure 24. MCA Board Representation by Type of Entity.

Respondents were asked how frequently the MCA Board meets. The greatest portion of MCA Board members (48%) reported that they meet every two months, while 24% meet quarterly, and 18% meet monthly. Another 10% of respondents reported meeting annually.

MCA Board members were asked to rate the effectiveness of the MCA Board in conducting its duties on a Likert-type scale ranging from 1 (not effective at all) to 10 (extremely effective). On average, they provided an effectiveness rating of 7.8. Overall, 83% of respondents rated the effectiveness of their MCA Board at 7 or higher (very effective) (Figure 25, top).

MCA Board respondents were further asked their level of agreement, on a Likert-type scale, that Board decisions are being made for the benefit of the entire system as opposed to the benefit of any individual member. A great majority, 86%, of MCA Board member respondents agreed or strongly agreed (Figure 25, bottom).

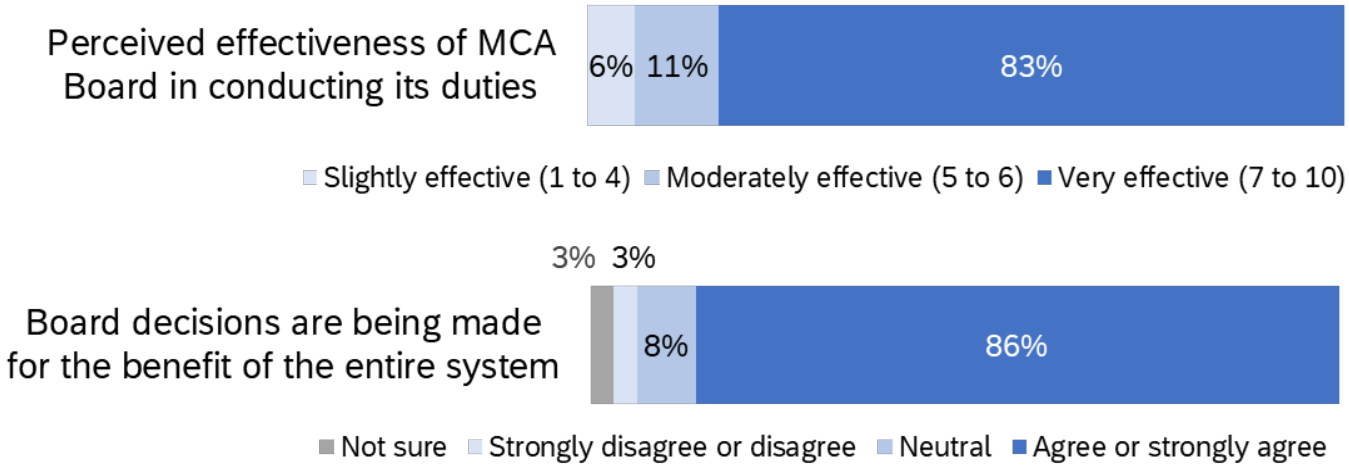

Figure 24. Perceived Effectiveness of Board (top) and the Degree to Which Board Decisions Benefit the Entire System (bottom).

Finally, MCA Board members were asked to respond to an open-ended question about ways by which their work could become more effective. Content analysis results showed that the most frequently reported themes in responses included the following, in order of frequency, with the most frequent suggestions listed first:

- More hospital and medical director leadership.
- Increased training and education opportunities, including a better understanding among Board members about EMS performance metrics.
- Greater participation and time commitment to Board duties.

Advisory Body Participants

Advisory Body respondents were asked about their meeting frequency. The greatest number of respondents (47%) reported that they met monthly, while another 39% met every two months, and 14% met quarterly. When asked about their meeting attendance, more than half (63%) of the respondents reported that they attended more than three-quarters of scheduled meetings, and a vast majority, 86%, attended at least half the time.

Advisory Body participants were asked to rate their level of agreement that the Advisory Body provides meaningful input into the appointment of the current medical director on a Likert-type scale. Overall, 54% agreed or strongly agreed with this statement (Figure 26, top).

Advisory Body participants were also asked about their subjective perspective of the effectiveness of their work, using a Likert-type scale ranging from 1 (not effective at all) to 10 (extremely effective). When asked to rate the effectiveness of the Advisory Body in conducting its duties on a scale of 1 (not effective at all) to 10 (extremely effective), 71% provided a rating of 7 or higher (very effective) (Figure 26, bottom).

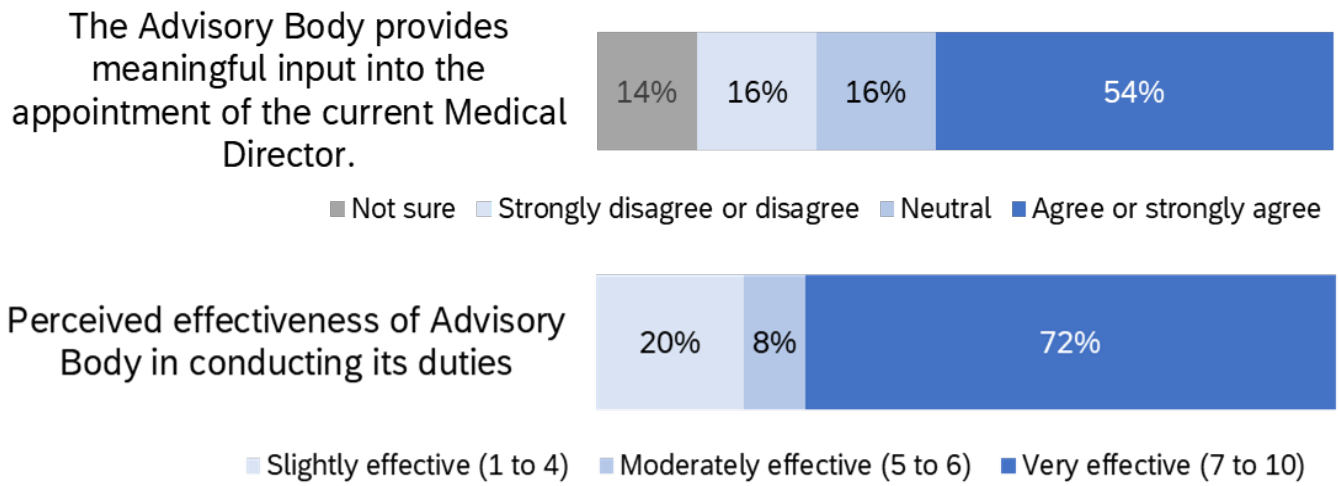

Figure 26. Level of Agreement that Advisory Body Provides Meaningful Input into Medical Director Appointment (top) and Perceived Effectiveness of Advisory Body (bottom).

Finally, Advisory Body participants were asked to respond to an open-ended question about ways in which their work could become more effective. Content analysis results showed that the most frequently reported themes in responses included the following, in order of frequency, with the most frequent suggestions listed first:

- Increased participation and interaction in meetings.
- Better communication between the MCA, hospitals, and agencies.
- More training and education opportunities.
- Beter analysis of benchmarks and data.
- Increased ability to provide input and set MCA goals and objectives.

PSRO Members

Respondents who were PSRO members were asked what type of entity they represented. Almost half the respondents (49%) are EMS providers, 28% are hospital personnel, and 18% represent agency leadership. Another 5% represented other types of entities (Figure 27, left).

PSRO members were asked about the type of position they represented on the PSRO. The types of positions represented on the PSRO include agency personnel who hold a supervisory or administrative position (12%), physicians other than the MD (10%), hospital staff (10%), agency personnel who do not hold a supervisory or administrative position (7%), and specialists (4%) (Figure 27, right).

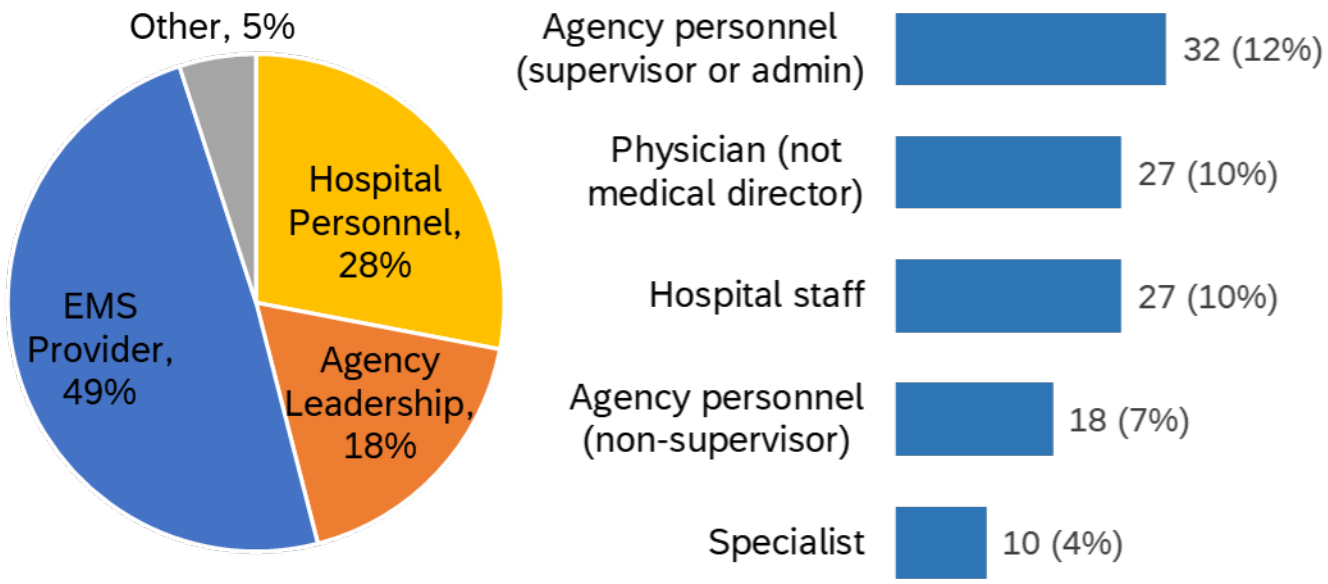

Figure 27. Entities Represented by PSRO Respondents (left) and Positions Represented on PSRO (right).

PSRO member respondents were asked if there are regularly scheduled PSRO meetings, as well as the frequency of such meetings. An overwhelming majority (97%) of PSRO members said that their PSRO has regularly scheduled meetings. Of those who reported having regularly scheduled meetings, 92% also said that an agenda is sent out for the meeting. Among those who have regularly scheduled meetings, 84% have monthly meetings, while 14% have meetings every two months.

As PSROs often review sensitive data, respondents were asked if they have signed a non-disclosure agreement. More than half (56%) of respondents said they have signed a non-disclosure agreement.

Finally, PSRO respondents were asked about their awareness of and utilization of the Just Culture program, which focuses on MCA shared accountability and patient safety. About 41% of PSRO respondents reported that they are aware of the Just Culture program. Only 28% of PSRO respondents reported that their PSRO actively utilizes the Just Culture program.

Predictors of MCA Performance

Phase 2 results were also analyzed regarding group differences in selected variables identified as potential predictors of MCA performance. The organizational structure and staffing model of MCAs, as well as medical director experience and frequency of quality improvement evaluation were examined as predictors of various facets of MCA performance, such as reported MCA effectiveness, understanding of MCA processes and requirements, familiarity with the MCA handbook, comprehensiveness of reading MCA bylaws, and existence of well-established protocol circulation and quality improvement processes.

Organizational Structure

Results showed that MCAs with an independent corporation structure had a greater portion of respondents (86%) reporting that their MCA was very effective (rating of 7 or higher), compared to 79% for MCAs within a hospital, 64% for MCAs within a county agency, and 60% for MCAs within an educational organization (Figure 28).

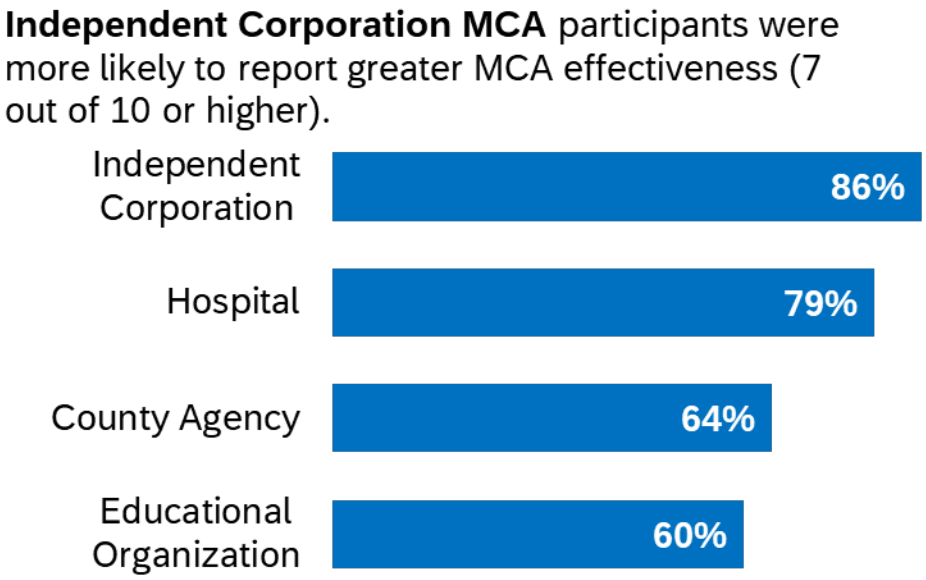

Figure 28. MCA Effectiveness by Organizational Structure.

Respondents from MCAs that are independent corporations also reported higher levels of agreement with the idea that their MCA allows circulation of proposed protocols that give all parties ample time to comment prior to adoption (87%), that their MCA has a defined quality improvement process (81%), and that they receive regularly scheduled reports of MCA quality indicators (60%).

MCAs that are independent corporations had respondents with a comprehensive understanding (7 or higher) of the statutory responsibilities of an MCA's functions (90%), statutory requirements for an MCA's structure (86%), protocol submission processes (79%), and agency licensure processes and requirements (85%). Respondents from MCAs within a hospital reported the highest levels of understanding of personnel credentialing processes and requirements (93%), Once again, respondents from MCAs within an educational organization or a county agency had the lowest levels of self-reported understanding of various MCA processes and requirements, in all areas they were asked about.

MCAs within a hospital had the greatest proportion of respondents reporting being very familiar (rating of 7 or higher) with the MCA Handbook, 52%. This was followed by those from MCAs that are independent corporations (33%), those within a county agency (23%), and those within an educational organization (20%) (Figure 29).

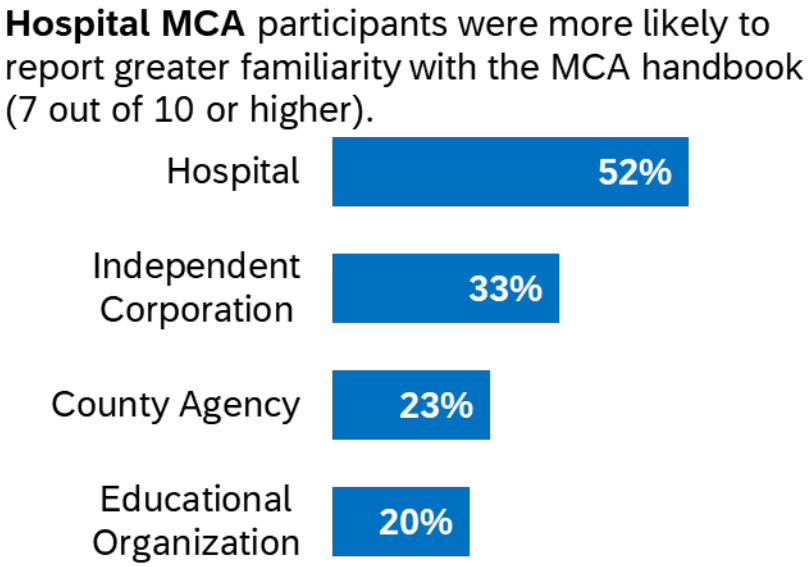

Figure 29. Familiarity with the MCA Handbook by Organizational Structure.

Interestingly, respondents from MCAs within an educational organization or a county agency reported the highest ratings of how comprehensively they had read their MCA's bylaws, with 59% reporting having read their bylaws carefully (rating of 7 or higher). The lowest proportions of respondents reporting they had read their bylaws carefully were from MCAs within a hospital (43%) and from MCAs that are independent corporations (42%) (Figure 30).

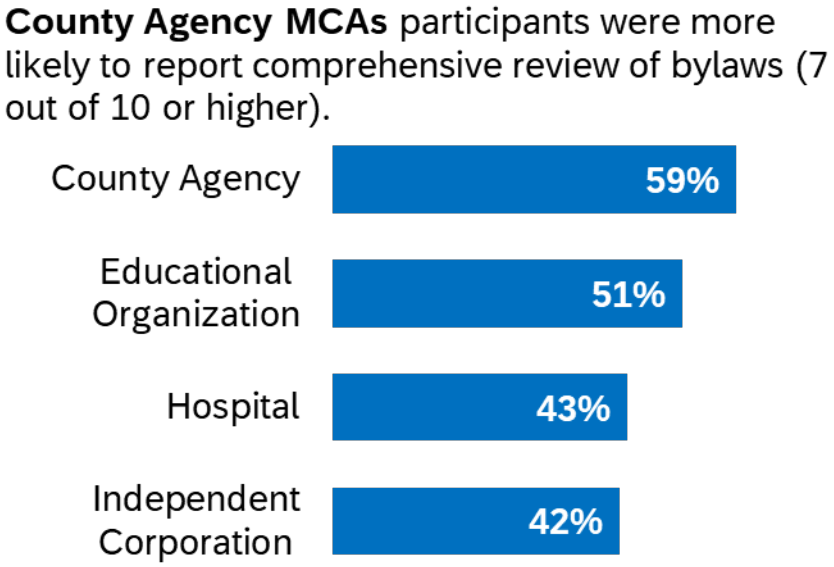

Figure 30. Comprehensive Review of Bylaws by Organizational Structure.

Staffing Model

Compared to MCAs that share staff with another entity, MCAs that have staff fully dedicated to the MCA have respondents with a slightly greater understanding of various MCA processes and requirements, in all areas they were asked about. This was also true for ratings of MCA effectiveness; 84% of respondents from MCAs where staff are employed entirely by the MCA rated their MCA as being very effective, compared to 77% from MCAs with shared staff (Figure 31, top).

Respondents from MCAs with fully dedicated staff also reported higher levels of agreement that their MCA provides ample opportunity to comment on proposed protocols (88%) compared to those from MCAs with shared staff (79%) (Figure 31, bottom).

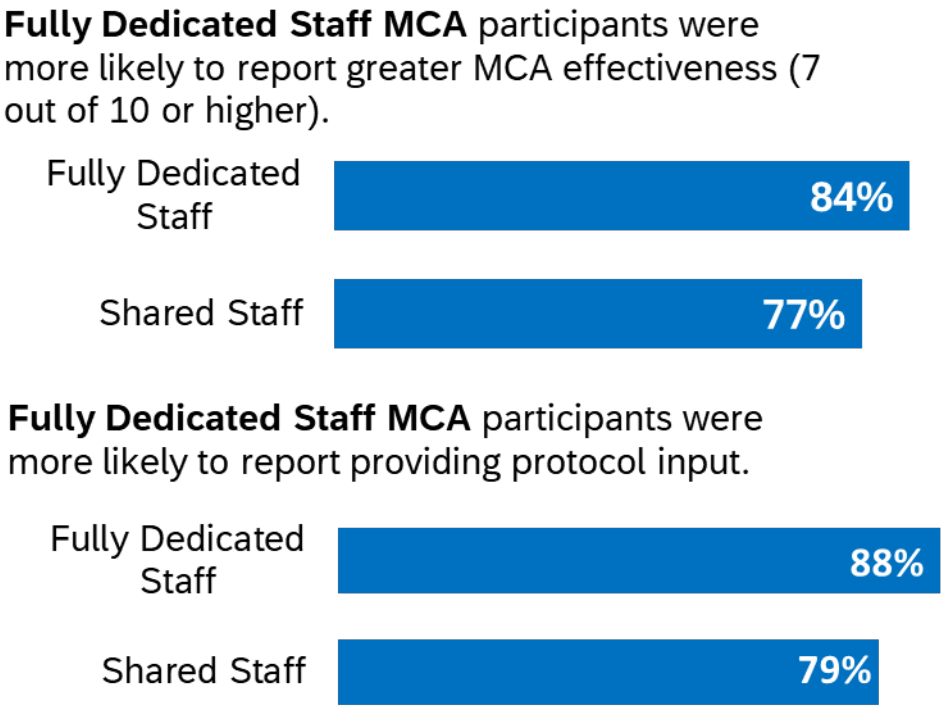

Figure 31. MCA Effectiveness (top) and Protocol Input (bottom) by Staffing Model.

Finally, respondents from MCAs with fully dedicated staff reported higher levels of agreement that MCA has a defined quality improvement process (82%) and that they receive regularly scheduled reports of quality indicators (54%) compared to those from MCAs with shared staff (67% and 45%, respectively) (Figure 32).

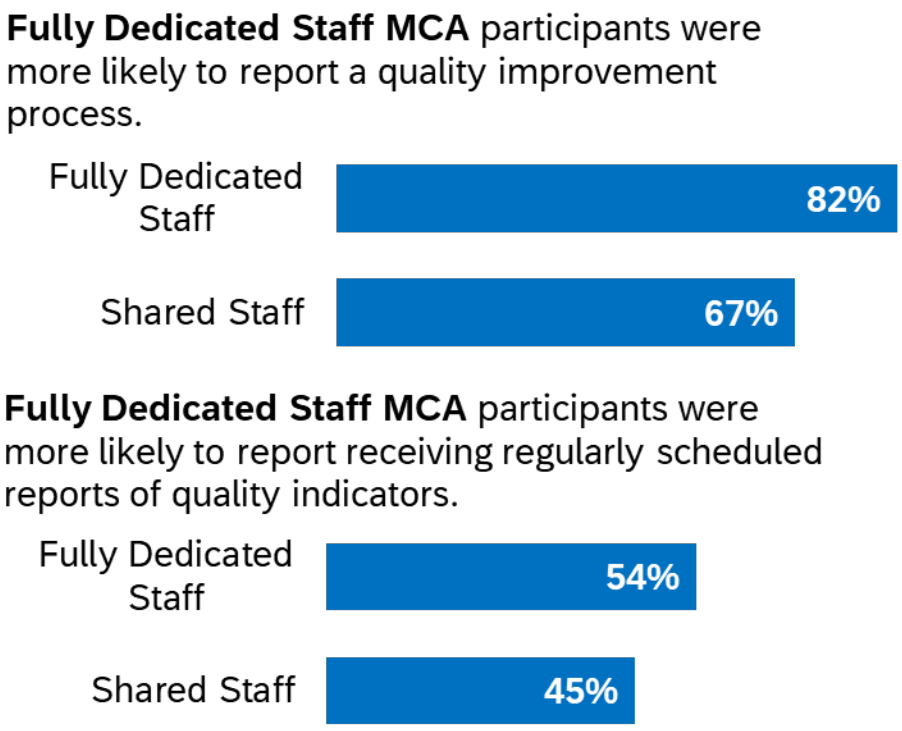

Figure 32. MCA Quality Improvement Process (top) and Regularly Scheduled Reports of Quality Indicators (bottom) by Staffing Model.

Interestingly, a significantly greater proportion of respondents from MCAs that share staff with another entity reported reading their MCA's bylaws carefully (62%) compared to those employed entirely by the MCA (36%).

Medical Director Experience

MCAs with medical directors appointed over five years ago yielded more respondents familiar with the MCA handbook. Respondents from these MCAs also had a greater understanding of various MCA processes and requirements, in all areas they were asked about. This was also true when respondents were asked their level of agreement that there is ample opportunity to comment on proposed protocols; 93% of respondents from MCAs with more experienced medical directors agreed or strongly agreed compared to 81% of respondents from MCAs with medical directors appointed less than 5 years ago (Figure 32, top).

Respondents from MCAs with medical directors appointed more than 5 years ago reported a higher level of agreement that their MCA has a defined quality improvement process (81%) compared to those from an MCA with a medical director appointed less than 5 years ago (74%) (Figure 32, bottom). There was no substantial difference when respondents were asked their level of agreement that they receive regularly scheduled reports of quality indicators.

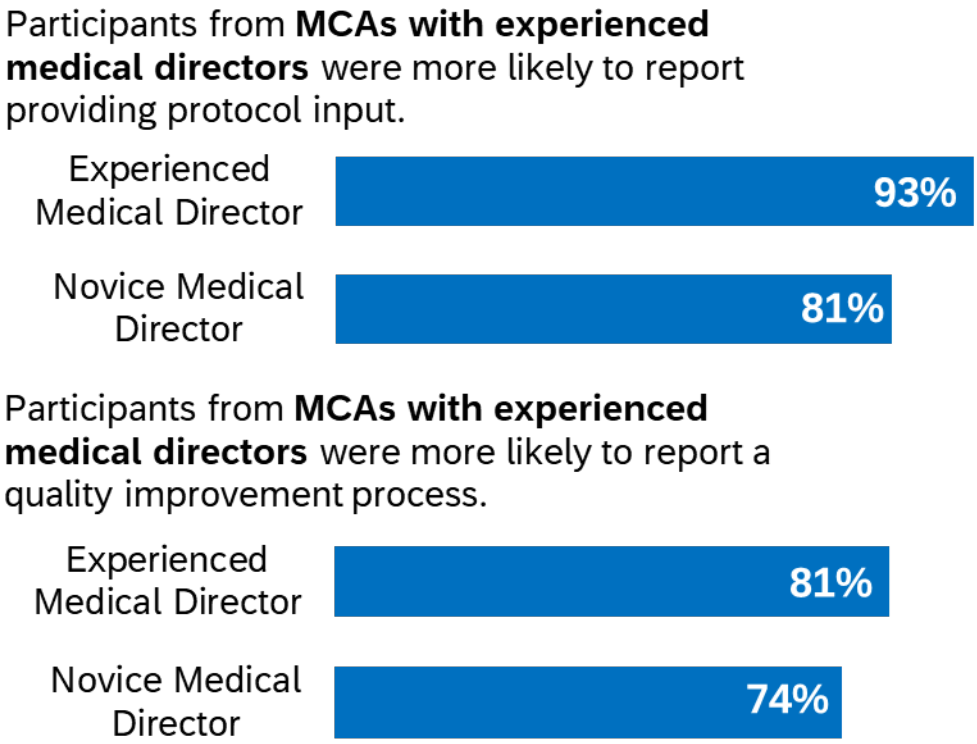

Figure 32. MCA Protocol Input (top) and Quality Improvement Process (bottom) by Medical Director Experience Level.

However, MCAs with recently appointed medical directors had more respondents (90%) reporting that their MCA was very effective, compared to 77% among those from MCAs with medical directors appointed over five years ago. In addition, a greater portion of respondents from MCAs with medical directors appointed within the last five years reported that they had carefully read the handbook (47%) compared to those from MCAs with medical directors appointed more than five years ago (39%) (Figure 33).

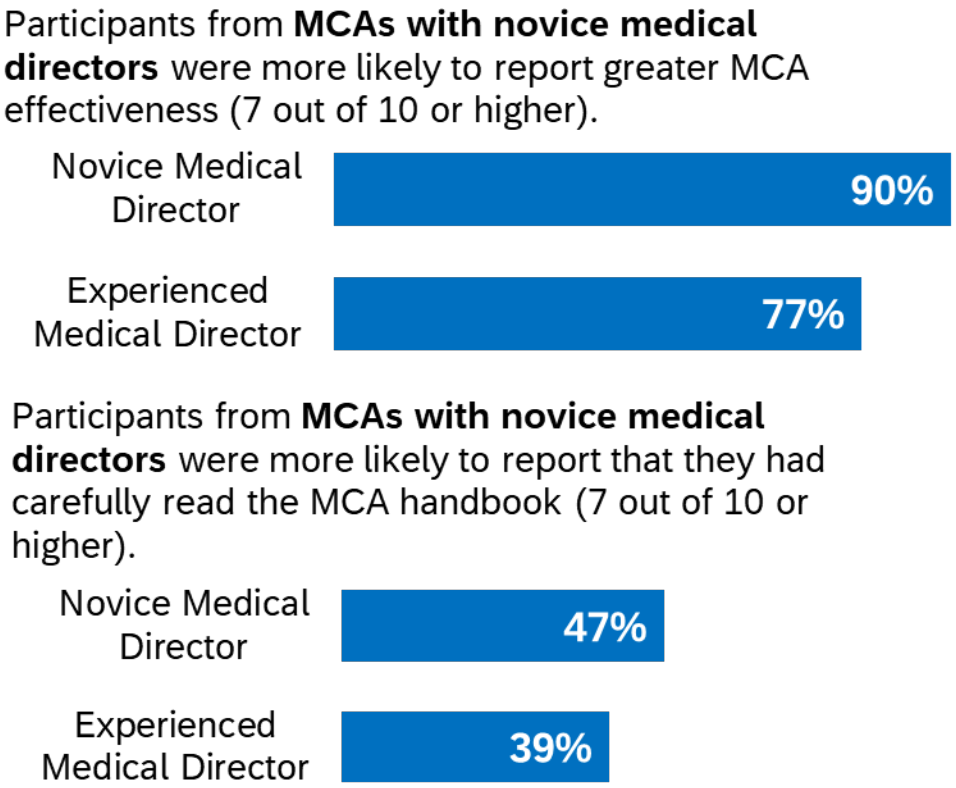

Figure 33. MCA Effectiveness (top) and Handbook Review (bottom) by Medical Director Experience Level.

While there was no major difference in most performance indicators among respondents from MCAs that conduct monthly and quarterly QI evaluations, those that conducted QI evaluations on an as-needed basis had consistently lower performance results. This was true for familiarity with the MCA handbook, understanding of MCA processes and requirements, rating of overall MCA effectiveness, and perceived opportunity to comment on proposed protocols.

Key Recommendations and Action Steps

Updated manuals and handbooks and accessibility of materials.

- Creation and distribution of a "quick manual" for those who may not read the MCA Handbook in full – especially for Board, Advisory Body, and PSRO members.
- Development of new MCA Handbook which is regularly updated based on need.
- Easily accessible MCA manuals and handbooks that are published electronically and provided in hard copy if needed.

Improved data collection for regular oversight of MCAs.

- Regular collection of relevant data points regarding the structure and functions of all MCAs.

- Creation and regular maintenance of databases encompassing relevant data points.

Increased enforcement of MCA policies and procedures.

- Level-setting with all stakeholders to stress importance and legal weight of MCA protocols.
- Administration of regular knowledge tests on understanding of MCA policies and procedures.
- Other enforcement mechanisms, as needed.

Increased stakeholder engagement.

- Review of knowledge test results with stakeholders based on composite scores, especially MCA Board, Advisory Body, and PSRO.
- More engagement with stakeholders, including increased feedback and input from Advisory Body and MCA Board.

Continued, consistent training and education.

- Provision of regular education and training opportunities regarding MCA policies and procedures, not just upon onboarding.
- Continued knowledge dissemination at conferences, workshops, etc.

Bureau of EMS, Trauma & Preparedness Division of EMS & Trauma Policies & Procedures		EMS-3XX~~13~~
Subject: Continuing Education for Course Coordination~~Clinical Field Practice~~		
Supersedes #: ~~EMS-313~~	**Previous Date:** ~~6/09/2022~~	**Pages:** ~~3~~1
Approved by:		**Date:** ~~3/20/2023~~

PURPOSE:

~~Licensed EMS personnel who are actively working for a licensed EMS agency have increased opportunity to provide assessments and interventions for patients in the EMS system. In order to provide consistent credit for clinical practice, the Division of EMS and Trauma will conduct routine analysis of data and award continuing education credit as outlined in this policy.~~ Licensed EMS IC personnel who successfully coordinate EMS education courses have increased opportunities to practice and demonstrate education administration skillsets. To recognize the value of these activities from a professional development perspective, the Department will award three (3) continuing education credits as outlined in this policy.

POLICY:

Upon successful approval of either the initial or renewal application for initial or continuing education programs, licensed EMS IC personnel will be awarded three credits in the Education Administration category. The Education Coordinator will generate a course and upload licensee credit information upon final approval by the department. No additional steps are required by the submitting course coordinator (program director). The licensee will be issued a certificate of attendance for 3 credits in education administration. A certificate will be emailed to the licensee's email address that is in the license management system.

~~Each month, at the beginning of the month, the license numbers of expiring licensees at the end of the third month will be generated in a spreadsheet. Additionally, a report will be generated from the Michigan EMS Information System (MIEMSIS) outlining all licensees performing the credit earning procedure on or after the start date of the current licensing period (approximately 33 months of data). Procedures performed will~~

be pulled from the flow chart or procedure section of the patient care report, using appropriate coding from the NEMSIS dataset. Procedures documented in the narrative section of the patient care report will not be counted. These spreadsheets are compared and generate a list of expiring licensees that will receive credit according to the following table.

Division staff will create courses and upload licensee credit information before the licensee receives their 60-day renewal notification. A chit sheet certificate will be emailed to the licensee's email address that is in the license management system.

Example:

Licensees expiring September 30th, 2022 will be generated in a report in the beginning of July. Data for these licensees will be pulled from MIEMSIS for the period of October 1st, 2019 through June 1st of 2022, making 33 months of data examined. The awarded credits will be uploaded to licensure by August 1st, 2022, prior to the licensee's renewal notice being emailed on August 2nd, 2022, 60 days from their renewal date.

The number of credits awarded by this mechanism is capped at 2 per category per licensure period.

Credit Category	Procedures Reported	Conversion
Airway (BLS)	Airway opened BVM CPAP Endotracheal Intubation LMA Mouth to mask/mouth Nasal airway Oral airway Suctioning Supraglottic insertion (dual and single)	One Credit for every Ten procedures performed successfully
Preparatory (paramedic and advanced EMT)	IV Insertion	One Credit for every Ten procedures performed successfully
Trauma	Chest/Thoracic: Needle Decompression Musculoskeletal: C-Spine Stabilization, Manual Musculoskeletal: Cervical Collar Applied Musculoskeletal: Immobilization Using Extrication Splint	One Credit for every Ten procedures performed successfully

	~~Musculoskeletal: Immobilization using Long Board~~ ~~Musculoskeletal: Immobilization using Short Extrication Splint~~ ~~Musculoskeletal: Reduction of Dislocated Joint~~ ~~Musculoskeletal: Spinal Immobilization, Cervical~~ ~~Musculoskeletal: Spinal Immobilization, Full~~ ~~Musculoskeletal: Splinting, General~~ ~~Musculoskeletal: Splinting, Pelvic Binder/Sling~~ ~~Musculoskeletal: Splinting, Traction~~ ~~Wound Care: Bandage~~ ~~Wound Care: Burn Care~~ ~~Wound Care: Escharotomy~~ ~~Wound Care: General Wound Care~~ ~~Wound Care: Hemostatic Agent~~ ~~Wound Care: Occlusive Dressing~~ ~~Wound Care: Pressure Dressing~~ ~~Wound Care: Skin Wound Closure~~ ~~Wound Care: Suture Removal~~ ~~Wound Care: Tourniquet~~ ~~Wound Care: Wound~~	
~~Medical~~	~~Cardiac: 12 Lead ECG Obtained~~ ~~Cardiac: 15 Lead ECG Obtained~~ ~~Cardiac: 18 Lead ECG Obtained~~ ~~Cardiac: 3/4 Lead ECG Monitoring~~	~~One Credit for every Ten procedures performed successfully~~

	~~Cardiac: CPR Discontinued due to ROSC~~ ~~Cardiac: Cardioversion~~ ~~Cardiac: Chest Compressions (Manual)~~ ~~Cardiac: Chest Compressions (Mechanical Device)~~ ~~Cardiac: Defibrillation, AED~~ ~~Cardiac: Defibrillation, Manual~~ ~~Cardiac: Electrocardiographic Monitoring~~ ~~Cardiac: Pacing, Cardiac (External or Internal)~~ ~~Cardiac: Vagal Maneuver~~	
~~Patient Assessment~~	~~Assessment: History and Physical Examination, Limited~~ ~~Assessment: Observation~~ ~~Assessment: Orthostatic Vital Signs~~ ~~Assessment: Physical Assessment~~ ~~Assessment: Vital Signs~~	~~One Credit for every Ten procedures performed successfully~~

HOUSE BILL NO. 5695

April 30, 2024, Introduced by Reps. McFall, Tsernoglou, Harris, Mentzer, MacDonell, Andrews, Jaime Greene, Price, Arbit, Steckloff, Liberati, Wilson, Snyder, Haadsma, Paiz, Shannon, Grant, Coffia, Breen, Hope, Brixie, Tyrone Carter, Dievendorf, McKinney, Glanville, Conlin, Martus, Weiss, Young, Byrnes, Brenda Carter and Hoskins and referred to the Committee on Insurance and Financial Services.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 109p.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 109p. (1) No later than 180 days after the effective date of the amendatory act that added this section, the department shall apply to the United States Department of Health and Human Services for an amendment to this state's Medicaid state plan to establish and administer a program to provide supplemental reimbursement to

eligible ground emergency medical transportation providers that provide ground emergency medical transportation services to medical assistance recipients.

(2) The department shall promptly seek any necessary federal approvals for the implementation of subsection (1). The department may limit the program described under subsection (1) to those costs that are allowable expenditures under title XIX of the social security act, 42 USC 1396 to 1396w-7. The department shall do both of the following:

(a) Submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.

(b) Submit necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law. The department may utilize intergovernmental transfers or certified public expenditures to implement this subdivision.

(3) A ground emergency medical transportation provider is eligible for supplemental reimbursement if the ground emergency medical transportation provider meets all of the following conditions during the period reimbursement is being claimed:

(a) Provides ground emergency medical transportation services to medical assistance recipients.

(b) Is enrolled as a Medicaid provider for the period reimbursement is being claimed.

(c) Is owned or operated by an eligible governmental entity.

(4) A supplemental reimbursement claimed under this section must be calculated and paid as follows:

(a) Except as otherwise provided in subdivision (b), the

supplemental reimbursement to an eligible provider is equal to the amount of federal financial participation received for the eligible provider's cost for the emergency medical transportation services under subdivision (c).

(b) The amount certified, when combined with the amount received from all other sources of reimbursement from the medical assistance program, must not exceed or be less than 100% of actual cost incurred, as determined under this state's Medicaid state plan for ground emergency medical transportation services.

(c) The supplemental reimbursement must be distributed exclusively to eligible providers under a payment methodology that is based on ground emergency medical transportation services provided to medical assistance recipients by eligible providers.

(5) An eligible provider shall make readily available to the department documentation, data, and certification, as prescribed by the department, that are necessary to establish that the emergency medical services expenditures qualify for federal financial participation in order to calculate the amount of supplemental reimbursement that is due.

(6) The department shall pay supplemental reimbursements to eligible providers for services provided on a fee-for-services basis and managed care program recipients in this state's Medicaid state plan.

(7) The department shall establish the uniform percentage of the eligible provider's net patient revenues so that the total amount of fees collected from an eligible provider in a fiscal year is an amount that is not less than 1/4 of 1% lower than the maximum limit for a provider's fee under 42 CFR 433.68(f) but does not exceed the maximum limit.

(8) Participation in the program described under subsection (1) is voluntary.

(9) As used in this section:

(a) "Eligible governmental entity" includes this state, a city, a county, a fire authority, a federally recognized Indian tribe, or a local unit of government.

(b) "Eligible ground emergency medical transportation provider" or "eligible provider" means a public provider that provides ground emergency medical transportation services to medical assistance recipients and meets the conditions described under subsection (3).

SENATE BILL NO. 849

May 01, 2024, Introduced by Senator WEBBER and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

(MCL 333.1101 to 333.25211) by adding section 16186b.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 16186b. (1) Beginning June 1, 2025, and not later than June 1 of each subsequent year, the department shall post on the department's website an annual report that includes all of the following information:

(a) A list of each state or country from which an individual

was granted a license or registration under this article for the year covered by the report on the basis of holding an equivalent license or registration from another state or country, and for which health profession the license or registration was granted.

(b) All licensing compacts and multijurisdictional agreements involving health professions under this article of which this state is a part.

(c) For every health profession under this article, a list that includes each state and health profession for which an individual may be granted a license or registration in this state if the individual holds a valid license or registration for that health profession in that state and the department determines the requirements for granting a license or registration in that state generally meet the requirements under this article. The list described in this subsection must be provided by the department regardless of whether the department granted a license or received an application.

(2) Beginning June 1, 2025, and not later than June 1 of each subsequent year, the department shall review any application received under this article from an individual who holds a valid license or registration from an equivalent licensing board or authority, as determined by the department, in at least 1 other state and submit an annual report to the senate and house of representatives standing committees with jurisdiction over occupational licensing. The report must include all of the following:

(a) If there is an impediment to the granting of a license or registration to an applicant described in this subsection, a description of the impediment.

(b) If the impediment described under subdivision (a) is due to statute, the statutory change needed to allow the department to grant a license or registration to an applicant described in this subsection.

(c) If the impediment described under subdivision (a) is not due to statute, any modifications the department will make to allow the department to grant a license or registration to an applicant described in this subsection.

(d) A recommendation on any licensing compacts or multijurisdictional agreements involving health professions under this article into which this state could enter.

HOUSE BILL NO. 5636

April 17, 2024, Introduced by Rep. Pohutsky and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

by amending sections 2811, 2823, 17101, 20104, 20106, and 20161 (MCL 333.2811, 333.2823, 333.17101, 333.20104, 333.20106, and 333.20161), section 2811 as amended by 1998 PA 332, section 17101 as added by 2016 PA 417, section 20104 as amended by 2022 PA 187, section 20106 as amended by 2017 PA 167, and section 20161 as amended by 2023 PA 138, and by adding sections 2823a and 22224c and part 207.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2811. The department shall prescribe the form and content of vital records and certificates, which, ~~shall~~ **except as otherwise provided in this part, must** conform as nearly as possible to recognized national standardized forms including, as required to comply with federal law, requirements for the entry of ~~social security~~ **Social Security** numbers.

Sec. 2823. (1) When a live birth occurs in a moving conveyance in the United States and the child is first removed from the conveyance in this state, the birth ~~shall~~ **must** be registered in this state. ~~The~~ **Except as otherwise provided in section 2823a, the** place where the child is first removed from the conveyance ~~shall~~ **must** be shown as the place of birth.

(2) When a live birth occurs in a moving conveyance while in international waters or air space or a foreign country and the child is first removed from the conveyance in this state, the birth ~~shall~~ **must** be registered in this state but the certificate ~~shall~~ **must** show the actual place of birth ~~insofar as~~ **if** the place can be determined.

Sec. 2823a. (1) Except as otherwise provided in subsection (2), when a live birth occurs in this state, the place of birth must be listed on the certificate as follows:

(a) If the live birth occurs in an institution or en route to an institution, the place of birth must be listed as the institution.

(b) If the live birth occurs in or en route to a freestanding birth center licensed under article 17, the place of birth must be listed as the freestanding birth center.

(c) If the live birth occurs in a home, the place of birth

must be listed as "home".

(2) The place of birth of a child of unknown parentage who is found is as provided in section 2825.

Sec. 17101. (1) As used in this part:

(a) "Appropriate health professional", for the purposes of referral, consultation, or collaboration with a midwife under this part, means any of the following:

(*i*) A physician.

(*ii*) A certified nurse midwife.

(*iii*) As identified in rules promulgated under section 17117, another appropriate health professional licensed, registered, or otherwise authorized to engage in a health profession under this article.

(b) "Certified nurse midwife" means a registered professional nurse **licensed** under part 172 who has been granted a specialty certification in the **health** profession specialty field of nurse midwifery by the **Michigan** board of nursing under section 17210.

(c) "Health care provider" means an individual who is licensed or registered under this article.

(d) "Midwife" means an individual licensed under this part to engage in the practice of midwifery.

(e) "Physician" means an individual licensed to engage in the practice of medicine under part 170 or the practice of osteopathic medicine and surgery under part 175.

(f) "Practice of midwifery", subject to subsection (2), means providing ~~maternity~~ **perinatal** care that is consistent with a midwife's training, education, and experience, to ~~women~~ **individuals** and neonates during the antepartum, intrapartum, and postpartum periods.

(2) For purposes of this part, practice of midwifery does not include either of the following:

(a) The practice of medicine or osteopathic medicine and surgery.

(b) The practice of nursing, including the practice of nursing with a specialty certification in the **health** profession specialty field of nurse midwifery under part 172.

(3) In addition to the definitions of this part, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 161 contains definitions applicable to this part.

Sec. 20104. (1) Except as otherwise provided in part 221, "certification" means the issuance of a document by the department to a health facility or agency attesting to the fact that the health facility or agency meets both of the following:

(a) It complies with applicable statutory and regulatory requirements and standards.

(b) It is eligible to participate as a provider of care and services in a specific federal or state health program.

(2) "Consumer" means a person who is not a health care provider as that term is defined in 42 USC 300jj.

(3) "County medical care facility" means a nursing care facility, other than a hospital long-term care unit, that provides organized nursing care and medical treatment to 7 or more unrelated individuals who are suffering or recovering from illness, injury, or infirmity and that is owned by a county or counties.

(4) "Department" means the department of licensing and regulatory affairs.

(5) "Direct access" means access to a patient or resident or

to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.

(6) "Director" means the director of the department.

(7) "Freestanding birth center" means that term as defined in section 20701.

(8) ~~(7)~~ "Freestanding surgical outpatient facility" means a facility, other than the office of a physician, dentist, podiatrist, or other private practice office, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care. Freestanding surgical outpatient facility does not include a surgical outpatient facility owned by and operated as part of a hospital.

(9) ~~(8)~~ "Good moral character" means that term as defined in, and determined under, 1974 PA 381, MCL 338.41 to 338.47.

Sec. 20106. (1) "Health facility or agency", except as provided in section 20115, means:

(a) An ambulance operation, aircraft transport operation, nontransport prehospital life support operation, or medical first response service.

(b) A county medical care facility.

(c) A freestanding surgical outpatient facility.

(d) A health maintenance organization.

(e) A home for the aged.

(f) A hospital.

(g) A nursing home.

(h) A hospice.

(i) A hospice residence.

(j) A facility or agency listed in subdivisions (a) to (g) located in a university, college, or other educational institution.

(k) A freestanding birth center.

(2) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of 1956, 1956 PA 218, MCL 500.3501.

(3) "Home for the aged" means a supervised personal care facility at a single address, other than a hotel, adult foster care facility, hospital, nursing home, or county medical care facility that provides room, board, and supervised personal care to 21 or more unrelated, nontransient, individuals 55 years of age or older. Home for the aged includes a supervised personal care facility for 20 or fewer individuals 55 years of age or older if the facility is operated in conjunction with and as a distinct part of a licensed nursing home. Home for the aged does not include an area excluded from this definition by section 17(3) of the continuing care community disclosure act, 2014 PA 448, MCL 554.917.

(4) "Hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(5) "Hospital" means a facility offering inpatient, overnight care, and services for observation, diagnosis, and active treatment of an individual with a medical, surgical, obstetric, chronic, or rehabilitative condition requiring the daily direction or supervision of a physician. Hospital does not include a mental health hospital licensed or operated by the department of health and human services or a hospital operated by the department of corrections.

(6) "Hospital long-term care unit" means a nursing care facility, owned and operated by and as part of a hospital, providing organized nursing care and medical treatment to 7 or more unrelated individuals suffering or recovering from illness, injury, or infirmity.

Sec. 20161. (1) The department shall assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this article. Until October 1, 2027, except as otherwise provided in this article, fees and assessments must be paid as provided in the following schedule:

(a) Freestanding surgical outpatient facilities.....	$500.00 per facility license.
(b) Hospitals	$500.00 per facility license and $10.00 per licensed bed.
(c) Nursing homes, county medical care facilities, and hospital long-term care units	$500.00 per facility license and $3.00 per licensed bed over 100 licensed beds.
(d) Homes for the aged	$500.00 per facility license and $6.27 per licensed bed.
(e) Hospice agencies	$500.00 per agency license.
(f) Hospice residences	$500.00 per facility license and $5.00 per licensed bed.
(g) Freestanding birth center	**$500.00 per facility license.**

(h) ~~(g)~~ Subject to subsection (11), quality assurance assessment for nursing homes and hospital long-term care units	an amount resulting in not more than 6% of total industry revenues.
(i) ~~(h)~~ Subject to subsection (12), quality assurance assessment for hospitals	at a fixed or variable rate that generates funds not more than the maximum allowable under the federal matching requirements, after consideration for the amounts in subsection (12)(a) and (i).
(j) ~~(i)~~ Initial licensure application fee for subdivisions (a), (b), (c), (d), (e), ~~and~~ (f), **and (g)**	$2,000.00 per initial license.

(2) If a hospital requests the department to conduct a certification survey for purposes of title XVIII or title XIX, the hospital shall pay a license fee surcharge of $23.00 per bed. As used in this subsection:

(a) "Title XVIII" means title XVIII of the social security act, 42 USC 1395 to 1395*lll*.

(b) "Title XIX" means title XIX of the social security act, 42 USC 1396 to ~~1396w-7.~~**1396w-8.**

(3) All of the following apply to the assessment under this section for certificates of need:

(a) The base fee for a certificate of need is $3,000.00 for each application. For a project requiring a projected capital expenditure of more than $500,000.00 but less than $4,000,000.00, an additional fee of $5,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $4,000,000.00 or more but less than $10,000,000.00, an additional fee of $8,000.00 is added to the base fee. For a project requiring a projected capital expenditure of $10,000,000.00 or more, an additional fee of $12,000.00 is added to the base fee.

(b) In addition to the fees under subdivision (a), the applicant shall pay $3,000.00 for any designated complex project including a project scheduled for comparative review or for a consolidated licensed health facility application for acquisition or replacement.

(c) If required by the department, the applicant shall pay $1,000.00 for a certificate of need application that receives expedited processing at the request of the applicant.

(d) The department shall charge a fee of $500.00 to review any letter of intent requesting or resulting in a waiver from certificate of need review and any amendment request to an approved certificate of need.

(e) A health facility or agency that offers certificate of need covered clinical services shall pay $100.00 for each certificate of need approved covered clinical service as part of the certificate of need annual survey at the time of submission of the survey data.

(f) Except as otherwise provided in this section, the department shall use the fees collected under this subsection only to fund the certificate of need program. Funds remaining in the

certificate of need program at the end of the fiscal year do not lapse to the general fund but remain available to fund the certificate of need program in subsequent years.

(4) A license issued under this part is effective for no longer than 1 year after the date of issuance.

(5) Fees described in this section are payable to the department at the time an application for a license, permit, or certificate is submitted. If an application for a license, permit, or certificate is denied or if a license, permit, or certificate is revoked before its expiration date, the department shall not refund fees paid to the department.

(6) The fee for a provisional license or temporary permit is the same as for a license. A license may be issued at the expiration date of a temporary permit without an additional fee for the balance of the period for which the fee was paid if the requirements for licensure are met.

(7) The cost of licensure activities must be supported by license fees.

(8) The application fee for a waiver under section 21564 is $200.00 plus $40.00 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses must be calculated in accordance with the state standardized travel regulations of the department of technology, management, and budget in effect at the time of the travel.

(9) An applicant for licensure or renewal of licensure under part 209 shall pay the applicable fees set forth in part 209.

(10) Except as otherwise provided in this section, the fees and assessments collected under this section must be deposited in the state treasury, to the credit of the general fund. The

department may use the unreserved fund balance in fees and assessments for the criminal history check program required under this article.

(11) The quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** and all federal matching funds attributed to that assessment must be used only for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment and all federal matching funds attributed to that assessment must be used to finance Medicaid nursing home reimbursement payments. Only licensed nursing homes and hospital long-term care units that are assessed the quality assurance assessment and participate in the Medicaid program are eligible for increased per diem Medicaid reimbursement rates under this subdivision. A nursing home or long-term care unit that is assessed the quality assurance assessment and that does not pay the assessment required under subsection ~~(1)(g)~~ **(1)(h)** in accordance with subdivision (c)(*i*) or in accordance with a written payment agreement with this state shall not receive the increased per diem Medicaid reimbursement rates under this subdivision until all of its outstanding quality assurance assessments and any penalties assessed under subdivision (f) have been paid in full. This subdivision does not authorize or require the department to overspend tax revenue in violation of the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

(b) Except as otherwise provided under subdivision (c), beginning October 1, 2005, the quality assurance assessment is based on the total number of patient days of care each nursing home and hospital long-term care unit provided to non-Medicare patients within the immediately preceding year, must be assessed at a

uniform rate on October 1, 2005 and subsequently on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(c) Within 30 days after September 30, 2005, the department shall submit an application to the Centers for Medicare and Medicaid Services to request a waiver according to 42 CFR 433.68(e) to implement this subdivision as follows:

(*i*) If the waiver is approved, the quality assurance assessment rate for a nursing home or hospital long-term care unit with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application is $2.00 per non-Medicare patient day of care provided within the immediately preceding year or a rate as otherwise altered on the application for the waiver to obtain federal approval. If the waiver is approved, for all other nursing homes and long-term care units the quality assurance assessment rate is to be calculated by dividing the total statewide maximum allowable assessment permitted under subsection ~~(1)(g)~~ **(1)(h)** less the total amount to be paid by the nursing homes and long-term care units with less than 40 licensed beds or with the maximum number, or more than the maximum number, of licensed beds necessary to secure federal approval of the application by the total number of non-Medicare patient days of care provided within the immediately preceding year by those nursing homes and long-term care units with more than 39 licensed beds, but less than the maximum number of licensed beds necessary to secure federal approval. The quality assurance assessment, as provided under this subparagraph, must be assessed in the first quarter after federal approval of the waiver

and must be subsequently assessed on October 1 of each following year, and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed.

(*ii*) If the waiver is approved, continuing care retirement centers are exempt from the quality assurance assessment if the continuing care retirement center requires each center resident to provide an initial life interest payment of $150,000.00, on average, per resident to ensure payment for that resident's residency and services and the continuing care retirement center utilizes all of the initial life interest payment before the resident becomes eligible for medical assistance under the state's Medicaid plan. As used in this subparagraph, "continuing care retirement center" means a nursing care facility that provides independent living services, assisted living services, and nursing care and medical treatment services, in a campus-like setting that has shared facilities or common areas, or both.

(d) Beginning May 10, 2002, the department shall increase the per diem nursing home Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the Medicaid nursing home reimbursement payment increase financed by the quality assurance assessment.

(e) The department shall implement this section in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(f) If a nursing home or a hospital long-term care unit fails to pay the assessment required by subsection ~~(1)(g),~~ **(1)(h)**, the department may assess the nursing home or hospital long-term care

unit a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(g) The Medicaid nursing home quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the Medicaid nursing home quality assurance assessment fund.

(h) The department shall not implement this subsection in a manner that conflicts with 42 USC 1396b(w).

(i) The quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** must be prorated on a quarterly basis for any licensed beds added to or subtracted from a nursing home or hospital long-term care unit since the immediately preceding July 1. Any adjustments in payments are due on the next quarterly installment due date.

(j) In each fiscal year governed by this subsection, Medicaid reimbursement rates must not be reduced below the Medicaid reimbursement rates in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection ~~(1)(g).~~ **(1)(h).**

(k) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** must be equal to 13.2% of the federal funds generated by the nursing homes and hospital long-term care units quality assurance assessment, including the state retention amount. The state retention amount must be appropriated each fiscal year to the department to support

Medicaid expenditures for long-term care services. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(*l*) Beginning October 1, 2027, the department shall not assess or collect the quality assurance assessment or apply for federal matching funds. The quality assurance assessment collected under subsection ~~(1)(g)~~ **(1)(h)** must not be assessed or collected after September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a nursing home or hospital long-term care unit that is not eligible for federal matching funds must be returned to the nursing home or hospital long-term care unit.

(12) The quality assurance dedication is an earmarked assessment collected under subsection ~~(1)(h).~~ **(1)(i).** That assessment and all federal matching funds attributed to that assessment must be used only for the following purpose and under the following specific circumstances:

(a) To maintain the increased Medicaid reimbursement rate increases as provided for in subdivision (c).

(b) The quality assurance assessment must be assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue, as reported in the most recently available Medicare cost report and is payable on a quarterly basis, with the first payment due 90 days after the date the assessment is assessed. As used in this subdivision, "Medicare net revenue" includes Medicare payments and amounts collected for coinsurance and deductibles.

(c) Beginning October 1, 2002, the department shall increase the hospital Medicaid reimbursement rates for the balance of that

year. For each subsequent year in which the quality assurance assessment is assessed and collected, the department shall maintain the hospital Medicaid reimbursement rate increase financed by the quality assurance assessments.

(d) The department shall implement this section in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(e) If a hospital fails to pay the assessment required by subsection ~~(1)(h),~~ **(1)(i)**, the department may assess the hospital a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(f) The hospital quality assurance assessment fund is established in the state treasury. The department shall deposit the revenue raised through the quality assurance assessment with the state treasurer for deposit in the hospital quality assurance assessment fund.

(g) In each fiscal year governed by this subsection, the quality assurance assessment must only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates and graduate medical education payments are not below the level of rates and payments in effect on April 1, 2002 as a direct result of the quality assurance assessment collected under subsection ~~(1)(h),~~ **(1)(i)**, except as provided in subdivision (h).

(h) The quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** must not be assessed or collected after

September 30, 2011 if the quality assurance assessment is not eligible for federal matching funds. Any portion of the quality assurance assessment collected from a hospital that is not eligible for federal matching funds must be returned to the hospital.

(i) The state retention amount of the quality assurance assessment collected under subsection ~~(1)(h)~~ **(1)(i)** must be equal to 13.2% of the federal funds generated by the hospital quality assurance assessment, including the state retention amount. The 13.2% state retention amount described in this subdivision does not apply to the Healthy Michigan plan. Beginning in the fiscal year ending September 30, 2018, and for each fiscal year thereafter, there is a retention amount of at least $118,420,600.00 for each fiscal year for the Healthy Michigan plan. By May 31 of each year, the department, the state budget office, and the Michigan Health and Hospital Association shall identify an appropriate retention amount for the Healthy Michigan plan. The state retention percentage must be applied proportionately to each hospital quality assurance assessment program to determine the retention amount for each program. The state retention amount must be appropriated each fiscal year to the department to support Medicaid expenditures for hospital services and therapy. These funds must offset an identical amount of general fund/general purpose revenue originally appropriated for that purpose.

(13) The department may establish a quality assurance assessment to increase ambulance reimbursement as follows:

(a) The quality assurance assessment authorized under this subsection must be used to provide reimbursement to Medicaid ambulance providers. The department may promulgate rules to provide the structure of the quality assurance assessment authorized under

this subsection and the level of the assessment.

(b) The department shall implement this subsection in a manner that complies with federal requirements necessary to ensure that the quality assurance assessment qualifies for federal matching funds.

(c) The total annual collections by the department under this subsection must not exceed $20,000,000.00.

(d) The quality assurance assessment authorized under this subsection must not be collected after October 1, 2027. The quality assurance assessment authorized under this subsection must no longer be collected or assessed if the quality assurance assessment authorized under this subsection is not eligible for federal matching funds.

(e) By November 1 of each year, the department shall send a notification to each ambulance operation that will be assessed the quality assurance assessment authorized under this subsection during the year in which the notification is sent.

(14) The quality assurance assessment provided for under this section is a tax that is levied on a health facility or agency.

(15) As used in this section:

(a) "Healthy Michigan plan" means the medical assistance program described in section 105d of the social welfare act, 1939 PA 280, MCL 400.105d, that has a federal matching fund rate of not less than 90%.

(b) "Medicaid" means that term as defined in section 22207.

PART 207. FREESTANDING BIRTH CENTERS

Sec. 20701. (1) As used in this part:

(a) "Certified nurse midwife" means an individual who is licensed as a registered professional nurse under part 172 who has

been granted a specialty certification in the health profession specialty field of nurse midwifery by the Michigan board of nursing under section 17210.

(b) "Freestanding birth center" means a facility that provides midwifery care for normal deliveries, well-person reproductive and sexual health care, extended postpartum care, and newborn care, that is within the scope of practice of the health care provider. Freestanding birth center does not include a hospital or freestanding surgical outpatient facility or a facility owned by and operated as part of a hospital or freestanding surgical outpatient facility.

(c) "Health care provider" means any of the following:

(*i*) A physician.

(*ii*) A physician's assistant licensed under part 170 or 175.

(*iii*) A certified nurse midwife.

(*iv*) A midwife.

(d) "Midwife" means that term as defined in section 17101.

(e) "Midwifery care" means the practice of midwifery as that term is defined in section 17101 by a midwife and the practice of nursing by a certified nurse midwife.

(f) "Physician" means that term as defined in section 17001 or 17501.

(g) "Social determinants of health" means the social and economic conditions that influence individual and group differences in health status.

(2) In addition, article 1 contains general definitions and principles of construction applicable to all articles in this code and part 201 contains definitions applicable to this part.

Sec. 20711. (1) A freestanding birth center must be licensed

under this article.

(2) "Freestanding birth center" or a similar term or abbreviation must not be used to describe or refer to a health facility or agency unless it is licensed by the department under this article.

Sec. 20713. The owner, operator, and governing body of a freestanding birth center licensed under this article:

(a) Are responsible for all phases of the operation of the freestanding birth center, selection of health care providers, and quality of care rendered in the freestanding birth center.

(b) Shall cooperate with the department in the enforcement of this article and require that the health care providers and other personnel working in the freestanding birth center and for whom a state license or registration is required be currently licensed or registered.

(c) Subject to section 20719, shall ensure that health care providers are of a sufficient number to maintain safety and quality of care and have the qualifications, training, and skills necessary to meet operational needs and the needs of a patient, considering the caseload and size of the freestanding birth center.

Sec. 20715. Subject to this part, part 171, and any rules promulgated for purposes of this part and part 171, a freestanding birth center shall comply with all of the following:

(a) Have a plan to identify needs caused by social determinants of health and, with the consent of a patient, refer the patient to a support service to address the patient's needs. For purposes of this subdivision, "support service" includes, but is not limited to, a food assistance program, a counseling service, an early childhood development resource, a housing assistance

program, or an intimate partner violence support group.

(b) Develop, implement, and enforce written policies and procedures for the freestanding birth center's operations. The policies and procedures must be made available to health care providers and other personnel who are employed by or under contract with the freestanding birth center and must comply with all of the following:

(*i*) Be administered in a manner that provides quality health care services in a safe environment.

(*ii*) Identify a process for hiring, credentialing, and training staff.

(*iii*) Ensure that the right of a patient to informed consent and to refuse treatment is upheld at every stage of care.

(*iv*) Include a process by which health care providers who are employed by or under contract with the freestanding birth center comply with all of the following:

(A) Refer a patient to services that are not directly provided by the freestanding birth center, including, but not limited to, outside laboratory testing services, lactation support services, and childbirth education.

(B) Consult with another health care provider.

(C) Refer a patient to another health care provider.

(D) Transfer the care of a patient to another health care provider with the informed consent of the patient.

(E) Initiate patient transport when needed by calling 9-1-1 or an ambulance operation or by arranging other means for patient transport.

(c) Ensure that services are provided in a community setting with adequate space for furnishings, equipment, supplies, and

accommodations for patients and the families of patients.

(d) Ensure that a patient is notified of each health care provider within the freestanding birth center who maintains a malpractice liability insurance policy and each health care provider who does not.

Sec. 20717. (1) A freestanding birth center shall not do any of the following:

(a) Except as otherwise provided in this subdivision, use general or regional anesthesia, including epidural anesthesia. Local anesthesia, nitrous oxide, and other forms of pain relief may be administered at the freestanding birth center if all of the following are met:

(*i*) It is determined to be clinically necessary by a health care provider.

(*ii*) It is administered by a health care provider who is acting within the scope of the health care provider's practice.

(*iii*) It is used according to the freestanding birth center's policies and procedures and according to the professionally recognized standards of practice described in section 20727.

(b) Use pharmacologic agents during the delivery of a placenta and in the postpartum period.

(c) Perform surgical procedures other than the following:

(*i*) Episiotomies.

(*ii*) Repairs of perineal lacerations.

(*iii*) Circumcisions.

(*iv*) Newborn frenulum revisions.

(*v*) Any other surgical procedure that is authorized by the department by rule.

(d) Use vacuum extractors or vaginal forceps.

(e) Except as otherwise provided in subsection (3), permit a patient to deliver at the freestanding birth center if any of the following limiting factors apply:

(*i*) Fetal gestation is less than 36 weeks and 0 days.

(*ii*) Labor has not started before fetal gestation of 42 weeks and 1 day.

(*iii*) Any other limiting factor established by rule under section 20727 is present in the patient or the clinical needs of the patient fall outside the scope of practice of a health care provider at the freestanding birth center.

(2) A freestanding birth center shall develop policies and procedures for assessing a patient seeking perinatal care to determine whether it is appropriate for the patient to deliver at the freestanding birth center.

(3) A freestanding birth center may permit a patient who meets a limiting factor described in subsection (1) or in rules promulgated under section 20727 to deliver at the freestanding birth center if there is insufficient time to convey the responsibility for the care of the patient to a hospital before the fetus is born.

Sec. 20719. (1) A freestanding birth center shall provide quality perinatal care that promotes physiologic birth, including, but not limited to, all of the following:

(a) Respectful, supportive care during labor, for which the patient has provided consent.

(b) Minimization of stress-inducing stimuli.

(c) Freedom of movement.

(d) Oral intake, as appropriate.

(e) Availability of nonpharmacologic pain relief methods.

(f) Regular and appropriate assessment of the patient and fetus throughout labor.

(2) The freestanding birth center shall provide a patient, at the inception of care, with all of the following information:

(a) A written description of the training, philosophy of practice, qualifications, and license or specialty certification of a health care provider who is employed by or under contract with the freestanding birth center.

(b) A written description of the freestanding birth center's patient practice policies.

(c) Whether a complaint process for state and national credentialing organizations for a health care provider who is employed by or under contract with the freestanding birth center is available.

(3) The freestanding birth center shall ensure that a health care provider is present or available to the patient at all times when a patient is admitted to the freestanding birth center and until the patient and the newborn are determined to be clinically stable, based on criteria established by the freestanding birth center.

(4) The freestanding birth center shall ensure that a health care provider monitors the progress of a patient's labor and the condition of the patient and fetus or newborn at intervals established in the freestanding birth center's policies and procedures.

(5) Subject to this subsection, the freestanding birth center shall have the personnel and equipment necessary to ensure patient safety, meet the demands for services that are routinely provided in the freestanding birth center, provide coverage during periods

of high demand or in the case of an emergency, and respond to patient health emergencies that may arise while a patient is receiving services in the freestanding birth center, including, but not limited to, basic life support, neonatal resuscitation, and the initial management of postpartum complications. The freestanding birth center shall ensure that at least 2 individuals are on the premises and immediately available during a delivery who are certified in basic life support from the American Heart Association or an equivalent organization as determined by the department and are certified in neonatal resuscitation from the American Academy of Pediatrics, the American Heart Association, or an equivalent organization, as determined by the department.

Sec. 20721. (1) A freestanding birth center shall not discharge a patient from the birth center until the patient is clinically stable and has met discharge criteria established by the freestanding birth center.

(2) A freestanding birth center shall ensure that a program for follow-up care and postpartum evaluation is planned for each patient.

(3) A freestanding birth center shall ensure that both of the following are available to a patient of the freestanding birth center 24 hours a day and 7 days a week:

(a) Consultation with a health care provider by telephone.

(b) A health care provider or other personnel who are available on call to provide intrapartum care to the patient.

Sec. 20722. The department shall not require a freestanding birth center to do any of the following:

(a) Maintain a collaborative agreement with another health facility or agency or with a health care provider who is not

employed by or under contract with a freestanding birth center.

(b) Provide care other than midwifery care.

Sec. 20723. (1) A freestanding birth center shall recommend that health care providers and other personnel who are employed by or under contract with the freestanding birth center receive an annual vaccination against influenza and recommend that health care providers and other personnel who are employed by or under contract with the freestanding birth center are fully vaccinated against COVID-19.

(2) A freestanding birth center shall provide evidence to the department, on request, of immunization, positive titer result, or documentation of refusal for health care providers and other personnel who are employed by or under contract with the freestanding birth center, for each of the following:

(a) Rubella.

(b) Tdap.

(c) Hepatitis B.

(d) Varicella.

(3) A freestanding birth center shall conduct tuberculosis testing before employing or entering into a contract with an individual who will work in the freestanding birth center.

Sec. 20727. The department, in consultation with representatives of freestanding birth centers, the Michigan Affiliate of the American College of Nurse-Midwives, the Michigan Midwives Association, the Michigan board of nursing, the Michigan board of licensed midwifery, and the State of Birth Justice, shall promulgate rules to implement this part. The rules must include at least all of the following:

(a) Professionally recognized standards of practice based on

standards issued by the American Association of Birth Centers, the American College of Nurse-Midwives, and the National Association of Certified Professional Midwives. If any of the standards described in this subdivision are revised after the effective date of the amendatory act that added this section, the department shall take notice of the revision. The department, in consultation with the persons described in this section, may promulgate rules to incorporate any revision by reference.

(b) Limiting factors that, when present, would preclude a patient from delivering at the freestanding birth center because the patient is not considered to be a patient with a normal delivery. The rules must allow a freestanding birth center to develop policies that would include additional limiting factors to preclude delivery at the freestanding birth center.

Sec. 22224c. A freestanding birth center as that term is defined in section 20701 is not required to obtain a certificate of need.

Proposed Rotary and Fixed Wing Equipment Changes
for Approval by EMSCC on 5-17-24

Item	Reason
Waveform Capnography (attached to the monitor or independent)	Currently listed as etco2 on checklist.
Nasal Canula Capnography Device for Waveform Capnography	Mandatory per protocol
Supraglottic Airway	MCAs will select a primary (default) type of supraglottic airway and may approve other or additional supraglottic airway types. Agencies are only required to carry 1 type (default or other option).
Cricothyroidotomy	MCA may elect to approve this.
14-Gauge Needles for Plural Decompression – at least 3.5 inches in length OR MCA approved Commercial Device	Based on protocol, changed from at least 3inches in length.

IV Fluids – NS (1) and Crystalloid Solutions (2). Total of three litters.	Based on protocol.
State MEDCOM Compliant-Programable radio	Clarification

Old language: “means to defibrillate pediatric patients”	New Language: “means to appropriately defibrillate pediatric and infant patients (device, pads and product indications must support defibrillation of all pediatric patients).”
Old language: “Defibrillation Pads (2)”	New language: Defibrillation Pads- 2 sets of adult pads (or combination pads when applicable to the device) and 1 set of pediatric pads (when required by device for pediatric use).
Old Language: “Gloves Non-Latex (One box or pouch of each size)”	New language: “Gloves Non-Latex (1 box or pouch of three different sizes)”.
ET Tubes	All tubes must be cuffed.
Change the Number of IV catheters from 4 to 2 each. #48 on the fixed wing checklist.	Will match the rotary requirement.

Number: BETP20240327-05573

Inspector: Derek Flory

Date: Mar 27, 2024

Michigan Department of Health & Human Services

Bureau of Emerger
Preparedness, EMS
and Systems of Ca

Division of EMS and Systems of Care
P.O. Box 30207
Lansing, Michigan 48909-0207
Phone: (517) 241-3025
Email: MDHHS-MichiganEMS@michigan.gov
Website: www.michigan.gov/ems

(DEMO) Michigan Demo Service
Expiration Date:
Mar 30, 2023

LSA Inspection

Agency Information

***Name of Agency:**

Draft

Full Disclosure of Agency Ownership

No.	Item
1	Administrative Rule 131(i): Documents related to the official types of legal organization of the service, stating whether it is an individual proprietorship, partnership, corporation, or subsidiary of any other corporation or unit of government. (Evidence includes: articles of business incorporation, city charter, township incorporation papers, township board meeting minutes for incorporation, etc.) C NC

***Type of Legal Organization and Evidence Provided:**

Draft

No.	Item
2	Administrative Rules 131 (f) (iii): Disclose any doing business as (DBA) or trade name(s) under which the organization operates, including but not limited to the name(s) by which said organization is known to the public (Evidence: Officially registered DBA documents from the County Clerks Office) C NC

***DBA or Trade Name:**

Draft

No.	Item
3	Administrative Rules 131(f)(iii): Maintain official registration of the entity with the State of Michigan or other designated official in each state in which the agency is chartered, incorporated, or authorized to do business (Evidence: Tax Exempt Certificate, Business License) C NC

***Business License Number:**

Draft

No.	Item
4	Administrative Rules 131(f)(iv): Disclose all parent organizations and any person as defined in the code that have at least a 10% interest in the applicant operation. (Examples of Evidence: Inter-facility agreements and intercept agreements. Interlocal agreement required for government entities. Current agreement signed and dated by all parties and has been reviewed at least once every 5 years) C NC

***Evidence Provided and Date of Agreement:**

Draft

Management

No.	Item

5

Administrative Rules 131(g): Organization has identified one individual (i.e. president, chief, director, or coordinator) who is responsible for overall day-to-day operations of the service and serves as the contact person (Examples of Evidence: position description, contract, meeting minutes showing appointment to position, etc.)

C NC

***Evidence Provided:**

Draft

6

Administrative Rules 132(a): Written policy or procedure that explains the steps that occur when a complaint is received by the agency (Evidence: current and reviewed at least once every 3 years)

C NC

***Date of Policy/Procedure:**

Draft

7

Administrative Rule 111(4)(5): Response capabilities are in place to ensure a response is provided to each request for emergency assistance originating within the bounds of your licensed service area (Evidence: current mutual aid agreement that has been reviewed at least once every 5 years)

C NC

***Date of Agreement:**

Draft

8

Administrative Rules 132(b): Demonstrate inclusion in the county/regional disaster plan and response (Examples of Evidence: official plan, MCA protocols, or after action reports that specifically identify the agency as participating. Current plan that has been reviewed at least once every 5 years)

C NC

***Evidence Provided and Date:**

Draft

Record Keeping

No.	Item

9

Administrative Rules 132(k)(l): Written policy AND evidence that a record is created to document each request for service that the agency receives, including calls cancelled prior to arrival and incidents which result in no patient being transported (Evidence: current policy that has been reviewed at least once every 3 years. Other evidence: dispatch logs, run log from dispatch center, electronic access)

C NC

***Evidence Provided and Date of Policy:**

Draft

10

Administrative Rules 132(k)(l): Written policy AND evidence that a record is created to document all findings and treatment given, if any, whenever contact is made with a patient or one presumed to be a patient regardless of whether or not the patient is ultimately treated or transported (Evidence: current policy that has been reviewed at least once every 3 years and copy of PCR)

C NC

***Evidence Provided and Date of Policy:**

Draft

11

Public Health Code Section 20910(1)(i): written policy AND evidence that all patient care records are uploaded into the Michigan EMS Information System (MI-EMSIS) database on a monthly basis (by the 15th of the month) for the past year (Evidence: current policy that has been reviewed at least once every 3 years and evidence of monthly data submission)

C NC

***Date of Policy:**

Draft

*Agency submitted data on a monthly basis for the past 12 months?

(•) Yes ( ) No

12	Aircraft tracking procedures that shall assure position reports at intervals not to exceed fifteen minutes	C NC

*Date of Policy

Draft

13	Administrative Rule 135 (A) Meet all equipment requirements of the federal aviation administration for the specific type of aircraft and flying conditions under which the aircraft will operate, as specified by the air taxi certificate of operation of the aircraft transport provider.	C NC
14	Administrative Rule 135 (b)) Maintain accurate medical flight records concerning the transportation of each emergency patient in intrastate flights or interstate flights originating in Michigan. The records must be available to the department and the medical control authority of the originating scene, when requested.	C NC
15	Administrative Rule 135 (e)) Provide verification of Medicaid participation. A new provider not currently enrolled in Medicaid must certify that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services.	C NC
16	Administrative Rule 135 (2) (a), (b), (c), (d), (g), (h), (j) (k) An ambulance operation licensed in Michigan that provides rotary or fixed wing air ambulance service must be accredited by a department approved national accrediting organization within two years of beginning operation. During the provisional period between licensing and accreditation, the air ambulance operation must provide all of the following:	C NC

*Written policies and procedures specifying the levels of patient care to be provided.

Draft

*Written patient care protocols including provisions for continuity of care.

Draft

*Written policies and procedures that define the roles and responsibilities of all staff members.

Draft

*Written policies and procedures addressing the appropriate use of air ambulance services in accordance with 333.20932 a.

Draft

*A planned and structured program for initial and continuing education and training, including didactic, clinical and in-flight, for all scheduled staff members.

Draft

*Written policies and procedures addressing the integration of the air ambulance service with public safety agencies governing the base hospitals including but not limited to the federal aviation adm

Draft

*A clinical data base for utilization review and Professional Standards Review Organization.

Draft

*Procedures to screen patients to assure appropriate utilization of the air ambulance service

Draft

Communications

No.	Item	
17	Administrative Rules 132(a): Maintain a copy of the current State MedCom Plan at the agency (Evidence: hard copy, online, or electronic)	C NC

Safety Policies & Procedures

No.	Item

Administrative Rule 132(d) Maintain written policies and procedures that address safety and accident reduction and comply with all applicable state and federal health and safety laws. These policies and procedures shall be maintained by the operation and shall be available to the department at the time of inspection. (Evidence: policies and procedures must be reviewed on an annual basis and include the date of review; unless otherwise noted):

18	Bloodborne Pathogens Plan: must include the components as outlined in Part 554 Bloodborne Infectious Diseases Rules.	C NC

***Date of Policy or Procedure:**

Draft

19	Disposal of Medical Waste Management Plan - Must include a list of the types of medical waste generated and methods of packaging, treatment, and disposal. Must also include training for employees.	C NC

***Date of Policy or Procedure:**

Draft

20	Equal Employment Opportunity Commission (EEOC) Poster (most current) and EEOC Agency Policy	C NC
21	General Safety Policy/Procedure (Ex: MiOSHA safety policies, MSDS data sheets)	C NC

***Date of Policy or Procedure:**

Draft

22	Glucometer Calibration and/or Maintenance Records	C NC
23	Lab Draws - Blood and Blood Glucose - Policy/Procedure with CLIA Waiver	C NC

***Date of Policy or Procedure:**

Draft

24	HAZMAT Response Policy/Procedure	C NC

***Date of Policy or Procedure:**

Draft

***Date of Policy or Procedure:**

Draft

25	Respiratory Protection Plan: Must include all components of the OSHA Respiratory Protection Standards - respiratory selection, medical evaluation, fit testing, respiratory use, maintenance, care, and disposal, training, recordkeeping, storage, program evaluation, and who the responsible individual is.	C NC

***Date of Policy or Procedure:**

Draft

Staffing

No.	Item	
26	Administrative Rules 132(e): Maintain a list and current license and certification documents of all EMS personnel licensed by MDHHS and employed with the life support agency (Evidence: agency roster with licensure level, number, and expiration date and employee certifications)	C NC
27	Administrative Rules 207(b): Assure that agencies are providing clinical competency assessments to EMS personnel before the individual provides EMS (Evidence: provide documentation of assessment, BLS or ACLS certification, and other ongoing education for staff)	C NC

28

Administrative Rules 132(i): Show evidence of an orientation for EMS personnel to familiarize them with the agency's policies and procedures. Orientation must include, at a minimum, a proper introduction to the duties to be performed, as well as MCA protocols (Evidence: orientation checklist. Review and update orientation program every 3 years)

C NC

29

Administrative Rules 132(i): Show evidence of and maintain documentation that demonstrates that EMS personnel are trained on equipment that is carried by the agency (Evidence: evidence of equipment checklist for each employee. Review and updated every 3 years)

C NC

Protocols/Quality

No.	Item

30

Administrative Rules 132(j): Maintain a copy of all applicable protocols for all MCA's the agency operates in (Evidence: show current copies and where they are kept. This can include electronic versions on the computer and/or phones)

C NC

***Where are they kept?**

Draft

31

Administrative Rules 132(l): Show evidence of participation in an agency based and/or MCA quality improvement process (Evidence: internal QA/QI process or policy, MCA letter of compliance, MCA meeting minutes showing participation)

C NC

***Evidence Provided:**

Draft

Equipment & Vehicles

No.	Item

32

Administrative Rules 132(m): Vehicles inspected are currently licensed and meet equipment requirements established by the department (Evidence: vehicle license with most current vehicle inspection report that is compliant)

C NC

33

Administrative Rule 119 : A life support agency shall have a written policy in place to ensure vehicles and equipment are operational and provide documentation of not less than a weekly inspection program for all vehicles, communication equipment, and mechanical and electronic medical equipment (Evidence: policy, vehicle checklists that are dated and signed by employees. Policy must be reviewed for updates at least once every 3 years)

C NC

***Evidence Provided:**

Draft

***How often does inspection occur?**

Draft

Miscellaneous - Other Health & Safety Concerns

Other Health and Safety Concerns:

Inspection Instructions

The findings from this inspection will be submitted to the Michigan Department of Health and Human Services (MDHHS) to determine compliance with requirements for licensure. This inspection form does not indicate licensure status. The MDHHS upon determination of compliance with applicable statutory and regulatory requirements and standards, will issue the license in accordance with Part 209 of the Public Health Code (PA368 of 1978), as amended.

Items on this inspection form checked "NC (Non-Compliant)" indicate that the item was inadequate or missing at the time of this inspection, causing MDHHS to consider the agency to be in violation of Part 209 of the Public Health Code (PA 368 of 1978), as amended.

Instructions for Required Corrections

Non-Compliant (NC)

If MDHHS makes the determination that an agency is non-compliant with the agency requirements, the agency has 15 days to provide a written response to the department with a corrective action plan or evidence of correction. The department may conduct a re-inspection to validate that corrections have been made.

Other Licensure Issues

- MDHHS may order a life support agency out of immediate service if it determines that the health, safey, and welfare of a patient may be in jeopardy due to non-compliance with minimum requirements, or other applicable reasons. A notice of such action shall be issued to the life support agency by MDHHS based upon the deficiencies identified in the inspection report.
- A life support agency may immediately address potential violations during the inspection. The inspection report will reflect the action taken and MDHHS will consider that the indicator was met.

Documentation of completed corrections may be faxed or emailed to MDHHS

Email: floryd@michigan.gov

Fax: 517-335-9434

Attestation & Signatures

By signing below, I confirm the following:

I, the undersigned representative of the above service, acknowledge receipt of a copy of this inspection report, supplemental notes and corrective action statement (if applicable). I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies within the established time frames will subject the service to administrative action and penalties as outlined in Sections 201 and 209 of the Michigan Public Health Code and the Administrative Rules thereunder.

Virtual Inspections for Transporting Agencies ONLY: I further understand the following two items on the MDHHS-Bureau of Emergency Preparedness, EMS and Systems of Care Vehicle Inspection Form, were not able to be visually inspected, and I attest that the items were fully functional at the time of the vehicle inspection:

•Patient Compartment: Climate and lighting must be maintained within vehicle standards;
•Drug package in climate-controlled area;
•Communication-State MEDCOM Compliant (HERN required for all vehicle except MFR);
•Suction portable and on-board

I, the undersigned MDHHS representative, acknowledge that I have conducted a full inspection of this vehicle in accordance with the equipment requirements set forth above and that all statements I have made on this inspection report are true and accurate to the best of my knowledge.

Comments:

Passed

Total: 0 deficiencies of 33 items

Responsible Party Signoff

*

***First Name:**

Draft

***Last Name:**

Draft

Certification Number:

Number: BETP20240201-05394

Inspector: Derek Flory

Date: Feb 1, 2024

ENGLISH

Michigan Department of Health and Human Services
Bureau of EMS, Trauma & Preparedness
P.O. Box 30207
Lansing, Michigan 48909-0207
Phone: (517) 241-3025
Fax: (517) 335-9434
Email: MDHHS-MichiganEMS@michigan.gov
Website: www.michigan.gov/ems

TEST VIN 7
Expiration Date:

Rotary Vehicle Minimum Critical Equipment

Agency Information

***Name of Agency:**

Sample

Vehicle Requirements

No.	Item	
1	Access that Allows for Safe Loading and Unloading of a Patient without Excessive Maneuvering of the Patient	C NC NR
2	Communication-State MEDCOM Compliant	C NC NR
3	Cot with straps with means of securing it. Capable of carrying a minimum of 1 patient in a horizontal position.	C NC NR
4	Equipment is Secured to the Helicopter, Readily Accessible, and when not in use, Securely Stored	C NC NR
5	Fire Extinguisher - per FAA Guidelines	C NC NR
6	Interior Affords an Adequate Patient Care and Treatment Area	C NC NR
7	Patient Compartment: Climate and Lighting Must Be Maintained Within Vehicle Standards	C NC NR

Airway

No.	Item	
8	Bag Valve Mask: Hand Operated Self-Expanding Bag with Oxygen Reservoir/Accumulator; Valve (Clear & Operable in Cold Weather); and Mask (Adult, Child, Infant, and Neonate Sizes) Child (450-750ml) (1 each) and Adult (= or >1000 ml) (1 each)	C NC NR
9	Endotracheal Tubes and Equipment: Sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 7.0, 8.0 Cuffed (2 of each size)	C NC NR
10	Gum Elastic Bougie (1)	C NC NR
11	Laryngoscope Blades: Curved Sizes 2, 3, or 4 (2); Stright Sizes 0, 1, 2, 3, or 4 (4) (1 each)	C NC NR
12	Laryngoscope Bulb, Batteries, and Handle (1 set)	C NC NR
13	Laryngoscope Handle (1) (Spare)	C NC NR

14	Magill Forceps: Adult & Pediatric (1 each)	C NC NR
15	Manometer Compatible with BVM System	C NC NR
16	Manual Peep Valve - Compatible with BVM System	C NC NR
17	Nasal Cannulas: Adult and Pediatric (1 each)	C NC NR
18	Nasopharyngeal Airways: 1 Size between 16-24 fr and 1 Size between 26-34 fr	C NC NR
19	Nebulizer (1)	C NC NR
20	Non-Rebreather Masks: Adult, Child, and Infant (1 each)	C NC NR
21	Oropharyngeal Airway: 0-1, 2-3, 4-5 (1 each)	C NC NR
22	Oxygen On-Board w/Regulator Capable of 15 lpm, and Supplies	C NC NR
23	Oxygen Portable with Regulator Capable of 15 lpm, and Supplies	C NC NR
24	Pulse Oximeter (1)	C NC NR
25	Stylettes for Endotracheal Tubes: Adult and Pediatric (1 each)	C NC NR
26	Suction On-Board with a Regulator	C NC NR
27	Suction Portable	C NC NR
28	Suction Tubing: Wide-Bore Tubing, Rigid Pharyngeal Curved Suction Tip and Tonsil and Flexible Suction Catheters 6F-16F (1 between 6F-10F and 1 between 12F-16F). 1 set for each mechanical suction device.	C NC NR
29	Supraglottic (Combitube, King, I-Gel) (1 of Each Adult and Pediatric Size Required)	C NC NR
30	Syringes (1, 3, 5, 10, and 20 ML) - Multiple of each size	C NC NR
31	Transport Ventilator with Volume/Pressure/NIVPPV Capabilities	C NC NR
32	Tube Holder (1)	C NC NR
33	Video Laryngoscope with Blades for Adult and Pediatric Capabilities	C NC NR

Trauma - Bandaging

No.	Item	
34	Arterial Tourniquet (commercial) (1)	C NC NR
35	Hemostatic Agent (1)	C NC NR
36	Occlusive Chest Seal, or Commercial Device	C NC NR
37	Sterile Sheets	C NC NR

Trauma - Splinting

No.	Item

38	Cervical Immobilizers: Infant, Child, Adult (1 each)	C	NC	NR
39	Pelvic Binder (Commercially Approved FDA Device) (1)	C	NC	NR

IV Requirements

No.	Item			
40	14 Gauge Needle at Least Three Inches or MCA Approved Commercial Device for Pleural Decompression	C	NC	NR
41	Alcohol Wipes (12)	C	NC	NR
42	Extension Set (2)	C	NC	NR
43	Filter Needles	C	NC	NR
44	Fluid Warmer	C	NC	NR
45	IM Needles - Sizes Suitable for Pediatric and Adult Patients	C	NC	NR
46	Injection Supplies - Sizes Suitable for Pediatrics and Adults	C	NC	NR
47	IO Drill Device	C	NC	NR
48	IO Supplies: Adult and Pediatric (1 each)	C	NC	NR
49	IV Catheters- Sizes 24-18 Gauge (2 each)	C	NC	NR
50	IV Solution and Supplies Secured	C	NC	NR
51	IV Administration Set: Macro Drip (4)	C	NC	NR
52	IV Infusion Pumps Sufficient to Maintain a Minimum of 3 Simultaneous Infusions	C	NC	NR
53	IV Fluids: 3 Liters of Crystalloid Sloution, 250 ML of D5W	C	NC	NR

***IV Fluids Filled by:**

( ) Hospital ( ) Wholesale

***Hospital or Wholesaler Name:**

Sample

***If Obtained through Wholesaler - Tracking Log?**

( ) Yes ( ) No ( ) Not Wholesale

***First Expiration Date of Fluids:**

Sample

54	Needles - Various Sizes	C	NC	NR
55	Pressure bags	C	NC	NR
56	Tourniquets (2)	C	NC	NR

Drug Package

No.	Item

57	Drug Package in Climate Controlled Area	C NC NR
58	Drug Package Secured	C NC NR
59	Drug Package Sealed	C NC NR

***Hospital Filled By:**

Sample

***Date Filled:**

Sample

***Expiration Date:**

Sample

60	Drug Package: Proof of Acquisition for additional Non-Sealed Medication through Hospital Pharmacy	C NC NR

***Physician Filled By:**

Sample

***Date Filled:**

Sample

***Expiration Date:**

Sample

61	Drug Package that is not Expired	C NC NR
62	MI-MEDIC Cards and Length Based Pediatric Dosing Tape	C NC NR

Cardiac Monitor/Defibrillator

No.	Item	
63	*12 Lead EKG	C NC NR
64	Cardiac Monitor that is Portable, Battery Operated and Operational. Includes Patient Cable, Electrodes, and ECG Paper.	C NC NR

***Type:**

Sample

***Serial Number:**

Sample

65	Means to appropriately defibrillate pediatric and infant patients (device, pads and product indications must support defibrillation of all pediatric patients).	C NC NR
66	Defibrillation Pads- 2 sets of adult pads (or combination pads when applicable to the device) and 1 set of pediatric pads (when required by device for pediatric use).	C NC NR
67	Invasive Line Capability (2)	C NC NR

68	Transcutaneous Cardiac Pacemaker that includes Pediatric Capability (may integrate with Monitor/Defibrillator)	C NC NR
69	Transvenous Pacer	C NC NR
70	Wave Form EtCo2	C NC NR

Miscellaneous - PPE & Other

No.	Item	
71	Alcohol-Based Hand Cleanser (Towlette, Spray, or Liquid) (1)	C NC NR
72	Disinfectant Cleaner for Bloodborne Pathogens EPA Registered (for vehicle cleaning) (1)	C NC NR
73	Documentation Tools (Pens, Tablet, Run Forms)	C NC NR
74	Gloves Non-Latex (1 Box or Pouch of three different Sizes)	C NC NR
75	Helmets (One set for each crew member)	C NC NR
76	HEPA Respirator or N-95 Masks (One for each crew member)	C NC NR
77	Personal Protection Equipment: Impervious Gown, Eye Protection (Full Peripheral Glasses, Goggles, or Face Shield), and Mask (One for each caregiver). Surgical Masks (One for each crew member, and patient)	C NC NR
78	Sharps Container (Portable or fixed)	C NC NR
79	Survival Kit - Signaling Mirror, Aerial Pyrotechnic or other Aerial Signaling Device, Fire Starting Device, Flashlight with Spare Batteries, and 4 Survival Blankets	C NC NR

Miscellaneous - Patient

No.	Item	
80	Blankets (2) with 1 being a Thermal Absorbent Blanket, or Appropriate Heat-Reflective Material (adult size)	C NC NR
81	Blood Pressure Cuff and Sphygmomanometer : Infant, Child, Adult, and Large Adult (Manual) (1 each)	C NC NR
82	Ambulance Child Restraint System (1)	C NC NR
83	Cold Packs (2)	C NC NR
84	Emesis Container (1)	C NC NR
85	Glucometer or Blood Glucose Measuring Device with Reagent Strips	C NC NR

***Expiration Date:**

Sample

86	Hearing Protection for Patient	C NC NR

87	Heat Packs (2)	C	NC	NR
88	Infant Thermal Cap (1)	C	NC	NR
89	NG Tubes	C	NC	NR
90	OB Kit: Sterile Contents (1) - (4 x 4 Dressing, Sterile Scissors or other Cutting Utensil, Bulb Suction, Clamps for Cord, Sterile Gloves, Blanket)	C	NC	NR

***Expiration Date:**

Sample

91	Stethoscope (1)	C	NC	NR
92	Thermometer with Low Temperature Capability down to 86 Degrees (i.e. hypothermia) (1)	C	NC	NR

Miscellaneous - Other Health & Safety Concerns

Other Health and Safety Concerns:

Inspection Instructions

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Items on this inspection form checked "NC" indicates that the item was not clean, was missing, or non-functional at the time of this inspection, causing MDHHS to consider each applicable vehicle to be in violation of Part 209 of the Public Health Code (PA 368 of 1978), as amended. Non-sterile items must be clean and functional. Sterile items must be intact in their package, usable, integrity of package must not be compromised, and must not be expired.

Instructions for Required Corrections

Non-Compliant (NC)

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- A vehicle that is not brought into compliance within 24 hours from the time it was determined to be out of compliance due to missing equipment items, shall be removed from service immediately. A vehicle taken out of service due to non-compliance shall not respond or provide emergency assistance, or conduct inter-facility transfers. The vehicle may return to service with approval of MDHHS, provided MDHHS was notified in writing that corrections were made. A re-inspection may occur within 15 calendar days of MDHHS receiving such notification.
- If a life support vehicle remains out of compliance for more than 15 calendar days from the date of inspection, then the vehicle license shall be automatically revoked.

Other Licensure Issues

- MDHHS may order a life support vehicle out of immediate service if it determines that the health, safey, and welfare of a patient may be in jeopardy due to non-compliance with equipment items, defective and non-functional equipment, or other applicable reasons. A notice of such action shall be issued to the life support agency by MDHHS based upon the deficiencies identified in the inspection report.
- A life support agency may immediately address potential violations during the inspection. The inspection report will reflect the action taken and MDHHS will consider that the indicator was met.

Documentation of completed corrections may be faxed or emailed to MDHHS

Email: floryd@michigan.gov

Fax: 517-335-9434

Attestation & Signatures

I, the undersigned representative of the above agency, acknowledge receipt of a copy of this inspection report, supplemental notes and corrective action statement (if applicable). I am aware of the deficiencies listed (if any) and understand that failure to correct the deficiencies within the established time frames will subject the agency to administrative action and penalties as outlined in Sections 201 and 209 of the Michigan Public Health Code and the Administrative Rules thereunder.

I, the undersigned MDHHS representative, acknowledge that I have conducted a full inspection of this fixed wing in accordance with the equipment requirements set forth above and that all statements I have made on this inspection report are true and accurate to the best of my knowledge.

Comments:

Passed

Total: 0 deficiencies of 92 items

Responsible Party Signoff

*

***First Name:**

Sample

***Last Name:**

Sample

Certification Number:

Number: BETP20240201-05393

Inspector: Derek Flory

Date: Feb 1, 2024

ENGLISH

MDHHS Michigan Department of Health & Human Services

Bureau of Emerger Preparedness, EMS and Systems of Ca

Division of EMS and Systems of Care
P.O. Box 30207
Lansing, Michigan 48909-0207
Phone: (517) 241-3025
Email: MDHHS-MichiganEMS@michigan.gov
Website: www.michigan.gov/ems

VIN TEST 123
Expiration Date:

Vehicle Call Sign:
TEST CALL SIGN

Vehicle Unit Number:
3

Fixed Wing Minimum Critical Equipment

Agency Information

***Name of Agency:**
Sample

Vehicle Requirements

No.	Item			
1	Air worthiness certificate and registration	C	NC	NR
2	Aircraft is Equipped with a Cargo Door or other Entry that Allows for Loading and Unloading of the Patient without Excessive Maneuvering of the Patient	C	NC	NR
3	Ambient Air Temperature Monitor in Cabin	C	NC	NR
4	Communication-State MEDCOM Compliant	C	NC	NR
5	Cot with straps with means of securing it. Capable of carrying a minimum of 1 patient in a horizontal position.	C	NC	NR
6	Equipment is Secured to the Aircraft, Readily Accessible, and when not in use, Securely Stored	C	NC	NR
7	Fire Extinguisher - per FAA Guidelines	C	NC	NR
8	Interior Affords an Adequate Patient Care and Treatment Area	C	NC	NR
9	Patient Compartment: Climate and Lighting Must Be Maintained Within Vehicle Standards	C	NC	NR

Airway

No.	Item			
10	Bag Valve Mask: Hand Operated Self-Expanding Bag with Oxygen Reservoir/Accumulator; Valve (Clear & Operable in Cold Weather); and Mask (Adult, Child, Infant, and Neonate Sizes) Child (450-750ml) (1 each) and Adult (= or >1000 ml) (1 each)	C	NC	NR
11	Endotracheal Tubes and Equipment: Sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 7.0, 8.0 Cuffed (2 of each size)	C	NC	NR
12	Gum Elastic Bougie (1)	C	NC	NR

13	Laryngoscope Blades: Curved Sizes 2, 3, or 4 (2); Stright Sizes 0, 1, 2, 3, or 4 (4) (1 each)	C NC NR
14	Laryngoscope Bulb, Batteries, and Handle (1 set)	C NC NR
15	Laryngoscope Handle (1) (Spare)	C NC NR
16	Magill Forceps: Adult & Pediatric (1 each)	C NC NR
17	Manometer Compatible with BVM System	C NC NR
18	Manual Peep Valve - Compatible with BVM System	C NC NR
19	Nasal Cannulas: Adult and Pediatric (1 each)	C NC NR
20	Nasopharyngeal Airways: 1 Size between 16-24 fr and 1 Size between 26-34 fr	C NC NR
21	Nebulizer (1)	C NC NR
22	Non-Rebreather Masks: Adult, Child, and Infant (1 each)	C NC NR
23	Oropharyngeal Airway: 0-1, 2-3, 4-5 (1 each)	C NC NR
24	Oxygen On-Board w/Regulator Capable of 15 lpm, and Supplies	C NC NR
25	Oxygen Portable with Regulator Capable of 15 lpm, and Supplies	C NC NR
26	Pulse Oximeter (1)	C NC NR
27	Stylettes for Endotracheal Tubes: Adult and Pediatric (1 each)	C NC NR
28	Suction On-Board with a Regulator	C NC NR
29	Suction Portable (Can be manually powered)	C NC NR
30	Suction Tubing: Wide-Bore Tubing, Rigid Pharyngeal Curved Suction Tip and Tonsil and Flexible Suction Catheters 6F-16F (1 between 6F-10F and 1 between 12F-16F). 1 set for each mechanical suction device. C NC NR	
31	Supraglottic (Combitube, King, I-Gel) (1 of Each Adult Size Required)	C NC NR
32	Syringes (1, 3, 5, 10, and 20 ML) - Multiple of each size	C NC NR
33	Transport Ventilator with Volume/Pressure/NIVPPV Capabilities	C NC NR
34	Tube Holder (1)	C NC NR
35	Video Laryngoscope with Blades for Adult and Pediatric Capabilities	C NC NR

IV Requirements

No.	Item	
36	14 Gauge Needle at Least Three Inches or MCA Approved Commercial Device for Pleural Decompression	C NC NR
37	Alcohol Wipes (12)	C NC NR
38	Extension Set (2)	C NC NR
39	Filter Needles	C NC NR
40	Fluid Warmer	C NC NR
41	IM Needles - Sizes Suitable for Pediatric and Adult Patients	C NC NR

42	Injection Supplies - Sizes Suitable for Pediatrics and Adults	C	NC	NR
43	IO Drill Device	C	NC	NR
44	IO Supplies: Adult and Pediatric (1 each)	C	NC	NR
45	IV Fluids: NS (1) and Crystalloid Solution (2) Total of three liters	C	NC	NR

***IV Fluids Filled by:**

(•) Hospital ( ) Wholesale

***Hospital or Wholesaler Name:**

Sample

***If Obtained through Wholesaler - Tracking Log?**

(•) Yes ( ) No ( ) Not Wholesale

***First Expiration Date of Fluids:**

Sample

46	IV Solution and Supplies Secured	C	NC	NR
47	IV Administration Set: Macro Drip (4)	C	NC	NR
48	IV Catheters - Size 24-18 Gauge (4 each)	C	NC	NR
49	IV Infusion Pumps Sufficient to Maintain a Minimum of 3 Simultaneous Infusions	C	NC	NR
50	Needles - Various Sizes	C	NC	NR
51	Pressure bags	C	NC	NR
52	Tourniquets (2)	C	NC	NR

Drug Package

No.	Item			
53	A method to determine weight based pediatric dosages	C	NC	NR
54	Drug Package in Climate Controlled Area	C	NC	NR
55	Drug Package Secured	C	NC	NR
56	Drug Package Sealed	C	NC	NR

***Hospital Filled By:**

Sample

***Date Filled:**

Sample

***Expiration Date:**

Sample

57	Drug Package: Proof of Acquisition for additional Non-Sealed Medication	C	NC	NR

***Physician Filled By:**

Sample

***Date Filled:**

Sample

***Expiration Date:**

Sample

No.	Item			
58	Drug Package that is not Expired	C	NC	NR

Cardiac Monitor/Defibrillator

No.	Item			
59	*12 Lead EKG	C	NC	NR
60	Cardiac Monitor that is Portable, Battery Operated and Operational. Includes Patient Cable, Electrodes, and ECG Paper.	C	NC	NR

***Type:**

Sample

***Serial Number:**

Sample

61	Means to appropriately defibrillate pediatric and infant patients (device, pads and product indications must support defibrillation of all pediatric patients).	C	NC	NR
62	Defibrillation Pads- 2 sets of adult pads (or combination pads when applicable to the device) and 1 set of pediatric pads (when required by device for pediatric use).	C	NC	NR
63	Invasive Line Capability (2)	C	NC	NR
64	Transcutaneous Cardiac Pacemaker that includes Pediatric Capability (may integrate with Monitor/Defibrillator)	C	NC	NR
65	Transvenous Pacer	C	NC	NR
66	Wave Form EtCo2	C	NC	NR

Miscellaneous - PPE & Other

No.	Item			
67	Alcohol-Based Hand Cleanser (Towlette, Spray, or Liquid) (1)	C	NC	NR
68	Disinfectant Cleaner for Bloodborne Pathogens EPA Registered (for vehicle cleaning) (1)	C	NC	NR
69	Documentation Tools (Pens, Tablet, Run Forms)	C	NC	NR
70	Gloves Non-Latex (1 Box or Pouch of three different Sizes)	C	NC	NR
71	HEPA Respirator or N-95 Masks (One for each crew member)	C	NC	NR
72	Personal Protection Equipment: Impervious Gown, Eye Protection (Full Peripheral Glasses, Goggles, or Face Shield), and Mask (One for each caregiver)	C	NC	NR
73	Sharps Container (Portable or fixed)	C	NC	NR
74	Survival Kit - Signaling Mirror, Aerial Pyrotechnic or other Aerial Signaling Device, Fire Starting Device, Flashlight with Spare Batteries, and 4 Survival Blankets	C	NC	NR

Miscellaneous - Patient

No.	Item			
75	Blankets (2) with 1 being a Thermal Absorbent Blanket, or Appropriate Heat-Reflective Material (adult size)	C	NC	NR

76	Blood Pressure Cuff and Sphygmomanometer : Infant, Child, Adult, and Large Adult (Manual) (1 each)	C	NC	NR
77	Ambulance Child Restraint System (1)	C	NC	NR
78	Cold Packs (2)	C	NC	NR
79	Emesis Container (1)	C	NC	NR
80	Glucometer or Blood Glucose Measuring Device with Reagent Strips	C	NC	NR

***Expiration Date:**

Sample

81	Heat Packs (2)	C	NC	NR
82	Infant Thermal Cap (1)	C	NC	NR
83	NG Tubes	C	NC	NR
84	OB Kit: Sterile Contents (1) - (4 x 4 Dressing, Sterile Scissors or other Cutting Utensil, Bulb Suction, Clamps for Cord, Sterile Gloves, Blanket)	C	NC	NR

***Expiration Date:**

Sample

85	Stethoscope (1)	C	NC	NR
86	Thermometer with Low Temperature Capability down to 86 Degrees (i.e. hypothermia) (1)	C	NC	NR

Miscellaneous - Other Health & Safety Concerns

Other Health and Safety Concerns:

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Fax: 517-335-9434

Attestation & Signatures

By signing below, I confirm the following:

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Virtual Inspections for Transporting Agencies ONLY: I further understand the following two items on the MDHHS-Bureau of Emergency Preparedness, EMS and Systems of Care Vehicle Inspection Form, were not able to be visually inspected, and I attest that the items were fully functional at the time of the vehicle inspection:

- •Patient Compartment: Climate and lighting must be maintained within vehicle standards;
- •Drug package in climate-controlled area;
- •Communication-State MEDCOM Compliant (HERN required for all vehicle except MFR);
- •Suction portable and on-board

I, the undersigned MDHHS representative, acknowledge that I have conducted a full inspection of this vehicle in accordance with the equipment requirements set forth above and that all statements I have made on this inspection report are true and accurate to the best of my knowledge.

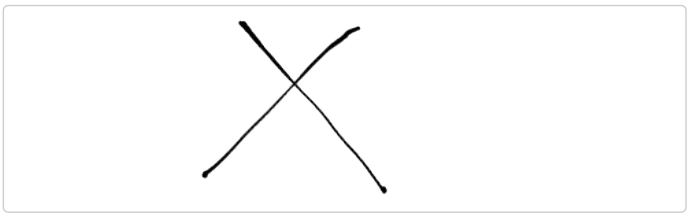
Comments:

Passed

Total: 0 deficiencies of 86 items

Responsible Party Signoff

*



***First Name:**

Sample

***Last Name:**

Sample

Certification Number:

Recruitment and Retention in the Michigan EMS Workforce

Stephanie Bliss, MS and Emily Bergquist, MSA, Paramedic, I/C

MDHHS Michigan Department of Health & Human Services | Bureau of Emergency Preparedness, EMS and Systems of Care

OBJECTIVE

The main objective is to gather information on potential performance improvement opportunities and interventions to enhance recruitment and retention of Michigan EMS clinicians. The findings will be used to develop and implement strategies that address these opportunities and improve the Michigan EMS workforce.

METHODS

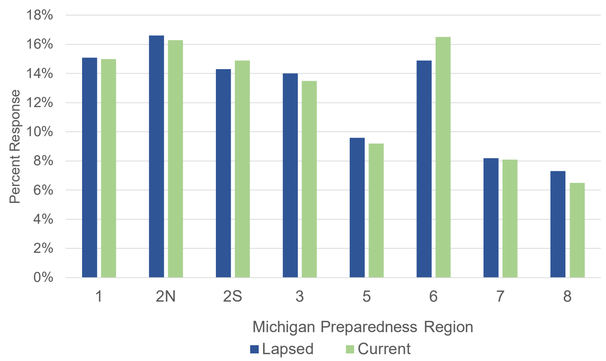
In 2023, the EMS Coordination Committee's Recruitment and Retention Work Group worked closely with Michigan staff to develop a workforce survey. Surveys were sent to individuals with current and recently expired licenses. 6,499 (24% response rate) surveys were completed by currently licensed clinicians and 1,403 (15% response rate) by recently license holders. Qualitative and quantitative data were collected as well as email addresses for follow-up conversations. Two surveys were developed using Qualtrics, one survey for individuals who currently hold a license (current) and one for individuals who recently held a license (lapsed).

RESULTS

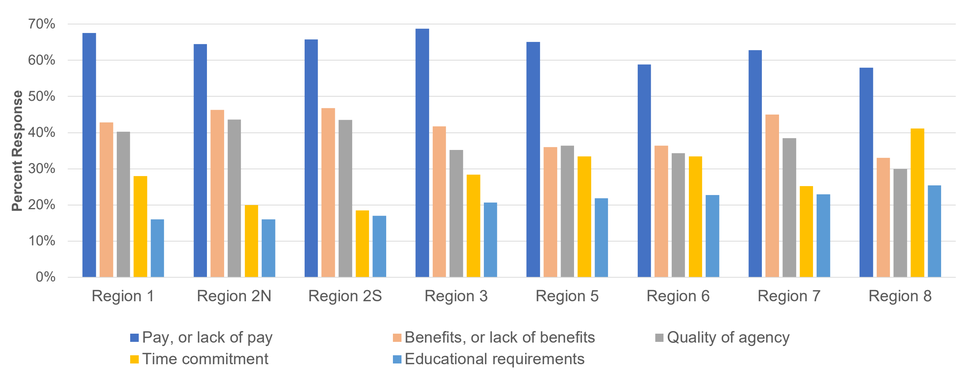
The majority of respondents were male and worked in an advanced level agency. 62.4% of individuals with a current license stated that they were extremely or somewhat happy in their current EMS position. The top five reasons for what keep respondents working in EMS include fulfillment, relationship with coworkers, scope of work, excitement and adventure, and pay. Top reasons for leaving or wanting to leave included pay (or lack of pay), benefits (or lack of benefits), quality of agency, time commitment, and educational requirements. 67.5% of respondents with a recently expired license answered yes or maybe that they would be willing to relicense.

RESULTS CONTINUED

Percent Response by Region

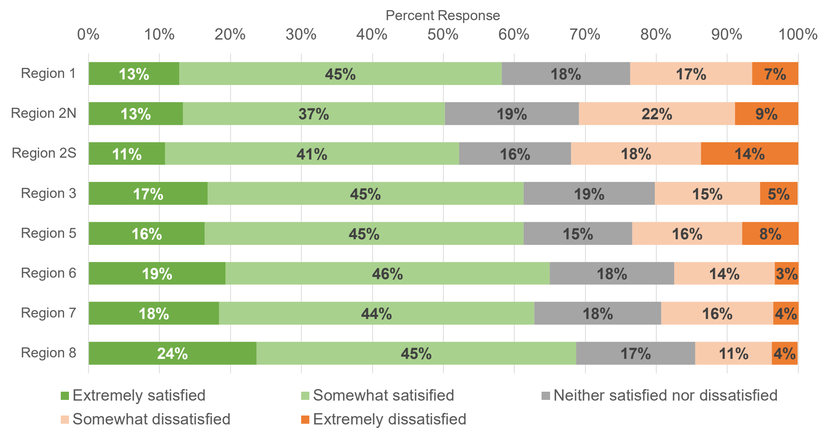


Top 5 Reasons-What Makes You Want to Leave EMS by Region

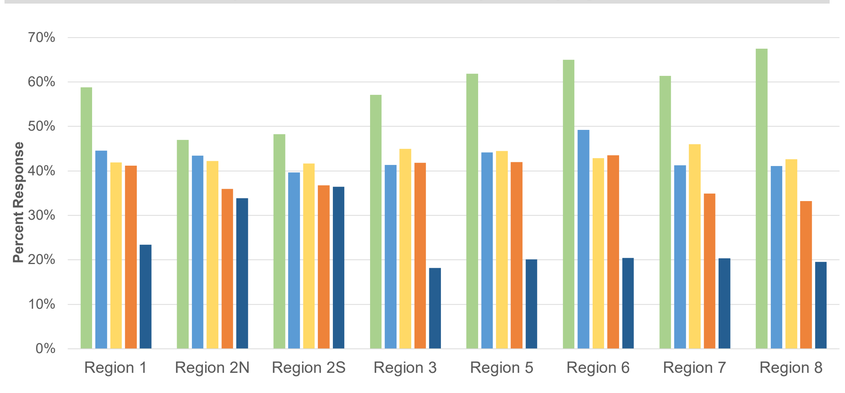


Current

Satisfaction of EMS Profession by Region

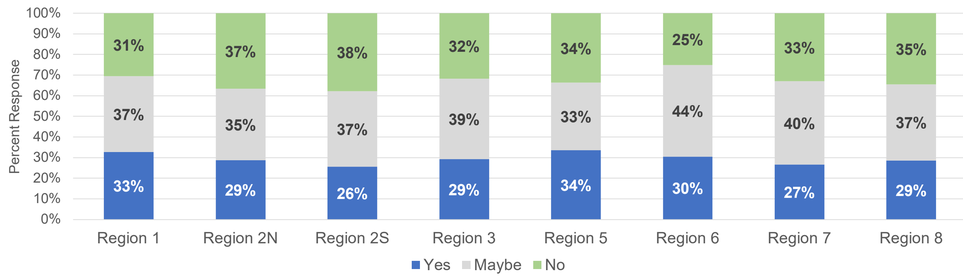


Top 5 Reasons-What Makes You Stay in EMS by Region

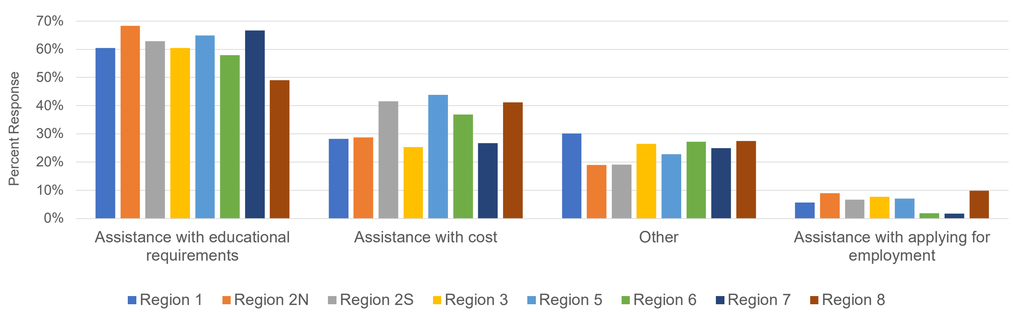


Lapsed

Willingness to Relicense by Region

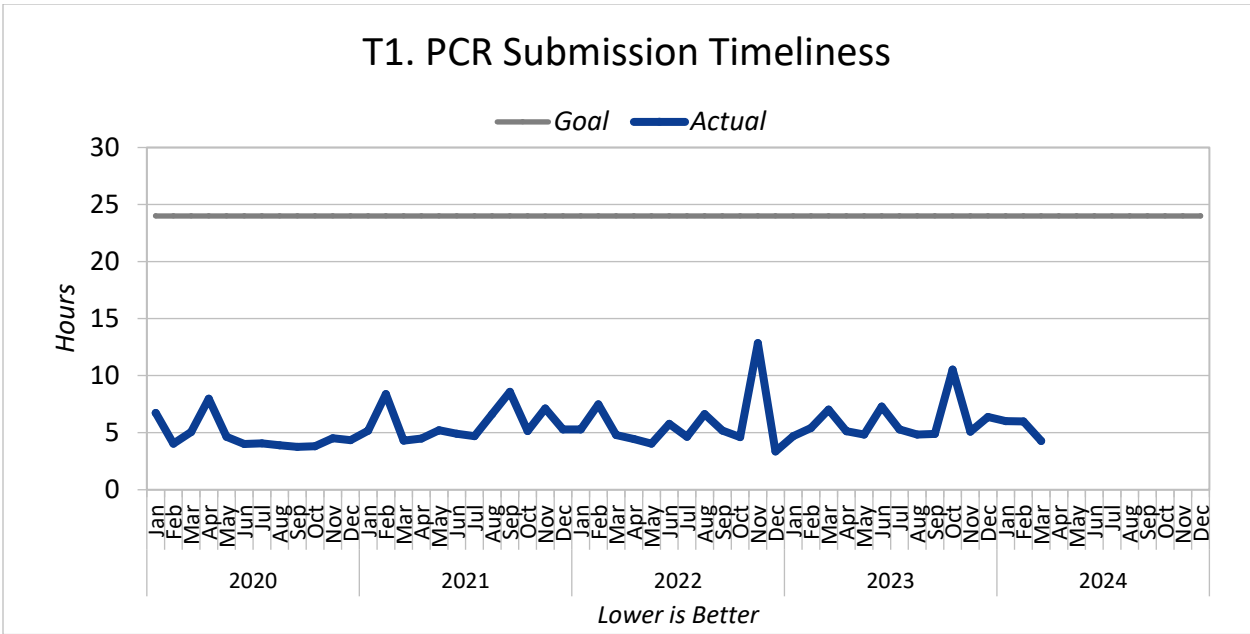


Resources That Would Help to Relicense by Region

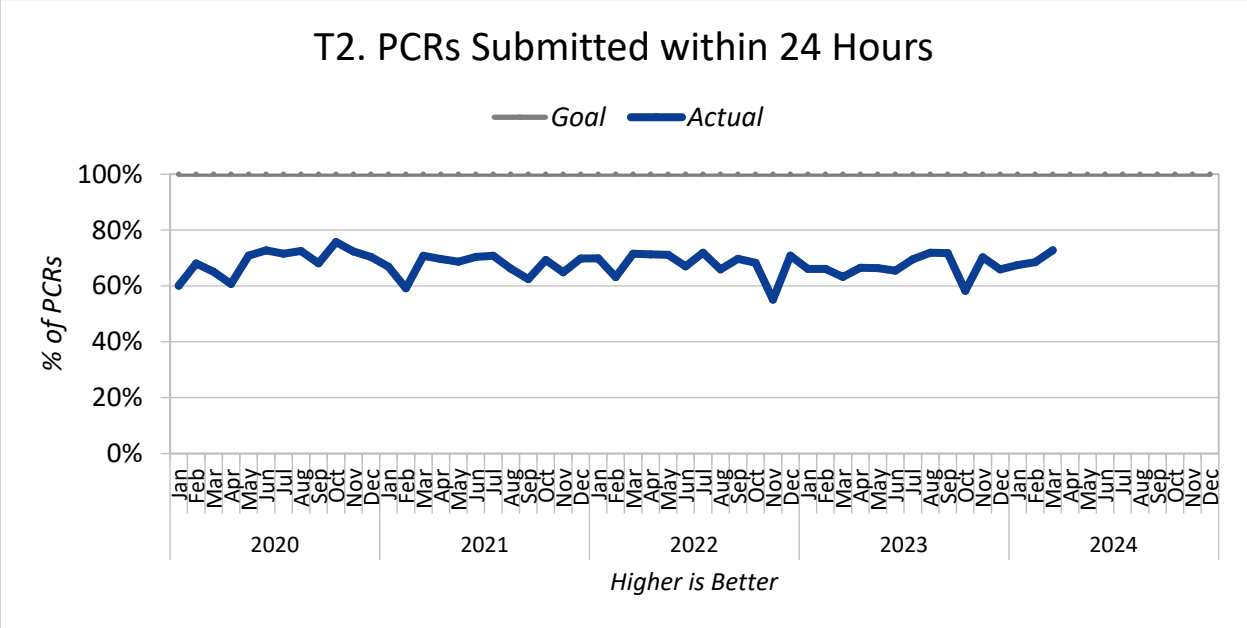


CONCLUSIONS

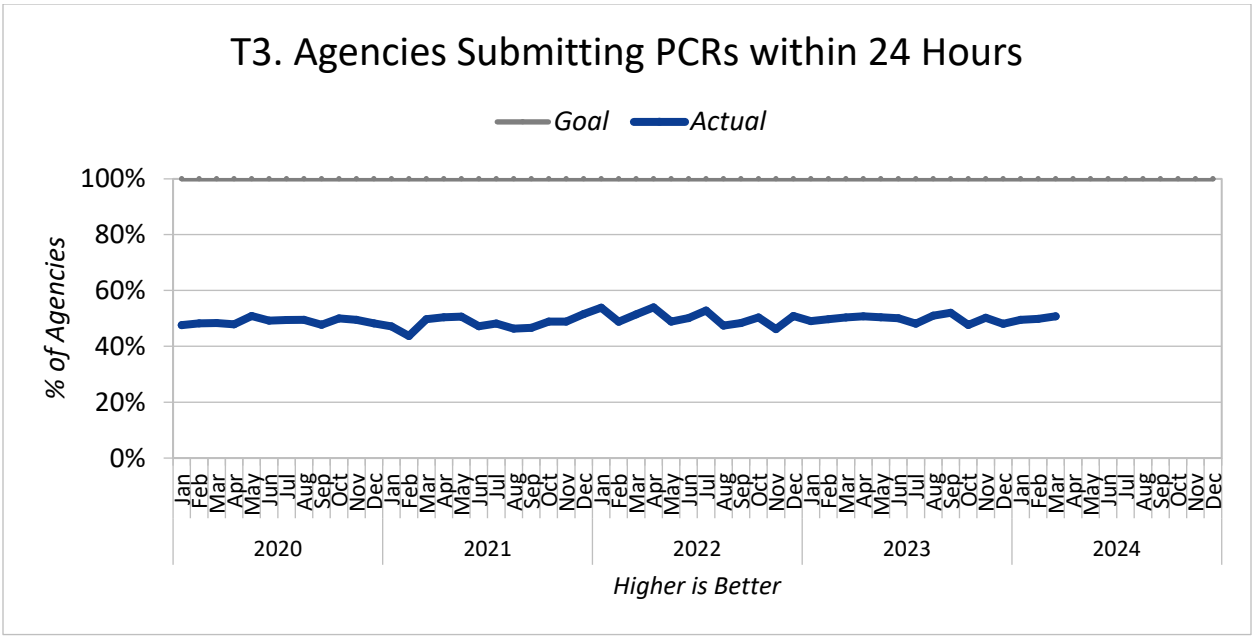
There were 7,902 respondents that provided feedback on what performance improvement opportunities exist to increase recruitment and retention of the Michigan EMS workforce. Potential performance opportunities include improved pay scale and benefits, increased leadership skills, and expanded advancement opportunities. Further data analysis, along with collaboration with subject matter experts, will help to create concrete actionable items for EMS agencies throughout Michigan.



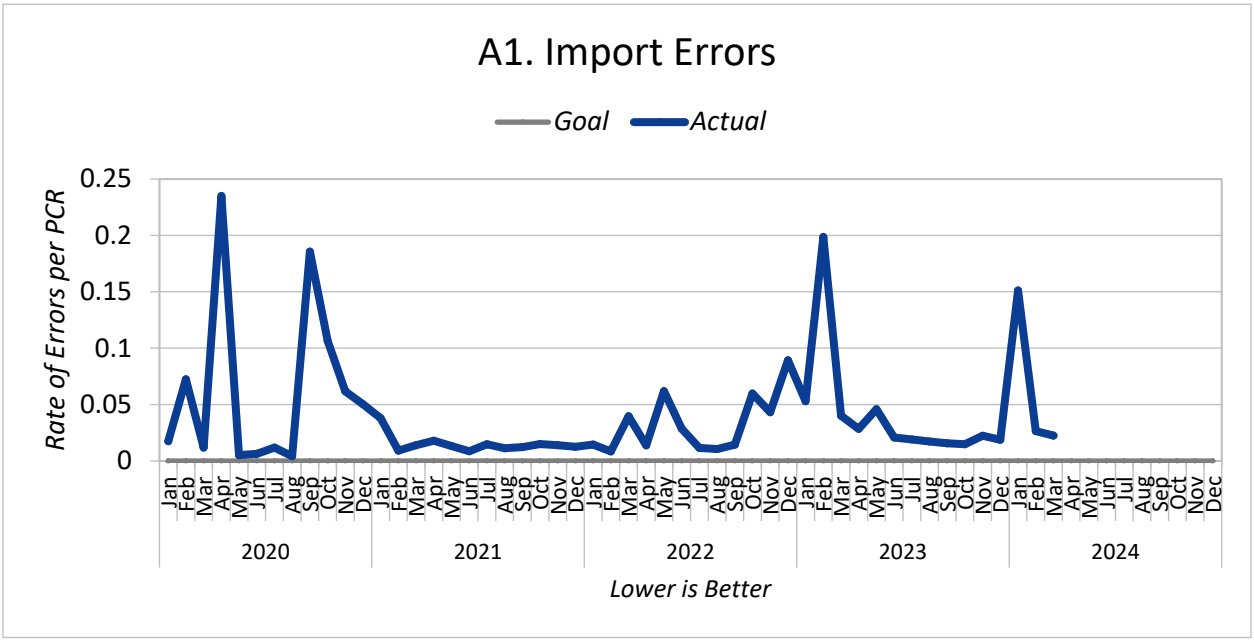
The median number of hours that it takes for a NEMSIS version 3 patient care report to be received by the state data system (from the time the EMS unit was back in service after the call).



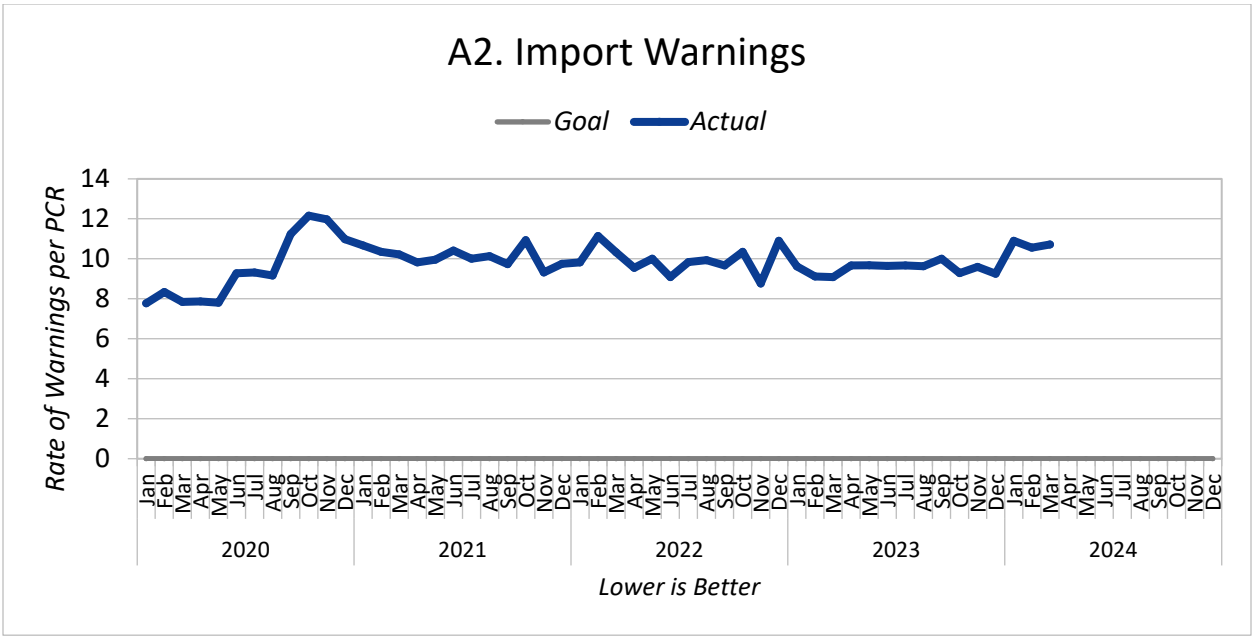
The percentage of NEMSIS version 3 patient care reports received by the state data system within 24 hours from the time the EMS unit was back in service after the call.



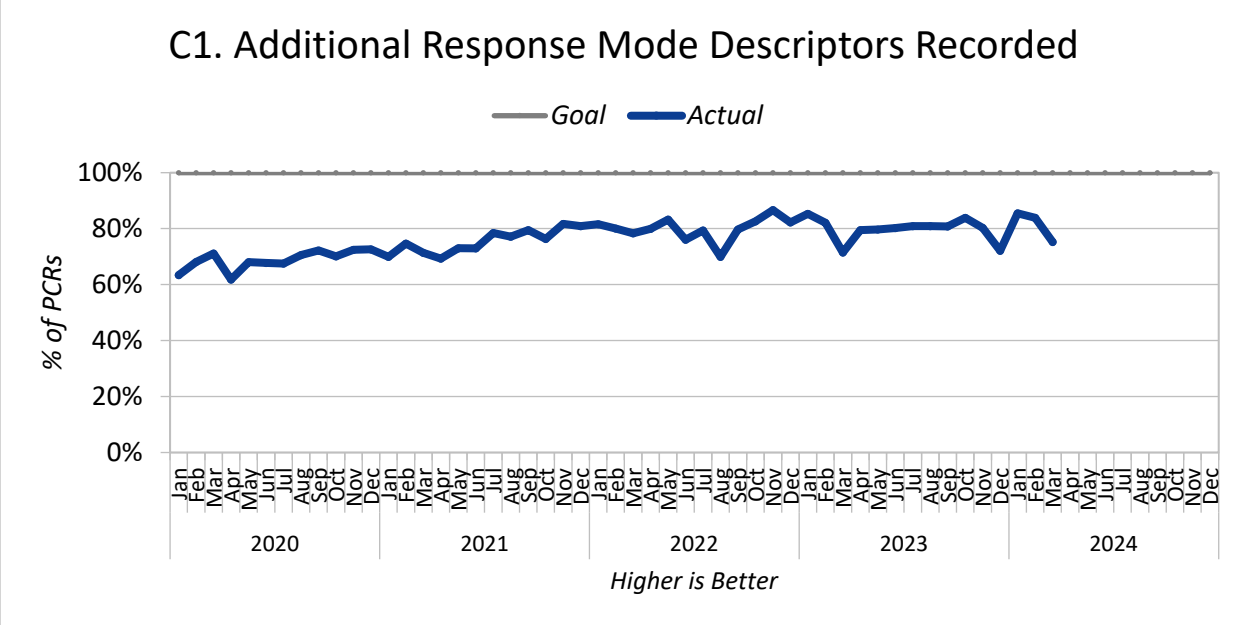
The percentage of agencies where the median number of hours that it takes for a NEMSIS version 3 patient care report to be received by the state data system (from the time the EMS unit was back in service after the call) is less than 24.



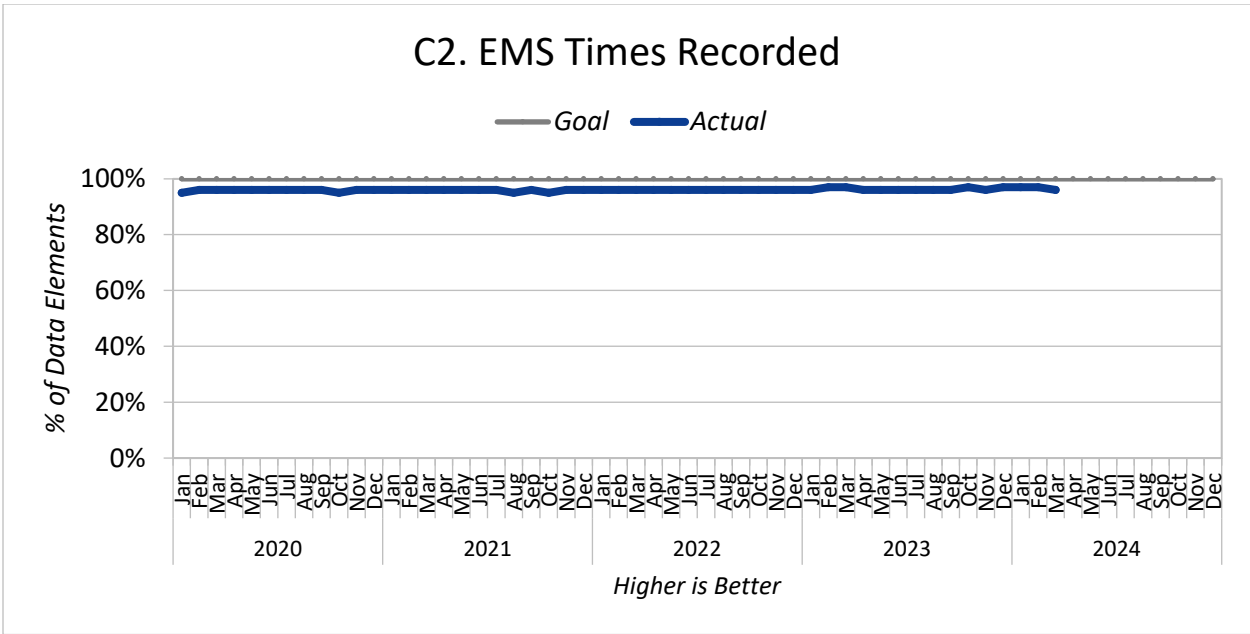
The rate of errors in NEMSIS 3 data submitted to the state EMS data system from other systems.



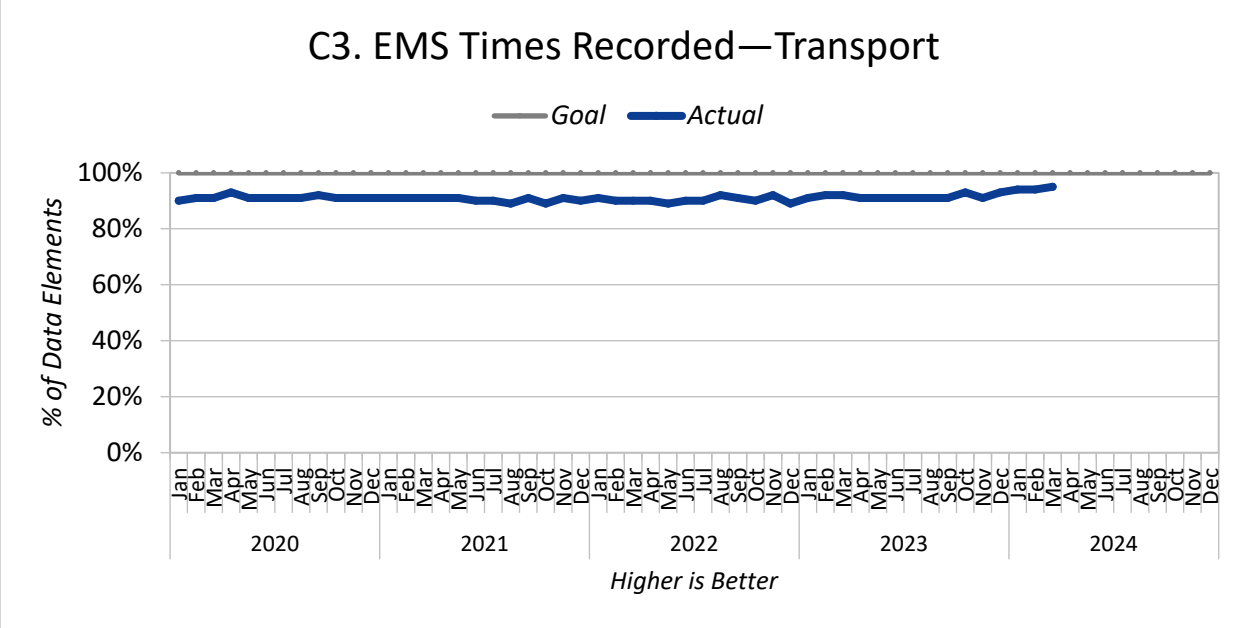
The rate of warnings in NEMSIS 3 data submitted to the state EMS data system from other systems.



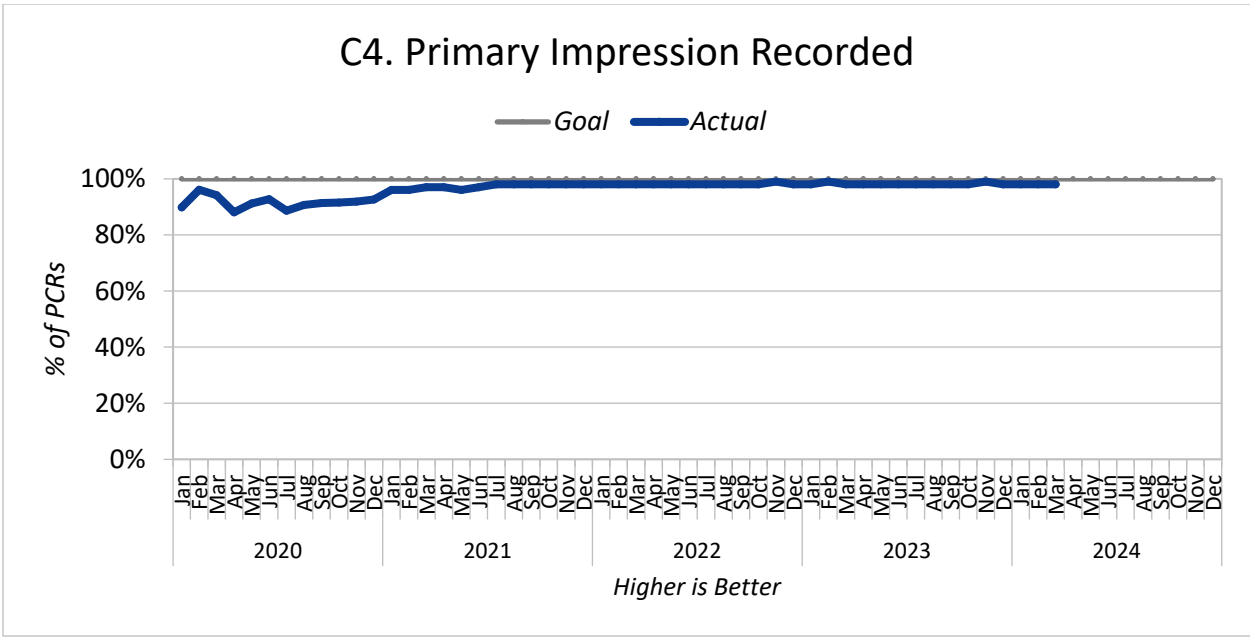
Where there is an incident scene, the percentage of patient care reports where Additional Response Mode Descriptors is recorded with a non-blank value.



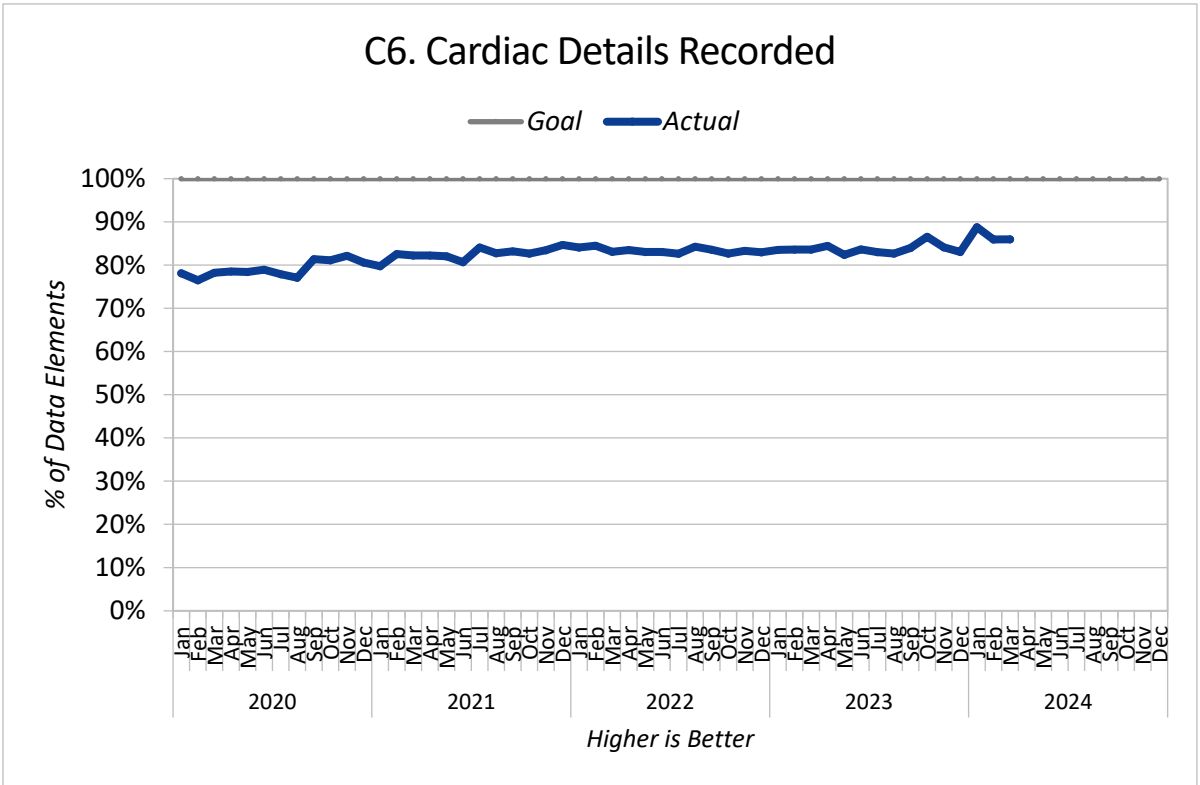
Where a patient is encountered, the average percentage of selected time-related elements with a non-blank value per NEMSIS 3 patient care report.



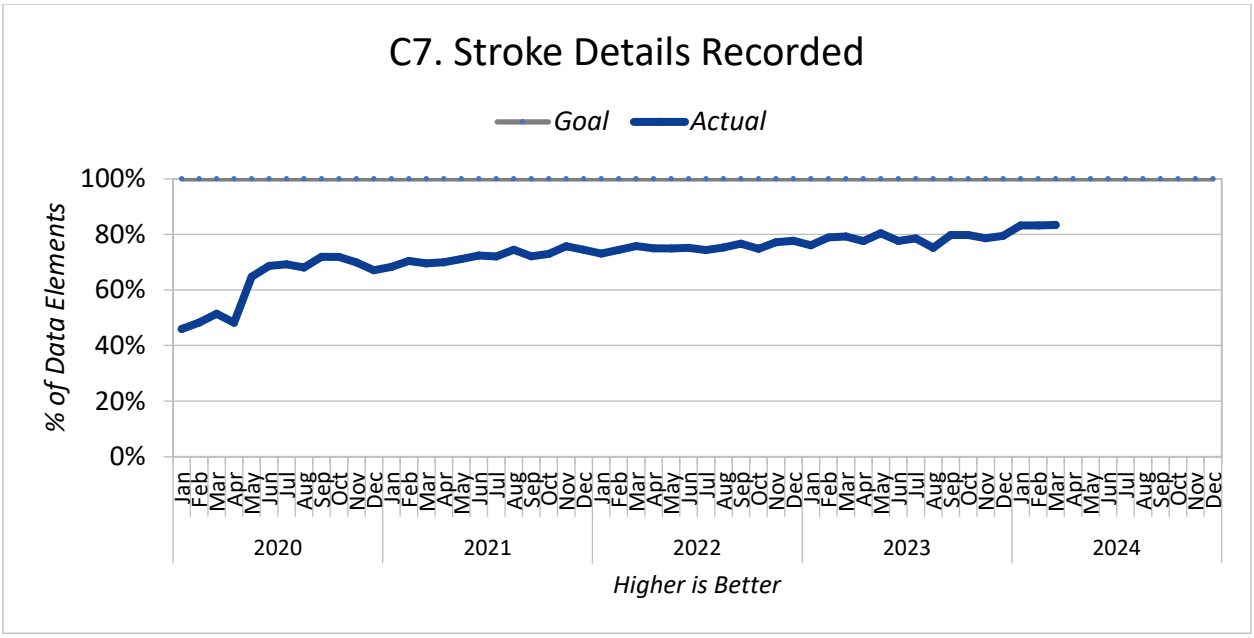
Where a patient is transported by EMS, the average percentage of selected time-related elements with a non-blank value per NEMSIS 3 patient care report.



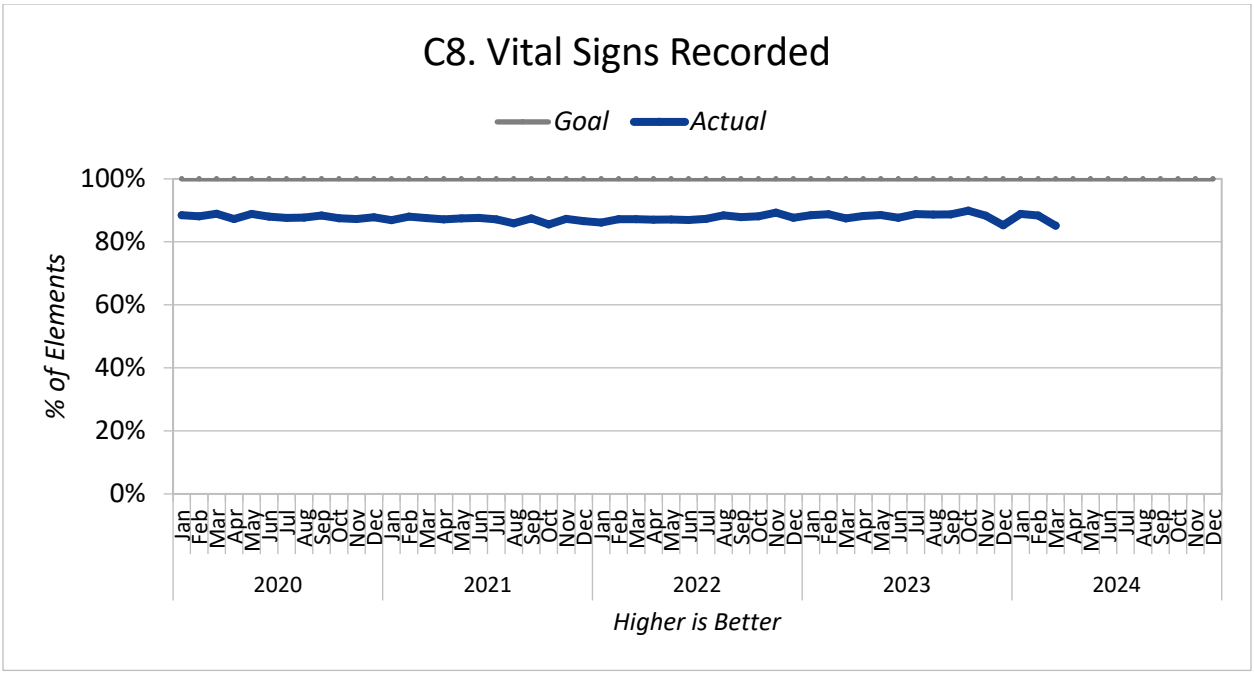
Where a patient is treated, the percentage of NEMSIS 3 patient care reports with a Primary Impression recorded



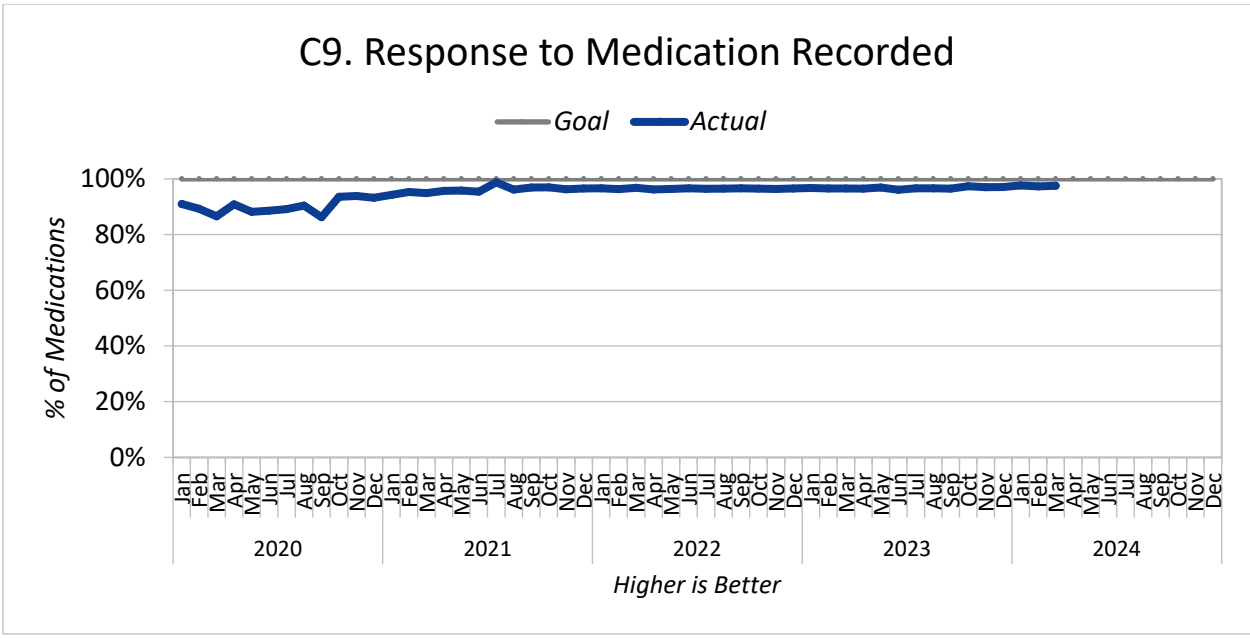
Where there is a cardiac arrest, the average percentage of selected cardiac-related elements with a non-blank value per NEMSIS 3 patient care report.



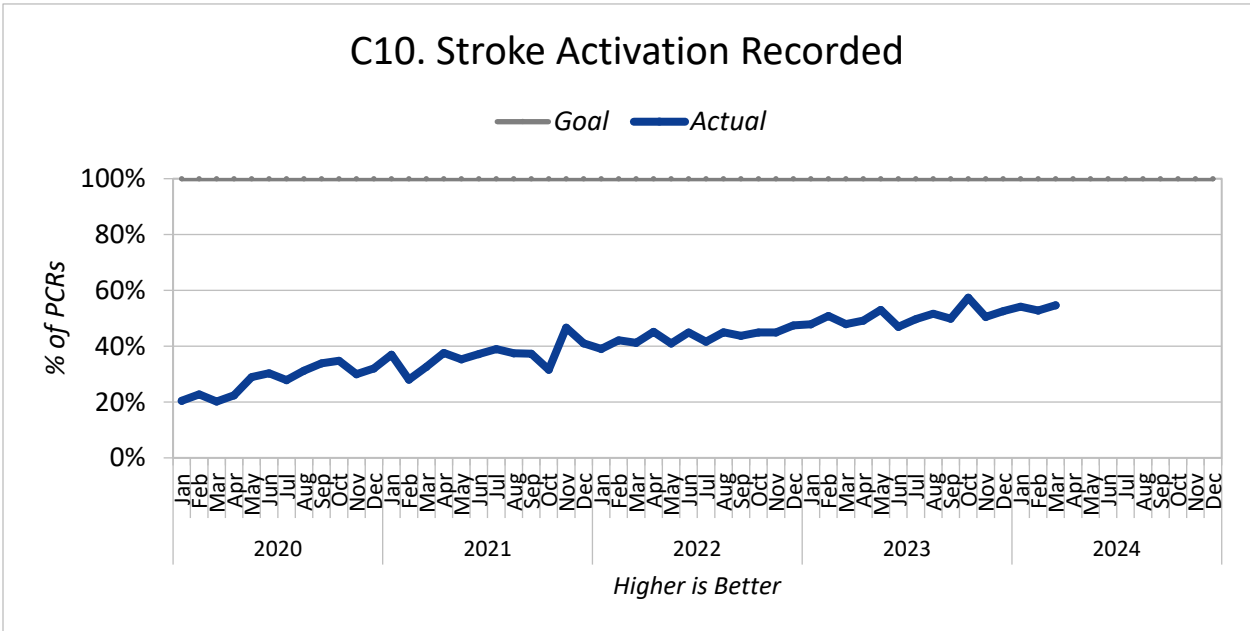
Where Primary Impression is stroke and Type of Service Requested is 911 response (scene), the average percentage of selected stroke-related elements with a non-blank value per NEMSIS 3 patient care report.



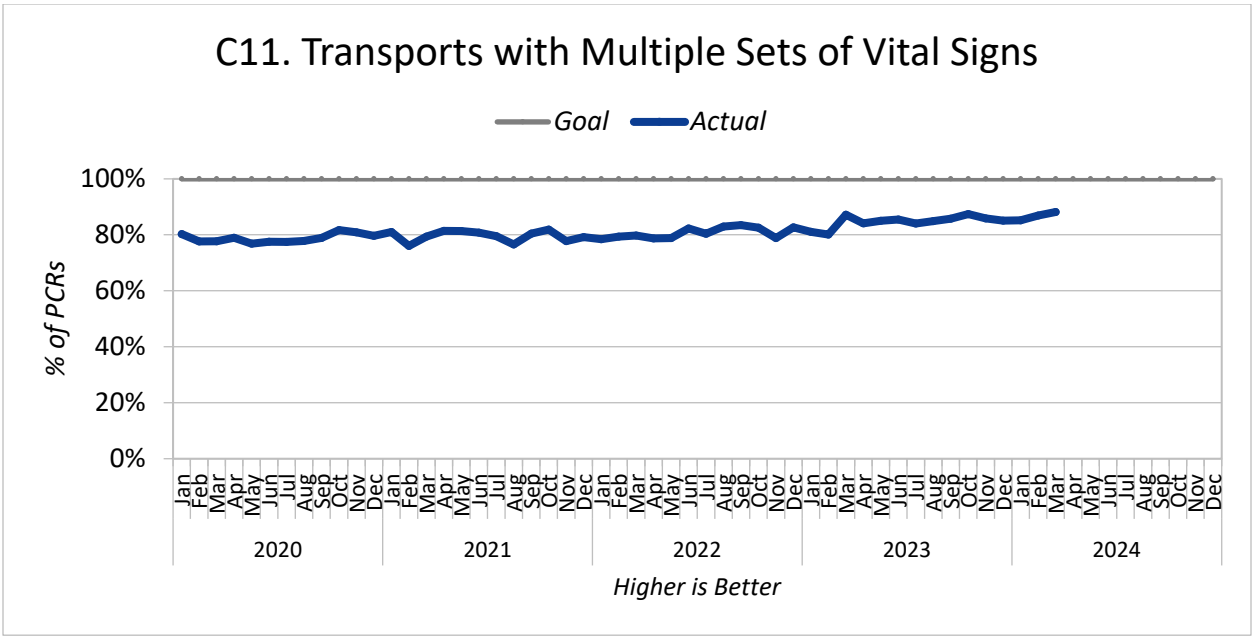
Where a patient is treated, the average percentage of selected vital sign elements with a non-blank value per NEMSIS 3 patient care report.



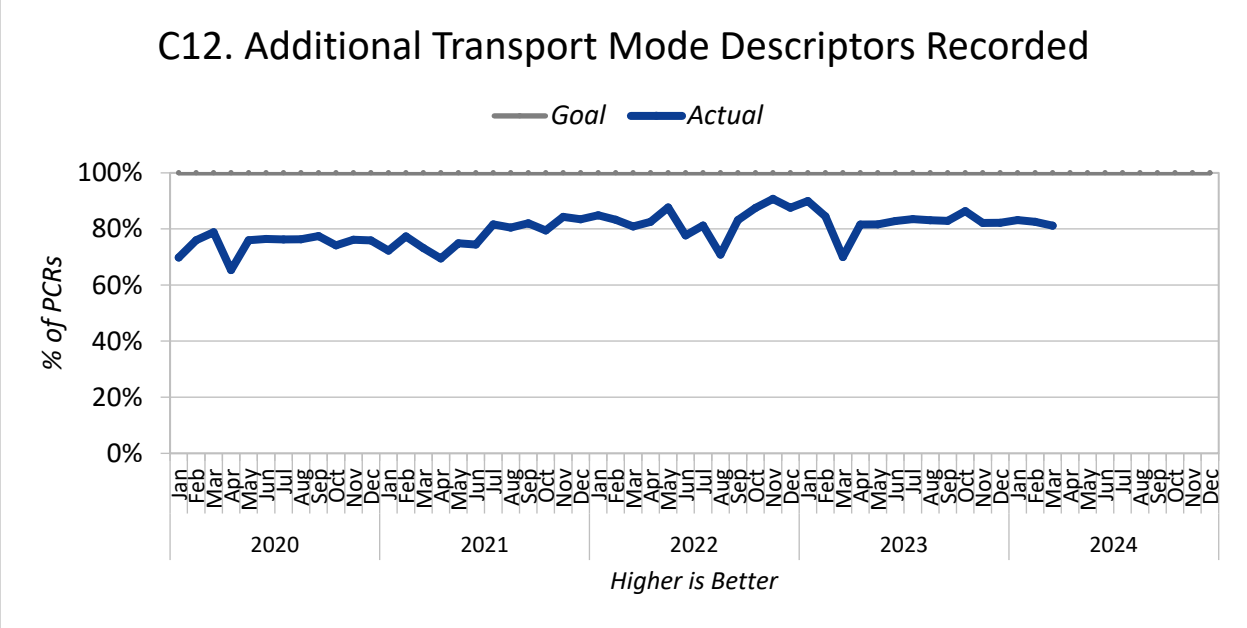
The percentage of medication administrations with Response to Medication recorded



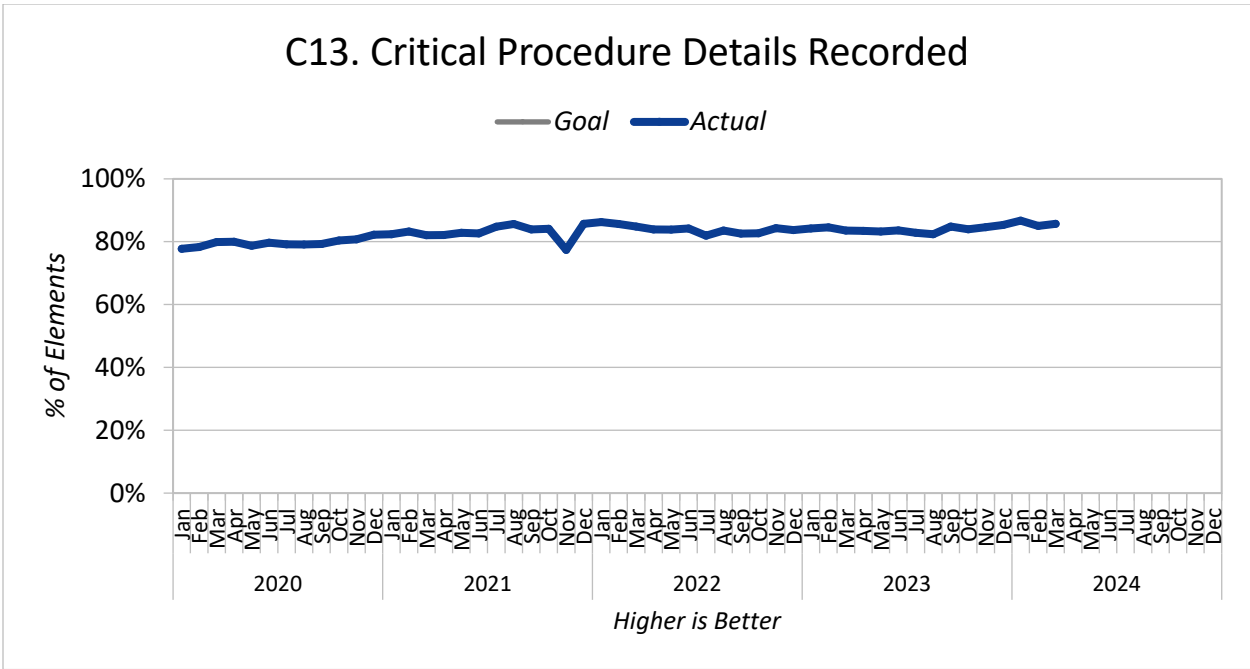
Where Primary Impression is stroke and Type of Service Requested is 911 response (scene) and a patient is treated and transported, the percentage of NEMSIS 3 patient care reports with a destination team stroke pre-arrival alert or activation recorded.



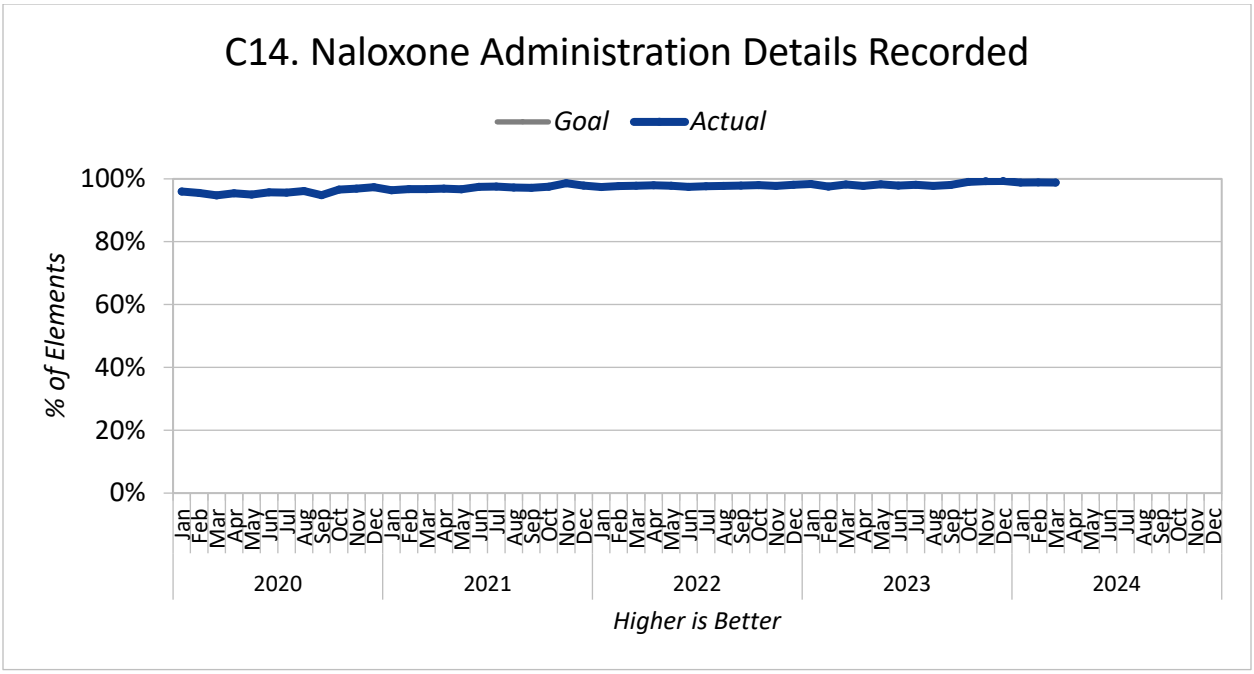
Where a patient is treated and transported, the percentage NEMSIS 3 patient care reports where more than one set of vital signs is recorded.



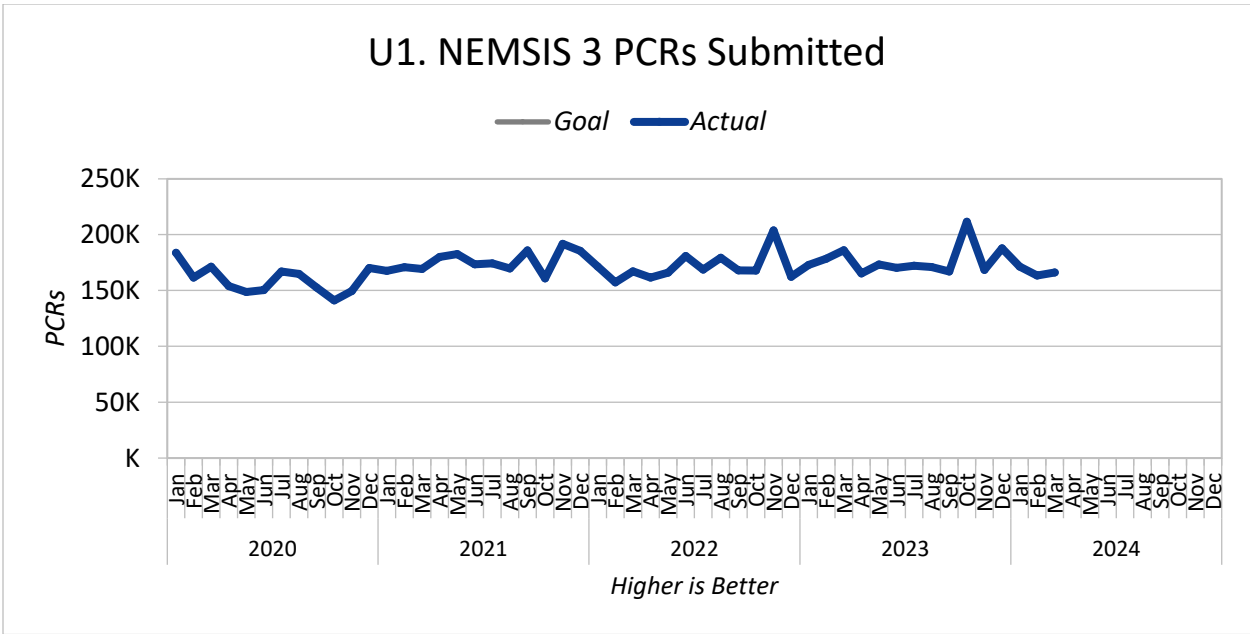
Where a patient is treated and transported, the percentage of patient care reports where Additional Transport Mode Descriptors is recorded with a non-blank value.



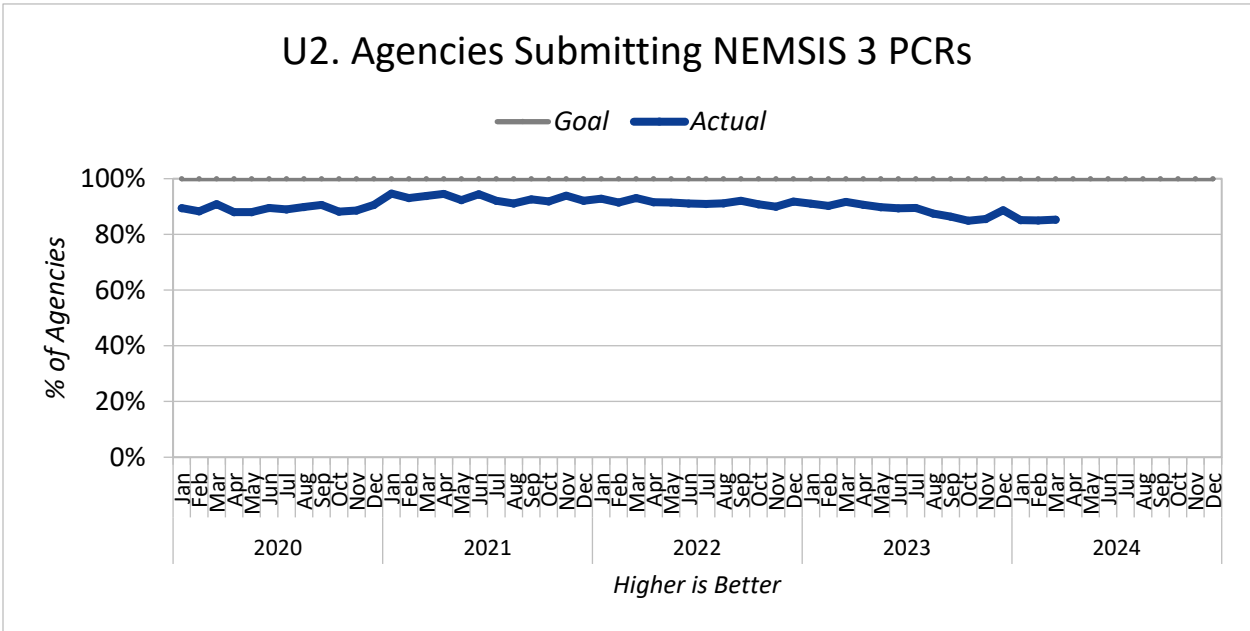
Where a critical procedure is performed, the average percentage of selected procedure-related elements with a non-blank value per procedure performed.



Where naloxone is administered, the average percentage of selected medication-related elements with a non-blank value per naloxone administration.



The number of NEMSIS version 3 patient care reports received by the state data system.



The percentage of agencies submitting NEMSIS version 3 data.