ENGLISH

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

NOTICE OF EMSCC APPEAL HEARING

01/22/2024

In the matter of:

Chad Klutman
(Petitioner) File No. 2301532

v.

Barry County Medical Control Authority
(Respondent)

To:
BLANCO WILCZYNSKI, PLLC
Orlando L. Blanco (P34480)
Derek S. Wilczynski (P57079)
Attorneys for Chad Klutman
2095 E. Big Beaver Road, Suite 400
Troy, MI 48083
(Attorney for Petitioner)
PETITIONER

SMITH HAUGHEY RICE & ROEGGE
Ashley Quackenbush
Attorney for Barry County Medical Control Authority
Dr. Jennifer Mervau, Medical Director
1009 W. Green St.
Hastings, MI 49058
(Attorney for Respondent)
RESPONDENT

On November 10, 2023, the Department received an appeal request from Chad Klutman through their Attorney, Orlando Blanco, in reference to the revocation of privileges by the Barry County Medical Control Authority (BCMCA).

An Emergency Medical Services Coordination Committee (EMSCC) appeal hearing has been scheduled in which both the Petitioner and Respondent (Parties) will have an opportunity to present oral testimony on their behalf. In accordance with section 20919(4) of the Public Health Code, the purpose of the appeal to the EMSCC is to determine whether the actions or decisions of the medical control authority are in accordance with their department-approved protocols of the medical control authority and state law. You are hereby notified that you may be represented by an attorney or representative, law permitting, at the hearing.

The Petitioner and Respondent shall each provide a short statement and all written material supporting their positions by Thursday, February 15, 2024 to:

Michigan Department of Health and Human Services
Bureau of Emergency Preparedness, EMS and Systems of Care
Division of EMS and Systems of Care
Attn: Nicole Babb, Executive Secretary
Email: BabbN@michigan.gov
Phone: 517-335-3077

EMSCC Appeal Hearing

The EMSCC has appointed the Quality Assurance Task Force (QATF) to review all appeals and to provide a summary and recommendation to the EMSCC. The QATF is serving as the investigatory body for appeals to MCA determinations. The hearing will be virtual and is scheduled with the QATF as follows in accordance with the EMSCC appeals procedure:

Hearing Date: February 23, 2024
Start Time: 10 a.m.
Hearing Location: Microsoft Teams meeting
Join on your computer, mobile app or room device
Click here to join the meeting
Or call in (audio only)
+1 248-509-0316 Phone Conference ID: 791 320 390#

EMSCC Appeal Hearing Procedures

1. If either party fails to appear at a proceeding scheduled in connection with this case, a default judgment or decision may be entered against you.

2. No additional material will be accepted after the appeal has been presented to the QATF.

3. The QATF will provide an opportunity for both the Respondent and Petitioner filing the appeal, to provide oral testimony. Testimony is limited to **15 minutes each** to allow sufficient time for the QATF to complete the hearing. Testimony includes the entire presentation by each party.

4. After review of all written materials and oral testimony, the QATF will close the meeting and deliberations by the QATF will be conducted under the Professional Standards Review Organization (PSRO) criteria.

5. **The QATF will base its opinion on whether the actions or decisions of the medical control authority are in accordance with their department-approved protocols of the medical control authority and state law.**

6. A written summary and opinion of the QATF will be provided to the EMSCC for review and recommendation at their next scheduled meeting on March 15, 2024.

The schedule and location of these public hearings may be obtained from our website at: https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/ems/inside/ems-coordination-committee-emscc.

All meetings and hearings are conducted in compliance with the Americans with Disabilities Act. Meetings and hearings are held in buildings that accommodate mobility impaired individuals and accessible parking is available. A disabled individual requiring additional accommodation for effective participation in a meeting or hearing should call Nicole Babb at 517-335-3077 to make the necessary arrangements. To ensure availability of the accommodation, please call at least one week in advance.

If you have any questions regarding the appeal process, please contact Sabrina Kerr, EMS Manager, at: KerrS3@michigan.gov or 517-243-9976.

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

QATF PACKET COVER PAGE

MCA: Genesee County MCA

PACKET FOR: February 23, 2024

PROTOCOLS INCLUDED:

- 8-2 Pt Prioritization
- 8-3 Transportation

Michigan Department of Health and Human Services
Bureau of Emergency Preparedness, EMS and Systems of Care
Division of EMS and Systems of Care
PO Box 30207
Lansing, MI 48909-0207
www.michigan.gov/ems

Medical Control Authority Request for Protocol Change

MCA Name: Genesee County

Medical Director Name: Joshua Newblatt

Name of Submitter: Bruce Trevithick

Date of Submission: February 10, 2024

Communication included with this form from the above-named medical director indicating this form has been reviewed and approved.

ADOPTING STATE PROTOCOLS AS WRITTEN

Protocol Number	Protocol Name	MCA Adoption Date	MCA Implementation Date	Dept Use ONLY

CHANGES TO A STATE PROTOCOL WITHIN THE YELLOW SELECTION BOX *ONLY*

Protocol Number	Protocol Name	MCA Adoption Date	MCA Implementation Date	Dept Use ONLY

Medical Control Authority Request for Protocol Change

ADOPTING A PROTOCOL CURRENTLY UTILIZED BY ANOTHER MCA *AS WRITTEN*

Contents of the original protocol has not been edited, the original protocol is included with the submission, the protocol was approved by MDHHS within the last 3 years and the protocol is in current use in the MCA from which it was obtained.

Proposed Protocol Number	Proposed Protocol Name	Proposed MCA Adoption Date	Proposed MCA Implementation Date	Dept Use Only

ALL OTHER PROTOCOLS

After QATF recommendation of department approval, a clean copy of the protocol with recommended changes (if applicable), MCA adoption date and MCA implementation date will be submitted to the department at least 15 business days prior to implementation. The department will issue an approval letter within 10 business days of receipt. The MCA is then required to submit a final copy of the protocol which must include the MDHHS approval date.

Proposed Protocol Name: Patient Prioritization and Use of Lights and Sirens

Rationale:
This is a combination of the state's protocol and previous language used by our MCA for patient prioritization, with the elimination of some language of the state's which we felt was too permissive and allowed for more lights and sirens responses that we believe is appropriate for our community.

Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):

There is a large volume of data regarding the dangers of lights and sirens response, so our protocol limits the use of lights and sirens to only patients that are critically ill or injured with an immediate life threat.

Patient Prioritization and Use of Lights and Siren

This protocol is designed to provide a safe and orderly response to all requests for emergency medical care in the State of Michigan.

Patient Prioritization

Lights and sirens will only be used with Priority 1 patients as outlined below. Priority 2 and 3 patients will be transported without lights and sirens.

1. Priority 1
   A. Critically ill or injured patient with an immediate life-threatening condition, including unstable or deteriorating vital signs.

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

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

Lights and Sirens Usage

A. **Michigan Motor Vehicle Code** *(§257.603 and 257.653)*
The Michigan Motor Vehicle Code governs the driving of emergency vehicles. All licensed life support vehicles will abide by the Michigan Motor Vehicle Code.

1. This protocol does not supersede the Michigan Motor Vehicle Code.

B. **Authority to Require Lights and Siren Use**
Neither the patient's sending nor receiving physician has the authority to require the use of lights and siren during transport; this policy shall be followed at all times. Only the EMS transport crew can determine transport mode, based on patient priority.

C. **Use of Emergency Medical Dispatch**
Where Emergency Medical Dispatchers (EMD) and/or a tiered EMS response are/is available, the EMS Agency is encouraged to develop procedures that reduce unnecessary use of lights and sirens. The procedures may include, but are not limited to, the use of established EMD call screening protocols and evaluation of the scene/patient by first responder personnel.

D. **Returning from the transport, returning to a service area**

1. EMS units may ONLY utilize lights and sirens to return to their area IF THEY ARE RESPONDING TO AN EMERGENCY CALL.
2. Lights and sirens will **NOT** be used to return to an area when the unit is not responding to another emergency call.

E. **Education**

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

F. **Agency and Medical Control Authority Specific Policies**

This protocol does not preclude MCAs from developing protocols and/or individual agencies from developing internal policies on this subject, as long as it includes the contents of this protocol as a minimum.

G. **Response and Transport**

Response to the scene and transport to the hospital is determined by patient priority.

1. If the on-scene patient priority is different from the dispatch priority, follow the on-scene patient priority for transport.
2. If the patient priority changes during transport follow the appropriate use of lights and sirens for the new patient priority.

H. **Prohibition on the Use of Lights and Sirens**

Lights and sirens will not be used regardless of the patient priority under the following circumstances:

1. During road conditions exist that could either place the emergency vehicle at risk of an accident or if doing so could result in wake effect accidents by nearby vehicles.
2. Visibility would be such that lights and sirens would have no effect.

Patient Prioritization and Use of Lights and Siren

This protocol is designed to provide a safe and orderly response to all requests for emergency medical care in the State of Michigan.

Patient Prioritization

Lights and sirens will only be used with Priority 1 patients as outlined below. Priority 2 and 3 patients will be transported without lights and sirens.

1. Priority 1
   A. Critically ill or injured patient with an immediate life-threatening condition, including unstable or deteriorating vital signs.

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

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

Lights and Sirens Usage

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This protocol does not preclude MCAs from developing protocols and/or individual agencies from developing internal policies on this subject, as long as it includes the contents of this protocol as a minimum.

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2. Visibility would be such that lights and sirens would have no effect.

Medical Control Authority Request for Protocol Change

ADOPTING A PROTOCOL CURRENTLY UTILIZED BY ANOTHER MCA *AS WRITTEN*

Contents of the original protocol has not been edited, the original protocol is included with the submission, the protocol was approved by MDHHS within the last 3 years and the protocol is in current use in the MCA from which it was obtained.

Proposed Protocol Number	Proposed Protocol Name	Proposed MCA Adoption Date	Proposed MCA Implementation Date	Dept Use Only

ALL OTHER PROTOCOLS

After QATF recommendation of department approval, a clean copy of the protocol with recommended changes (if applicable), MCA adoption date and MCA implementation date will be submitted to the department at least 15 business days prior to implementation. The department will issue an approval letter within 10 business days of receipt. The MCA is then required to submit a final copy of the protocol which must include the MDHHS approval date.

Proposed Protocol Name: 8.3 Transportation

Rationale:
This is our MCA's traditional Transportation protocol with changes to four (4) sections: I.11; III.1B; IV. (new); V.; and VI.

Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):

I.11 - change is to be consistent with the time frame in the state ALS and LALS Intercept/Transfer of Care protocol
III.1.B. - change reflects the recommendation of our Level 1 trauma center on when a pregnant patient should be transported to a pediatric center.
IV. - this new section was added at the request of one of our hospitals due to the lack of capability they have to care for this type of patient.
V. & VI. - changes made to these two sections were made to limit transport times for stroke and STEMI patients.

Transportation

Prehospital patients shall be transported to an in-hospital emergency facility, a GCMCA recognized free standing outpatient surgical facility (FSOF), or provider-based emergency department as follows:

I. General Transport Criteria:

1. Facility of patient's choice.

2. Patient's medical home (i.e. the facility of past use and/or affiliated with the patient's primary care physician – if known).

3. If patient is a minor, or incompetent, facility of family or guardian choice.

4. In matters of life and death or loss of limb, the closest appropriate facility as determined by the medical control physician and the pre-hospital provider.

5. EMS Personnel must consider when a patient's/patient's relative choice would endanger the patient due to:
   A. increased transport time;
   B. lack of appropriate facilities capable of addressing patient's specific problems;
   C. over-burdening of facilities for any reason(s) (i.e., ambulance hold, disaster).

6. If facility of choice is in an adjacent county, the EMS provider should use their best judgment if this would be appropriate for the patient, and can occur without online medical control approval as long as it does not contradict other sections of this protocol. If the facility of choice is in a location other than Genesee County or one of its adject counties online medical control should be contacted, unless transporting an LVAD patient.

7. No other individuals (police, fire, other physician) shall be allowed to determine the destination of a patient without prior approval from online medical direction.

8. GCMCA recognized Freestanding Surgical Outpatient Facilities (FSOFs) may receive patients via ambulance except the following:
   Patients With:
   A. Multi-system trauma
   B. Blunt torso trauma
   C. Penetrating torso trauma

D. Patients in active labor
E. High risk obstetrics
F. Critical care pediatrics
G. Reimplantation above the ankle or wrist
H. Burns per Burn Protocol
I. Head injury with GCS < 13
J. Priority I patients whose condition could be expected to deteriorate or patients who would be better served by a more specialized medical facility.

9. The following criteria must be met in order for a facility to be considered a GCMCA recognized FSOF:
   A. Must maintain appropriate Joint Commission, AOA, HFAB or DNV accreditation.
   B. Must be operational 24 hours a day.
   C. Must be licensed by the department as a free standing outpatient surgical facility (FSOF).

Patients requesting a FSOF, who do not meet criteria to go to that facility, shall be diverted by the usual Genesee County Medical Control Authority Advisory Committee protocols (i.e. patient preference if stable, or closest, most appropriate facility if unstable).

10. A patient may be transported to a provider-based emergency department if they meet any of the following criteria:
    a. A priority 3 patient who requests transport to the provider-based emergency department.
    b. Unstable patients are not appropriate for provider-based emergency department unless, in the opinion of the EMS personnel and online medical control physician, transporting the patient to a further facility could have an adverse effect on the patient's outcome.
    c. A trauma patient with minor injuries such as sprains and minor fractures without deformity or without high velocity mechanism who requests transport to the provider-based emergency department.

11. In the event that a BLS or LALS transporting rig is more than ~~5~~10 minutes from an in-hospital emergency facility and is in need of an ALS provider for appropriate patient treatment, the BLS/LALS agency will contact the appropriate 911 agency to request an ALS intercept. The intercept should not cause more than a brief delay in transport. Intercepts are to take place at a fixed meeting location. The responding ALS unit will maintain communication with the intended intercept vehicle. Upon meeting with due care and caution, members of the ALS vehicle should board the intercept vehicle bringing

appropriate equipment. All units operating in the Genesee County Medical Control region shall cooperate and provide all necessary verbal information to coordinate an intercept. In the event that the LALS/BLS unit is in route to the hospital and is less than 5 minutes from the hospital, a request for ALS intercept will not be made.

II. Pediatric Destination Criteria:

Pediatric patients (ages 14 and under) can be transported to any of the three Genesee County hospitals with the following exceptions:

1. Unstable trauma patients meeting any of the following criteria, but not in cardiac arrest, should be transported to Hurley Medical Center:

ABSOLUTE CRITERIA

Vital signs & level of consciousness
- Glasgow Coma Scale <14
- Systolic Blood Pressure <90
- Respiratory Rate <10 or >29 (<20 in infant less than 1 year)

Anatomy of injury
- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee.
- Flail Chest
- Two (2) or more proximal long bone fractures (femur and or humerus).
- Crush, degloved or mangled extremity
- Amputation proximal to wrist or ankle
- Pelvic fracture
- Open or depressed skull fracture
- Paralysis

Mechanism and evidence of high-energy impact
- Falls >10 feet or 2 to 3 times the height of the child
- High-risk auto crash
  - Intrusion > 12 in. occupant site, 18 in any site
  - Ejection (partial or complete) from automobile
- Death in same passenger compartment
- Auto v. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash > 20 mph

RELATIVE CRITERIA

Special patient or system considerations

- Anticoagulation and bleeding disorders (patient on coumadin or plavix)
- Burns
  - Without other trauma mechanism
  - With trauma mechanism
- Time sensitive extremity injury
- End-stage renal disease requiring dialysis
- Any other injuries felt by EMS personnel to require specialized trauma care.

2. All non-traumatic **Priority 1** medical patients should not be transported to McLaren Regional Medical Center. **Priority 1** patients per protocol are "critically ill or injured patients, which include those unstable patients with abnormal vital signs, or those with a suspected disease process or mechanism of injury which posses immediate threat to life."

3. If based upon the above criteria the unit will bypass a closer facility and, in the opinion of EMS personnel or on-line medical control, this decision would result in an adverse effect on the patient's outcome, then the closer facility may be selected as the final destination.

III. Adult Trauma Destination Criteria:

1. Cases meeting the following criteria will be transported to Hurley Medical Center unless communication between field personnel and receiving hospital determines otherwise:
   A. Burns - Patients with greater than 5 percent 3rd degree; or greater than 15 percent 2nd degree; or respiratory burns; or burns involving hands, feet, face, perineum.
   B. Pregnancy - Trauma patients greater than 20 weeks gestation. ~~in 2nd or 3rd trimester~~.

Commented [BT1]: Recommendation from Hurley - 1-8-24

IV. OB High Risk Delivery

Because infants may require newborn intensive care, women in active labor with pregnancy of more than 20 weeks and less than 35 weeks gestation should **NOT** be transported to McLaren-Flint and should be transported to one of the other two Genesee County hospitals. In addition, any newborns delivered at home where the mother's gestation was more than 20 week and less than 35 weeks should also **NOT** be transported to McLaren-Flint and should be transported to one of the other two Genesee County hospitals.

~~I~~V. Acute ST Elevation Myocardial Infarction:

Currently all Genesee County hospitals have the capability to adequately care for ~~stable and unstable~~ ST Elevation Myocardial Infarction (STEMI) patients. These patients should be transported to the closest hospital or to the patient's medical home hospital (must document the patient/family statement to that effect in the narrative).

Unstable STEMI patients should be transported to the closest hospital regardless of the patient's medical home hospital.

VI.CVA/Stroke:

Currently all Genesee County hospitals have the capability to adequately care for CVA/stroke patients and these patients should be transported to the closest hospital or to the patient's medical home hospital (must document the patient/family statement to that effect in the narrative).

Unstable stroke patients should be transported to the closest hospital regardless of the patient's medical home hospital.

Commented [BT2]: It has been suggested by one of the committee members and not previously discussed that "closest hospital" be changed to "most appropriate hospital." The AC will need to address this request before final action.

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3. If patient is a minor, or incompetent, facility of family or guardian choice.

4. In matters of life and death or loss of limb, the closest appropriate facility as determined by the medical control physician and the pre-hospital provider.

5. EMS Personnel must consider when a patient's/patient's relative choice would endanger the patient due to:
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    a. A priority 3 patient who requests transport to the provider-based emergency department.
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- Crush, degloved or mangled extremity
- Amputation proximal to wrist or ankle
- Pelvic fracture
- Open or depressed skull fracture
- Paralysis

Mechanism and evidence of high-energy impact
- Falls >10 feet or 2 to 3 times the height of the child
- High-risk auto crash
  - Intrusion > 12 in. occupant site, 18 in any site
  - Ejection (partial or complete) from automobile
- Death in same passenger compartment
- Auto v. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash > 20 mph

RELATIVE CRITERIA

Special patient or system considerations

Michigan Department of Health and Human Services
Bureau of Emergency Preparedness, EMS and Systems of Care
Division of EMS and Systems of Care
PO Box 30207
Lansing, MI 48909-0207
www.michigan.gov/ems

Medical Control Authority Request for Protocol Change

MCA Name: Genesee County

Medical Director Name: Joshua Newblatt

Name of Submitter: Bruce Trevithick

Date of Submission: February 10, 2024

Communication included with this form from the above-named medical director indicating this form has been reviewed and approved.

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  - With trauma mechanism
- Time sensitive extremity injury
- End-stage renal disease requiring dialysis
- Any other injuries felt by EMS personnel to require specialized trauma care.

2. All non-traumatic **Priority 1** medical patients should not be transported to McLaren Regional Medical Center. **Priority 1** patients per protocol are "critically ill or injured patients, which include those unstable patients with abnormal vital signs, or those with a suspected disease process or mechanism of injury which posses immediate threat to life."

3. If based upon the above criteria the unit will bypass a closer facility and, in the opinion of EMS personnel or on-line medical control, this decision would result in an adverse effect on the patient's outcome, then the closer facility may be selected as the final destination.

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Currently all Genesee County hospitals have the capability to adequately care for ~~stable and unstable~~ ST Elevation Myocardial Infarction (STEMI) patients. These patients should be transported to the closest hospital or to the patient's medical home hospital (must document the patient/family statement to that effect in the narrative).

Unstable STEMI patients should be transported to the closest hospital regardless of the patient's medical home hospital.

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Currently all Genesee County hospitals have the capability to adequately care for CVA/stroke patients and these patients should be transported to the closest hospital or to the patient's medical home hospital (must document the patient/family statement to that effect in the narrative).

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

QUALITY ASSURANCE TASK FORCE
AGENDA
February 23, 2024
10:00 a.m.
VIRTUAL ONLY
Click here to join the meeting
+1 248-509-0316 Conference ID: 791 320 390#

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

EMSCC Appeal Hearing:
Chad Klutman, Paramedic IC vs. Barry County Medical Control Authority
File No. 2301532

Agenda and Minutes:

MCA Protocols/Bylaws:

1. **GENESEE COUNTY MCA**
   a. 8-2 Patient Prioritization
   b. 8-3 Transportation
2. **WASHTENAW/LIVINGSTON MCA**
   a. 4-7 Pediatric Seizures
3. **WAYNE COUNTY MCA (HEMS)**
   a. 7-13 (S) Pain Management Supplement
   b. 8-29 General Operations
   c. 8-29 (S3) Transfer of Care

State Protocols/Bylaws:

1. **Other matters – K. Kuhl**
   a. Protocol status/update
   b. General Q & A with Krisy Kuhl

Michigan Department of Health & Human Services

Bureau of Emergency Preparedness, EMS and Systems of Care

QATF PACKET COVER PAGE

MCA: WASHTENAW/ LIVINGSTON MCA

PACKET FOR: February 23, 2024

PROTOCOLS INCLUDED:

- 4-7 Pediatric Seizures

Michigan Department of Health and Human Services
Division of EMS and Trauma
P.O. Box 30207
Lansing, MI 48909-0207

Medical Control Authority Request for Addendum of Michigan Protocols

MCA Information

MCA:	**Washtenaw/Livingston**	Medical Director:	**Robert Domeier, M.D.**
Protocol:	**4.7 Pediatric Seizures**	Submitted by:	**Kevin Henderson**

Identify where you are requesting to make change/changes:

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

☐ Other (specify)

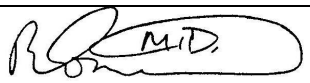
☐ Additional Protocol

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

Justification (must be based on medical research, facts and/or data; attach additional pages if needed):
Continuation of Pedidose study with change to age and volume for administration of Midazolam IM or IN.

Rationale: Why is this addendum necessary for your MCA?
Request to change made by Pedidose study physician group.

Specify where in the protocol this addendum takes place (list page numbers, sections, etc.)
II. D. age based chart

Medical Director's Signature:  *Date:* 1/22/24

Deleted: 10/25/2017

Pediatric Seizures

I. Follow **Patient Assessment Protocol**.
II. **IF PATIENT IS ACTIVELY SEIZING:**
A. Protect patient from injury.
B. Do not force anything between teeth.
C. Determine patient age either by bystander report or length based tape.
D. Administer Midazolam IM or IN according to the age based chart.

Tape color						
age	0-5mo	6-16mo	17-24mo	2y-5y	6y-11y	12-13y
volume	MIMEDIC	MIMEDIC	0.5mL	0.5mL	1mL	2mL
dose	MIMEDIC	MIMEDIC	2.5mg	2.5mg	5mg	10mg

a. If patient determined to be significantly small for age or known to be pregnant utilize MIMEDIC card or administer Midazolam 0.1mg/kg IM.
b. Maximum individual dose 10 mg

E. Measure blood glucose level.

MCA Approval of Blood Glucose Testing by specific MFR Agencies
(Provide participating agency list to BETP)

☒YES ☐NO

F. Start IV/IO if needed to treat hypoglycemia after administering the first midazolam dose.
G. If glucose is less than 60 mg/dL, administer Dextrose according to MI-MEDIC cards.
H. If MI-MEDIC unavailable, administer Dextrose 0.5 g/kg
a. For patients up to 2 months of age, utilize Dextrose 12.5%
b. For patients between 2 months and 6 years of age, utilize Dextrose 25%
c. For patients age 7 or greater, utilize Dextrose 50%
I. Per MCA selection, if unable to start IV, administer Glucagon according to MI-MEDIC cards.

Glucagon Included?
☐ Yes ☒ No

J. For ongoing seizures ≥5 minutes after the first dose of midazolam has been given, repeat midazolam IM/IN dose as noted in the table above.
K.

III. If patient is not currently seizing, but has altered mental status, refer to **ALTERED MENTAL STATUS PROTOCOL.**

Commented [MS1]: If the bystander does not know the age, I have been recommending that sites use their length-based tape as a backup. Since your site uses MIMEDIC, not Broselow or Handtevy, let me know what the paramedics would do if they do not know a patient's age with MIMEDIC.

Commented [MS2R1]: Broselow colors correlate with MIMEDIC

Commented [MS3]: Just checking that this is an option or if you only want the paramedics to use IM at your site.

Commented [MS4R3]: IM is currently used, but IN is allowed

Commented [MS5]: This is good for now. Once we implement age de-escalation, this can be updated.

Commented [MS6]: Dosing for ages >14 years (including adults) is beyond the scope of PediDOSE. But I have been suggesting that this dose also be 10 mg to avoid confusion. This is not absolutely necessary for the study, but it would be helpful based on prior feedback I have received from paramedics. I just want to make sure that people older than 13 years old are not getting a lower dose, since this may make paramedics hesitant to give the 10 mg dose to the 12-13 year olds for the study.

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Commented [MS7]: 40 mg/dL is a very low cut-off beyond the newly born age range. I suggest using 60 mg/dL for all ages or just restrict <40 mg/dL to the newly born (<24 hours since birth)

Commented [MS8]: This is beyond the scope of PediDOSE, but I suggest adding doses in ml/kg for dextrose as follows, so that they do not have to do multiple calculations:

D12.5: 5 ml/kg
D25: 2 ml/kg
D50: 1 ml/kg

Commented [MS9]: Stacey needs to get state approval to give a 2nd IM/IN dose without the need for contacting medical control and to not give it IV/IO

Commented [MS10]: Lorazepam is not used by HVA and Livingston; it is there for other agencies to have available in Michigan, since this is a statewide protocol

Commented [MS11]: I took this out to keep things simple. For PediDOSE, to avoid dose confusion and calculations, we want the first and the second doses of midazolam to be given IM/IN, regardless of whether there is IV/IO access.

Deleted: March 28, 2018

Deleted: June 1, 2018

Pediatric Seizures

I. Follow **Patient Assessment Protocol**.

II. **IF PATIENT IS ACTIVELY SEIZING:**

A. Protect patient from injury.

B. Do not force anything between teeth.

C. Determine patient age either by bystander report or length based tape.

D. Administer Midazolam IM or IN according to the age based chart.

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age	0-5mo	6-16mo	17-24mo	2y-5y	6y-11y	12-13y
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Glucagon Included?
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MDHHS Michigan Department of Health & Human Services | Bureau of Emergency Preparedness, EMS and Systems of Care

QATF PACKET COVER PAGE

MCA: Wayne County MCA

PACKET FOR: February 23, 2024

PROTOCOLS INCLUDED:

- 7-13(S) Pain Mgmt Supplement
- 8-29 General Operations
- 8-29 (S3)Transfer of Care

Michigan Department of Health and Human Services
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Lansing, MI 48909-0207
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ALL OTHER PROTOCOLS: ADDITIONAL PAGE(S)

This page may accompany the original Medical Control Authority Request for Protocol Change form when additional space is needed.

MCA Name: Patient Prioritization and Use of Lights and Sirens

Date of Submission: This is a combination of the state's protocol and previous language used by

Proposed Protocol Name: There is a large volume of data regarding the dangers of lights and sirens

Rationale:

Genesee County

Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):

Joshua Newblatt

~~Proposed Protocol Name:~~ ~~Bruce Trevithick~~

~~Rationale:~~

~~This is a HEMS protocol that we are maintaining and renumbering to 7.15 S. There are no~~ changes to the protocol.

~~Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):~~

PAIN MANAGEMENT SUPPLEMENT

Purpose: In face of the opioid crisis there has been a national push to decrease the use of opioid pain medication.

1. Many EDs are using ALTO programs (Alternative To Opioids) to treat pain in their departments.
2. Opioid medications are only being used for severe pain when alternatives have failed.

Procedure:

1. Per the **Pain Management Protocol**
    a. Opioid medications should only be used in patients with severe pain (Wong score greater than 8).
    b. In order to better serve our patients, we are asking that ALS providers consider limiting the use of IV opioids since we now have available several non-narcotic options to address our patient's pain.
2. Please restrict IV opioid use to the following indications:
    a. Major burns
    b. Significant extremity fractures
    c. Cardiac chest pain not relieved with administration of 3 SL Nitro tabs
    d. Obvious severe kidney stone pain
3. Please do not use IV opioids for the following indications:
    a. Headache
    b. Abdominal pain
    c. Non kidney stone back pain
    d. Any other pain not defined in either of these lists

4. Contact Medical Control as needed for additional guidance.

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ALL OTHER PROTOCOLS: ADDITIONAL PAGE(S)

This page may accompany the original Medical Control Authority Request for Protocol Change form when additional space is needed.

MCA Name: HEMS, Inc

Date of Submission: January 8, 2024

Proposed Protocol Name: 8.29 (S1) and 8.29 (S2) and 8.27(S)

Rationale:

8.29 (S1) Access to the HEMS Communication System- number changed from 8.20
8.29 (S2) EMS Communications Interoperability- number changed from 8.20(S)
8.27 (S) Integrated Agency-System Quality Improvement Plan- no number change

These are HEMS protocols that we are maintaining with no language change to the protocol.

Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):

Proposed Protocol Name: 8.29 (S3) Transfer of Care (Hand-Off) Protocol

Rationale:

This is being renumber from 8.29. Removed the language about Provider communication since it is listed in the new 8.29. Added the referenced form to the protocol. Added language about when on hospital property and the patient wants to go to another facility due to wait time.

Evidence used to determine/display the need for the change. This may include MCA level data, published articles, peer reviewed journals, etc., (explained or attached):

I. **Purpose:** The purpose of this policy is to establish standards for the transfer of patient care from Emergency Medical Services (EMS) providers to emergency department (ED) providers in the HEMS Medical Control Authority.

II. **Policy:** Acute care hospital emergency departments receiving 9-1-1 transported patients shall be prepared to receive patients from EMS providers and accept care of patients upon arrival. The transfer of care process will support best practices of safe handoff and a goal of EMS departure within 20 minutes of arrival to ED.

III. **Definition:**

Transfer of Care- Transfer of Care will be noted when:

1. The patient is removed from the EMS stretcher and transferred to the ED stretcher, bed, chair or other acceptable location.
2. EMS personnel provide a face-to-face verbal report to the accepting ED approved person.
3. Accepting ED approved person signs the Prehospital Patient Care Record (PCR).

~~IV. **Provider Communication:**~~

~~1. Priority 1 and 2 radio communication~~

~~EMS provider will notify the hospital of patient transport (reference HEMS protocol **General Considerations**)~~

~~EMS radio communication responsibility:~~

- ~~Unit number~~
- ~~Priority~~
- ~~Age/Sex~~
- ~~Chief complaint. As appropriate state STEMI, Stroke, Cardiac/respiratory arrest, Trauma or Sepsis alert~~
- ~~GCS / Vital Signs / Physical findings~~
- ~~Other pertinent information (mechanism of injury, scene observations, medical history etc.)~~
- ~~Treatments initiated~~
- ~~ETA~~

~~The signal for report end is the question "Are there any questions or further orders?"~~
~~As appropriate request Security assist, Lift assist, or Infectious Disease isolation.~~

~~Hospital staff radio communication responsibility:~~

- ~~The hospital will respond to EMS communication and prepare to receive the patient.~~
- ~~Respond to radio alert in a timely manner.~~
- ~~Listen carefully.~~
- ~~Ask for relevant missing information~~

Commented [LM1]: This is covered in General Operations

~~Hospital signals transmission end by stating "we will be expecting your arrival Hospital X is clear." When possible assign room number, treatment area, or external triage.~~

~~2. Priority 3 radio communication~~

~~EMS responsibility: EMS provider will radio HEMS operator Priority 3 information.~~
- ~~EMS unit number~~
- ~~Chief complaint~~
- ~~Need for a stretcher~~
- ~~ETA~~

~~HEMS Operator responsibility: relay and repeat Priority 3 transfer information to receiving hospital.~~
- ~~Alternatively the EMS provider may utilize HEMS radio to establish contact with the hospital for providing a direct Priority 3 report.~~

~~V.~~IV. Transfer of Care Communication

1. Effective transfer of care (handoff) from EMS to the ED/EC is critical to providing safe and quality patient care. Structured communication during the transfer of care is essential to prevent missed information. A handoff is more than the transfer of patient care information; it is also the transfer of professional responsibility.

2. Optimal transfer of care communication staging
- The goal of the transfer of care report is to develop a shared understanding among providers.
- Handoff should be face-to-face and held at the patient bedside to provide mutual understanding of current clinical appearance and VS; and to include the patient in the report.
- Report should be provided and received in a professional and mutually respectful manner.
- The clinician receiving transfer of care information should be:
  - the next giver of care
  - clearly identifiable
  - prepared to receive the handover uninterrupted and with limited distractions

3. EMS provider verbal report responsibilities
- Identify the next direct caregiver. "Are you the nurse that will be caring for the patient?"
- Provide a succinct, relevant, complete report in 45-60 seconds
- Utilize CHEATED acronym to guide report and documentation.
  - C – Chief Complaint. Why was EMS called?
  - H – History. Medical/surgical history, allergies, medications, Advance Directive
  - E – Examination. Relevant physical exam findings
  - A – Assessment and field diagnosis. What is perceived to be wrong with patient?
  - T – Treatment provided. What did you do for the patient?
  - E – Evaluation. Response to treatment. Did patient get better/ worse during transport?
  - D – Disposition. Document transfer of care to the medical facility/care provider.

- Share any changes since the initial report.
- Include additional information that may help the ED team.
- Show gratitude and appreciation for the work of the ED team.

The signal for EMS provider report end is the question: "Are there any questions?"

4. EMS personnel shall provide continuity of treatments upon arrival at the ED. If a change in patient condition or other situation arises in which EMS personnel believes additional care is required, EMS will notify ED staff on arrival.

5. Hospital provider verbal report responsibilities (See Transfer of Care Information Form)

- Make yourself available to receive report in a timely manner
- Signal readiness to receive report.
- Offer focused, respectful attention, allowing complete provider report without interruption.
- Show gratitude and respect for the work of the EMS team
- Summarize and "speak-back" key aspects of priority information
- Ask questions to clarify information

Commented [LM2]: Where is this form. Add to protocol

6. Patient Care Report

- A Patient Care Report (PCR) will be completed and provided to the ED staff for each patient transport via HEMS approved documentation delivery methods, i.e. email, fax, or paper report. (Reference HEMS protocol **Documentation and Patient Care Records~~ and EPCR-PCR and Transfer of Care.~~** ~~**Patient Care Record, Electronic Documentation & EMS Information System**~~).

~~VI.~~V. Collaborative management of delays in transfer of care

EMS/ED/Hospital responsibilities:

1. ED personnel will work with the EMS personnel and/or EMS supervisor to:
   - assure optimal transfer of care
   - resolve instances of offload delays and/or extended offload delays
   - provide, as requested, communication of reason(s) offload delays
2. When a delay in transfer of care occurs EMS personnel will make face-to-face contact with the ED supervisory staff, regarding ED bed availability timing and to inquire for potential offload delay reason.
3. EMS personnel will notify their EMS supervisor when wait times are ≥ 20 minutes and they have not received satisfactory resolution from ED supervisory staff.
4. EMS supervisor, once notified by EMS personnel, will make contact with the ED supervisory staff to communicate urgent need to release ambulance resources.
5. ED supervisory staff will provide situational awareness to Hospital/ED administration of periods of high ED demand associated with unusual or escalating offload delay situations.
6. When on hospital property, the EMS provider cannot transport to another hospital without physician notifications and medical screening. Exam from the current location.

~~5.~~ Documentation Note: physician name must be documented in the narrative.

I. **Purpose:** The purpose of this policy is to establish standards for the transfer of patient care from Emergency Medical Services (EMS) providers to emergency department (ED) providers in the HEMS Medical Control Authority.

II. **Policy:** Acute care hospital emergency departments receiving 9-1-1 transported patients shall be prepared to receive patients from EMS providers and accept care of patients upon arrival. The transfer of care process will support best practices of safe handoff and a goal of EMS departure within 20 minutes of arrival to ED.

III. **Definition:**

Transfer of Care- Transfer of Care will be noted when:

1. The patient is removed from the EMS stretcher and transferred to the ED stretcher, bed, chair or other acceptable location.
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3. Accepting ED approved person signs the Prehospital Patient Care Record (PCR).

IV. Transfer of Care Communication

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2. Optimal transfer of care communication staging
   - The goal of the transfer of care report is to develop a shared understanding among providers.
   - Handoff should be face-to-face and held at the patient bedside to provide mutual understanding of current clinical appearance and VS; and to include the patient in the report**.**
   - Report should be provided and received in a professional and mutually respectful manner.
   - The clinician receiving transfer of care information should be:
     - the next giver of care
     - clearly identifiable
     - prepared to receive the handover uninterrupted and with limited distractions

3. EMS provider verbal report responsibilities
   - Identify the next direct caregiver. "Are you the nurse that will be caring for the patient?"
   - Provide a succinct, relevant, complete report in 45-60 seconds
   - Utilize CHEATED acronym to guide report and documentation.
     C – Chief Complaint. Why was EMS called?
     H – History. Medical/surgical history, allergies, medications, Advance Directive
     E – Examination. Relevant physical exam findings
     A – Assessment and field diagnosis. What is perceived to be wrong with patient?
     T – Treatment provided. What did you do for the patient?
     E – Evaluation. Response to treatment. Did patient get better/ worse during transport?
     D – Disposition. Document transfer of care to the medical facility/care provider.

- Share any changes since the initial report.
- Include additional information that may help the ED team.
- Show gratitude and appreciation for the work of the ED team.
- The signal for EMS provider report end is the question: "Are there any questions?"

4. EMS personnel shall provide continuity of treatments upon arrival at the ED. If a change in patient condition or other situation arises in which EMS personnel believes additional care is required, EMS will notify ED staff on arrival.

5. Hospital provider verbal report responsibilities (See Transfer of Care Information Form)
   - Make yourself available to receive report in a timely manner.
   - Signal readiness to receive report.
   - Offer focused, respectful attention, allowing complete provider report without interruption.
   - Show gratitude and respect for the work of the EMS team
   - Summarize and "speak-back" key aspects of priority information
   - Ask questions to clarify information

6. Patient Care Report
   - A Patient Care Report (PCR) will be completed and provided to the ED staff for each patient transport via HEMS approved documentation delivery methods, i.e. email, fax, or paper report. (Reference HEMS protocol **Documentation and Patient Care Records and EPCR-PCR and Transfer of Care.**).
   - The PCR or Field Note will include at least the minimum data required by protocol.

V. Collaborative management of delays in transfer of care

EMS/ED/Hospital responsibilities:

1. ED personnel will work with the EMS personnel and/or EMS supervisor to:
   - assure optimal transfer of care
   - resolve instances of offload delays and/or extended offload delays
   - provide, as requested, communication of reason(s) offload delays
2. When a delay in transfer of care occurs EMS personnel will make face-to-face contact with the ED supervisory staff, regarding ED bed availability timing and to inquire for potential offload delay reason.
3. EMS personnel will notify their EMS supervisor when wait times are ≥ 20 minutes and they have not received satisfactory resolution from ED supervisory staff.
4. EMS supervisor, once notified by EMS personnel, will make contact with the ED supervisory staff to communicate urgent need to release ambulance resources.
5. ED supervisory staff will provide situational awareness to Hospital/ED administration of periods of high ED demand associated with unusual or escalating offload delay situations.
6. When on hospital property, the EMS provider cannot transport to another hospital without physician notifications and medical screening exam from the current location.
   - Documentation Note: physician name must be documented in the narrative.
   - Contact and document the receiving facility and accepting physician prior to leaving the hospital.

Emergency Department
Patient Transfer Record

Radio Report

Date: _____ Time: _____ Unit Number: _____

Priority: 1 2 3

Age: _____ Chief Complaint: _____

Alert?: STEMI Stroke Code Trauma Sepsis

Vitals:

BP	Pulse	Resp	Temp	O2 Sat	BS	LOC	GCS	Pain

Treatment/ MOI/ Notes etc:

IV	O2	monitor	12 lead	C-collar	airway	dressing	splint

_____

_____

_____
Initials taking Radio Report

Bedside Handoff Report

EMS Agency: _____ Sending Facility Name/Address : _____

PT Name: _____ DOB: _____

History: _____

Meds: _____ Allergies: _____

Assessment Details: _____

Other Findings/ Changes: _____

Additional Treatment: _____

Treatment Response: _____

Additional questions? _____

_____

_____
ED Staff Initials

_____
EMS Initials

General Operations~~Considerations~~

Purpose: ~~Standard Operating Procedures~~

~~The purpose of the SOP's is~~ to provide pre-hospital care personnel with the guidance in the pre-hospital treatment of persons who utilize the EMS system. Refer to section II for guidance in the use of the treatment protocols.

Medical Control:
Contact shall be made with a HEMS approved medical control hospital, or approved medical control free standing facility, to report patient condition and to receive appropriate instructions from a physician or a physician designee concerning the patient's treatment and/or destination**.**

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

1. ~~With a communications failure or inability to contact medical control, EMS personnel may initiate medical treatment protocols and procedures including interventions identified after the "Post-Medical Control" section (unless specifically prohibited in the Protocol).~~
2. ~~Contact medical control as soon as communications can be established and inform them of the situation, including care or procedures rendered.~~
3. ~~A written report describing the situation, actions taken, and description of the communication failure shall be provided to the HEMS within 24 hours (See Radio Failure Report).~~

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

~~Protocol Deviation~~

1. ~~It is acknowledged that there are situations in which deviation from the protocols, policies and procedures may be needed in the interest of patient care.~~
   A. ~~In those situations, EMS personnel should request permission for deviation from on-line medical direction whenever possible.~~
   B. ~~Unavailability of on-line medical direction and the immediacy of patient care needs may, in very rare instances, prohibit such requests, but those situations should occur rarely.~~
2. ~~All instances of protocol deviation must be documented in the EMS patient care record, noting the deviation which occurred and the reason for that deviation.~~
3. ~~All deviations must be reported to medical control.~~

~~program.~~

Patient Care Record & EPCR and Transfer of Care

See Documentation and Patient Care Record & EPCR and Transfer of Care

Initial Patient Assessment

Mechanism of injury – Overview the scene/patient (note age, sex, build, general state of health of patient, check for major visible injuries/bleeding).

Primary survey:

1. Airway/C-Spine immobilization, if suggested by mechanism of injury
2. Breathing
3. Circulation
4. Stop bleeding
5. Assess for shock
6. Chief Complaint

Secondary survey:

1. Head to toe exam including vital signs, level of consciousness
2. History of episode

Radio Communications

An ambulance transporting a patient to a Wayne County facility will contact HEMS via the HEAR radio (340 or 400 VHF), UHF radio~~ or the~~ 800 MHZ Trunk System (MPSCS) or E-Bridge~~verbridge~~ system at the earliest opportunity.

For radio report, follow the steps listed below. For E-Bridge~~verbridge~~ contact, follow the prompts on the screen and pick the appropriate selection based on the type of transport. Complete all required elements and include all appropriate information for hospital personnel.

On priority #1 patients, units should ~~make radio~~ contact the hospital while en- route to the closest appropriate facility. On priority #2 and #3 patients, first complete assessment and pre-radio treatment. Then contact~~call~~ the hospital prior to leaving the scene unless an exception arises placing crew or patient in jeopardy, (sooner, if conditions dictate).

Radio Traffic Should Proceed As Follows For Priority #1 And #2 Patients:

Ambulance:	"HEMS radio, HEMS radio, this is Alpha 725 with priority 2 traffic, how do you copy?"
HEMS:	"This is HEMS radio, go ahead A725."
Ambulance:	"HEMS please patch us through to hospital X priority 2"
HEMS:	*If the requested hospital is Status B or C announce to the ambulance and ask if a patch to the requested hospital is still*

wanted or a patch to another hospital.

HEMS: As necessary request ambulance to switch to a different talk group/med channel.

Ambulance: Confirms switch to talk group/ med channel.

HEMS: "Hospital X, hospital X, I have Alpha 725 with priority 2 traffic how do you copy?"

Hospital: "This is hospital X go ahead Alpha 725."

Ambulance: "Hospital X, this is Alpha 725, how do you copy?"

Hospital: "Copy you loud and clear, go ahead."

Ambulance: Proceed with patient report

Include: Priority
Age/Sex
Chief Complaint (As appropriate state STEMI, Stroke, Cardiac/Respiratory Arrest, Trauma or Sepsis Alert)
GCS/ Vital Signs/Physical Findings
Other pertinent information (See Mass Causality Incidents and Scene and Patient Management)
Treatment initiated
ETA
Are there any questions or further orders?

Hospital: "We will be expecting your arrival. Hospital X clear."

Ambulance: "HEMS, HEMS, Alpha 725 is clear at this time. Thank you."

HEMS: "HEMS radio clear at 14:25, call sign as necessary."

Priority 3 Radio Report: Radio Format for Priority #3 Patients

Ambulance: "HEMS radio, HEMS radio, this is Alpha 725 with priority 3 traffic, how do you copy?"

HEMS: "This is HEMS radio, go ahead A725."

Ambulance: "This is (unit #) with priority #3 traffic for (hospital), with a chief complaint of , patient requires (or does not require) a stretcher, ETA ".

HEMS: "OK Alpha 725 hospital will be notified of your priority #3 transport and report". (*If the requested hospital is Status B or C announce to the ambulance and ask if the requested hospital is still to be notified or another hospital.)*

Ambulance: "HEMS, HEMS, Alpha 725 is clear at this time. Thank you."

HEMS: "HEMS radio clear at 14:25."

HEMS: "Hospital this is HEMS priority #3 announcement: unit , chief complaint of , patient requires (or does not require) a stretcher, ETA ".
"Repeat Hospital this is HEMS priority #3 announcement: unit , chief complaint of , patient requires (or does not require) a stretcher, ETA ".

HEMS "HEMS radio clear at 14:26".

The EMS provider may utilize HEMS radio to establish contact with the hospital for providing a direct Priority 3 report.

Patient Prioritization

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

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

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

General Operations

Purpose: to provide pre-hospital care personnel with the guidance in the pre-hospital treatment of persons who utilize the EMS system. Refer to section II for guidance in the use of the treatment protocols.

Medical Control: Contact shall be made with a HEMS approved medical control hospital, or approved medical control free standing facility, to report patient condition and to receive appropriate instructions from a physician or a physician designee concerning the patient's treatment and/or destination**.**

Patient Care Record & EPCR and Transfer of Care

See **Documentation and Patient Care Record** & **EPCR and Transfer of Care**

Initial Patient Assessment

Mechanism of injury – Overview the scene/patient (note age, sex, build, general state of health of patient, check for major visible injuries/bleeding).

Primary survey:

1. Airway/C-Spine immobilization, if suggested by mechanism of injury
2. Breathing
3. Circulation
4. Stop bleeding
5. Assess for shock
6. Chief Complaint

Secondary survey:

1. Head to toe exam including vital signs, level of consciousness
2. History of episode

Radio Communications

An ambulance transporting a patient to a Wayne County facility will contact HEMS via the HEAR radio (340 or 400 VHF), UHF radio< 800 MHZ Trunk System (MPSCS) or E-Bridge system at the earliest opportunity.

For radio report, follow the steps listed below. For E-Bridge contact, follow the prompts on the screen and pick the appropriate selection based on the type of transport. Complete all required elements and include all appropriate information for hospital personnel.

On priority #1 patients, units should contact the hospital while en- route to the closest appropriate facility. On priority #2 and #3 patients, first complete assessment and pre-radio treatment. Then contact the hospital prior to leaving the scene unless an exception

arises placing crew or patient in jeopardy, (sooner, if conditions dictate).

Radio Traffic Should Proceed As Follows For Priority #1 And #2 Patients:

Ambulance:	"HEMS radio, HEMS radio, this is Alpha 725 with priority 2 traffic, how do you copy?"
HEMS:	"This is HEMS radio, go ahead A725."
Ambulance:	"HEMS please patch us through to hospital X priority 2"
HEMS:	*If the requested hospital is Status B or C announce to the ambulance and ask if a patch to the requested hospital is still wanted or a patch to another hospital.*
HEMS:	As necessary request ambulance to switch to a different talk group/med channel.
Ambulance:	Confirms switch to talk group/ med channel.
HEMS:	"Hospital X, hospital X, I have Alpha 725 with priority 2 traffic how do you copy?"
Hospital:	"This is hospital X go ahead Alpha 725"
Ambulance:	"Hospital X, this is Alpha 725, how do you copy?"
Hospital:	"Copy you loud and clear, go ahead."
Ambulance:	Proceed with patient report Include: Priority Age/Sex Chief Complaint (As appropriate state STEMI, Stroke, Cardiac/Respiratory Arrest, Trauma or Sepsis Alert) GCS/ Vital Signs/Physical Findings Other pertinent information (See Mass Causality Incidents and Scene and Patient Management) Treatment initiated ETA Are there any questions or further orders?
Hospital:	"We will be expecting your arrival. Hospital X clear."
Ambulance:	"HEMS, HEMS, Alpha 725 is clear at this time. Thank you."
HEMS:	"HEMS radio clear at 14:25, call sign as necessary."

Priority 3 Radio Report: Radio Format for Priority #3 Patients

Ambulance:	"HEMS radio, HEMS radio, this is Alpha 725 with priority 3 traffic, how do you copy?"
HEMS:	"This is HEMS radio, go ahead A725."
Ambulance:	"This is (unit #) with priority #3 traffic for (hospital_____), with a chief complaint of_____, patient requires (or does not require) a stretcher, ETA_____".
HEMS:	"OK Alpha 725 hospital_____will be notified of your priority #3 transport and report". (*If the requested hospital is Status B or C announce to the ambulance and ask if the requested hospital is still*

	to be notified or another hospital.)
Ambulance:	"HEMS, HEMS, Alpha 725 is clear at this time. Thank you."
HEMS:	"HEMS radio clear at 14:25."
HEMS:	"Hospital_____this is HEMS priority #3 announcement: unit_____, chief complaint of_____, patient requires (or does not require) a stretcher, ETA_____". "Repeat Hospital_____this is HEMS priority #3 announcement: unit_____, chief complaint of_____, patient requires (or does not require) a stretcher, ETA_____".
HEMS	"HEMS radio clear at 14:26".

The EMS provider may utilize HEMS radio to establish contact with the hospital for providing a direct Priority 3 report.

Patient Prioritization

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

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

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