### Protocol Number | Protocol Name
---|---
8.1 | Agency and EMS Personnel Criteria for Participation
8.1.1 | Appendix A: Life Support Agency Letter of Compliance
8.2 | ALS to BLS Transfer of Care
8.3 | Aircraft Transportation
8.3.1 | Appendix A: Aircraft Letter of Compliance
8.4 | Alternative EMS Response Team
8.5 | Bloodborne Pathogen Exposure Policy
8.6 | Cancellation/Downgrade of Call: State Protocol
8.7 | Communicable Disease: State Protocol
8.8 | Communications/Communications Failure
8.9 | Determination of Death, Death in an Ambulance and Transport of a Body: State
8.10 | Dispatch Protocol
8.11 | Distribution of Antibiotic Caches to Emergency Personnel
8.12 | Documentation Policy
8.12.1 | Appendix A: OCMCA Approved Medical Abbreviations
8.13 | EMS Response Time Standards
8.14 | Equipment
8.15 | Evidentiary Blood Draw Protocol (optional)
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8.19 | Inter-facility Patient Transfers and Critical Care Patient Transports: State Protocol
8.20 | Licensure Level Requirement of Attendant During Transport: State Protocol
8.21 | Medical Control and Participating Hospital Policy
8.21.1 | Appendix A: Hospital Letter of Compliance
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8.22 | Mutual Aid
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8.24 | Patient Prioritization: State Protocol
8.25 | Physician on Scene: State Protocol
8.26 | Protocol Deviation: State Protocol
8.27 | Professional Standards Review Organization Protocols
8.27.1 | Complaint Investigation: State Protocol
8.27.2 | Disciplinary Action Appeal: State Protocol
8.27.3 | Due Process: State Protocol
8.27.4 Quality Improvement: State Protocol
8.27.5 Incident Classification: State Protocol
8.27.6 EQIP Program Policy
8.27.7 EMS Research for Publication Policy
8.27.8 Confidentiality Agreement
8.28 Provisional Designation of Adult and Pediatric Trauma Facilities
8.29 Rerouting
8.30 Safe Delivery of Newborns: State Protocol
8.31 Scene Patient Management
8.32 Taser Removal (Optional)
8.33 Transportation Protocol
  Appendix 1: Approved Emergency Facilities
  Appendix 2: Approved Interventional Cardiac Facilities
  Appendix 3: Approved Burn Centers
  Appendix 4: Approved Stroke Facilities
  Appendix 5: Approved OB Facilities
  Appendix 6: Approved Trauma Criteria and Centers
8.34 Use of Lights and Sirens
8.35 Violent/Chemical/Hazardous Scene: State Protocol
8.36 Waiver of EMS Patient Side Communication Capabilities/MCA Checklist: State

NOTE: All protocols in this section are OCMCA protocol, unless specified as State
Agency and EMS Personnel Criteria for Participation

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

NEW AND UPGRADING AGENCIES
(see New or Upgrading EMS Agency Policy)

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

1. Evidence of licensure with the State EMS Division;
2. Evidence of compliance with OCMCA criteria for practice by completion of the Letter of Compliance;
3. List of current personnel including level of licensure, expiration dates, and current ACLS certification; and
4. Approval of the PSRO, MCC and Board of Directors.

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

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

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

LICENSED TRANSPORTING ALS UNITS
1. Provide a minimum of one paramedic and one EMT staffing each licensed Transporting ALS unit at all times.
2. Contract for staffing services shall only be rendered with OCMCA approved Life Support Agencies.
Oakland County Medical Control Authority
System Protocols
AGENCY AND EMS PERSONNEL CRITERIA FOR PARTICIPATION

October, 2018

Section 8.1

BLS Agencies Only
LICENSED NON-TRANSPORTING BLS AGENCY
Must provide a minimum of one (1) EMT to staff a licensed Non-Transporting BLS unit at all times.

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

Agency Communications
An agency shall appoint an EMS Coordinator who will be the liaison person between the medical control hospital, the OCMCA and the life support agency. Agencies will designate an Oakland County Instructor Coordinator who will be responsible for maintaining ongoing education according to MDHHS licensing requirements. In order to participate in the Oakland County Emergency Medical Services Communications system, it is required that all basic and advanced life support units are capable of communicating on the following channels:

- 155.340 Michigan HERN Channel (Primary Vehicle to Hospital Channel)
- 155.355 “VMEDTAC” (Scene Coordination Channel)
- 155.7525 “VCALL10” (National Interoperable Channel)
- 151.1375 “VTAC11” (National Interoperable Channel)
- 154.4525 “VTAC12” (National Interoperable Channel)
- 158.7375 “VTAC13” (National Interoperable Channel)
- 159.4725 “VTAC14” (National Interoperable Channel)

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

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

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

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

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

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

**EMS RESPONSE**
When responding to a non-emergency facility (e.g. nursing home, Urgent Care, physicians office, private residence, etc.) to a patient with a potentially life threatening condition, EMS personnel/life support agency must activate, upon identification of a potentially life threatening condition, the primary life support agency for that geographic service area of the call.
Life Support Agency Name: __________________________________________________________

(Print Name)

1. Licensed by the Michigan Department of Health and Human Services (MDHHS), or license pending.

Compliant

2. This Agency agrees to comply with the Oakland County EMS Response Time Standards. (See EMS Response Time Standards 6-18)

Compliant

3. Medical supplies, communications, equipment, procedures and protocols utilized meet criteria, as established by MDHHS and Oakland County Medical Control Authority.

Compliant

4. It is the agency’s responsibility to educate and update all personnel on the OCMCA protocols and policies.

Compliant

5. Agency and personnel will follow the OCMCA Medical Control and Participating Hospital Policy. (See Medical Control and Participating Hospital Policy 6-15)

Compliant

6. This agency designates the OCMCA (including its PSRO) to perform professional practice review functions on behalf of the agency, including review of pre-hospital care provided in Oakland County and recommendations for improvement of such care.

Compliant

7. This agency agrees to participate in PSRO studies, EMS QI Program and abide by all PSRO policies and procedures.

Compliant

8. Agency has designated a Medical Control Hospital and Medical Control Hospital Physician.

Compliant

9. Units are identified through standard terminology and uniform numbering system, issued by the Oakland County Medical Control Authority. The OCMCA unit number will be documented on each run form and/or e-PCR and used in all radio communications. (See Agency and EMS Criteria for Participation Policy 6-1)

Compliant

10. The agency has designated an EMS Coordinator, EMS QI Coordinator and State Licensed Instructor Coordinator.

Compliant

11. The agency has Emergency Medical Dispatch (EMD) protocols to ensure the appropriate dispatching of a life support agency based upon medical need and capability of the emergency medical services system. All calls have access to pre-arrival instructions through an approved MCA EMD program that meets the American Society for Testing and Measurement (ASTM). (See Dispatch Protocol 6-10)

Compliant

12. The agency has a policy to ensure that use of lights and sirens is based on EMD protocols and patient condition. (See Use of Lights and Sirens Policy 6-29)

Compliant
13. The agency is responsible for completing and forwarding the necessary quality improvement data, approved by the OCMCA Board of Directors, to the MI-EMSIS on a monthly basis, by the 15th of each month.
(Patient Care Record & Electronic Documentation & EMS Information System 5-22/5-22.1)

14. All Life Support Agencies that provide emergency response in Oakland County agree to respond to emergency requests for aid across municipal boundaries, if available to respond. This response will occur regardless of what type of primary agency (private or public) provides primary response to that municipality.

15. Completed Addendum (See Addendum).

For ALS Agencies Only
16. Provide staffing in accordance with the Agency and EMS Personnel Criteria for Participation Policy

   A. Provides two paramedics on each licensed ALS unit.

   B. Provides one paramedic/one Basic EMT on each ALS unit.

17. Personnel shall be trained and licensed in accordance with appropriate statutes, rules, and criteria and maintain current ACLS.
(See Agency and EMS Criteria for Participation Policy 6-1)

For BLS Agencies Only
18. LICENSED NON-TRANSPORTING BLS AGENCY
   Must provide a minimum of one Basic EMT and one MFR to staff BLS unit at all times. Assigned personnel shall maintain current BCLS with training and license in accordance with the appropriate statues and criteria.

   OR

   LICENSED TRANSPORTING BLS AGENCY
   A transporting BLS agency must provide a minimum of one Basic EMT and one MFR to staff a BLS unit for transport. Assigned personnel shall be BCLS certified with training and license in accordance with the appropriate statues, rules and criteria.

19. Personnel shall be trained and licensed in accordance with appropriate statutes, rules, and criteria and have current BCLS certification.

For MFR Agencies Only
20. Personnel shall be trained and licensed in accordance with appropriate statutes, rules, and criteria and maintain current BCLS.
Addendum to Letter of Compliance

1. Licensed transporting agency?  
   Yes  No
2. Agency regularly transports?  
   Yes  No
3. List the communities the agency primarily services.
4. List the communities your agency provides secondary services.
5. Number of vehicles: 
   Non Transporting  Transporting
   MFR  ________
   BLS  ________  ________
   ALS  ________  ________
6. Number of EMS personnel.  
   __________
7. Agency has 12 lead EKG capabilities (ALS only).  
   Yes  No
8. Agency has capnography capabilities (ALS only).  
   Yes  No
9. Agency has C-PAP capabilities.  
   Yes  No
10. Type of IO device used by agency (ALS only).  
    __________
11. Data e-PCR Reporting System (NEMSIS 3.0 or higher)  
    __________
   Zoll
   ESO Solutions
   Image Trend/MI-EMSIS
   Health EMS
   Emergency Reporting
   Other
12. Attach a list of all personnel with their level of licensure.
13. Attach a copy of the current agency license.
14. Agency Annual Licensure Renewal Date  
   __________
OCMCA Life Support Agency
Emergency Contact Information

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

Agency:_____________________________ Address:_____________________________________

Agency Dispatch #: _____________________ Fax #:_____________________________________

Chief/CEO:___________________________ E-mail address ____________________________

Work # ______________________________ Cell #_____________________________________

EMS Coordinator:_______________________ E-mail address __________________________

Work # ______________________________ Cell #_____________________________________

Second Contact:_______________________ E-mail address __________________________

Work # ______________________________ Cell #_____________________________________

EMS QI Coordinator:____________________ E-mail address __________________________

Work # ______________________________ Cell #_____________________________________

State Licensed Instructor Coordinator:_______ E-mail address __________________________

Work # ______________________________ Cell #_____________________________________

ACES Representative:__________________ E-mail address __________________________

Work # ______________________________ Cell #_____________________________________

Please let the staff at the OCMCA know of any changes throughout the year.
COMPLIANCE: If any of the above criteria cannot be met, the provider will submit documentation of the exceptions.
This agency agrees to comply with protocols, operating procedures and standards of pre-hospital care promulgated by MDHHS and the Oakland County Medical Control Authority, including the Agency and EMS Personnel Criteria for Participation Policy. This will assure accountability for care rendered within our advanced emergency care system, effective this date, and as may be promulgated from time to time.
We acknowledge that each criterion and verification is subject to inspection by the EMS Medical Director or his/her physician designee, at any time, and at his/her direction. Should cause exist, the EMS Medical Director, or, his/her designee may request formal verification.
ALS to BLS Transfer of Care

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

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

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

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

Indications
To be used only if one or more of the following are met:
1. The speed of the transport from the scene to definitive care may have an impact on patient outcome.
2. When special equipment on-board the aircraft is needed.
3. When special skills and expertise of the flight crew is needed.
4. When search, rescue and transport of victims is inaccessible by ground transport systems.

Contraindications
1. Unsafe weather conditions as determined by aircraft agency
2. Any patient who represents a threat to the crew or operation of the aircraft:
   a. Radioactive exposure, chemical exposure, or similar who has not undergone or cannot undergo proper decontamination prior to transport;
   b. Combative and who are unable to be pharmacologically sedated or restrained;
   c. Psychiatric disorder (suicidal ideation) that cannot be pharmacologically sedated;
   d. Non intubated prisoner
3. Patients who can be safely transported by an alternate method.

General Guidelines
1. Only Oakland County Medical Control Authority approved air medical services can operate in Oakland County and may be requested (See Appendix 1). In the event of a disaster, refer to the Disaster Protocol.
2. Only Oakland County Life Support Agency and dispatch personnel may request air medical transportation. Requesting Agency or at least one agency on scene must have training in helicopter landing zone preparation and safety for emergency scenes.
3. Fixed-winged aircraft (non-rotary) must use most appropriate airport.
4. The Medical Control Physician (MCP) in concurrence with the on-scene ALS provider may cancel air medical transport at any time.
5. All pre-hospital requests for air medical transport will be reviewed by the PSRO Committee.

Procedure for Activation of Helicopter Transport
1. Ground transportation will be dispatched, as needed, with the helicopter.
2. Advise on-line MCP as soon as possible, of helicopter request.
3. The patient will be transported to the closest appropriate Emergency Facility according to the OCMCA transportation policy.
4. The helicopter’s medical personnel must abide by the Medical Control Transport and Destination Protocols of the system requesting helicopter transport.
Aircraft Dispatch Notification (24/7 Operations Only)

The Oakland County Medical Control Authority recognizes the following aircraft companies available for emergency calls 24/7. Note: Only Oakland County EMS and dispatch personnel may request air medical transport.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Telephone Number</th>
<th>Location of Helicopter</th>
</tr>
</thead>
<tbody>
<tr>
<td>LifeFlight of Michigan</td>
<td>888-476-0005</td>
<td>Troy</td>
</tr>
<tr>
<td>U of M Survival Flight</td>
<td>800 822-2233</td>
<td>Ann Arbor</td>
</tr>
</tbody>
</table>
Oakland County Medical Control Authority
Aircraft Letter of Compliance
2018

Agency Name: ________________________________________
(Print Name)

1. Licensed by the Michigan Department of Health and Human Services (MDHHS), or license pending.
   Fixed Wing ____________
   Helicopter ____________

2. Assigned medical personnel shall be trained and licensed in accordance with appropriate statutes, rules, criteria and ACLS certified.

3. Medical supplies, communications, equipment, procedures and protocols utilized meet criteria as established by MDHHS and Oakland County Medical Control Authority (OCMCA).

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

5. It is the agency’s responsibility to educate and update all personnel on the OCMCA protocols and policies.

6. Agency and personnel will follow the OCMCA Medical Control Hospital Policy.

7. The agency has medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system.

8. The agency is responsible for completing and forwarding the necessary quality improvement data, approved by the OCMCA Board of Directors, to the OCMCA office on a monthly basis, by the 15th of each month.

9. This agency agrees to participate in PSRO studies, and abide by the PSRO Incident Investigation Procedure.

10. Agency has designated a Medical Control Hospital and Medical Control Physician.

11. The agency is responsible for forwarding a completed copy of each run report originating in Oakland County to the OCMCA office within 24 hours of the run.

12. The agency will transport Oakland County patients as per the Oakland County Transportation Policy and Aircraft Transportation Policy (6-4).

13. Aircraft available 24/7 for emergency scene responses.
NOTE: If any of the above criteria cannot be met, the provider will submit documentation explaining reasons for the exceptions.

This agency agrees to comply with the protocols, operating procedures and standards of pre-hospital care promulgated by MDHHS and the Oakland County Medical Control Authority. This will assure accountability for care rendered within our advanced emergency care system, effective this date, and as may be promulgated from time to time.

We acknowledge that each criterion and verification are subject to inspection by the EMS Medical Director or his/her physician designee at any time and at his/her direction. Should cause exist, the EMS Medical Director, or his/her designee may request formal verification.

Be advised that if your aircraft is not available 24/7 for emergency scene responses, your aircraft dispatch number will not be added to the OCMCA dispatch list that is provided to all OCMCA Life Support Agencies and Dispatch Centers.

******************************************************************************

COMPLIANCE: If any of the above criteria cannot be met, the provider will submit documentation of the exceptions.

This agency agrees to comply with protocols, operating procedures and standards of pre-hospital care promulgated by MDHHS and the Oakland County Medical Control Authority, including the Agency and EMS Personnel Criteria for Participation Policy. This will assure accountability for care rendered within our advanced emergency care system, effective this date, and as may be promulgated from time to time.

We acknowledge that each criterion and verification are subject to inspection by the EMS Medical Director or his/her physician designee, at any time, and at his/her direction. Should cause exist, the EMS Medical Director, or his/her designee may request formal verification.

Authorized Representative Signature

Title Date

State Licensed Instructor Coordinator (PRINT)

EMS Coordinator (PRINT)

EMS QI Coordinator (PRINT)

Medical Control Physician Signature (MCC member/alt)

Medical Control Physician (PRINT)

Hospital

Hospital EMS Coordinator/Liaison (PRINT)
OCMCA Life Support Agency
Emergency Contact Information

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

Agency: ____________________________ Address: ____________________________

Agency Dispatch #: __________________ Fax #: ____________________________

Chief/CEO: ___________________________ E-mail address ______________________

Work # ____________________________ Cell # ____________________________

EMS Coordinator: ___________________________ E-mail address ______________________

Work # ____________________________ Cell # ____________________________

Second Contact: ___________________________ E-mail address ______________________

Work # ____________________________ Cell # ____________________________

Third Contact: ___________________________ E-mail address ______________________

Work # ____________________________ Cell # ____________________________

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

Oakland County EMS Medical Control Authority
1200 N. Telegraph Rd., Building 36E
Pontiac, MI  48341
Fax # - 248-975-9723
E-mail – ems@ocmca.org
Alternative EMS Response Team

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

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

When responding to an emergency, the Team will respond along with a transport capable unit to assure appropriate transport of the patient. The Team will give a complete report of patient condition and treatments to the transporting unit, and will follow the OCMCA protocols. Mandatory communication capabilities include, allowing the Team to reach their agency’s dispatch and to reach an OCMCA approved hospital for medical control.

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

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

Drug Box (ALS only)
Any ALS agency wanting to obtain a drug box for use on an Alternative EMS Response Team vehicle will take a device that can be sealed and is capable of carrying all of the medications up to what is carried in the Oakland County drug box (see SE Michigan Medication Exchange and Replacement Procedure) to the agency’s Medical Control Hospital to be filled. The agency must also provide a device that can carry all controlled substances that can be attached to a paramedic. Only one set of boxes (two) may be filled for each paramedic Team an ALS agency deploys. Both boxes will be inventoried and sealed with expiration date labeled on the box. The boxes will be kept in a secured area when not in use.
Drug Box Exchange:
1. During an event, all medications used by the team will be replaced from the drug box of the transporting ALS unit.
2. The transporting ALS unit will use their opened drug box for any additional treatment the patient may need during the transport. The ALS unit will be responsible for documentation of drug use. Upon arrival at the hospital, the ALS unit will follow the usual drug box exchange procedure.
3. The paramedic Team will keep a daily log of all patients treated, drugs used and replaced from an ALS drug box.
4. At the end of the paramedic Team’s event, the drug box must be returned to the hospital pharmacy for update of its contents, seal and expiration date.
Bloodborne Pathogen Exposure Policy

Police, Fire or EMS personnel who, in the performance of their duty, sustain a needle stick, mucous membrane or open wound exposure to blood or other potentially infectious material (OPIM) may request, under Public Act 368 and 419, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a Michigan Department of Health and Human Services Form. The exposed healthcare provider must go to the same hospital as the source patient.

The health facility that receives an exposure request from Police, Fire or EMS personnel shall accept as fact the description of their exposure to the patient’s blood or OPIM. The health care facility shall make the determination as to whether or not an exposure was a needle stick, mucous membrane or open wound pursuant to the Michigan Administrative Codes. Determination may occur in person, by phone or by appropriate personnel according to MIOSHA standards.

Exposure Testing:

1. If an exposure occurs, it must be documented on the PCR, and verbal notification given to the physician caring for the source patient (if known).
2. A Physician determines if an exposure has occurred.
3. The exposed healthcare provider must complete the standard State Form and give to the hospital attending emergency physician.
4. The hospital will test the patient for HIV/ Hepatitis B and C surface antigen with the most expedient method utilized. The test results will be disseminated to Police, Fire or EMS personnel as soon as test results are available. Notification will be released on positive or negative results to the individual specified on the standard State Form. The form, after completed by the hospital, will be returned to the agency.
5. The exposed individual will be referred to their respective department and MIOSHA Exposure Control Plan for follow-up, testing, logistics and counseling.

Exposures Where There is No Patient (unknown Source Patient, Patient left hospital prior to testing)

1. If an exposure occurs, it must be documented on the PCR, and verbal notification given to the physician caring for the source patient (if known).
2. A health care professional determines whether an exposure has occurred. A health care professional is defined in above section.
3. State Form is completed and given to the source patient’s emergency department (if known).
4. If the patient left prior to testing, the receiving hospital will attempt to contact the patient to initiate testing for HIV/ Hepatitis B and C surface antigen. If the patient agrees to be tested, refer to this policy, section “Exposure Testing”.
5. If the patient is unavailable for testing, the exposed individual may undergo testing outlined in their department’s MIOSHA Exposure Control Plan. The exposed individual’s department and designated testing facility shall be responsible for testing, logistic and counseling of their employee.

Exposure Where the Patient is Declared Dead on The Scene.

1. The EMS or Police agency on scene will notify the Oakland County Medical Examiner’s office that there is a first responder who has a suspected body fluid exposure from a patient who has been declared dead on scene. The Oakland Medical Examiner is requiring that this case be ordered into the office.
2. An exposure sticker will be placed on the patient’s EMS Medical report form and the EMS report will be forward to the Medical Examiner’s office.
3. A Physician determines if an exposure has occurred.
4. State Form is completed and forward to Medical Examiner’s office.
5. The Medical Examiner’s office will initiate testing for HIV/ Hepatitis B and C surface antigen, in accordance with the Exposure Testing section of this policy.
6. If for some reason the patient’s blood was not drawn by the Medical Examiner’s Office for testing, the exposed individual may undergo testing outlined in their department’s MIOSHA Exposure Control Plan. The exposed Individual’s department and designated testing facility shall be responsible for, logistics and counseling of their employees.

In all cases, follow-up testing, logistics and counseling will be at the expense discretion of the exposed individual’s life support agency and respective exposure control plans.

Treatment
All treatment will be provided to exposed individuals according to the current Center for Disease Control (CDC) recommendations.
Cancellation/Downgrade of Call Policy

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

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

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

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

      or

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

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

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

**NOTE:** The EMS provider must recognize that any patient that presents with one of the following may be potentially infectious, and must take the necessary precautions to avoid secondary exposure. These precautions include following this protocol.

- A skin rash
- Open wounds
- Blood or other body fluids
- A respiratory illness that produces cough and/or sputum

**Exposure Defined:**

An exposure is determined to be any breach of the skin by cut, needle stick, absorption or open wound, splash to the eyes, nose or mouth, inhaled, and any other parenteral route.

**Reporting Exposures:**

Police, Fire or EMS personnel who, in the performance of their duty, sustain a needle stick, mucous membrane or open wound exposure to blood or other potentially infectious material (OPIM) may request, under Public Act 368 or 419, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a Bureau of EMS, Trauma and Preparedness Form J427 (MDCII Form J427). The exposed individual should also report the exposure in accordance with their employer's policies and procedures.

Follow appropriate infection control procedures.

1. If a patient presents with one of the following symptom complexes, then follow the remainder of this protocol.
   - Fever > 100.5 F with headache or malaise or myalgia, and cough or shortness of breath or difficulty breathing.
   - Pustular, papular or vesicular rash distributed over the body in the same stage of development (trunk, face, arms or legs) preceded by fever with rash progressing over days (not weeks or months) and the patient appears ill.

2. Consider the patient to be both airborne and contact contagious. Crew will don the following PPE:
   - N95 or higher protective mask/respiratory protection
   - Gloves
   - Goggles or face shield

**DO NOT REMOVE** protective equipment during patient transport.
3. Positive pressure ventilation should be performed using a resuscitation bag-valve mask. If available, one equipped to provide HEPA or equivalent filtration of expired air should be used. Also see the section in this protocol “Mechanically Ventilated Patients”.

4. Patient should wear a paper surgical mask to reduce droplet production, if tolerated.

5. Notify the receiving facility, prior to transport, of the patient's condition to facilitate preparation of the facility and institution of appropriate infection control procedures.

6. Hands must be washed or disinfected with a waterless hand sanitizer immediately after removal of gloves. Hand hygiene is of primary importance for all personnel working with patients.

7. Vehicles that have separate driver and patient compartments and can provide separate ventilation to these areas are preferred for patient transportation. If a vehicle without separate compartments and ventilation must be used, the outside air vents in the driver compartment should be turned on at the highest setting during transport of patient to provide relative negative pressure in the patient care compartment.

8. Patients should also be encouraged to use hand sanitizers.

9. Unless critical, do not allow additional passengers to travel with the patient in the ambulance.

10. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival at destination and disposed of in accordance with the direction from the hospital personnel.

MECHANICALLY VENTILATED PATIENTS

PARAMEDIC

1. Mechanical ventilators for potentially contagious patient transports must provide HEPA filtration of airflow exhaust.

2. EMS providers should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive pressure ventilation.

CLEANING AND DISINFECTION

Cleaning and Disinfection after transporting a potentially contagious patient must be done immediately and prior to transporting additional patients. Contaminated non-reusable equipment should be placed in biohazard bags and disposed of at hospital. Contaminated reusable patient care equipment should be placed in biohazard bags and labeled for cleaning and disinfection according to manufacturer's instruction.

INTER-FACILITY TRANSFERS

1. Follow the above precautions for inter-facility transfers.

2. Prior to transporting the patient, the receiving facility should be notified and given and ETA for patient arrival allowing them time to prepare to receive this patient.
3. Clarify with receiving facility the appropriate entrance and route inside the hospital to be used once crew has arrived at the receiving facility.

4. All unnecessary equipment items should be removed from the vehicle to avoid contamination.

5. All transport personnel will wear the following PPE:
   
   A. Gloves
   
   B. Gown
   
   C. Shoe Covers
   
   D. N-95 (or higher) protective mask

6. Drape/cover interior of patient compartment and stretcher (utilizing plastic or disposable sheets with plastic backing).

7. Place disposable surgical mask on patient

8. Cover patient with linen sheet to reduce chance of contaminating objects in area.

9. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival the receiving destination and disposed of in accordance with the direction from the hospital personnel.

10. The ambulance(s)/transport vehicle will not be used to transport other patients (or for any other use) until it is decontaminated using the CDC guidelines for decontamination.

11. Patient cohorting may occur if resources are exhausted and patients are grouped with same disease. Cohorting should only be utilized as a last resort.
Communications with Emergency Facilities

Purpose: Facilitate effective communications between EMS units and the OCMCA Emergency Facilities. Medical direction is available from all OCMCA Emergency Facilities (see Transportation Protocol Appendix 1).

Communicating with Emergency Facilities
EMS units may contact an Emergency Facility by the following:
- 800 MHz Radio
- Cell phone (recorded line – see Appendix A)
- VHF Radio

Emergency Facilities must assure that all forms of communication (listed above) are recorded.

EMS units should contact the Emergency Facility based on the following:
- Transporting: As soon as possible prior to arrival at the Emergency Facility.
- Non-transporting: Prior to leaving the scene.

Notification of Transport
A. Approved OCMCA Emergency Facilities
   1. When transporting a patient, start your communication with one of the following:
      - Request for Medical Direction
         o Example: “Hospital this is Alpha 431 with a priority 1 traffic, requesting a physician to the radio.”
      - Notification only
         o Example: “Hospital this is Bravo 042 with priority 3 traffic. Notification of transport only.”

   2. After the Emergency Facility acknowledges your communication provide the following information:
      - Patient priority
      - Age
      - Gender
      - Chief complaint
      - Vital signs if outside of normal limits, including significant EKG changes and GCS.
      - Field treatment (e.g. IV, O2, Meds given)
      - ETA
      - Request for medical direction, if applicable.
3. Re-contact the receiving facility, if necessary.

B. Non-approved OCMCA Emergency Facilities
Requests for transport to a non-approved Oakland County Medical Control Authority emergency facility, if medically appropriate, utilizing online medical control, as described below:
   1. Contact your medical control hospital.
   2. Provide rationale for transport.
   3. Obtain approval.
   4. If approved, contact the receiving emergency facility as described in this protocol.

Other Medical Direction Communications
In the following situations, EMS personnel will contact their Medical Control Hospital or the closest appropriate facility for medical direction from a physician or for documentation purposes.
   1. Pronouncement of death on scene (See Pronouncement of Death).
   2. In situations where EMS providers believe an emergency condition still exists and a patient is attempting to refuse care or transport (See Refusal of Care).
   3. Deviations from any protocol (See Protocol Deviation).
   4. Any situation where EMS personnel feel medical direction from a physician is indicated.

Communications Failure
Communications Failure is the inability to make contact with an Emergency Facility by all available methods, as defined in this protocol. This includes technology failures or failure of the Emergency Facility to acknowledge communication transmissions.
   1. EMS personnel may initiate medical treatment protocols and procedures including interventions identified after the “Post Medical Control” section.
   2. Notify your immediate supervisor and/or EMS Coordinator of the communications failure.
   3. The LSA will provide a written report describing the situation, actions taken, and description of the communication failure shall be provided to the Oakland County Medical Control Authority within 24 hours (fax: 248-975-9723, or email: Q1@ocmca.org).
## Appendix A

### EMERGENCY FACILITY TELEPHONE NUMBERS

<table>
<thead>
<tr>
<th>Hospital Emergency Departments</th>
<th>800MHz Identifier</th>
<th>Recorded Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascension Genesys Hospital</td>
<td>GENESYS</td>
<td>(810) 606-6922</td>
</tr>
<tr>
<td>Ascension Macomb – Oakland Hospital, Madison Hts. Campus</td>
<td>STJOHNO</td>
<td>(248) 967-7656</td>
</tr>
<tr>
<td>Ascension Providence Novi Campus</td>
<td>PROVNOV</td>
<td>(248) 465-4213</td>
</tr>
<tr>
<td>Ascension Providence Rochester Hospital</td>
<td>PROVROC</td>
<td>(248) 601-6060</td>
</tr>
<tr>
<td>Ascension Providence Southfield Campus</td>
<td>PROVSFD</td>
<td>(248) 849-4160</td>
</tr>
<tr>
<td>Beaumont Hospital-Farmington Hills (Botsford)</td>
<td>BOTSO</td>
<td>(248) 471-7273</td>
</tr>
<tr>
<td>Beaumont Hospital-Royal Oak</td>
<td>WBRO</td>
<td>(248) 898-4566 Line 1 (248) 898-8811 Line 2</td>
</tr>
<tr>
<td>Beaumont Hospital-Troy</td>
<td>WBTROY</td>
<td>(248) 964-5486</td>
</tr>
<tr>
<td>Children’s Hospital of MI - Troy</td>
<td>CH_TROY</td>
<td>(248) 457-1406</td>
</tr>
<tr>
<td>DMC Huron Valley – Sinai Hospital</td>
<td>HVSH</td>
<td>(248) 937-4555</td>
</tr>
<tr>
<td>Henry Ford West Bloomfield Hospital</td>
<td>HFWB</td>
<td>(248) 325-3671</td>
</tr>
<tr>
<td>McLaren Hospital-Clarkston</td>
<td>McClARK</td>
<td>(248) 922-6899</td>
</tr>
<tr>
<td>McLaren Hospital-Oakland</td>
<td>McLAREN</td>
<td>(248) 338-5369</td>
</tr>
<tr>
<td>St. Joseph Mercy-Oakland</td>
<td>SJMO</td>
<td>(248) 858-6660</td>
</tr>
<tr>
<td>St. Mary Mercy-Livonia</td>
<td>ST_MARY</td>
<td>(734) 464-1714</td>
</tr>
</tbody>
</table>
Determination of Death, Death in an Ambulance and Transport of a Body

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

I. Pronouncement/Determination of Death
   A. Per the Determination of Death Act (Act 90 of 1992, MCL 333.1033), the MCA may establish which of its medical personnel may pronounce death.¹ Per this policy, paramedics holding MCA privileges, while on duty with a licensed ALS life support agency, with primary or secondary operations within this MCA or while providing mutual aid within this MCA, may pronounce the death of a patient who meets the following criteria:
      1. Irreversible cessation of circulatory and respiratory functions
         a) Irreversible cessation of circulatory and respiratory functions is implied when a patient has experienced cardiac arrest and a valid DNR is in place, such that no attempt will be made to reestablish either circulation or respiratory functions.
         b) Irreversible cessation of circulatory and respiratory functions is also implied when a patient meets the criteria established under the Dead on Scene protocol or the termination criteria are met under the Termination of Resuscitation Protocol.
   B. Contact with on-line medical control for the purpose of determination of death or pronouncement is not necessary unless expressly stated in the enabling protocol.
   C. Contact with Dispatch for the purposes of recording the death is required.

II. Out of hospital death – Notification of the Medical Examiner
   A. The Medical Examiner’s office shall be notified for any out-of-hospital death under the following circumstances:
      1. The individual dies by violence
      2. The individual’s death is unexpected
      3. The individual dies without medical attendance by a physician, or the individual dies while under home hospice care without medical attendance by a physician or registered nurse, during the 48 hours immediately preceding the time of death, unless the attending physician, if any, is able to determine accurately the time of death.
      4. If the individual dies as a result of an abortion, whether self-induced or otherwise.
      5. Death of a prisoner in a county or city jail.
   B. Responsibility to notify the Medical Examiner
      1. If a patient is transported to a hospital from the scene, having met the above criteria, EMS shall notify the hospital of the criteria which requires notification. Responsibility for the notification of the Medical Examiner resides with the hospital.

¹ MCL 333.1033 (3) A physician or registered nurse may pronounce the death of a person in accordance with this act. This subsection does not prohibit a health facility or agency licensed under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws, from determining which of its medical personnel may pronounce the death of a person in that health facility or agency.
2. If a patient meeting the above criteria is pronounced dead without being transported to the hospital, the responsibility for notification of the Medical Examiner is shared between law enforcement and EMS personnel having authority for the management of the patient.

3. Patients who do not meet the above criteria and who are pronounced dead outside of a hospital do not require notification of the medical examiner.
   a) Any patient who is attended by a physician or registered nurse at the time of death (nursing home)
   b) Any patient who was under home hospice care and had medical attendance by a physician or registered nurse within the 48 hours immediately preceding the time of death (hospice patient either at home or in hospice facility)

III. Out of Hospital Death – Management, Handling and Movement of Body
   A. A body shall not be moved from the location of death if any mandatory Medical Examiner reporting criteria are present, unless the ME’s office provides official notification that an autopsy or external examination will not be performed and that the body will be released to the funeral home.
   B. Alternately, the body of a person who has unexpectedly died in a public location may be moved only after approval from the ME’s office to EMS. Such approval shall not be requested if there is any indication of violence, criminal activity or if the physical environment may contain evidence related to a cause of death or an injury pattern.
   C. A situation which does not require notification of the ME’s office does allow for movement of the body pending retrieval by the funeral home.
   D. Bodies must remain in the physical custody of the police or EMS until custody is transferred to the funeral home or the ME’s office staff.
   E. Medical devices utilized during care by EMS may be removed from the patient if the body is released by the ME’s office to the funeral home (IV’s, advanced airways, defibrillation pads, etc.)
   F. Medical devices utilized during care by EMS must remain in place if the ME’s office advises that an autopsy of examination will be performed.
   G. If there is evidence of suspicious, violent or unusual cause of death, caution should be taken to avoid contamination of the scene.
      1. Police may choose to photograph or document the placement of medical devices, medical equipment, etc. in suspicious situations, prior to their movement or removal.
   H. No personal items should be removed from the body with the exception of identification.
   I. Bodies may be covered with a burn sheet or other sheet which does not shed fibers.
   J. If a body is moved, as permitted in the prior criteria, the location should be to a private, secure and nearby location pending retrieval by the funeral home or the ME’s staff.
   K. Bodies must be handled with care and respect for the deceased, the family and the public.

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

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

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

B. If a patient is being transferred to a nursing home or to their home, immediately following discharge from a hospital, and death is determined, the body should be brought back to the hospital from which they were discharged, unless the patient is a hospice patient.
1. If the patient is a hospice patient and hospice will be meeting you at the destination, or the destination is a hospice facility, you may continue on to the destination and relinquish the body to hospice personnel. This is permitted, without notification of the Medical Examiner, since the patient was both a hospice patient and received medical attendance within the 48 hours immediately preceding the time of death. However, if the death was unexpected, the Medical Examiner must be notified.
2. If the patient is a hospice patient and hospice personnel will not be meeting you at the destination, continue on toward the destination, contact a supervisor from your agency and evaluate the situation. Where you ultimately go is dependent on how far you are from the destination, if family was intending to meet you at the destination, if the death was unexpected and any confounding factors. The body may not be left without there being a custodial transfer from EMS to an appropriate healthcare provider.
   a) Consider contacting the hospice care provider
   b) Consider consultation with online medical control
   c) If the death was unexpected, contact the Medical Examiner

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


**Dispatch Protocol**

**Purpose**

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

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

**Protocol**

1. E-911 shall be utilized and will dispatch the closest appropriate vehicle. By communicating effectively with the use of an EMD program, the dispatcher may be able to reduce the frequency of death or the severity of disability.
2. Since ALS can provide optimal medical care and any delay can negatively impact patient outcome, in areas where ALS is available it shall be **simultaneously dispatched** to certain medical emergencies including, but not limited to:
   a. Cardiac Arrest
   b. Chest Pain
   c. Stroke
   d. Drug Overdose / Poison
   e. Altered Mental Status / Unconscious
   f. Allergic Reaction
   g. Difficulty Breathing
   h. Drowning or Near Drowning
   i. Injury with Bleeding or Immobility
   j. Seizures / Convulsions
   k. Diabetic Reactions
   l. Child Birth
   m. Burns
   n. or as determined through prioritized dispatch developed through an approved EMD program by Michigan Department of Health and Human Services (MDHHS).

All residents shall have access to pre-arrival instructions through an Emergency Medical Dispatch program approved by Michigan Department of Health and Human Services.
Oakland County Medical Control Authority  
System Protocols  
Distribution of Antibiotic Caches to Emergency Personnel

June, 2018  

Section 8.11

**Distribution of Antibiotic Caches to Emergency Personnel**

**Purpose:** In collaboration with Oakland County Department of Health and Human Services/Health Division, to dispense life-saving pharmaceuticals to first responders, in the event of a bioterrorism attack, thus ensuring the health and safety of responding personnel in Oakland County.

**Objective:** To provide prophylactic treatment to emergency responders and their families, enabling responders to safely perform their duties in the event of bioterrorism incident in Oakland County. Oakland County must be able to provide these personnel and their families with emergency prophylaxis during a health emergency to ensure that essential personnel can adequately perform their duties.

**Medication:**

1. Doxycycline is an antibiotic treatment used to treat Anthrax, Plague, and Tularemia. The dosage for Doxycycline is 100mg twice daily x 10 days.

2. Ciprofloxacin is also used as antibiotic treatment for Anthrax, Plague, and Tularemia. The dosage for Ciprofloxacin is 500 mg twice daily for 10 days.

3. Ciprofloxacin, Amoxicillin, or other antibiotic may be used for pregnant women but this will be under the guidance of their obstetrician or other medical provider at the time of emergency.

**Distribution of Antibiotic Caches for Storage**

All approved OCMCA EMS agencies (ALS, BLS, and MFR) will be issued a secured cache of antibiotics to be used in the event of a bioterrorism attack that puts the emergency responder at risk for Anthrax, Plague, or Tularemia. The OCMCA agency will serve as a dispensing site for public sector police, fire and EMS.

The OCMCA will work in partnership with the Oakland County Department of Health and Human Services/Health Division to regulate and distribute antibiotics caches to Oakland County emergency response agencies. The locked caches will be kept secured within the confines of the agency’s building at room temperature.

**Activation of Doxycycline Caches**

In an event, caches of Doxycycline will be distributed to all public sector emergency response agencies (fire, police, and EMS) in Oakland County in the following manner:

1. All OCMCA agencies will designate license the EMS Coordinator or designee (ALS, BLS, or MFR) to dispense the medication. Only designated licensed personnel will activate the cache after being notified by the OCMCA.
2. Each agency will maintain a dispensing log, and have each patient complete a questionnaire prior to administration (including family members). That form shall serve as the permanent medical record of physician orders for drugs administered.
3. A medication instruction sheet shall be given to each patient receiving the medication.

Expiration of Drug
1. The caches will be labeled with the expiration date.

Discrepancies
DEFINITION: For purposes of this policy, a "discrepancy" is any breakage, shortage, theft or diversion of a cache, or any contents thereof.

1. A standard "MEDICATION DISCREPANCY REPORT" will be completed each time a discrepancy occurs. Pre-hospital staff that discovers the discrepancy shall initiate the Medication Discrepancy form. The person initiating the report shall be responsible for distributing the forms as required.

2. The Medical Control copy of discrepancy reports will be sent to the Medical Control Authority in which the discrepancy occurred, which will serve as the central filing point.
Documentation Policy

1. An EMS patient care record will be completed by all responding Life Support Agencies (LSA) on all patients where any type of care has been rendered, to include: vital signs, assessment, including those patients who refuse treatment or transport, and cancelled calls.

2. LSAs accompanying the patient will complete the EMS patient care record in a timely fashion and deliver a copy of the record to the receiving facility (See Data Submission Protocol).

3. All EMS patient care records will be completed in their entirety and the EMS personnel completing the EMS patient care record will create clear, legible, and professional documentation.

4. Medical abbreviations that are not on the OCMCA Approved Medical Abbreviation List are not permitted.

5. All appropriate additional documentation pertinent to patient care shall be attached to the patient care record. Any information pertaining to the patient (e.g. 12-Lead EKG) must include the patient’s full name and date of birth.

Possible examples may include, but are not limited to:
- Consider tracing for electrical therapies, such as Cardioversion, Pacing, Defibrillation
- Consider tracing for Adenosine
- 12 lead ECG’s, when indicated
- Pronouncement

NOTE: The EMS patient care record is a confidential patient care document and is not to be released to anyone other than those involved in the patient’s care or OCMCA’s Professional Standards Review Organization, without the patient’s written release of information permission.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>a</td>
<td>before</td>
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<tr>
<td>abd.</td>
<td>abdomen</td>
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<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<tr>
<td>AED</td>
<td>automated external defibrillator</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ALS</td>
<td>advanced life support</td>
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<tr>
<td>A/Ox3</td>
<td>alert and oriented to person, place, time</td>
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<td>a-fib</td>
<td>atrial fibrillation</td>
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<td>a-flutter</td>
<td>atrial flutter</td>
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<td>AMA</td>
<td>against medical advice</td>
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<td>acute myocardial infarction</td>
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<td>ant</td>
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<td>adult respiratory distress syndrome</td>
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<td>Attach</td>
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<td>ATF</td>
<td>Arrived to find</td>
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<td>ATA</td>
<td>At time of arrival</td>
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<td>AV</td>
<td>atrioventricular</td>
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<tr>
<td>BC</td>
<td>birth control</td>
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<td>BLS</td>
<td>basic life support</td>
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<td>BM</td>
<td>bowel movement</td>
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<td>BP</td>
<td>blood pressure</td>
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<tr>
<td>BS</td>
<td>blood sugar / breath sounds/bowel sounds</td>
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<td>BSA</td>
<td>body surface area</td>
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<tr>
<td>BVM</td>
<td>bag-valve-mask</td>
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<tr>
<td>CA</td>
<td>cancer/cardiac arrest</td>
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<td>CAD</td>
<td>coronary artery disease</td>
</tr>
<tr>
<td>CBC</td>
<td>complete blood count</td>
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<td>CC</td>
<td>chief complaint</td>
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<tr>
<td>CABG</td>
<td>coronary artery bypasses graft</td>
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<td>CHF</td>
<td>congestive heart failure</td>
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<tr>
<td>cm</td>
<td>centimeter</td>
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<tr>
<td>CNS</td>
<td>central nervous system</td>
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<tr>
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<td>carbon monoxide</td>
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<td>carbon dioxide</td>
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<tr>
<td>COPD</td>
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<tr>
<td>CPR</td>
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<td>CSF</td>
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<td>CVA</td>
<td>cerebrovascular accident</td>
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<td>D₃W</td>
<td>5% dextrose in water</td>
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<td>D/C</td>
<td>discontinue</td>
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<td>D &amp; C</td>
<td>dilation and curettage</td>
</tr>
<tr>
<td>Defib</td>
<td>defibrillation</td>
</tr>
<tr>
<td>DIB</td>
<td>difficulty in breathing</td>
</tr>
<tr>
<td>DKA</td>
<td>diabetic ketoacidosis</td>
</tr>
<tr>
<td>IDDM</td>
<td>Insulin-dependent diabetes mellitus</td>
</tr>
<tr>
<td>DNR</td>
<td>do not resuscitate</td>
</tr>
<tr>
<td>DOA</td>
<td>dead on arrival</td>
</tr>
<tr>
<td>DOE</td>
<td>dyspnea on exertion</td>
</tr>
<tr>
<td>DOS</td>
<td>dead on scene</td>
</tr>
<tr>
<td>DTs</td>
<td>delirium tremens</td>
</tr>
<tr>
<td>Dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>ECG, EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>EC</td>
<td>emergency center</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>EDC</td>
<td>Estimated date of confinement</td>
</tr>
<tr>
<td>epi</td>
<td>epinephrine</td>
</tr>
<tr>
<td>ET, ETT</td>
<td>endotracheal, endotracheal tube</td>
</tr>
<tr>
<td>ETA</td>
<td>estimated time of arrival</td>
</tr>
<tr>
<td>ETOH</td>
<td>alcohol (ethanol)</td>
</tr>
<tr>
<td>Exp</td>
<td>expiratory</td>
</tr>
<tr>
<td>♀</td>
<td>female</td>
</tr>
<tr>
<td>Fx</td>
<td>fracture</td>
</tr>
<tr>
<td>FBAO</td>
<td>foreign body airway obstruction</td>
</tr>
<tr>
<td>GI</td>
<td>gastrointestinal</td>
</tr>
<tr>
<td>GSW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>gtt</td>
<td>drop</td>
</tr>
<tr>
<td>GU</td>
<td>gasterourinary</td>
</tr>
<tr>
<td>GYN</td>
<td>gynecologic</td>
</tr>
<tr>
<td>G/P</td>
<td>pregnancies/births (gravid/para)</td>
</tr>
<tr>
<td>hr.</td>
<td>hour</td>
</tr>
<tr>
<td>H/A</td>
<td>headache</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HR</td>
<td>heart rate</td>
</tr>
<tr>
<td>HTN</td>
<td>hypertension</td>
</tr>
<tr>
<td>Hx</td>
<td>history</td>
</tr>
<tr>
<td>ICP</td>
<td>intracranial pressure</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
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<tr>
<td>IM</td>
<td>intramuscular</td>
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<tr>
<td>inf.</td>
<td>Inferior</td>
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<tr>
<td>Insp</td>
<td>inspiratory</td>
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<tr>
<td>IO</td>
<td>intraosseous</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>IVP</td>
<td>intravenous push</td>
</tr>
<tr>
<td>IVPB</td>
<td>intravenous piggyback</td>
</tr>
<tr>
<td>JVD</td>
<td>jugular venous distention</td>
</tr>
<tr>
<td>Kg</td>
<td>kilogram</td>
</tr>
<tr>
<td>KVO</td>
<td>keep vein open</td>
</tr>
<tr>
<td>L</td>
<td>liter</td>
</tr>
<tr>
<td>lac</td>
<td>laceration</td>
</tr>
<tr>
<td>lbs</td>
<td>pound</td>
</tr>
</tbody>
</table>
### OCMCA APPROVED MEDICAL ABBREVIATIONS

**June 1, 2018**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>L &amp; D</td>
<td>labor and delivery</td>
</tr>
<tr>
<td>LLQ</td>
<td>left lower quadrant</td>
</tr>
<tr>
<td>LOC</td>
<td>level of consciousness</td>
</tr>
<tr>
<td>LPM</td>
<td>liters per minute</td>
</tr>
<tr>
<td>LUQ</td>
<td>left upper quadrant</td>
</tr>
<tr>
<td>♂</td>
<td>male</td>
</tr>
<tr>
<td>m</td>
<td>meter</td>
</tr>
<tr>
<td>MCI</td>
<td>mass casualty incident</td>
</tr>
<tr>
<td>meg.</td>
<td>microgram</td>
</tr>
<tr>
<td>meds</td>
<td>medications</td>
</tr>
<tr>
<td>mEq</td>
<td>milliequivalent</td>
</tr>
<tr>
<td>MI</td>
<td>myocardial infarction</td>
</tr>
<tr>
<td>mg</td>
<td>milligram</td>
</tr>
<tr>
<td>ml</td>
<td>milliliter</td>
</tr>
<tr>
<td>mm</td>
<td>millimeter</td>
</tr>
<tr>
<td>MSDS</td>
<td>manufacturers safety data sheet</td>
</tr>
<tr>
<td>MVA</td>
<td>motor vehicle accident</td>
</tr>
<tr>
<td>MVC</td>
<td>motor vehicle crash</td>
</tr>
<tr>
<td>NaCl</td>
<td>sodium chloride</td>
</tr>
<tr>
<td>NAD</td>
<td>no apparent distress</td>
</tr>
<tr>
<td>NaHCO₃</td>
<td>sodium bicarbonate</td>
</tr>
<tr>
<td>NC</td>
<td>nasal cannula</td>
</tr>
<tr>
<td>neg.</td>
<td>negative</td>
</tr>
<tr>
<td>NIDDMM</td>
<td>Non-insulin-dependent diabetes mellitus</td>
</tr>
<tr>
<td>NPO</td>
<td>nothing by mouth</td>
</tr>
<tr>
<td>NKA</td>
<td>no known allergies</td>
</tr>
<tr>
<td>NS</td>
<td>normal saline</td>
</tr>
<tr>
<td>NSR</td>
<td>normal sinus rhythm</td>
</tr>
<tr>
<td>NTG</td>
<td>nitroglycerin</td>
</tr>
<tr>
<td>N/V</td>
<td>nausea/vomiting</td>
</tr>
<tr>
<td>O₂</td>
<td>oxygen</td>
</tr>
<tr>
<td>OB</td>
<td>obstetrics</td>
</tr>
<tr>
<td>OD</td>
<td>overdose</td>
</tr>
<tr>
<td>P</td>
<td>pulse</td>
</tr>
<tr>
<td>Pt</td>
<td>Patient</td>
</tr>
<tr>
<td>PAC</td>
<td>premature atrial contraction</td>
</tr>
<tr>
<td>PASG</td>
<td>pneumatic anti-shock garment</td>
</tr>
<tr>
<td>Palp</td>
<td>palpation</td>
</tr>
<tr>
<td>PAT</td>
<td>paroxysmal atrial tachycardia</td>
</tr>
<tr>
<td>P.E.</td>
<td>physical exam, pulmonary embolism</td>
</tr>
<tr>
<td>PEA</td>
<td>pulseless electrical activity</td>
</tr>
<tr>
<td>PERRL</td>
<td>pupils equal round reactive to light</td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>PIH</td>
<td>pregnancy induced hypertension</td>
</tr>
<tr>
<td>PMD</td>
<td>private medical doctor / primary medical</td>
</tr>
<tr>
<td>PND</td>
<td>paroxysmal nocturnal dyspnea</td>
</tr>
<tr>
<td>p.o.</td>
<td>by mouth</td>
</tr>
<tr>
<td>post.</td>
<td>posterior</td>
</tr>
<tr>
<td>POV</td>
<td>privately-owned vehicle</td>
</tr>
<tr>
<td>PSVT</td>
<td>paroxysmal supraventricular tachycardia</td>
</tr>
<tr>
<td>psych.</td>
<td>psychiatric</td>
</tr>
<tr>
<td>pt.</td>
<td>patient</td>
</tr>
<tr>
<td>PTA</td>
<td>prior to arrival</td>
</tr>
<tr>
<td>PVC</td>
<td>premature ventricular contraction</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
</tr>
<tr>
<td>Resp</td>
<td>respiratory</td>
</tr>
<tr>
<td>RL</td>
<td>Ringer’s lactate</td>
</tr>
<tr>
<td>R/O</td>
<td>rule out</td>
</tr>
<tr>
<td>Rx</td>
<td>prescription, treatment, therapy</td>
</tr>
<tr>
<td>S/S</td>
<td>signs/symptoms</td>
</tr>
<tr>
<td>SQ</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SIDS</td>
<td>sudden infant death syndrome</td>
</tr>
<tr>
<td>subL</td>
<td>sublingual</td>
</tr>
<tr>
<td>SOB</td>
<td>shortness of breath</td>
</tr>
<tr>
<td>stat</td>
<td>immediately</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>SVT</td>
<td>supraventricular tachycardia</td>
</tr>
<tr>
<td>tach.</td>
<td>tachycardia</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>VF</td>
<td>ventricular fibrillation</td>
</tr>
<tr>
<td>VS</td>
<td>vital signs</td>
</tr>
<tr>
<td>VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>TIA</td>
<td>transient ischemic attack</td>
</tr>
<tr>
<td>TKO</td>
<td>to keep open</td>
</tr>
<tr>
<td>temp.</td>
<td>temperature</td>
</tr>
<tr>
<td>TOT</td>
<td>Turned over to</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment, therapy</td>
</tr>
<tr>
<td>uncon.</td>
<td>unconscious</td>
</tr>
<tr>
<td>URI</td>
<td>upper respiratory infection</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>WNL</td>
<td>within normal limits</td>
</tr>
<tr>
<td>W/S</td>
<td>watts/second</td>
</tr>
<tr>
<td>y/o</td>
<td>year old</td>
</tr>
</tbody>
</table>

**Section 8.12.1**

- Increased, elevated
- Decreased, depressed
- None
- Right
- Left
- Primary, first degree
- Secondary, second degree
- Approximate
- Times
- Positive
- Negative
- Change
EMS Response Time Standards

Purpose
Quality pre-hospital emergency care is directly related to high performance life support agencies with unified EMS response standards. The purpose of this protocol is to establish unified and consistent EMS response expectations for the Oakland County Life Support Agencies.

GLOSSARY OF TERMS

90% Fractile Value: The value or measurement at which 90% of all events occur. This is typically used in time measurements to better standardize performance across systems.

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

Cold Response: A normal traffic speed response (no lights and sirens) to or from an EMS event. For example, “cold” response may include Alpha, Omega, and occasionally a Charlie or Bravo response level.

Hot Response: A lights and sirens, emergent response to or from an EMS event. For example, “hot” response may be an Echo, Delta, and occasionally a Charlie or Bravo response level.

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

Response Time Measurement: Response time is measured from Unit Notified by Dispatch to Unit Arrived on Scene.

DEFINITION OF EMS TIMES

PSAP Call Date/Time: The date/time the phone rings (911 call to public safety answering point or other designated entity) requesting EMS services.

Dispatch Notified Date/Time: The date/time dispatch was notified by the 911 call taker (if a separate entity).

Unit Notified By Dispatch Date/Time: The date/time the responding unit was notified by dispatch.
Unit En Route Date/Time: The date/time the unit responded; that is, the time the vehicle started moving.

Unit Arrived on Scene Date/Time: The date/time the responding unit arrived on the scene; that is, the time the vehicle stopped moving.

Arrival at Patient Date/Time: The date/time the responding unit arrived at the patient’s side.

Transfer of Patient Care Date/Time: This is the time the patient was transferred from one EMS agency to another EMS agency for care.

Unit Left Scene Date/Time: This is the time the responding unit left the scene (started moving).

Patient Arrived at Destination Date/Time: This is the date/time the responding unit arrived with the patient at the destination or transfer point.

Arrival Time of Transport Unit: The time that the transporting unit has arrived on scene; that is, the time the vehicle stopped moving.

Unit Back in Service Date/Time: This is the date/time the unit is back in service and available for response (finished with the call, but not necessarily back in the home location).

Unit Back at Home Date/Time: The date/time the responding unit was back in their service area. In agencies that utilized Agency Status Management, home location means the service area as assigned through their agency status management protocol.

EMS RESPONSE OPERATIONS

Tiered Response Configurations
The Oakland County EMS System has two types of response structures.

Single tier - one agency provides response and transport at one level of care. It is expected that a single tier system meet the Primary Unit Response Time Requirement.

Primary Response Unit: a MDHHS licensed vehicle that is dispatched as part of an initial EMS response in a single tier deployment.

Multi-tier - EMS systems with multiple organizations providing varying levels of response or care. It is expected that life support agencies with multi-tiered response configurations meet the Primary Unit and Transport Unit Response Time Requirements

First Response Unit: a MDHHS licensed vehicle that is dispatched in a multi-tiered response to provide initial patient care.
Transport Unit: a BLS or ALS MDHHS licensed vehicle that is dispatched in a multi tiered response to provide transportation to the hospital.

Examples of Multi-tiered response configurations include:

<table>
<thead>
<tr>
<th>Primary First Response Unit</th>
<th>Transport Response Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Primary Unit Response Time Requirement</em></td>
<td><em>Transport Unit Response Time Requirement</em></td>
</tr>
<tr>
<td>MFR</td>
<td>ALS/BLS transport</td>
</tr>
<tr>
<td>BLS</td>
<td>ALS/BLS transport</td>
</tr>
<tr>
<td>ALS</td>
<td>ALS/BLS transport</td>
</tr>
</tbody>
</table>

Scene Arrival
The time of arrival on scene for “hot” responses for both single and multi-tier systems is considered the arrival of a licensed EMS Unit.

Individual licensed EMS responders responding with an unlicensed vehicle or personal operating vehicles (POV) should report their on-scene time to dispatch. However, the MCA is only collecting the response time of licensed EMS units.

GEOGRAPHIC SERVICE AREA DESIGNATION CRITERIA

<table>
<thead>
<tr>
<th>GSA Designation</th>
<th>Demographics</th>
<th>Primary Unit Emergency Response Time Requirement*</th>
<th>Transport Unit Emergency Response Time Requirement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban area</td>
<td>&gt;1000 people/sq mi</td>
<td>6 mins 0 secs</td>
<td>10 mins 0 secs</td>
</tr>
<tr>
<td>Suburban area</td>
<td>500–1000 people/sq mi</td>
<td>6 mins 0 secs</td>
<td>10 mins 0 secs</td>
</tr>
<tr>
<td>Rural area</td>
<td>&lt;500 people/sq mi</td>
<td>8 mins 0 secs</td>
<td>14 mins 0 secs</td>
</tr>
</tbody>
</table>

• 90% of the time, fractile.

GEOGRAPHIC SERVICE AREA

1. LSAs authorized to operate within the OCMCA will have a defined geographic service area (GSA) within the OCMCA.

2. The minimum service area defined for any Advanced Life Support (ALS), Basic Life Support (BLS), or Medical First Response (MFR) agency will be a municipality jurisdiction. Municipality jurisdictions will be designated by the township, village, city, or county governmental body authorized to designate public safety contracts whether subsidized or unsubsidized.
3. LSAs shall provide the OCMCA with written verification of all geographic service area agreements.


5. The LSA will maintain 24 hour, 7 day per week availability and respond or assure a response to all requests for emergency assistance occurring in their designated geographic service area.

6. LSAs providing ancillary non-emergent and/or inter-facility transport services shall provide sufficient coverage through extra staffing and vehicles to maintain emergency availability.

7. When a LSA is responding outside of its designated GSA to a non-emergency run (e.g. nursing home, urgent care, physicians office, private residence, etc.) for a patient with a potentially life threatening condition, EMS personnel, the LSA or the LSA dispatcher must activate the LSA responsible for that geographic service area.

**EMS EMERGENCY “HOT” RESPONSE TIME REQUIREMENTS**

**Urban And Suburban Geographic Service Areas**

When providing Single Tiered emergency response for an urban and suburban geographic service area, assure a response time not to exceed six (6) minutes, 90% of the time, from receipt of call (unit notified time) to time of arrival on scene for the Life Support Agency’s Primary Response Unit, when responding to emergency (“hot”) calls.

When providing Multi Tiered emergency response for an urban and suburban geographic service area, assure a response time not to exceed six (6) minutes, 90% of the time, from receipt of call (unit notified time) to time of arrival on scene for the Life Support Agency’s First Response Unit, when responding to emergency (“hot”) calls. Additionally, assure a response time not to exceed ten (10) minutes, 90% of the time, from receipt of call (unit notified time), to time of arrival on scene for the Life Support Agency’s Transport Response Unit, when responding to emergency (“hot”) calls

**Rural Geographic Service Areas**

When providing Single Tiered emergency response for an urban and suburban geographic service area, assure a response time not to exceed eight (8) minutes, 90% of the time, from receipt of call (unit notified time) to time of arrival on scene for the Life Support Agency’s Primary Response Unit, when responding to emergency (“hot”) calls.

When providing Multi Tiered emergency response for an urban and suburban geographic service area, assure a response time not to exceed eight (8) minutes, 90% of the time, from receipt of call (unit notified time) to time of arrival on scene for the Life Support Agency’s First Response Unit, when responding to emergency (“hot”) calls.
Unit, when responding to emergency (“hot”) calls. Additionally, assure a response time not to exceed fourteen (14) minutes, 90% of the time, from receipt of call (unit notified time), to time of arrival on scene for the Life Support Agency’s Transport Response Unit, when responding to emergency (“hot”) calls.

Response Time Exceptions

1. Severe weather conditions that would provide reason to believe that attempting to comply with the response time performance would be hazardous to the responders or others, or where the road or other weather conditions would not allow safe driving.
2. During disaster situations within the primary service area or neighboring communities.
3. Response time compliance should not include Automatic or Mutual Aid Responses.

Compliance

The OCMCA will address individual compliance issues in accordance with the PSRO Due Process and Disciplinary Procedures Protocol.
Anatomy of EMS Response

Total EMS Call Time

PSAP TIME

Response Time

En Route Time

Scene Time

Transport Time

Back in Service Time

911 Call - PSAP

Dispatch Notified

Unit Notified

Unit En Route

Unit on Scene

Arrival at Pt

Unit Left Scene

Arrival at Dest.

Back at Home

Transport Unit Arrival

*Unit on Scene may be a transport unit in a single tiered EMS response structure
Equipment

The patient-care equipment carried on BLS or ALS vehicles shall not exceed the state-approved list without OCMCA authorization. Authorization consists of requesting a review of the equipment by PSRO, for MCA approval. The following equipment list must be carried unless stated otherwise. Each agency must choose a device type (FDA approved, when applicable) with their Medical Control Hospital.

Mandatory Equipment
1. Disposable ET Holder (ALS only)
2. Broslow Pediatric Tape, or similar device as approved by the OCMCA (ALS only).
3. Supraglottic Airway Device (SAD) as approved by local MCA protocol include:
   a. Combitube
   b. King (all appropriate sizes)
   c. Intersurgical i-gel 0₂
4. All ALS units shall have 12 lead ECG Capabilities
5. IO Device (ALS only) as approved by the OCMCA
6. Oral glucose paste (BLS and ALS)
7. Mass Casualty Triage Tape

Optional Equipment
1. Non-invasive Cardiac Compression Device as approved by the OCMCA.
2. CPAP/BiPAP Device
3. Impedance Threshold Device
4. Occlusive Dressing: may use a dressing with a valve release
5. Capnography
6. Heat packs
7. Pleural decompression device (ALS only) as approved by the OCMCA
8. Pelvic Binder
9. Commercial Percutaneous Cricothyrotomy: Pertrach or Quicktrach only (ALS only)
10. Soft commercial restraints (all levels)
11. SAD Holder
12. Speedsplint femoral traction kit
13. Tracheal tube introducer (i.e. Bougie)
14. Video Laryngoscope
15. IV Warmer (ALS only)
16. Hemostatic Dressings
Evidentiary Blood Draw Protocol (optional)

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

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

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

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

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

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

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

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

1. Obtain blood draw kit from law enforcement officer and only use the provided contents within the kit for collection.
2. Sample shall be obtained in the presence of a law enforcement officer.
3. Do not use alcohol or alcoholic solutions to sterilize skin surface, needle or syringe.
4. In the presence of a law enforcement officer tell the subject that no alcohol was used in sterilizing the skin surface, needle, or syringe; then draw two tubes of venous blood from subject and upon completion of obtaining the specimen, slowly invert blood collection tube(s) several times to distribute the sodium fluoride/potassium oxalate preservative.
5. Complete blood specimen label(s) by entering name of subject, date and time of blood collection, and your name in ink.
6. In the presence of subject, hand tube(s) of blood and label(s) to law enforcement officer for signing, packaging, and transfer to the laboratory.
**Health Insurance Portability Accountability Act (HIPAA)**

**Purpose:**

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

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

**Policy:**

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

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

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

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

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

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

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

Definition
Hospital Provider-based ED is a term used by CMS to describe an Emergency Department operated by a Medicare-participating hospital at an off-campus location. Services provided at the off-site ED are included under the hospital’s Medicare Provider Agreement and must comply with all Hospital Conditions of Participation found in 42 CFR 482.1 – 482.45, which include, but are not limited to the following:

- Medical staff and nursing personnel practicing at the off-campus ED must be part of the hospital’s medical staff/nursing service.
- Hospital’s Governing Body is responsible for the services and activities of the off-campus ED.
- Emergency laboratory services must be available onsite to the off-campus ED 24/7.
- Off-campus ED must be integrated into the hospital’s quality assessment/performance improvement program as well as medical records system.
- Policies and procedures regarding medical care provided at the off-campus ED are the responsibility of the hospital’s medical staff, and must operate under the same general policies and procedures when practical.

Guidelines for Participation

A. Responsibilities
1. The facility must agree to comply with the Medical Control and Participating Hospital Policy (see System Protocols).
2. The facility must agree to complete the OCMCA Letter of Compliance each year.
3. Emergency care must be available 24 hours-a-day and 7 days-a-week.
4. The facility must agree to comply with any appropriate policies or protocols established by the OCMCA.
5. Radiological (CT Scan and Plain Film Radiograph) and typical emergency department laboratory services shall be immediately available onsite 24 hours a day to provide diagnostic evaluation of patients with life-or-limb threatening conditions.
6. The facility will have Medication Boxes and A-Packs, with contents as approved by the OCMCA and MDCH, available for replacement of supplies used by approved ALS Units. Replacement Boxes/Packs will be maintained in a locked area, under the control of facility staff, and made available 24 hours a day, 7 days a week.

B. Responsibilities for the Continuity of Patient Care
1. Patients should be transported to the nearest appropriate facility in accordance with the Oakland County MCA protocols.
2. The facility must comply with the State’s Medcom Plan, as well as the Oakland County Radio System for notice of arrival or advance information concerning critically ill or injured patients, and to give medical control.
3. Emergency facility personnel shall be familiar with the OCMCA Protocols.
4. The facility must have available a plan for transfer of patients by EMS vehicle or other conveyance with appropriate life support capabilities when necessary. Transfers must be EMTALA compliant.

C. Transportation

1. Priority one patients are not appropriate for hospital provider-based emergency departments. Unstable priority two patients are not appropriate for hospital provider-based emergency department unless, in the opinion of the on-line medical control physician, transporting the patient to a further facility could have an adverse effect on the patient’s outcome.

2. Stable Patients
   a. Stable Medical Patients – If no preference, transport to the closest approved Oakland County Emergency Facility (see Transportation Protocol).
   b. Stable Trauma Patients -- Only patients with minor injuries (e.g. injured ankle from stumble, injured wrist from a fall, etc.) may be transported to a hospital provider-based emergency department (see Transportation Protocol).

3. EMS will communicate to the patient or patient’s family of the hospital provider-based facility’s abilities that they are an emergency department, but not a hospital emergency department with the ability to admit.
**Infection Control**

**NOTE:** Any information obtained or exchanged regarding communicable disease exposures must be handled with strict confidentiality.

I. Standard Precautions and Body Substance Isolation (BSI)

A. Purpose: To prevent the transmission of all bloodborne pathogens that are spread by blood, tears, sweat, saliva, sputum, gastric secretions, urine, feces, CSF, amniotic fluid, semen, and breast milk.

B. Rationale: Since medical history and examination cannot reliably identify all patients infected with HIV, or other bloodborne pathogens, blood and body fluid precautions shall be consistently used for all patients. This approach, previously recommended by the CDC, shall be used in the care of all patients. This is especially important in the emergency care settings in which the risk of blood or body fluids exposure is increased and the infection status of the patient is usually unknown.

1. Standard Precautions/BSI shall be done for every patient if contact with their blood or body fluid is possible, regardless of whether a diagnosis is known or not. This includes but is not limited to starting IVs, intubation, suctioning, caring for trauma patients, or assisting with OB/GYN emergencies.

C. Procedures

1. Handwashing shall be done before and after contact with patients regardless of whether or not gloves were used. Hands contaminated with blood or body fluids shall be washed as soon as possible after the incident.

2. Nonsterile disposable gloves shall be worn if contact with blood or body fluids may occur. Gloves shall be changed in-between patients and not used repeatedly.

3. Outerwear (example: gown, Tyvek® suit, turnout gear) shall be worn if soiling clothing with blood or body fluids may occur. The protection shall be impervious to blood or body fluids particularly in the chest and arm areas.

4. Face Protection (including eye protection) shall be worn if aerosolization of blood or body fluids may occur (examples of when to wear include: suctioning, insertion of endotracheal tubes, patient who is coughing excessively and certain invasive procedures).

5. Mouth-to-mouth resuscitation: CDC recommends that EMS personnel refrain from having direct contact with patients whenever possible, and that adjunctive aids be carried and utilized. These adjunctive aids include pocket masks, face shields or use of BVM.

6. Contaminated Articles: Bag all non-disposable articles soiled with blood or body fluids and handle according to agency procedures. Wear gloves when handling soiled articles. Bloody or soiled non-disposable articles shall be decontaminated prior to being placed back into service. Refer to manufacturer’s recommendations for proper cleaning and disinfecting. Non-disposable equipment shall be decontaminated appropriately prior to reusing.
Bloody or soiled disposable equipment shall be carefully bagged and discarded.

7. Drug/IV Bags shall be inspected and all contaminated waste removed prior to bag exchange. If the bag is contaminated, it must be spot cleaned or laundered prior to being placed back into service.

8. Linens soiled with blood or body fluids shall be placed in appropriately marked container. Gloves shall be worn when handling soiled linens.

9. Needles and syringes shall be disposed of in a rigid, puncture-resistant container. Any grossly contaminated container, or one that is within 1” of the top, should be disposed of appropriately.

10. Blood spills shall be cleaned up promptly with a solution of 5.25% sodium hypochlorite (household bleach) diluted 1:10 with water or other FDA approved disinfectant. Wear gloves when cleaning up such spills.

11. Routine cleaning of vehicles and equipment shall be done. Cleaning and disinfecting solutions and procedures shall be developed by provider agencies following manufacturer’s guidelines and CDC recommendations.

D. Respiratory Isolation
1. In the event of a suspected or confirmed TB patient, an appropriate HEPA mask must be worn, in accordance with MIOSHA regulations.

2. Decontamination of equipment and vehicle after exposure to a patient with a known or suspect respiratory route of transmission shall be carried out following manufacturer’s recommendations and CDC guidelines or as described in the text Infection Control Procedures for Pre-Hospital Care Providers.

II. Radio Communications
A. Anytime the unit and/or dispatcher is made aware of the potential for any communicable disease, that information should be communicated in a format that ensures that patient confidentiality is adhered to.

III. EMS Personnel Exposure to a Communicable Disease
A. Definition of a Reportable Exposure
1. Contaminated needle or sharp instrument puncture
2. Blood/body fluid splash into mucous membrane including mouth, nose, and eye
3. Blood/body fluid splash into non-intact skin area

B. Cooperating Hospitals’ Responsibilities
1. Each cooperating hospital in the Medical Control region will designate an infection control contact to serve as liaison(s) with the staff of medical control and all EMS agencies for the purpose of communicating information about infectious patients or potential exposures.

2. Hospitals, upon learning that any patient has a reportable infectious or communicable disease, will check the patient chart to determine if any EMS agencies were involved with the patient prior to hospitalization. When
determined that EMS may have had contact with the patient, designated individual will notify the EMS agency for further follow-up and complete the required State forms.

3. Hospitals, when requested to do so, will obtain lab tests and results on source patients when exposure to a pre-hospital provider has occurred
   a. Hospitals will report the results of testing on the form DCH-1179(E) and return to the address indicated on the form.

4. Hospitals will notify transporting agencies at the time a transfer is scheduled if any infection potential exists with the patient and the precautions necessary (standard precautions and/or mask).

C. Pre-hospital Agency Responsibilities
   1. Each pre-hospital provider agency will be responsible for assuring that their personnel, trainees and students are familiar with infection control procedures, epidemiology, modes of transmission and means of preventing transmission of communicable disease per CDC guidelines and MIOSHA regulations.
   2. Each pre-hospital provider agency will be responsible for supplying personnel with the appropriate personal protective equipment.
   3. It is recommended that each pre-hospital provider agency ensures adequate immunizations per CDC Immunization Guidelines for Health Care Workers.

D. Follow-up Care/Counseling
   1. Follow-up care and counseling of exposed personnel shall be the responsibility of the pre-hospital provider agency and shall be carried out without delay upon notification of exposure.

E. Summary of EMS Personnel Post-Exposure Procedures
   1. Wash exposed area very well.
   2. Affected personnel may notify ED staff of potential exposure, but ED staff may choose not to test patient until potential exposure confirmed by Medical Control.
   3. Notify agency supervisor of possible exposure.
   4. Fill out form DCH-1179(E) and forward to Medical Control.
   5. Supervisor contacts Medical Control to request source patient testing.
   6. Medical Control contacts hospital personnel to request source patient testing.
   7. Provider obtains exposure evaluation and counseling.
   8. Medical Control reviews form DCH-1179(E) for completeness and forwards to hospital infection control office.
   9. Hospital infection control office returns form with tests results to EMS agency supervisor.
Inter-facility Patient Transfers

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

1. Responsibility:
   A. Patient transfer is a physician-to-physician referral. The transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility prior to the transportation. The name of the accepting physician must be included with the transfer orders.
   B. It is the responsibility of the transferring facility to:
      a. Perform a screening examination.
      b. Determine if transfer to another facility is in the patient’s best interest.
      c. Initiate appropriate stabilization measures prior to transfer.
   C. During transport, the transferring physician is responsible for patient care until arrival of the patient at the receiving facility.
   D. If unanticipated events occur during patient transport, and contact with the transferring physician is not possible, then on-line Medical Control will serve as a safety net.
   E. It is the transferring physician’s responsibility to know and understand the training and capabilities of the transporting EMS personnel.

2. Transportation
   A. Pre-transport
      a. Care initiated by the transferring facility may need to be continued during transport. The transferring physician will determine the method and level of transport and any additional treatment(s), if any, that will be provided during the course of transport.
      b. Orders for treatment, including medications for ALS transfers, or other orders shall be provided in writing to the EMS personnel prior to initiation of the transport by the transferring Physician.
      c. For ALS transfers, ordered medications not contained within the EMS System Medication Box/Bag must be supplied by the transferring hospital.
      d. EMS personnel must be trained in all the equipment being used in the patient’s care or appropriately trained staff must accompany the patient.
      e. Should the patient require care and/or equipment above and beyond the normal scope of practice and training of the EMS personnel, the transferring facility shall provide appropriate staff or consider other appropriate means of medical transportation.
      f. The paramedic has the right to decline transport if he/she is convinced patient care is outside their scope of practice and training or, alternatively, to insist a hospital staff member accompany them on the transfer or consider other appropriate means of medical transportation.
      g. If additional staff accompanies the patient, the transferring physician is responsible for ensuring their qualifications. This staff will render care to the patient under the orders of the transferring physician. It will be the responsibility of the transferring facility to provide arrangements for the return of staff, equipment, and medications.
h. The following information should accompany the patient (but not delay the
transfer in acute situations):
   1. Copies of pertinent hospital records
   2. Written orders during transport
   3. Any other pertinent information including appropriate transfer
documents.

B. During Transport
   a. Hospital supplied medications not used during transport must be
      appropriately tracked, wasted and documented. All controlled substances
      and Propofol must have a documented chain of custody.
   b. The concentration and administration rates of all medications being
      administered will be documented on the patient care record.
   c. Interventions performed en route, and who performed them, will be
      documented on the patient care record.
   d. In the event that a patient's condition warrants intervention beyond the
      written Physician orders provided by the transferring Physician, the EMS
      personnel will contact the transferring Physician. If that is not possible, the
      EMS personnel will follow local Medical Control Protocols and initiate
      contact with the on-line Medical Control Physician from either the sending or
      receiving facility or, if not able to contact those facilities, the closest
      appropriate on-line Medical Control facility.
**Licensure Level Requirement of Attendant during Transport (Optional)**

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

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

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

I. Patient care transport level is to be determined by the individual(s) whose license is at least equal to the level of the vehicle license. This individual will perform a patient assessment to determine the level of patient care transport.

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

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

   C. EMT-Paramedic may transport a patient at any level.

II. Ambulance(s) must maintain minimum staffing in accordance with Public Health Code Act 368 of 1978 Section 333.20921:

   (3a) If designated as providing basic life support, with at least 1 emergency medical technician and 1 medical first responder.

   (3b) If designated as providing limited advanced life support, with at least 1 emergency medical technician specialist and 1 emergency medical technician.

   (3c) If designated as providing advanced life support, with at least 1 paramedic and 1 emergency medical technician.
Medical Control and Participating Hospital Policy

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

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

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

2. Non-Compliance –
   Upon adequately establishing a Receiving Emergency Facility’s inability to comply with the OCMCA Hospital Letter of Compliance, PSRO will:
   a. Advise the facility of its noncompliance status.
   b. Request a plan within two weeks from the hospital containing a timeline for achieving compliance.
      i. If the timeline to comply is less than one month, PSRO will monitor and assure completion.
      ii. If the time allotted is more than one month, or, if the facility cannot complete the plan, its 800 MHz radio shall be relinquished until compliance with criteria for participating is met.
Any appeals of the decision or actions shall be according to the Incident Investigation Procedure.

Receiving Emergency Facility Responsibilities:
1. Receive EMS patients and provide medical direction.
2. Provide case-by-case quality assurance and performance reviews and communicate with the OCMCA office regarding deviations from protocol.
3. Participate in LSA QI programs, including a review of online medical control at their institution, and provide documentation to PSRO, when requested.
4. Adhere to Oakland County Medical Control Authority approved protocols and policies.

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

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

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

## EMERGENCY FACILITY TELEPHONE NUMBERS

<table>
<thead>
<tr>
<th>Hospital ER’s</th>
<th>ER Telephone</th>
<th>Secure Fax</th>
<th>Recorded Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beaumont – Farmington Hills</td>
<td>(248) 471-8566</td>
<td>(248) 471-8951</td>
<td>(248) 471-7273</td>
</tr>
<tr>
<td>Beaumont-RO</td>
<td>(248) 898-9111</td>
<td>(248) 898-6872 (Area B)</td>
<td>(248) 898-4566 Line 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(248) 898-4671 (Area A)</td>
<td>(248) 898-8811 Line 2</td>
</tr>
<tr>
<td>Beaumont-Troy</td>
<td>(248) 964-8787</td>
<td>(248) 964-9866</td>
<td>(248) 964-5486</td>
</tr>
<tr>
<td>Children’s Hospital of Michigan – Troy</td>
<td>248-524-7224</td>
<td>(248) 457-1402</td>
<td>(248) 457-1406</td>
</tr>
<tr>
<td>Crittenton Hospital</td>
<td>(248) 652-5311</td>
<td>(248) 601-6025</td>
<td>(248) 601-6060</td>
</tr>
<tr>
<td>Genesys Regional Medical Center</td>
<td>(810) 606-5933</td>
<td>(810) 606-6381</td>
<td>(810) 606-6922</td>
</tr>
<tr>
<td>Henry Ford Medical Center-West Bloomfield</td>
<td>(248) 325-0300</td>
<td>(248) 325-3276</td>
<td>(248) 325-3671</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(248) 325-2811 (Clinical Co-ord)</td>
<td></td>
</tr>
<tr>
<td>Huron Valley-Sinai</td>
<td>(248) 937-4400</td>
<td>(248) 937-3306</td>
<td>(248) 937-4555</td>
</tr>
<tr>
<td>McLaren Hospital-Clarkston</td>
<td>(248) 922-6880</td>
<td>(248) 922-6897</td>
<td>(248) 922-6899</td>
</tr>
<tr>
<td>McLaren Hospital-Oakland</td>
<td>(248) 338-5332</td>
<td>(248) 338-5340</td>
<td>(248) 338-5369</td>
</tr>
<tr>
<td>Providence Hospital-Novi</td>
<td>(248) 465-3030</td>
<td>(248) 465-4889</td>
<td>(248) 465-4213</td>
</tr>
<tr>
<td>Providence Hospital-Southfield</td>
<td>(248) 849-3331</td>
<td>(248) 849-5431</td>
<td>(248) 849-4160</td>
</tr>
<tr>
<td>St John-Oakland</td>
<td>(248) 967-7661</td>
<td>(248) 967-7876</td>
<td>(248) 967-7656</td>
</tr>
<tr>
<td>St Joseph Mercy-Oakland</td>
<td>(248) 758-7000</td>
<td>(248) 858-2286</td>
<td>(248) 858-6660</td>
</tr>
<tr>
<td>St Mary Mercy-Livonia</td>
<td>(734) 655-1230</td>
<td>(734) 655-1270</td>
<td>(734) 464-3407</td>
</tr>
</tbody>
</table>

Updated: November 15, 2017
1. Licensed by the Michigan Department of Health and Human Services (MDHHS) as: (check one) YES NO
   A. Hospital ______
   B. Free Standing Facility ______
   C. Hospital Provider-based ED ______

2. If a hospital/facility makes a permanent change in their categorization, the facility shall notify the Oakland County Medical Control Authority (OCMCA) 30 days in advance of the change. YES NO

3. Hospital has 24/7 interventional cardiac catheterization capabilities. YES NO

4. Verified by the American College of Surgeons as a Level 1, 2, or 3 Trauma Center. Please indicate level date of last inspection/verification. ADULT LEVEL: __________ DATE: __________ PEDIATRIC TRAUMA LEVEL: __________ DATE: __________

5. Assure that the emergency facility has a full-time emergency medicine Board Certified/Eligible emergency physician director whose primary clinical responsibility is emergency medicine. YES NO

6. Assure that an emergency medicine Board Certified/Eligible emergency physician be available to handle ALS runs at all times. YES NO

7. Accept the responsibility for replenishing medication and medical supplies, expended by ALS personnel during treatment of a patient, as per the Regional Drug Box Policy and IV Auxiliary Supply Policy. YES NO

8. This facility designates the OCMCA (including its PSRO) to perform professional practice review functions on behalf of the facility, including review of pre-hospital medical direction furnished in Oakland County and recommendations for improvement of such care. YES NO

9. Facility will participate in the EMS system quality assurance program, and will supply data on outcome of patients as agreed to by the OCMCA. YES NO

10. Facility follows the OCMCA Medical Control and Participating Hospital Policy, and the Epi-Auto Injectors Exchange Policy. YES NO

11. Completion of Addendum Facility Survey (see addendum). YES NO
Addendum to Letter of Compliance
Facility Survey

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

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

3. Patient bed capacity.
   __________

4. EMS entrance code.
   __________

5. Please indicate the specialties that are available at your facility:
   - Cardiac – Cooling
   - Cardiac – Open heart
   - Cardiac - 24/7 interventional cardiac catheterization capabilities
   - Neonatal
   - NICU Level III II I
   - OB/Labor
   - Pediatrics
   - PICU Level I II
   - Adult Burn (severe)
   - Pediatric Burn (severe)
   - Stroke –
     - Primary Stroke Center
       - Yes  No
     - Interventional
       - Yes  No
     - Comprehensive
       - Yes  No
# OCMCA Hospital
## Emergency Contact Information

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

<table>
<thead>
<tr>
<th>Hospital:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED 24/7 #:</td>
<td>ePCR Fax #:</td>
</tr>
<tr>
<td>ePCR E-mail Address</td>
<td>EMS Recorded Line:</td>
</tr>
<tr>
<td>CEO:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>Hospital EMS Coordinator/Liaison:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>ED Director:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>MCC Physician:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>MCC Physician Alternate:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>Pharmacy Director:</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
<tr>
<td>Trauma Program Coordinator: (if applicable)</td>
<td>E-mail address</td>
</tr>
<tr>
<td>Work #</td>
<td>Cell #</td>
</tr>
</tbody>
</table>

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

_______________________________________  __________________________________
ED Director (Signature)                      ED Director (PRINT)

Date

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

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

Definitions

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

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

Procedure

1. Mutual and Automatic aid agreements entered into by life support agencies within the OCMCA, shall be retained by the agency and a copy given to the OCMCA office.
2. Automatic aid is restricted to congruent staffing and level of licensure. Mutual aid is not restricted to congruent staffing and level of licensure.

Request for mutual aid (as defined above) should not exceed more than 5% of the requesting LSA’s normal call volume.
New or Upgraded EMS Agency Policy

Requirements for new life support agencies (LSA’s) and agencies that propose to change their level of services.

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

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

List of Required Paperwork:
1. A copy of the completed proposed application to be submitted to the State, with all signatures present. This will include:
   a. A list of all vehicles licensed/proposed to be licensed by the service with the State, the year, make, VIN, and license plate number for each vehicle.
   b. A list of all licensed EMS personnel, their names, license number, level, expiration date, and, if they are paramedics, ACLS certification expiration date; and
   c. Proof of State of Michigan required insurance.
2. A copy of the completed OCMCA Letters of Compliance, with all signatures present.
3. Copies of all mutual aid agreements with other Oakland County approved LSA’s who are licensed at or above the level proposed by the applying agency. One mutual aid agreement is required with an OCMCA approved LSA at or above the level proposed by the applying agency.
4. A complete “New/Upgraded EMS Agency Form” signed by the Chief of the department, or the President of the agency.
5. Provide written documentation from each approving geographic service area (GSA), explaining how your agency will operate in the GSA and respond to emergencies in that area. Documentation must be signed by the GSA, or designee and agency. The documentation shall include the following:
   a. Provide at least 1 vehicle available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.
   b. Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its geographic service area.
   c. Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.
   d. Proposed start of operations date.
6. Provide the OCMCA with at least two references from other Medical Control Authorities where you have operated. The OCMCA will send a letter and form to each MCA requesting a report of Good Standing.

7. Maintain a physical station with a minimum of one life support vehicle with 24/7 staffing (of a type commensurate with what is written on the agency’s license) that is available for response to requests for emergency assistance, and is staffed on a 24/7 basis within Oakland County.

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

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

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

Date: ___________________ Agency: ______________________________________________

Complete the following:

<table>
<thead>
<tr>
<th>AGENCY:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agrees to operate under all Oakland County Medical Control Authority protocols, policies and procedures.</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>2. Has a medical control hospital and medical control hospital physician. Medical Control Hospital: ____________________________ Physician (MCC member/alt): ____________________________</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>3. If proposed coverage is less than current coverage in quantity of vehicles, level of licensure, or average response time, justification is attached explaining the reason for the proposed coverage.</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>4. Have the owners/officers of the agency have ever been convicted of a felony?</td>
<td>❑</td>
<td>❑</td>
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<thead>
<tr>
<th>STAFFING:</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>5. Meets Oakland County staffing requirements and the personnel meet Oakland County qualifications.</td>
<td>❑</td>
<td>❑</td>
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NOTE: If “No” is checked for any statement (except for number 4), you must provide sufficient documentation to explain the variance. If “Yes” is checked for number 4, provide an explanation.

Agency will provide the following:

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

<table>
<thead>
<tr>
<th>Level of Licensure:</th>
<th>Number of Vehicles:</th>
<th>Average Response Time:</th>
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</table>

MCA Oakland County
MCA Board Approval Date: December 2, 2017
MDHHS Approval Date: January 27, 2017
MCA Implementation Date: February 1, 2017
6. Provide written documentation from each approving geographic service area (GSA), explaining how your agency will operate in the GSA and respond to emergencies in that area. Documentation must be signed by the GSA or designee and agency. The documentation shall include the following:
   a. Provide at least 1 vehicle available for response to requests for emergency assistance on a 24-hour-a-day, 7-day-a-week basis in accordance with local medical control authority protocols.
   b. Respond or ensure that a response is provided to each request for emergency assistance originating from within the bounds of its geography service area.
   c. Operate under the direction of a medical control authority or the medical control authorities with jurisdiction over the ambulance operation.
   d. Proposed start of operations date.

7. If the application involves upgrading the level of service, a plan must be attached that explains how the agency will deal with newly licensed personnel working together.

8. Provide mutual aid agreement(s) with an OCMCA approved LSA at or above the level proposed by the applying agency.

9. If the service is a corporation, articles of incorporation are included.
**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.
**Physician on Scene**

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

I. **Responsibility of Medical Control**
   A. “When a life support agency is present at the scene of the emergency, authority for the management of an emergency patient in an emergency is vested in the physician responsible for medical control until that physician relinquishes management of the patient to a licensed physician at the scene of the emergency”. MCL 333.20967

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

II. **Patient Management in the Presence of an On Scene Physician**
   A. The EMS provider may accept assistance and/or advice of the on-scene physician provided they are consistent with medical control protocols. The assistance of an on-scene physician may be provided without accepting full responsibility for patient care, as long as there is ongoing communications and approval by the medical control physician. The medical control physician may relinquish control of the patient to the on-scene physician provided the on-scene physician agrees to accept full responsibility for the patient. Full responsibility includes accompanying the patient to the hospital and completing a patient care record. The EMS personnel should encourage the on-scene physician to communicate with the on-line medical control physician.

   B. The medical control physician may reassume responsibility of the patient at their discretion at any time.
Protocol Deviation

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

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

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

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

III. All deviations must be reported to medical control.

IV. All deviations will be reviewed within the medical control quality improvement program.
PSRO Structure and Operational Policy

**Mission:** The Oakland County Professional Standards Review Organization (PSRO) Subcommittee exists to promote the EMS system, and organize and integrate quality assurance activities to ensure the delivery of consistent, quality emergency patient care for Oakland County.

I. Professional Standards Review Organization
   A. The Professional Standards Review Organization (PSRO) is a review entity that is provided information or data regarding the physical or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or the qualifications, competence, or performance of a health care provider. The PSRO is a committee established by the Medical Control Authority for the purpose of improving the quality of medical care.
   B. The Oakland County Medical Control Authority (OCMCA) shall determine the membership of the PSRO in accordance with the OCMCA’s Bylaws.
   C. All Quality Improvement activities shall be considered activities of the PSRO.

II. PSRO Membership:
   A. Appointments: Chair, Vice Chair and membership shall be appointed by the Executive Committee and approved by Medical Control Committee (MCC) and Board of Directors.
   B. Term: 2 years
   C. Meetings: Monthly, with additional meetings as deemed necessary.
   D. Membership: 4 ED physicians from different OCMCA approved facilities  
   1 ED Nurse Manager/Director  
   1 ALS Public Provider**  
   1 ALS Private Provider**  
   1 BLS/MFR Provider**  
   8 Total Voting Membership
   E. Ex Officio: OCMCA Staff, EMS Medical Director, Deputy Medical Director, MCC Chairperson, Chairpersons of the subcommittees: EMS Operations, and Protocols.
F. Subject Matter Experts: Ad hoc, for subject-specific advice to PSRO. Subject Matter Experts will be required to sign the PSRO Confidentiality Statement.

G. Attendance: 75% required attendance with semi-annual assessment.

H. Quorum: 2 physicians, 2 providers and greater than 50% of voting members.

I. Confidentiality Statement: Each PSRO Member (voting and ex-officio) will be required to sign the OCMCA PSRO Confidentiality Statement annually (See Appendix A of System Protocols).

** Indicates that the member must be from an Oakland County-based Life Support Agency (LSA) that provides emergency services to a city, township, or village within the OCMCA area, and the LSA’s headquarters is located in the OCMCA service area.

III. Peer Review Confidentiality:
Information and data collected by or for the PSRO is confidential professional/peer review PSRO information of the OCMCA. It is protected from disclosure pursuant to MCL 333.20919(1)(g), MCL 333.20175, MCL 333.21515, MCL 331.531-331.533 and other State and Federal laws. Unauthorized disclosure or duplication of PSRO information is absolutely prohibited.

IV. EMS Patient Care Records:
A. The PSRO is authorized to request copies of EMS patient care records (PCRs) within the OCMCA’s service area. Copies of PCRs shall be provided to the PSRO as requested and shall be submitted by the LSA no later than the timeframe designated by OCMCA. Additional time may be granted per request of the LSA and such request shall be determined by the OCMCA.

B. Any individual may request, with justification, that a specific PCR be reviewed by the PSRO. This includes but is not limited to Physicians, Nurses, EMS Providers, and Patients.

C. All reviews of PCRs will be based on OCMCA protocols that were approved and active on the date of the EMS call for service.

V. Protocol Review:
A. The PSRO may review proposed and revised protocols as they pertain to quality improvement, patient care, or special circumstances and provide with the PSRO’s comments.
VI. PSRO Responsibilities:
A. Incident review:
   To assess, investigate and make recommendations to the Board of Directors pertaining to issues of concern posed by any person(s) regarding Oakland County EMS activities. Investigations will be processed according to the Incident Investigation Procedure.
B. Audits:
   To regularly assess quality assurance processes performed by pre-hospital care personnel/agencies/facilities.
C. QI Studies/Planning:
   To develop an annual plan and perform study evaluations for the purpose of EMS system assessment and improvement of processes, protocols, EMS personnel, equipment, medications, etc. that may affect patient outcomes.
D. Licensure/Relicensure/Letter of Compliance: Assessment of LSAs’ and facilities’ applications, reapplications, and compliance with OCMCA protocols, policies, and QI.
E. Life Support Agency data collection.
F. Evaluation of proposed research projects that involve the Oakland County EMS System or EMS patients within the OCMCA’s service area.

VII. Reporting:
A. PSRO reports to the EMS Medical Director, MCC and Board of Directors.
B. The following will be reported to the MCC and Board of Directors:
   1. Retraining
   2. Probation with conditions and reevaluation time frame
   3. Suspension/removal of Medical Control for personnel/LSA/facility
   4. Revocation of license – through the Michigan Department of Community Health (MDCH).

VIII. PSRO Quality Improvement Recommendations:
A. The PSRO and/or the EMS Medical Director will determine the severity of an incident and develop an action plan to address the matter, if necessary.
B. Incident Review:
   The following will be reviewed for EMS system and LSA compliance:
   1. Demographics, times, mileage, etc.
   2. Accuracy of patient assessment
   3. Appropriateness of treatment
   4. Compliance with protocols
Section 8.27

C. Incident Review and Audit Recommendations/Findings:
1. Absolution, complaint unfounded, unsubstantiated or not of consequence
2. Informational/educational reporting without recommendation for action
3. Endorsement of activity
4. Trending
5. Revision of protocols/policies/procedures
6. Corrective action plan by personnel/LSA/facility
7. Education recommendations for the system

D. Referral to Due Process and Disciplinary Procedures
1. Written reprimand to personnel/LSA/facility
2. Remediation of individuals involved
3. Modification of clinical privileges
4. Continued monitoring
5. Individual/LSA probation
6. Removal of Medical Control
7. Other actions as determined by the PSRO and/or EMS Medical Director
Complaint Investigation & Resolution

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

I. Definitions:
   A. Complaint
      For the purpose of this policy, a complaint shall be defined as any notification of dissatisfaction or concern regarding medical care rendered by a MCA licensed EMS provider/agency, or any issues that involve the performance of the EMS system in whole or in part.
   B. Privileged Documents
      Privileged documents are those which are collected by the Professional Standards Review Organization (PSRO) of the MCA.
   C. Formal Inquiry
      Formal inquiry means that a complaint has been found to either be valid, or that more detailed inquiry is necessary to determine the validity of the complaint; either of which will require that the subject licensee (individual/agency) be notified of the specific complaint. A formal inquiry may involve the gathering of incident reports which provide explanations for care rendered or justification for actions, as well as subject/witness interviews. Some information gathering may not necessitate a formal inquiry.
   D. Sentinel Event
      A sentinel event is any complaint which involves at least one single level I infraction, a violation of Michigan or Federal laws, EMS rules, or 2 or more level II infractions, as described in the Medical Incident Review and Corrective Action Policy. Refer to Incident Classification Protocol.
   E. Licensee
      A licensee is defined as an individual or an agency (fire department, rescue squad, life support agency, etc.) holding a valid State of Michigan Medical First Responder, Emergency Medical Technician, Specialist, Paramedic, or agency licensed to operate within the Medical Control Authority service area. Said individual licensee shall be an employee of a provider licensed to operate within the Medical Control Authority.

II. Professional Standards Review Organization of the MCA
   A. The medical control authority shall establish a PSRO to perform its duties and functions related to complaints, investigations or quality improvement activities, both prospective and retrospective.
   B. The PSRO may be comprised of members of the board(s), MCA employees and
contract staff, EMS agency staff, hospital staff, committee members, and other designated individuals when acting on behalf of, or at the direction of the MCA when performing PSRO tasks.¹

III. Complaints Which Will be Considered

All complaints, in order to be considered for action by the MCA, shall meet the following criteria:

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

B. The complainant must provide the MCA with his/her name, address, and telephone number. A request for anonymity by a complainant shall be honored by the MCA to the extent possible.

C. The complaint must be directed toward a licensee (individual or agency) within the MCA.

IV. Complaints That May Not Be Considered

Complaints regarding conduct of a licensee, exclusive of medical practice or actions bearing upon medical practice, shall be referred to the employer of the individual. These complaints may also be referred to the PSRO for investigation at the discretion of the MCA.

V. Complaint Delegation

A. Complaints directed toward an individual acting while employed by an agency outside of the jurisdiction of the MCA shall not be accepted or investigated but will be forwarded, or the complainant directed to, the MCA/agency under whose jurisdiction it does fall.

B. MCAs may cooperate on investigations which overlap jurisdictional boundaries. For the purposes of remediation or discipline, the MCA granting Medical Control to the provider or agency where the primary action or actions being investigated took place shall be considered the jurisdictional MCA.

C. Complaints more appropriately investigated at the agency or operational level may be turned over to the life support agency or hospital involved. Investigation results should be reported to the MCA.

VI. Receipt of Complaints

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

¹ MCL §331.531, (Et Seq.)
The complainant for a case should be asked if they would like to be contacted by the agency/individual that is the subject of the complaint. This will allow the complainant the opportunity to voice a request to remain anonymous or to allow their information to be provided to the subject of the complaint.

VII. Investigation of Complaints

Once a complaint is received by the MCA, the complaint will be assigned to the PSRO. The person(s) charged with complaint investigation will gather information to determine the validity of the complaint and, if valid, will communicate with the employing agency of the subject(s) involved in the complaint. The PSRO may request copies of documents, incident reports, video and audio recordings relating to a complaint without formal notification of the complaint to the subject licensee. All requests for information will be documented in the investigation notes or with attached documentation/emails. Formal notification of the subject licensee will occur if MCA disciplinary actions or formal inquiry are indicated. A copy of the initial complaint, or a complaint summary (if the initial complainant requested anonymity), may be provided upon request.

VIII. Documentation

The documentation of the investigation of a complaint may include, but is not limited to, the following:
A. The name, address, and telephone number of the complainant (if known)
B. A copy of the stated complaint
C. The date and time of the receipt of the complaint
D. A copy of the complaint acknowledgement, if appropriate.
E. A copy of the notice to the subject licensee, if appropriate.
F. A copy of the pertinent protocol(s) and/or policy/policies.
G. Written statements of witnesses including notes from telephone interviews
H. Copies of pertinent reports, transcriptions of audio tapes; video recordings and copies of other pertinent documents or emails.

IX. General Complaint Review

The complaint review process will first seek to identify the validity of each complaint. Complaints found to be invalid will be closed as unsubstantiated; notification to the individual or the agency of the closure will only occur if prior knowledge of the complaint was provided to, or exists with, the involved individual/agency.

Complaints found to be valid, but of a minor or less severe nature may be handled in cooperation with the agency’s quality improvement personnel or management. These incidents may involve education and remediation but may not involve suspension, limitation or revocation of the individual’s or agency’s privileges to function in the MCA
X. Sentinel Event Complaint Review

A sentinel event complaint shall be reviewed by the PSRO at a special meeting called for that purpose. Prior to a review meeting, the subject licensee shall be provided with copies of all documentation gathered regarding the complaint with the exception of any documents that would reveal the identity of an individual who requested anonymity. The licensee will be informed if documents are withheld or summarized to maintain the anonymity of an individual.

The subject licensee (individual/agency) may request a postponement, of up to thirty (30) days, of a special meeting in order to prepare his/her/their response to the complaint. The subject individual/agency must submit copies of all supporting documentation to the PSRO at least one week prior to the review meeting.

A. Attorneys and Union representatives are not permitted in PSRO case reviews without prior expressed permission of the MCA.

B. A subject licensee may bring a representative of their life support agency, such that the agency may provide guidance for the individual, and so the agency may fairly represent themselves and their policies.

C. The following steps shall be taken in the complaint review process:

1. The violation of policy or protocol shall be defined.
2. The impact on patient outcome will be evaluated.
3. The subject licensee shall be given time to speak on the issue of the complaint including the opportunity to present supporting documentation.
4. Counseling, remedial, and/or disciplinary action shall be considered and/or ordered as deemed appropriate by a majority vote of the MCA or their designated and pre-established Professional Standards Review Organization/Quality Review Committee.

D. The complainant shall, to the extent allowed under confidentiality statutes, be notified of the outcome of the complaint review process. The employer shall be notified if one of their employees has their privileges suspended or revoked.

E. If the MCA has enacted a temporary suspension, in accord with the Due Process and Disciplinary Action Policy, and the subject licensee requests a 30-day postponement, the suspension of privileges to function shall remain in place during the postponement.

F. The PSRO shall remove all the names and addresses of patients from the record before the review entity releases or publishes a record of its proceedings, or its
reports, findings, and conclusions.²

² MCL 331.533
Disciplinary Action Appeal

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

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

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

III. Appeal Hearing for an Immediate Threat
If the MCA determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control privileges can be taken immediately until the MCA has had the opportunity to review the matter at a MCA hearing. The hearing shall be held within 3 business days after the MCA’s (or Medical Director’s) determination to remove medical control.
Due Process & Disciplinary Procedures

Purpose: To establish a fair and equitable method of applying remediation and/or discipline to licensees found to be violation of protocol.

I. Due Process

The **Complaint Investigation & Resolution Policy** establishes the initial steps of Due Process. Under that policy, a complaint will be investigated for validity and severity. Both individuals and agencies shall be notified of formal or sentinel reviews.

A. The MCA will provide at least 4 business days’ notice to affected providers and agencies prior to convening a special PSRO meeting.

B. Subjects of a complaint will be provided with copies of all, complaint/investigation related materials at the time of a special meeting with the exception of materials that would reveal the identity of an individual that provided information under the condition of anonymity. The subject individual or agency may request the complaint/investigation related materials in advance of the special meeting.

C. Any MCA suspension enacted as a measure to ensure the safety of the community or patients shall remain in effect pending sentinel event review and disposition.

D. In the event of criminal charges being filed against a provider or agency related to acts of violence, diversion of medications, illegal possession of controlled substances, criminal sexual conduct, or other practice which may pose a threat to the community or patients, the MCA may act with suspension of MCA privileges without convening a special PSRO meeting.
   1. The individual or agency shall be notified of the suspension per the **Disciplinary Action and Appeal Policy**.
   2. If found guilty in a court of law, MCA privileges will be considered to be revoked.
   3. If found not guilty of charges, the individual or agency must provide copies of court documents, including transcripts, to the MCA.
   4. If a court case is dismissed based on procedural failings or errors, the MCA may decline to extend privileges if the conduct of the individual or agency may pose a threat to the community or patients.

E. A subject licensee may request a postponement of up to thirty (30) calendar days of a special PSRO meeting in order to prepare his/her individual or agency response to the complaint. The subject licensee must submit a copy of all supporting documentation to the MCA at least one week (5 business days) prior to the postponed review meeting.

F. The MCA is not a hiring entity and is not subject to collective bargaining. Union representation during MCA PSRO reviews is not permitted.

G. The MCA’s PSRO investigates incidents, complaints, personnel and agencies. While a deed or misdeed may be civil or criminal in nature, the MCA’s PSRO is not an adjudicating body for either of these conditions. The PSRO is not subject to the rules and statutes which govern civil or criminal
adjudication; as such, attorneys and legal representatives are not permitted in PSRO reviews.

H. Recording, monitoring or any manner of duplicating a PSRO review is not permitted unless conducted by the PSRO entity and expressly for PSRO purposes.

I. Disclosure of confidential PSRO materials\(^1\) by individuals or agencies both before and after review shall be cause for possible suspension or revocation of MCA privileges, as well as possible statutory violations.

J. The MCA may disclose non-specific information relating to discipline of individuals or agencies. Care must be taken to not compromise any confidential information.\(^2\)

K. Subject individuals or agencies may have agency representation at PSRO reviews provided PSRO standards are maintained.

L. Individuals or agencies failing to appear for PSRO reviews waive their right to representation and are subject to the summary findings of the review body. Failure to appear also constitutes a violation as defined in the Incident Classification Policy.

M. Subject individuals or agencies shall be notified of the findings of a PSRO review. If disciplinary action results, the individual or agency will be provided with any required remediation steps/actions and a copy of the Disciplinary Action Appeal Policy.

N. In the event that a complaint/investigation involves both the function of an individual and the compliance of their agency or department, the requirement for a 4 business day notice of any special meeting shall apply, unless a postponement is granted to the individual.

II. Application of Disciplinary Action

A. A primary function of disciplinary action is to ensure the protection and safety of the community and patients.

B. The application of remediation and/or discipline is intended to promote improvement in clinical and operational performance.

C. The MCA shall engage in a process to ensure that licensees maintain an appropriate level of clinical and operational performance.

D. The review process outlined in the Complaint Investigation Procedure shall be utilized in assessing the remedial and/or disciplinary action required.

E. MCAs should utilize Just Culture when applying or considering disciplinary action. There should be a balance between provider and system accountability.

III. Remediation

A. The Medical Control Authority may issue an order of remediation to correct substandard clinical performance.

B. A defined time period for completion of remedial activity shall be stated in the order.

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\(^1\) MCL 331.533
\(^2\) MCL 331.533
C. Licensees shall be required to perform remedial activity under the supervision of an appointed proctor to correct an identified performance shortcoming.

D. Notice of a remedial order, or the order itself, shall be forwarded to the licensee’s employer (or MCA board in the case of an agency provider).

E. A licensee shall be allowed only one opportunity for remediation of repetitive substandard performance in a twelve-month period. Subsequent episodes of substandard performance of the same nature occurring within the same twelve-month period shall be addressed under the disciplinary portion of this policy.

F. Disciplinary action may be accompanied by assignment of additional remedial activity.

IV. Discipline

Disciplinary action may or may not be ascending in severity. In cases where misconduct (by action or omission), regardless of where the misconduct occurred, is determined to be reckless, willful, or criminal, ascending discipline may be bypassed with a more severe disciplinary action imposed.

A. Order of Disciplinary Action

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

2. ODAs include, but are not limited to, written reprimands, written notice of suspension, written notice of revocation, a letter of warning and a letter of reprimand.

3. The ODA must be delivered in a way that confirmed receipt by the licensee may occur.

4. The licensee that receives an ODA must provide a copy to all MCAs in which they are privileged.

5. Licensees receiving an ODA from another MCA must provide a copy of the ODA to this MCA.

B. Temporary Suspension of Privileges

1. The Medical Director may temporarily suspend a licensee’s privileges in cases where there is a clearly definable risk to the public health and welfare. The Medical Control Authority shall review such action within three business days after the Medical Director’s determination.

2. If a licensee’s MCA privileges have been temporarily suspended from a licensee, the licensee shall not provide prehospital care until MCA privileges are reinstated.

C. Written Reprimand

1. A written reprimand shall be issued to a licensee stating
   a. the details of the substandard performance
   b. the remedial action, if required
   c. the time allowed for completion of remedial action
   d. the consequences for repetitive noncompliance
2. Notice of disciplinary action shall be forwarded to the licensee’s employer (or MCA board in the case of an agency provider).

3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

### D. Probation

1. A probationary letter shall be issued to a licensee stating
   a. the details of the substandard performance
   b. the details of the probation
   c. the remedial action required
   d. the restriction of privileges, if applicable
   e. the time of probationary period
   f. the consequences for repetitive noncompliance

2. Notice of probationary action shall be forwarded to the licensee’s employer (or MCA board in the case of an agency provider).

3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

### E. Suspension of Privileges

A licensee’s medical privileges shall be suspended for a specified period of time.

1. A written notice of the suspension shall be issued to the licensee stating
   a. the details of the substandard performance
   b. the violation(s) of protocol and/or policy
   c. the term of suspension
   d. the remedial activity, if required
   e. the time allowed for the completion of the remedial activity

2. Notice of disciplinary action shall be forwarded to the licensee’s employer, if employed (or MCA board in the case of an agency provider).

3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.

4. If a licensee’s MCA privileges have been suspended from a licensee, the licensee shall not provide prehospital care until the MCA privileges are reinstated.

5. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.

### F. Revocation of Privileges

1. The notice of revocation shall state the violation(s) of protocol and/or policy.

2. Notice of disciplinary action shall be forwarded to the licensee’s employer (or MCA board in the case of an agency provider).

3. A copy of the **Disciplinary Action Appeal** policy shall be included in the notice to the licensee.
4. The Medical Control Authority must notify the department within one (1) business day of the removal of medical control privileges from a licensee.

5. Within one (1) business day of the removal of medical control privileges, the Medical Control Authority must notify all other Medical Control Authorities which it knows, or has reason to believe, have granted the licensee or agency Medical Control privileges.

G. Financial Penalties
The MCA may not apply financial penalties to individuals, per this policy. No such prohibition exists within statute; however, a MCA wishing to establish individual financial penalties must purposely develop an addendum to this policy.

H. PSRO Communications
PSRO protected entities may share PSRO information with other PSRO entities for the following purposes:

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

V. Alleged violations of administrative or operational protocol requirements by an EMS agency shall be resolved as follows:

A. The Medical Control Authority will notify the department chief or agency official of the alleged protocol violation.

B. Details of the alleged violation, and any response received from the EMS agency, will be presented to the MCA designated PSRO review body at their next meeting. The agency involved will be notified of and may attend the meeting and present any information it believes pertinent.

C. If the PSRO discussion will take place at an otherwise open meeting, the committee must go into closed session for PSRO purposes, prior to discussion. The predesignated PSRO of the MCA will then meet in closed session to perform the PSRO review. All parties not principal to the PSRO review shall be excluded from such a closed session review. No record of PSRO reviews shall be entered into the general minutes except to state that the committee entered/exited closed session for a PSRO review.

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3 MCL 331.532

MCA Name: Oakland County
MCA Board Approval Date: April 6, 2018
MCA Implementation Date: June 1, 2018
Protocol Source/References: Click here to enter text.
D. The PSRO of the MCA will review the alleged violation and by majority vote of the members present decide a course of action. Any sanction imposed shall follow the guidelines below:

1. Severity of the violation will determine the level of sanction to be imposed:
   a. A violation is considered “minor” if it involves administrative infractions, including but not limited to, failure to timely file reports.
   b. A violation is considered “serious” if it involves intentional operational issues, including but not limited to, a failure to provide staffing as required by statute.
   c. An otherwise minor violation that is frequent or recurring may be considered by the Medical Control Authority to be “serious” for purposes of this section.

2. If a minor protocol violation is determined by the Medical Control Authority to have occurred, a letter of warning will be sent to the EMS agency.

3. If an initial serious violation or a second minor protocol violation within a six month period is determined to have occurred, a letter of reprimand will be sent and the EMS agency may be required to submit, within 15 days, a written statement of actions it will take to prevent future protocol violations.

4. At the discretion of the Medical Control Authority, notice of these actions may be made public.

5. A MCA may assess restrictions or limitations upon a licensed life support agency for non-compliance with protocols.

E. If a third of more frequent minor protocol violation is determined by the Medical Control Authority to have occurred within a period of 18 months, or if the violation is a second serious violation within 18 months, the Medical Control Authority may suspend or revoke its medical control oversight for the EMS agency. The EMS agency shall not provide pre-hospital care until medical control is reinstated. At its discretion, the Medical Control Authority may take any other action within its authority to prevent further protocol violations. Notice of this action shall be made public.

F. An EMS agency may appeal a decision of the Medical Control Authority. The EMS Agency must follow the Disciplinary Action Appeal policy.

VI. A licensee must notify the MCA of disciplinary action from the State of Michigan.
Quality Improvement Policy

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

I. Confidentiality Assurance

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

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

II. Professional Standards Review Organization

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

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

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

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

E. All Quality Improvement activities shall be performed by the PSRO, and all documents collected for Quality Improvement activities shall be held
by the PSRO subject to Michigan’s peer review privilege.¹

III. Data Collection

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

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

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

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

E. Incident Report Collection

¹ MCL 331.531 et seq.
1. Incident reports and requests for additional information directed to an individual provider or to an EMS agency/department requested by the MCA/PSRO must be submitted to the MCA/PSRO within 96 hours.

2. The MCA may establish an online reporting system.

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

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

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

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

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

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

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

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

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

Purpose: To establish a process for the classification of Incidents reviewed by the MCA. Incidents will be divided into two categories, Level I and Level II.

Discretionary Powers
If the Medical Control Authority determines that an immediate threat to the public health, safety, or welfare exists, appropriate action to remove medical control privileges can be taken immediately and until the Medical Control Authority has had the opportunity to review the matter. A Professional Standards Review Organization (PSRO) hearing shall be held within three business days after the Medical Control Authority’s determination to remove medical control. The Medical Director or his /her designee shall determine the personnel needed for the hearing.

Receipt and Investigation of Incidents
When the MCA becomes aware of a potential violation of the state approved policies, procedures, protocols, or statutes, the Medical Director, his/her designee, or the PSRO of the MCA will investigate the complaint per the state approved Complaint Investigation Policy.

Classification of Complaints
Complaints determined to be valid will be reviewed and will be classified using the criteria below. These criteria are for example purposes and do not form an all-inclusive list of potential violations. Violations that are substantively similar in type or severity will fall under the closest, most appropriate classification category.

Level I Incidents
The following categories of incidents are defined as Level I incidents:
1. Willful neglect of a patient
2. Abandonment of a patient
3. Failure to obey a medical control physician's legitimate orders either by omission or commission in the presence of good communications.
4. Improper and inappropriate care which may result in compromise of wellbeing of the patient
5. Conviction of a felony or misdemeanor
6. Two or more Level II offenses in any six month period *
7. Breach of Confidentiality
8. Intentional falsification of EMS documentation, including patient care records.
9. Found to be under the influence of drugs or intoxicants while involved with patient care.
10. Violation of the EMS statute and its attendant rules and regulations, including care outside the scope of practice, as defined by protocol.
11. Practicing in the MCA without a current Michigan EMS provider license.
12. Practicing in the MCA without current privileges on two separate occasions within a single licensure period. Certifications required by the MCA in order to maintain privileges are identified in the Authorization for Medical Control Privileges Policy.
13. Any other patient care offense resulting from violation of policies, protocols and procedures of similar severity not listed above at the discretion of the EMS Medical Director.

14. Failure to complete prescribed remediation from a previous incident. (Or see #14 of LEVEL II)

15. Arrest or criminal charges for criminal sexual conduct of any degree, violent crime, drug diversion or illegal possession or distribution of controlled substances.

16. Failure to notify the MCA of a criminal charge, arrest or conviction within 1 business day

17. Gross negligence or willful misconduct

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

Level II Incidents

The following categories of incidents are defined as Level II incidents:

1. Failure to adhere to system protocols, policies and procedures that had the potential to negatively impact patient care, as determined by the EMS Medical Director.

2. Failure of personnel or agency to respond within 96 hours of receipt of requests for information or documentation regarding an incident under investigation by the MCA. A response shall be submitted in writing and with a signed delivery receipt to MCA staff within the allotted time period.

3. Abuse and/or loss of system equipment due to neglect.

4. Significant documentation errors

5. Failure to accurately perform procedures as defined in protocols, policies and procedures.

6. Failure to check and maintain functional equipment necessary to provide adequate patient care at the level of licensure, the failure of which may lead to an inability to communicate with medical control, inability to administer appropriate medications, or otherwise negatively affecting the ability of the personnel to function at his/her level of training in the field. This includes verification that a sealed drug and IV box, functional monitor/defibrillator, functional airway equipment, etc. are present on the unit.

7. Improper or unprofessional medical communications including, but not limited to, any violation of Federal Communications Regulations, and falsification of identification during medical communications.

8. Failure to appear before the EMS Medical Director, designated PSRO committee or MCA Governing Body when so requested by the MCA, as defined in the Complaint Investigation, Quality Improvement and Disciplinary Action Policies.

9. Furnishing of information known to be inaccurate in response to any official request for information relative to quality improvement activities or other investigations subsequent to this policy.

10. Two or more orders of disciplinary action within a 6 month period **
11. Any other patient care offense resulting from violation of policies, protocols and procedures of similar severity not listed above at the discretion of the EMS Medical Director.

12. Practicing in the MCA without current credentials required in order to maintain privileges, as identified in the Authorization for Medical Control Privileges Policy.

13. Medication error, which has a negative impact on patient care.

14. A determination by the designated PSRO Committee of failure to complete prescribed remediation within the prescribed time frame.

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

Due Process and Disciplinary Actions
The application of disciplinary measures shall be defined by the state approved Due Process and Disciplinary Action Protocol.

Appeal Process
An appeal may be filed according to the Disciplinary Action Appeal Protocol.

Reapplication after Revocation
Following revocation of an involved party's privilege to practice in the MCA, the involved party may reapply to the MCA for privileges after no less than 24 months have elapsed from the date of revocation. Those issued a permanent revocation may not reapply for privileges at any time.
EMS Quality Improvement Program (EQIP)

Purpose: The Oakland County Medical Control Authority (OCMCA) is responsible for verification of skills and knowledge of EMS personnel. To that end, the purpose of the EMS QI Program (EQIP) is to provide direction to Life Support Agencies (LSAs) with respect to quality improvement and verification of skills and knowledge. EQIP will provide a uniform, standardized, systematic, and responsible quality improvement program through education and OCMCA support.

I. EQIP Components

The Program consists of three components:

1. **Skill and knowledge verification process**
   a. Education: All OCMCA LSA’s will provide EMS skill and knowledge education to their personnel as directed by the OCMCA. All LSA’s will be provided with the necessary education materials to complete the training requirements.
   b. LSA Verification: All LSA’s will submit an OCMCA EQIP CE Completion form that signifies that all skill and knowledge education was conducted as described by the OCMCA PSRO Committee. This standardized form will acknowledge that the training was successfully completed, and all related skills and knowledge have been verified by the LSA. LSA’s will maintain all related training records for a minimum of five (5) years.
   c. OCMCA Verification: OCMCA will verify the completion of all skills and knowledge education as dictated by the OCMCA PSRO Committee by reviewing each LSA’s OCMCA EQIP CE Completion Form. Any LSA that does not complete skills and knowledge education as dictated by the PSRO Committee will be subject to an OCMCA EQIP CE Audit. In addition, all LSA’s are subject to a random OCMCA EQIP Audit to verify that the training was conducted completely and that adequate records were maintained.

2. **Required data reporting – Quarterly**
   a. All OCMCA LSA’s will provide a quarterly report (provided in template form) to the PSRO that verifies the following data:
      1. Comparison of e-PCR forms submitted to LSA’s vendor with MI-EMSIS, to include:
         • Number of runs in LSA’s vendor and number of MI-EMSIS runs.
         • Other, as requested by PSRO.
      2. 100% of cardiac arrests submitted to CARES.
      3. 100% Multiple Casualty Incident (MCI) PCRs.
      4. 100% of requested information pertaining to PSRO studies.
3. Measurement of protocol knowledge
   a. The PSRO will analyze the protocol knowledge assessments methods and results to determine the most appropriate assessment parameters for each EMS license level (MFR, EMT-Basic, Paramedic).
   b. 100% of all OCMCA LSA EMS personnel will participate in a protocol knowledge assessment. This assessment will be a multiple-choice test created and administrated by the OCMCA PSRO Committee, and kept confidential.

II. EQIP Compliance
   1. All OCMCA LSA’s and their EMS personnel must comply with all EQIP components. Any LSA and/or EMS personnel that do not comply with EQIP components are subject to PSRO review.
   2. Any LSA that fails to send a representative to any mandatory EQIP in-service, without prior notification, will be subject to PSRO review and possible sanctions.
EMS Research Policy

General Principles:
The OCMCA generally supports EMS Research for the purpose of improving system efficiencies, patient outcomes, cost burden, quality and safety. The OCMCA reserves the right to review, recommend edits, approve or deny proposed research affecting the pre-hospital system in Oakland County,

Confidentiality:
The confidentiality rights of patients, agencies, and hospitals should be preserved in all cases. No patient, agency or hospital identifying data will be reported without their expressed written approval. Case reports may be considered under special circumstances with approval by the OCMCA, and the patient, agency and hospital involved.

Review Process:
The OCMCA reserves the right to review, recommend edits, approve or deny proposed research as stated above. The OCMCA PSRO Committee will perform this initial review. Only approvals by PSRO will be recommended for action by the MCC and final action by OCMCA Board.

Hospital-based research projects must be approved by the applicable hospital’s Institutional Review Board before final approval by the OCMCA.

The OCMCA reserves the right to remove its support of any approved study at any time and thereby terminate its allowance of the research project being conducted with respect to patients, hospitals, LSAs and providers located in OCMCA’s region.

Authorship:
The OCMCA may require periodic updates of the research status from a Principal Investigator.
Confidentiality Statement

Responsibilities:

The responsibilities of the PSRO Committee shall be to:

1. Assess, investigate and when necessary, make recommendations to OCMCA Board pertaining to issues of concern regarding non-compliance with OCMCA policies, procedures or protocols posed by any person(s) regarding Oakland County EMS activities. Investigations will be processed in accordance with OCMCA Protocols.

2. Regularly assess quality assurance processes performed by Oakland County Life Support Agencies and their professional personnel through an audit process using data provided by the agencies and other system participants.

3. Develop an annual plan and perform study evaluations for the purpose of EMS system assessment and improvement of processes, protocols, EMS personnel, equipment, medications, etc. that may affect patient outcomes. Additional studies can be conducted on an ad hoc basis as issues arise or system deficiencies are recognized.

4. Assess agency and facility applications, reapplications, and compliance with OCMCA protocols, policies, and PSRO recommendations.

5. Provide additional planning, coordination, monitoring and evaluation of the EMS system within Oakland County as it relates to the quality of care provided by individuals and Life Support Agencies within the system, or as designed by the OCMCA Board.

Expectations:

1. All data, discussions, deliberations, documents, correspondence, materials and any other information either written or verbal shared either within the PSRO meeting setting or provided or generated in connection with carrying out the responsibilities of the PSRO are confidential, are not public records, may not be used for other purposes, and are protected by federal and state laws. Furthermore, these items and information as outlined are not to be discussed or disseminated to any person not currently serving as a PSRO member or staff.

2. As an active member of the PSRO Committee I am committed to maintaining the confidentiality practices of this Committee as stated in the OCMCA Protocols and state law. I understand that if I breach the aforementioned confidentiality I may be dismissed from this Committee.

Date: ________________________________

Signature: ____________________________

Printed Name: __________________________
Provisional Designation of Adult and Pediatric Trauma Facilities

Purpose
To allow a process for a hospital to obtain Provisional designation to participate in the Oakland County Medical Control Authority (OCMCA) as a Level I or Level II Adult and/or Pediatric Trauma Center, or a Level III Trauma Center.

Process
A hospital requesting to participate in the Oakland County Medical Control Authority as a Level I or Level II Adult and/or Pediatric Trauma Center, or a Level III Trauma Center must meet the following criteria:

1. Must be verified by the American College of Surgeons (ACS) as an Adult or Pediatric Level I, Level II Trauma Center or Level III Trauma Center.

OR

2. Be granted a one-time PROVISIONAL status as a Trauma Center, by the Oakland County Medical Control Authority for no longer than 24 months. Only those facilities that have had a consultative visit by the American College of Surgeons shall be eligible for consideration as PROVISIONAL. Facilities requesting such status are subject to ALL of the following:
   A. Hospitals seeking Provisional status must submit an application to the PSRO Committee requesting provisional designation, including ACS Consultative Visit Summary. Any major deficiencies will not be granted Provisional status until further documentation of acceptable corrective action is submitted to PSRO. Minor deficiencies will be reviewed by PSRO.

   B. The PSRO Committee will review application submitted by the hospital. Based upon the findings of the PSRO, a recommendation will be submitted to the OCMCA Board of Directors, which shall make the final determination regarding approval of Provisional status.

   C. Hospitals that have been granted Provisional status must have their final verification survey by ACS completed within 18 months of date application was submitted with a letter of verification from ACS within 24 months.

   D. If granted Provisional status, the hospital must limit its activities to those authorized by the level of verification being sought.

   E. Hospitals obtaining Provisional status shall comply with all requirements established by the American College of Surgeons that must be met for the level of verification being sought.

   F. Hospitals obtaining Provisional status must submit progress reports to the Oakland County Medical Control Authority’s PSRO every six months during the 18-month period necessary to complete verification process.

3. If approved by the OCMCA, the hospital will be added to the list of Oakland County participating trauma facilities with a notation that status is provisional.
Rerouting Policy

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

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

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

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

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

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

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

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

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

   **STATUS A:** Accepting patients appropriate for that emergency facility.

   **STATUS B:** Emergency facility’s capabilities are limited. Services or resources not available should be specified, and that facility’s use avoided for patients requiring them.

   **STATUS C:** The emergency facility meets the criteria to reroute EMS patients (see A.).
I. Facility
   1. Each facility shall have and follow their internal rerouting policy.
   2. Patients will not be rerouted on the basis of ability to pay.
   3. On-line medical control, via participating Medical Control hospitals, will remain available at all times.
Safe Delivery of Newborns

Purpose

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

Definitions

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

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

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

Procedures

1. The surrender of the infant must occur inside the fire department, police station or in response to a 9-1-1 emergency call to paramedics or EMT.
2. To protect the parent’s right to anonymity/confidentiality, the EMS agency responding to a 9–1–1 emergency call from a parent(s) wanting to surrender a newborn, should not use the vehicle sirens or flashing lights.
3. The firefighter, police officer, paramedic or EMT personnel cannot refuse to accept the infant and must place the infant under temporary protective custody.
4. Fire departments, police stations, paramedics and EMTs have statutory obligations under the law, including:
   a. Assume that the child is a newborn and take into temporary protective custody.
   b. Ask surrendering person(s) if they are the biological parent(s). If they are not the biological parent(s) the newborn cannot be surrendered under the Safe Delivery of Newborns law.
   c. Make a reasonable effort to inform the parent(s) that:
      i. By surrendering the newborn, the parent(s) is releasing the newborn to a child placement agency to be placed for adoption.
      ii. He or she has 28 days to petition the Circuit Court, Family Division to regain custody of the newborn.
      iii. There will be a public notice of this hearing and the notice will not contain the parent(s) name.
      iv. The parent(s) will not receive personal notice of the hearing.
v. Information the parent(s) provides will not be made public. A parent(s) may contact the Safe Delivery of Newborns hotline for information. The toll free number is: 866-733-7733

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

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

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

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

* For Safe Delivery purposes EMS is defined as a paramedic or emergency medical technician.
Michigan’s Safe Delivery of Newborns Law

FACT Sheet

SAFE. LEGAL. ANONYMOUS.

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

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

What are the rights of the surrendering parent?
- To be informed that by surrendering the newborn, the parent is releasing the newborn to a child placing agency to be placed for adoption.
- To petition the court to regain custody of the newborn within 26 days of surrender or notice of surrender.
- Any information the parent(s) provides the ESP will not be made public.
- A criminal investigation shall not be initiated solely on the basis of a newborn being surrendered to an ESP.
- To file a consent to release identifying information with the Adoption Central Registry.
# CONFIDENTIAL

## VOLUNTARY MEDICAL BACKGROUND FORM FOR A SURRENDERED NEWBORN

**Michigan Department of Human Services**

<table>
<thead>
<tr>
<th>Preference for Child's Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where was the child born?</td>
<td></td>
</tr>
<tr>
<td>SURRENDERING PARENT BACKGROUND (Optional)</td>
<td></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Marital Status</strong></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Affiliated with American Indian Tribe</td>
</tr>
<tr>
<td><strong>Height</strong></td>
<td><strong>Weight</strong></td>
</tr>
</tbody>
</table>
| Any Family History of:  
  Sickle Cell Disease | Yes | No | Cancer | Yes | No | If Yes Type  
  Heart Disease | Yes | No | Genetic Disease | Yes | No | If Yes Type  
  Diabetes | Yes | No | Family History of Mental Illness | Yes | No | If Yes Type  
  HIV | Yes | No | Drug Usage | Yes | No | If Yes Type  
  Hepatitis | Yes | No | Alcohol Usage | Yes | No | If Yes Type  
  Other | Yes | No |  
| Surgical History |
| OTHER PARENT BACKGROUND (Optional) |
| **Name** | **Marital Status** | **Date of Birth** | **Phone Number** |
| Address |
| Race | Affiliated with American Indian Tribe | Identify Tribe |
| **Height** | **Weight** | **Hair Color** | **Eye Color** |
| Any Family History of:  
  Sickle Cell Disease | Yes | No | Cancer | Yes | No | If Yes Type  
  Heart Disease | Yes | No | Genetic Disease | Yes | No | If Yes Type  
  Diabetes | Yes | No | Family History of Mental Illness | Yes | No | If Yes Type  
  HIV | Yes | No | Drug Usage | Yes | No | If Yes Type  
  Hepatitis | Yes | No | Alcohol Usage | Yes | No | If Yes Type  
  Other | Yes | No |  
| Surgical History |
| INFORMATION ABOUT THE PREGNANCY |
| **Length of Pregnancy** | **Weight Gain** | **Drug or Alcohol Use During Pregnancy** | **Lbs.** | Yes | No | If yes, Explain |
| EMERGENCY SERVICE PROVIDER OBSERVATIONS |
| **Comments** |
| **ESP Signature** | **Date** | **Phone Number** |
| **Address.** | **City** | **State** | **Zip Code** |

DHS-4819 (Rev. 4-11) Previous edition obsolete. MS Word
VOLUNTARY RELEASE FOR ADOPTION OF A SURRENDERED NEWBORN BY PARENT
Michigan Department of Human Services

In the matter of ________________________, a newborn child.

1. I, ________________________, DOB __/__/____ am the □ mother □ father of the above child, who was born on __/__/____ at _________ (place).

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

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

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

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

6. I acknowledge receipt of the following:
   _____ Fact Sheet (Pub 867)
   Date __/__/____ Parent Signature ______________________________
   Address ______________________________________________________
   City __________________________ State ____ Zip __________

   Witnessed by
   ____________________________
   Name (type or print)
   ____________________________
   on ____________ at ____________________________
   Date _______ Agency and Address ________________

   ____________________________
   Signature: ____________________________

   IF A NOTARY IS AVAILABLE: Notary Public
   Subscribed and sworn to before me on ____________
   Date ____________ County and State ________________
   My commission expires: ____________
   Signature: ____________________________

   ____________________________
   Date ____________
   Name (type or print)

AUTHORITY: State P.A. 232 of 2000
RESPONSE: Voluntary
PENALTY: None

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
Scene Patient Management

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

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

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

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

“Call Jumping” will be dealt with accordingly and reported to the appropriate agency.

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

Pre-Radio
MFR/EMT/SPECIALIST/PARMEDIC
1. Insure patient is restrained prior to removal of Taser prongs, if necessary.
2. Remove prongs following manufacturer’s recommendations.
3. Treat entry wounds, as needed.
4. Obtain a baseline set of vitals and assess patient for potential secondary injuries.
5. If findings are outside of normal limits or patient presents with a medical condition, follow the General Pre-Hospital Care Protocol.

NOTE: Consult local law enforcement to determine manufacture and appropriate means of removal procedure.
Transportation Protocol

Purpose: To define the decision-making process to be followed by EMS personnel in order to ensure patients are transported to a facility appropriate for their condition.

I. Transportation Procedure

A. Priority 3 patients (medical or trauma): Shall be transported to an appropriate Emergency Facility of the patient’s or patient’s family choice, or closest if no preference (See Appendix 1).

- Patient Priority is defined in the Patient Prioritization Protocol 8.24 for criteria.
- For psychiatric emergencies, transport patient to the closest facility per the Psychiatric Emergencies Protocol 1-8.

B. Priority 1 and 2 (medical) Patients: shall be transported to the closest appropriate Emergency Facility, unless one of the following conditions exist:

1. ST Elevation Myocardial Infarction (STEMI) - Acute
   Patients with presumed acute myocardial infarction shall be transported to an interventional cardiac facility (see Appendix 2). Notify receiving hospital, as soon as possible, of impending arrival of a “STEMI ALERT” patient and give ETA.
   - See Chest Pain/Acute Coronary Syndrome Protocol 5.5 for STEMI criteria.

2. Return of Spontaneous Circulation (ROSC)
   Patients with ROSC, in most circumstances will be transported to an interventional cardiac facility (see Appendix 2). Notify receiving hospital, as soon as possible, of impending arrival of the patient and give ETA.

3. Burns
   After receiving approval from the medical control hospital, transport to the closest appropriate facility (see Appendix 3). Notify destination hospital as soon as possible of impending arrival of the patient and give ETA.
   - See Burns Protocol 2.3 for criteria.

4. Stroke
   If Cincinnati Stroke Scale is abnormal, notify receiving hospital as soon as possible of impending arrival of a “STROKE ALERT” patient, with the time the patient was “last seen normal” and give ETA. Transport to closest appropriate stroke facility (see Appendix 4).
   - See Stroke Protocol 3.2 for criteria.

5. Obstetrical
   Pregnancy greater than 20 weeks, transport to an OB facility (see Appendix 5). Notify receiving hospital, as soon as possible, of impending arrival of the patient and give ETA.
   - See Obstetrical Emergencies Protocol 4.2 for criteria.

6. Pediatrics (medical)
   Transport after receiving approval from the closest appropriate facility (see Appendix 1). Notify hospital as soon as possible of impending arrival of the patient and give ETA.
C. **Priority 1 and 2 (trauma) Patients:** Patients meeting any of the trauma criteria in Appendix 6, but not in cardiac arrest, should be transported to a trauma center (see Appendix 6).
   - Pediatric trauma patients should be transported to a Pediatric Trauma Center (age ≤ 14 yrs.) (see Appendix 6).
   - OB trauma patients must be transported to a trauma center with OB capabilities (see Appendix 6).

**Note:** Requests for transport to hospitals outside of the OCMCA, based on provider discretion and when medically appropriate, may be honored. For questions, contact online Medical Control.

II. **ALS Intercept Procedure**
   When a transporting BLS Agency responds to an EMS request and subsequently initiated patient transport to a receiving Hospital, and an ALS Agency has been simultaneously dispatched to the same EMS request, ALS intercept will only occur:
   1. When ALS intercept would probably result in an improved patient care outcome.
   2. With Medical Control approval.
   3. When requested by the transporting BLS Agency.

III. **Inter-County EMS Response and Transporting Procedure**
   In the pre-hospital setting, emergency medical services situations occurring in proximity to a county line are the responsibility of the Medical Control Authority in which the situation occurred. As such, the responding EMS unit will operate under their home MCA protocols.
Appendix 1

Approved Emergency Facilities

The following approved emergency facilities are defined as **appropriate** by the Oakland County Medical Control Authority. Note: Unstable patients are not appropriate for freestanding surgical outpatient facilities or provider-based emergency departments (ED) unless, in the opinion of the EMS personnel or on-line medical control physician, transporting the patient to a further facility could have an adverse effect on the patient’s outcome. Priority one patients are not appropriate for freestanding surgical outpatient facilities or provider-based emergency departments (ED).

- Ascension Genesys Hospital
- Ascension Macomb – Oakland Hospital, Madison Hts. Campus
- Ascension Providence Novi Campus
- Ascension Providence Rochester Hospital
- Ascension Providence Southfield Campus
- Beaumont Hospital – Farmington Hills
- Beaumont Hospital – Royal Oak
- Beaumont Hospital – Troy
- Children’s Hospital of MI - Troy (Provider-based ED for pediatric patients, only)
- DMC Huron Valley – Sinai Hospital
- Henry Ford West Bloomfield Hospital
- McLaren – Clarkston (provider-based ED)
- McLaren – Oakland Hospital
- St. Joseph Mercy Oakland Hospital
- St. Mary Mercy Livonia Hospital
Appendix 2

Approved Interventional Cardiac Facilities

The following approved emergency facilities are defined as *appropriate* by the Oakland County Medical Control Authority for interventional cardiac patients. Receiving hospital may elect to activate the cath lab without transmission of 12 Lead EKG.

Interventional Cardiac Centers (ICC): Hospitals with 24/7 interventional cardiac catheterization labs.

1. Oakland County ICC
   - Ascension Genesys Hospital
   - Ascension Providence Novi Campus
   - Ascension Providence Rochester Hospital
   - Ascension Providence Southfield Campus
   - Beaumont Hospital – Farmington Hills
   - Beaumont Hospital – Royal Oak
   - Beaumont Hospital – Troy
   - DMC Huron Valley – Sinai Hospital
   - Henry Ford West Bloomfield Hospital
   - St. Joseph Mercy – Oakland
   - St. Mary Mercy Livonia Hospital
Appendix 3

Approved Burn Centers

The following approved emergency facilities are defined as appropriate by the Oakland County Medical Control Authority for burn patients meeting the criteria and with medical control.

Out-of-County

Adult Burn Centers
- DMC Detroit Receiving Hospital
- University of Michigan – Ann Arbor
- Hurley Medical Center

Pediatric Burn Center
- Children’s Hospital of Detroit
Appendix 4

Approved Stroke Facilities

The following approved emergency facilities are defined as **appropriate** by the Oakland County Medical Control Authority for stroke patients meeting the criteria and with medical control.

- Ascension Genesys Hospital
- Ascension Macomb – Oakland Hospital, Madison Hts. Campus
- Ascension Providence Novi Campus
- Ascension Providence Rochester Hospital
- Ascension Providence Southfield Campus
- Beaumont Hospital – Farmington Hills
- Beaumont Hospital – Royal Oak
- Beaumont Hospital – Troy
- DMC Huron Valley – Sinai Hospital
- Henry Ford West Bloomfield Hospital
- McLaren – Oakland
- St. Joseph Mercy Oakland Hospital
- St. Mary Mercy Livonia Hospital
Appendix 5

Approved OB Facilities

The following approved emergency facilities are defined as **appropriate** by the Oakland County Medical Control Authority for non-traumatic **Obstetrical** patients meeting the criteria and with medical control.

- Ascension Genesys Hospital
- Ascension Providence Novi Campus
- Ascension Providence Rochester Hospital
- Ascension Providence Southfield Campus
- Beaumont Hospital – Farmington Hills
- Beaumont Hospital – Royal Oak
- Beaumont Hospital – Troy
- DMC Huron Valley – Sinai Hospital
- Henry Ford West Bloomfield Hospital
- St. Joseph Mercy Oakland Hospital
- St. Mary Mercy Livonia Hospital
Appendix 6

I. Trauma Criteria

Criteria for Transport to Level 1 and 2 Trauma Centers Only:

Vital Signs
- Glasgow coma scale ≤13
- Systolic blood pressure < 90 mmHg
- Respiratory rate < 10 or > 29 breaths per minute: Infant < 20; aged < 1 year, or need for ventilatory support

Anatomy of Injury
- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved or mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fractures
- Paralysis

Criteria for Transport to a Level 1, 2 or 3 Trauma Center

Mechanism of Injury
- Falls
  - Adults >20 feet (one story is equal to 10 feet)
  - Children >10 feet or two to three times the height of the child
- High-risk auto crash
  - Intrusion, including roof: >12 inches occupant site; >18 inches on any site
  - Ejection (partial or complete) from the automobile
  - Death in the same passenger compartment
  - Vehicle telemetry data consistent with a high risk of injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20mph) impact
- Motorcycle crash >20 mph

Special Considerations
- Older adults:
  - Risk of injury/death increases after 55 years
  - SBP <110 might represent shock after age 65 years
  - Low impact mechanisms (e.g. ground level falls) might result in severe injury.
- Children:
  - Should be triaged preferentially to pediatric-capable trauma centers
- Anti-coagulation and bleeding disorders
  - Patients with head injury are at high risk for rapid deterioration
• Burns
  Without other trauma mechanism: triage to a burn facility
  With trauma mechanism: triage to a trauma center
• Pregnancy >20 weeks (with OB/Neonatal Capabilities)
• EMS provider judgment

Note: The patient will be transported to the closest appropriate Trauma/Specialty Centers. EMS personnel, taking into account distance, weather, construction or time of day will determine destination.

II. Approved Trauma Facilities
The following approved emergency facilities are defined as appropriate by the Oakland County Medical Control Authority for trauma patients.

Trauma Centers (A hospital verified ACS 1 or 2)
1. Oakland County Trauma Center
   ➢ Ascension Genesys Hospital
   ➢ Ascension Providence Novi Campus (Provisional Level 2)
   ➢ Ascension Providence Southfield Campus
   ➢ Beaumont Hospital – Farmington Hills
   ➢ Beaumont Hospital – Royal Oak
   ➢ Beaumont Hospital – Troy
   ➢ McLaren – Oakland
   ➢ St. Joseph Mercy Oakland
   ➢ St. Mary Mercy Livonia Hospital

Trauma Centers (A hospital verified ACS 3)
   ➢ Ascension Providence Rochester Hospital
   ➢ Henry Ford West Bloomfield Hospital

Pediatric Trauma Center
1. Oakland County Trauma Center
   ➢ Beaumont Hospital – Royal Oak
2. Out-of-County Trauma Centers
   ➢ Hurley Hospital – Flint
   ➢ Children’s Hospital – Detroit
   ➢ St. John Hospital and Medical Center - Detroit
   ➢ University of Michigan – Ann Arbor

Trauma Center with Neonatal capability
1. Oakland County Trauma Center
   ➢ Beaumont Hospital – Royal Oak
2. Out-of-County Trauma Centers
   ➢ Hurley Hospital – Flint
   ➢ Children’s Hospital – Detroit
   ➢ University of Michigan – Ann Arbor
Use of Lights and Sirens

Purpose
To provide a countywide policy on the appropriate use of lights and sirens.

Procedure
A. Michigan Motor Vehicle Code (Public Act 300, Sections 257.603 and 257.653), the Michigan Motor Vehicle Code governs the driving of emergency vehicles. All Oakland County EMS Agencies will abide by the Michigan Motor Vehicle Code.

B. Responding to Calls
1. EMS units may respond to requests for service with lights and sirens where there is:
   • a threat to life
   • a threat to limb
   • a threat of personal injury
   • an unknown situation
2. 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.

C. Transporting a Patient
1. EMS units may transport patients with lights and sirens when:
   • the patient is determined to be a priority 1 patient.
   • the patient is determined to be a priority 2 patient AND their condition is unstable during the course of the transport or the patient becomes violent.
   • the patient is a stable priority 2 or priority 3 when transport is initiated, but the patient’s condition deteriorates en route to the hospital.
2. Priority 3 patients will NOT be transported with the use of lights and sirens.

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 as described in B. above.
2. Lights and sirens will NOT be used to return to an area when the unit is not responding to another emergency call.

E. Agency Specific Policies
This policy does not preclude individual agencies from developing internal policies on this subject, as long as the policy includes the contents of this policy as a minimum.
**Violent/Chemical/Hazardous Scene**

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

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

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

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

II. In any situation in which the scene is not secured, EMS personnel ARE NOT TO ENTER THE SCENE until it has been secured by the appropriate agency.
   A. When responding to an unsecured scene, EMS personnel will stage an appropriate distance away from the scene to protect themselves from danger.

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

**Special Considerations:** For those patients, who have been contaminated in a hazardous material incident, refer to **Contaminated Patient Procedure**
**Waiver of EMS Patient Side Communication Capabilities**

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

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